MALCOR
MEDICAL AID SCHEME
Administered by Discovery

Malcor Medical Aid Scheme

BENEFIT GUIDE
2020

INFORMATION

in this benefit brochure

A HEALTHY APPROACH
to quality and care in 2020

Malcor Medical Aid Scheme provides excellent healthcare benefits that would truly make a difference in the lives of you and your loved ones. You have complete peace of mind that your healthcare is in good hands at every stage of your health journey.

We have designed this benefit guide to provide you with a summary of information on how to get the most out of the Scheme's benefits. To see what we have in store for you in 2020, you can also access the guide on the homepage of the website **www.malcormedicalaid.co.za.**

This brochure provides you with a summary of the benefits and features of the Malcor Medical Aid Scheme, pending approval from the Council for Medical Schemes. The Malcor Medical Aid Scheme is a closed Scheme, and is administered by Discovery Health (Pty) Ltd.

This brochure gives you a brief outline of the benefits Malcor Medical Aid Scheme offers. This does not replace the Scheme Rules. The registered Scheme Rules are legally binding and always take precedence.

Detailed benefit documents may be obtained from **www.malcormedicalaid.co.za > Find a document** if you are registered as an online user. Please share this information with your dependants who are your beneficiary members of the Malcor Medical Aid Scheme.

About this benefit guide

This booklet serves as a guide to the Malcor Medical Aid Scheme. It consists of information about your membership and benefits. This Benefit Guide is merely a summary of the benefits and features of the Malcor Medical Aid Scheme plans and is subject to the Rules of the Malcor Medical Aid Scheme. The Rules of the Scheme will apply in all circumstances. Members who require further information should contact their personnel departments or the Scheme at **0860 100 698**.

WHO CAN JOIN the Malcor Medical Aid Scheme?

The Malcor Medical Aid Scheme is a restricted-access medical scheme for a number of associated employer groups. An employer is defined as 'any company or organisation that was previously a subsidiary or an associated company of Malbak Limited at the time of the latter's dissolution in 1996, or has subsequently been acquired by such companies or organisations'. Employers currently making use of the Malcor Medical Aid Scheme include, but are not limited to, Unitrans Automotive, Defy Appliances (Pty) Ltd, Aspen Holdings (Pty) Ltd and Omnia Holdings Limited.

Membership is available to all employees of approved employers subject, in certain cases, to the satisfactory outcome of a medical examination.

Who may join as your **DEPENDANT**?

- Your spouse or partner in a committed and serious relationship similar to marriage, including mutual dependency and both partners living in a shared and common household.
- Your children can be added as dependants on your health plan. Your child needs to be financially dependent on you to qualify for cover as an adult dependant. They may be students, or are mentally or physically disabled.
- You have 30 days in which to register a new spouse. We count the 30 days from the date of marriage.
- You have 30 days in which to register a newborn baby. We count the 30 days from the date of birth.

GENERAL GUIDELINES
on the Malcor Medical Aid Scheme

- Members and their dependants are entitled to benefits from the date their membership commences as reflected on their membership cards.
- There are certain limitations and exclusions applicable to all members. To avoid incurring personal liability for medical treatment, members should, if in any doubt, refer to the Scheme's Rules or contact the Scheme for clarification prior to agreeing to such treatment.
- The Scheme is, according to the Medical Schemes Act, allowed to apply a Late-Joiner Penalty (LJP) to an applicant or to the dependant of an applicant who fits the definition of a late-joiner. The LJP fee is a percentage increase in a member's contribution. It is a lifetime penalty that is not be removed, even when members move from one registered South African medical scheme to another.
- It is recommended that members who are about to embark on any costly treatment that does not require specific pre-authorisation, such as orthodontic treatment, submit quotations to the Scheme to obtain information about the extent to which the Scheme will cover the proposed treatment.
- PLAN D members might be required to pre-authorise all benefits BEFORE consulting with service providers. You may confirm benefits by calling Enablemed on **0860 002 402**.
- Annual limits are apportioned according to the period of membership in relation to the benefit year i.e. 1 January to 31 December. Thus your benefit limits will be prorated if you join during the benefit year.

Four innovative cover plans

Plan A

A traditional, fully comprehensive plan designed for those seeking complete healthcare cover

Excellent out-of-hospital limits

All in-hospital costs are covered at 100% of the Scheme Rate.

Plan B

A traditional, fully comprehensive plan designed for those seeking decent healthcare cover

Good out-of-hospital limits

All in-hospital costs are covered at 100% of the Scheme Rate.

Plan C

A traditional, fully comprehensive plan designed for those seeking basic healthcare cover

Limited out-of-hospital cover

All in-hospital costs are covered at 100% of the Scheme Rate.

Plan D

Low-cost, network option administered by Enablemed

Choice of own GP and access to private hospitals

Chronic medicine is covered as set out in the Prescribed Minimum Benefit guidelines and includes chronic illnesses that are on the Chronic Disease List.

Pre-authorisation for hospitalisation

You must call the Malcor Medical Aid Scheme on **0860 100 698** to get pre-authorisation for all your hospital treatment, except in the case of an emergency.

You will be given an authorisation number if your treatment is approved. In the case of an emergency where you are unable to phone the Malcor Medical Aid Scheme to obtain authorisation in advance, you or a family member must call the Scheme within three days from the date of admission.

If you do not obtain authorisation, the Scheme will not pay the claims.

Pre-authorisation is also required for the following treatment

- Chronic renal dialysis
- Oncology and radiotherapy
- Hospice
- Sterilisation
- Infertility treatments
- Step-down and rehabilitation facilities in the private sector
- Specialised dentistry in hospital
- Registered nursing services
- Super antibiotics
- Biologicals.

Helping you get the **MOST OUT OF YOUR COVER**

MAKE THE **FULL COVER CHOICE**

We offer members the choice to be covered in full for hospitalisation, specialists (in-hospital), chronic medicine and GP consultations. Look out for the Full Cover Choice stamp in this benefit guide. It shows you when to use our range of online tools that guide you to full cover.

Remember that your claims are still subject to the overall annual limit. We have payment arrangements with certain GPs. These GPs agree to join the Discovery Health GP Network to which you have access.

We will refer to the networks and payment arrangements throughout the Benefit Guide.

MEMBERS ON THE MALCOR MEDICAL AID SCHEME MAY HAVE A CO–PAYMENT **FOR IN- AND OUT-OF-HOSPITAL SPECIALIST COVER**

If you are treated by a specialist out-of-hospital, the Malcor Medical Aid Scheme will cover up to 120% of the Scheme Rate for Plan A and 100% of the Scheme Rate for Plan B and C. Please log in to the Malcor Medical Aid Scheme website at **www.malcormedicalaid.co.za > Doctor visits > Find a healthcare professional** to find your nearest in-hospital network specialist at a DSP hospital for full cover. The Malcor Medical Aid Scheme has selected the following hospitals as as the Scheme's in-hospital

Designated Service Provider (DSP) or 'network':

- **National**

  All MediClinic hospitals

- **Kwazulu-Natal**

  Busamed Gateway

  Busamed Hillcrest

- **East London**

  Life East-London

- **Port-Elizabeth**

  Life St George's

The Scheme will cover up to 100% of the Scheme Rate if you are treated by a specialist in-hospital, who is not part of the network.

WHEN YOU NEED TO **GO TO THE DOCTOR**

Our Medical and Provider Search Advisor (MaPS) tool helps you find a healthcare professional with whom we have an agreement. These healthcare professionals have agreed to only charge you the Scheme Rate and we pay them in full.

Log in to **www.malcormedicalaid.co.za** and click on **Doctor visits > Find a healthcare professional**. You will be able to search for providers by geographical location or speciality. Each provider shown on the MaPS tool is shown with a tag to indicate whether or not they are a network doctor.

GP NETWORK DOCTORS ARE PAID DIRECTLY IN FULL

When you see a GP in the GP Network, their consultation cost will be paid in full. If you choose to use a GP that is not in the network, the Scheme will reimburse your consultation at the Scheme Rate.

Please log in to the Malcor Medical Aid Scheme website at **www.malcormedicalaid.co.za > Doctor visits > Find a healthcare professional** to find your nearest participating GP.

COMPREHENSIVE MATERNITY AND POST-BIRTH BENEFITS

Members on **Plan A** and **Plan B** will have access to Comprehensive maternity and post-birth risk benefits. Members will be further supported through access to 24/7 support, advice and guidance. These benefits do not affect member's day-to-day benefits and are funded from the risk benefit at the Scheme Rate. The benefit must be activated by the member by dialing **0860 100 698.**

Benefits during Pregnancy

- Antenatal Consultations: 12 visits to a GP, gynaecologist or midwife
- Ultrasound Scans & Prenatal Screening: Up to 2 ultrasound scans, 1 nuchal translucency or Non-Invasive Prenatal Test (NIPT) or down syndrome screening test covered
- Blood Tests: Defined list of tests per pregnancy
- Antenatal Classes or Consultation with a nurse: Up to 5 pre or post natal classes or consultations with a registered nurse
- Private Ward Cover: up to R2 070 p/day (Plan A only)
- Essential registered devices: up to R4 000 (Plan A) R2 000 (Plan B) e.g. breast pumps and smart thermometers.

Post-birth Benefits

- Post natal classes or consultation with a nurse: 5 pre or post natal classes or consultations with a registered nurse
- GP & Specialist Consultations: Up to 2 visits with a GP, paediatrician or ENT for baby
- Six Week Consultation: 1 six week post-birth consultation with a GP or gynaecologist
- Nutrition Assessment: 1 nutrition assessment with a dietician
- Mental Health: 2 mental health consultations with a GP, gynaecologist or psychologist
- Lactation Consultation: 1 lactation consultation with a registered nurse or lactation specialist.

COVER FOR **GOING TO CASUALTY**

If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your Hospital Benefit, as long as we confirm your admission. If you go to a casualty or emergency room and you are not admitted to hospital, the Scheme will pay the claims from your out-of-hospital benefits. Some casualties charge a facility fee, which we do not cover.

CHRONIC ILLNESS
Cancer and HIV cover

Cover for chronic medicines

The following guidelines apply to chronic medication covered by the Scheme

The Chronic Illness Benefit covers approved medicine for the 27 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions, including HIV and AIDS. The Scheme will fund approved medicine on the medicine list or medicine with the same active ingredient as the approved medicine up to the Maximum Medical Aid Price (MMAP). Medicine not on the medicine list will be funded from the Acute Medicine limit or by yourself.

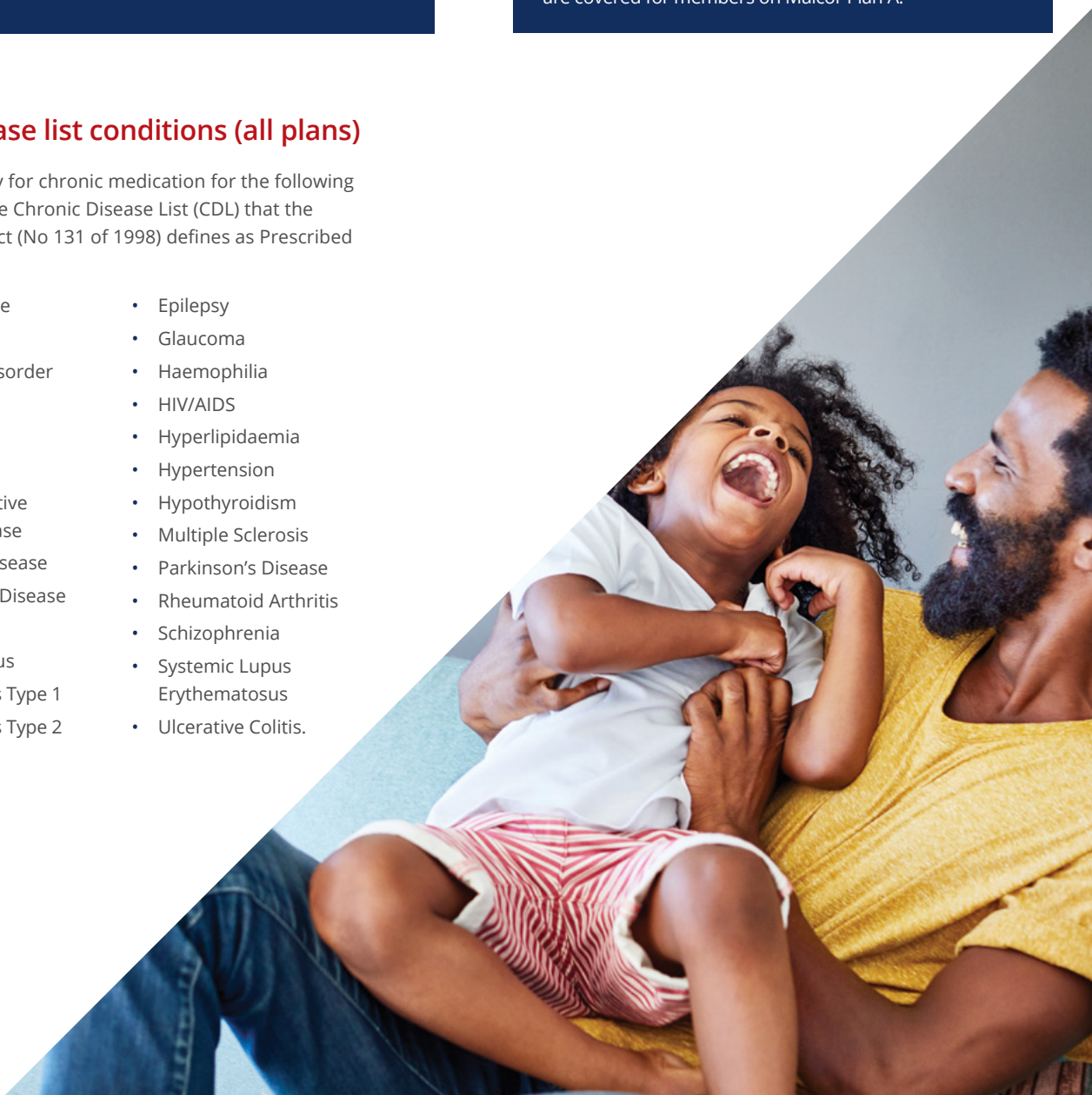
If your condition is approved by the Chronic Illness Benefit, it will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the 27 Prescribed Minimum Benefits (PMBs) CDL conditions (including HIV and AIDS) in line with Prescribed Minimum Benefits.

The Scheme will fund approved medicine on the medicine list or medicine with the same active ingredient as the approved medicine list up to the Maximum Medical Aid Price (MMAP). Medicine not on the medicine list will be funded from the Acute Medicine limit or by yourself. There are further Additional Disease List conditions that are covered for members on Malcor Plan A.

Chronic disease list conditions (all plans)

All members qualify for chronic medication for the following 27 conditions on the Chronic Disease List (CDL) that the Medical Schemes Act (No 131 of 1998) defines as Prescribed Minimum Benefits:

- 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 1
- Diabetes Mellitus Type 2
- Dysrythmia
- Epilepsy
- Glaucoma
- Haemophilia
- HIV/AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis.



Additional Disease List (ADL) available to Plan A members only

- Acne
- Allergic Rhinitis
- Ankylosing Spondylitis
- Arthritis
- Attention Deficit and Hyperactivity Disorder (ADHD)
- Barret's Oesophagus
- Chronic Hepatitis
- Cystic Fibrosis
- Depression
- Gastro-oesophageal Reflux Disease
- Motor Neurone Disease
- Myasthenia Gravis
- Narcolepsy
- Obsessive Compulsive Disorder
- Osteoarthritis
- Osteoporosis
- Paget's Disease
- Psoriasis
- Psoriatic Arthritis.

You must apply for chronic cover by completing a *Chronic Illness Benefit application form* with your doctor and submit it for review. The application form is available at **www.malcormedicalaid.co.za > Find a document.** Alternatively you can call **0860 100 698** or your healthcare professional can call **0860 44 55 66** for assistance. For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that the member needs to meet. If necessary, you or your doctor may have to supply extra motivation or copies of certain documents to finalise your application. If you leave out any information or do not provide the medical tests or documents needed with the application, cover will only start from when we receive the outstanding information.

Chronic medication DSP

Dis-Chem has been appointed as the Scheme's designated service provider (DSP) for all chronic medicine requirements. Dis-Chem has offered the Scheme a beneficial dispensing fee structure. All chronic medicine is to be obtained from Dis-Chem. Should members choose to obtain their chronic medication from a provider who is unable to match this dispensing fee arrangement, then the member may be liable for any co-payments.

HIVCare Programme

For members living with HIV and AIDS, the HIV*Care* Programme provides comprehensive disease management. We take the utmost care to protect the right to privacy and confidentiality of our members.

Malcor members are encouraged to enrol in the HIV*Care* Programme by calling the Malcor Medical Aid Scheme on **0860 100 698.**

The case managers will assist you and guide you with your treatment plan and benefits. Members or dependants who are HIV positive but have not yet enrolled are encouraged to do so. Your health and medical treatment are of the utmost importance.

Cover for HIV prophylactics

If you, as a Malcor member, need HIV prophylactics to prevent HIV infection from mother-to-child transmission, occupational and traumatic exposure to HIV or sexual assault, please call Malcor Medical Aid Scheme immediately on **0860 100 698** as treatment must start as soon as possible.

This treatment is paid for by the Malcor Medical Aid Scheme at Scheme rate.

Blood transfusions

Blood transfusions are covered at 100% of the Scheme Rate.

Oncology programme

If you are diagnosed with cancer, you must register on the Malcor Medical Aid Scheme's Oncology Programme. The Malcor Medical Aid Scheme's Oncology Programme follows the ICON or SAOC protocols and guidelines.

Please register by calling **0860 100 698.**

Advanced illness benefit

Members with cancer have access to a comprehensive quality care programme. This programme offers unlimited cover for approved care at home.

Benefit tip

Call **0860 100 698** to confirm your cover for these benefits.

Medicine **BENEFITS**

GENERAL GUIDELINES: The Scheme applies the following guidelines in respect of medicine benefits on Plans A, B and C:

Generic medication

Generic medicines are produced once patents of original drugs have expired. They have the same active ingredients as the original medicines. They may, however, be in a different form from the original drug and will not be in the same packaging.

By using generics, members can use less of their Acute Medicine Benefit each time they claim. However, members are still assured of quality because all generic medicines sold in South Africa must be approved by the Medicines Control Council.

Maximum medical aid price (MMAP®)

The Scheme covers the cost of medication up to the recommended MMAP®. This price represents the lowest average price available in the marketplace for a particular classification of drug. This price is in most cases the lowest average generic price as well.

Members are fully responsible for the difference between the actual price charged for medication and the related MMAP® level. For this reason members are urged to ask their doctors to prescribe generic medication wherever possible.
If there is no generic alternative on the MMAP list, the full cost of the original drug will be paid by the Scheme.

Medicine price structure

Current legislation regulates the pricing of all medication and the Scheme will cover medication up to a maximum of this Single Exit Price, subject to MMAP®. Legislation also allows for a dispensing fee to be charged and this is covered by the Scheme up to the amount charged by the Scheme's DSP, being Dis-Chem.

However, administrative costs, including those for faxes, telephone calls, transaction and delivery fees and any other sundry fees charged by the medication supplier, are not covered by the Scheme.

Medication preferred provider

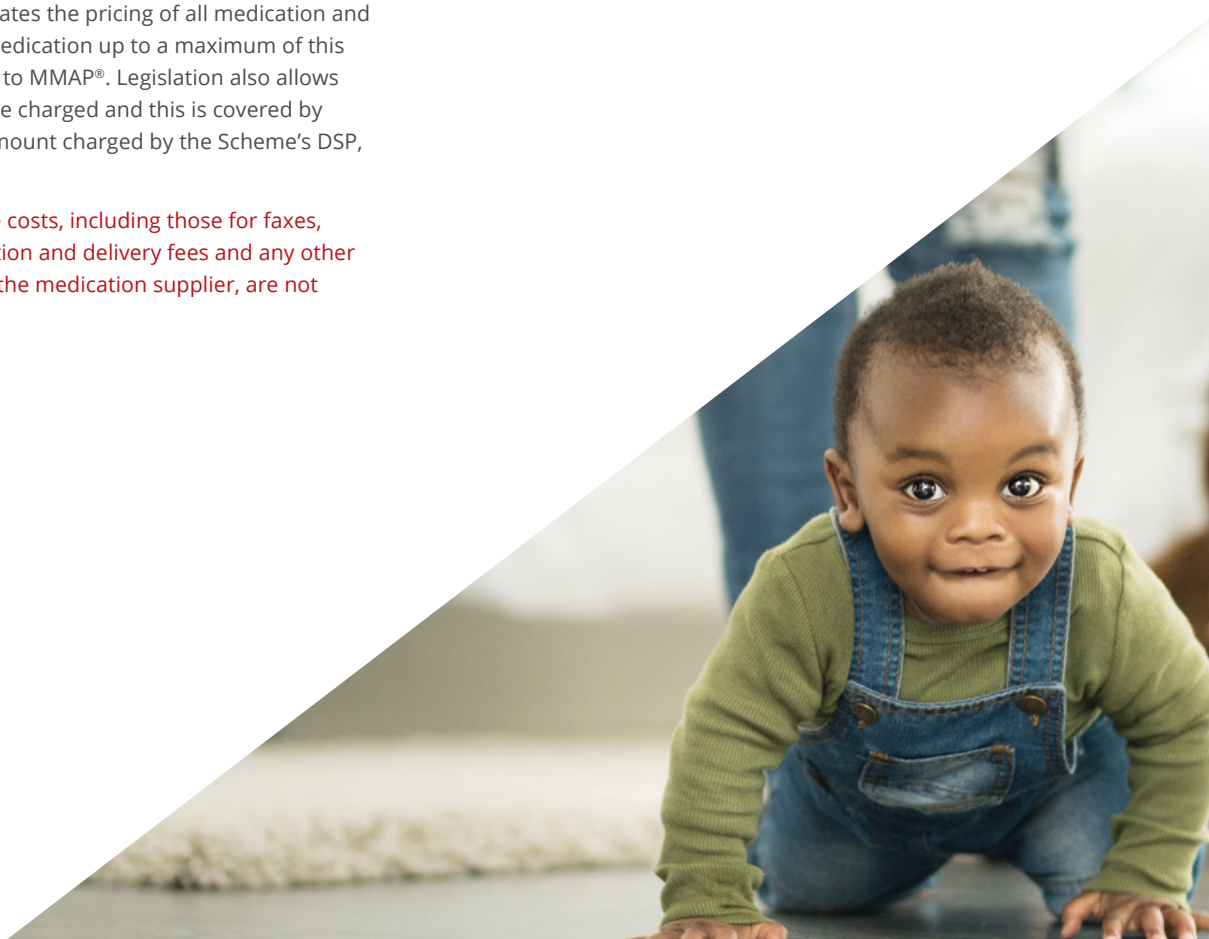
Dis-Chem have been appointed as the Scheme's Designated Service Provider (DSP) for all medication requirements. Dis-Chem have offered the Scheme a beneficial dispensing fee structure. Should a member choose to obtain their medication from a provider who is unable to match this dispensing fee arrangement, they will be personally liable for any resultant excess.

Over-the-counter medicines (OTC)

Pharmacists can prescribe and dispense schedule 0, 1 and 2 medicines for the treatment of minor ailments such as dysmenorrhoea, headaches, sinusitis, abdominal colic, stomach cramps, dyspepsia, heartburn, constipation, diarrhoea, muscular pain, coughs and colds, flu, sprains, insect bites, rashes, itchy skin, hayfever, nausea and vomiting, migraines, worms, vaginitis, anti-fungal and anti-viral conditions. These costs will be paid by the Scheme and deducted off the relevant plan-specific acute medicine OTC sub-limit.

Visit

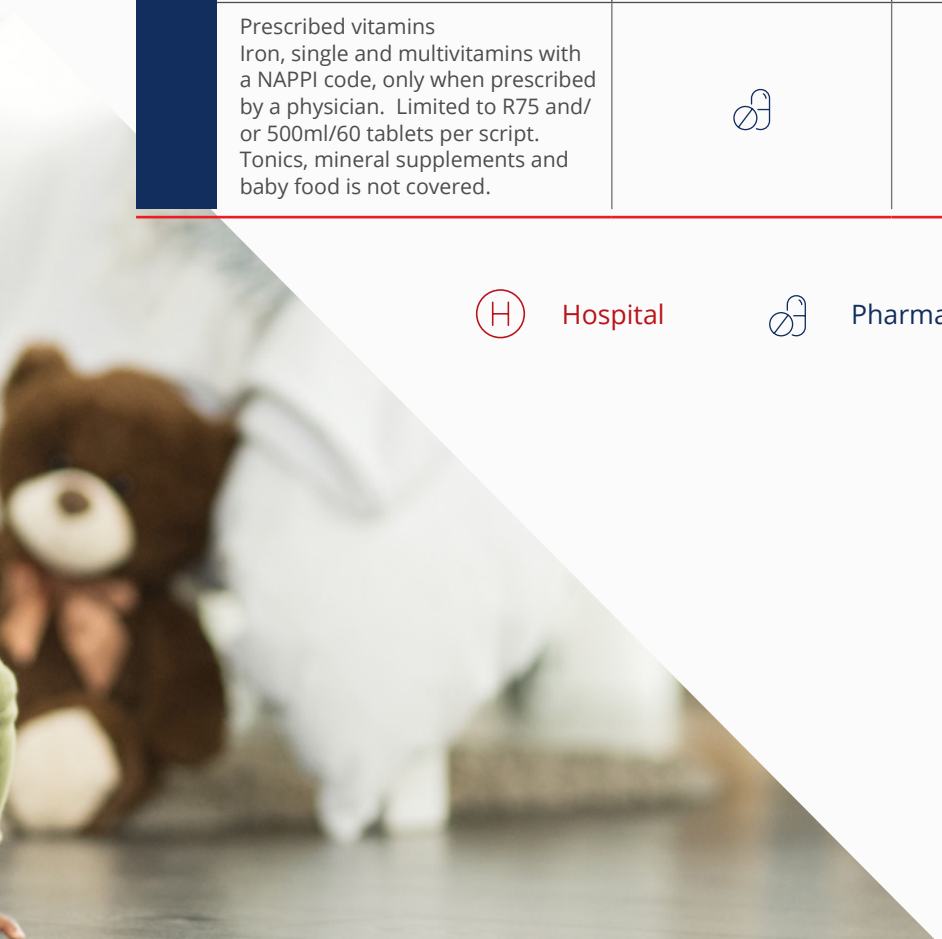
www.malcormedicalaid.co.za > Medicine for more information.



Medicine **BENEFIT**

	TYPE OF **MEDICINE**	**OBTAINED** FROM	**PRESCRIBED** BY	**PAID** FROM
IN-HOSPITAL	Medicines given to you while you are in-hospital (you are an admitted patient)	H		In-Hospital Benefit
	Medicines given to you when you leave the hospital (you are being discharged as a patient). Medicine is billed by the hospital directly – you are not handed a script to collect from the pharmacy	H		Hospital Benefit
	Medicines given to you when you leave the hospital (you are being discharged as a patient). Medicine is not billed by the hospital directly – you are handed a script to collect from the pharmacy	H		Seven day supply: paid from your Acute Medicine Benefit
OUT-OF-HOSPITAL	Prescribed acute (schedule 0-6)			Acute Medicine Benefit
	Approved prescribed chronic (must be registered on the Chronic Illness Benefit)	or		Chronic Illness Benefit
	Pharmacy prescribed or self-prescribed (schedule 0, 1 or 2)		or	Acute Medicine Benefit (up to the over-the-counter medicine sub-limit)
	Approved vitamins (HIV, Oncology, Pre-natal only)	or		Acute Medicine Benefit or Managed Care Programme risk
	Prescribed vitamins Iron, single and multivitamins with a NAPPI code, only when prescribed by a physician. Limited to R75 and/or 500ml/60 tablets per script. Tonics, mineral supplements and baby food is not covered.			Acute Medicine Benefit

H Hospital Pharmacy Doctor Self



Ex Gratia **BENEFITS**

What is ex gratia?

Ex-Gratia is defined by the Council for Medical Schemes (CMS) as 'a discretionary benefit which a medical aid scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights thereto'.

The Board of Trustees may in its absolute discretion increase the amount payable in terms of the Rules of the Scheme as an Ex-Gratia award. As Ex-Gratia awards are not registered benefits, but are awarded at the discretion of the Board of Trustees. Ex-Gratia requests are considered on an individual basis and any decision made will in no way set a precedent or determine future policy. Decisions taken by the Board is final and are not subject to appeal or dispute.

A discretionary benefit which a medical aid scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights thereto.

Prescribed Minimum Benefits **(PMBS)** and Designated Service Providers **(DSPS)**

What is a PMB?

Prescribed Minimum Benefits are prescribed by law as a minimum benefit package to which each medical scheme member is entitled. The Council for Medical Scheme's regulations require that medical schemes need to provide cover for certain conditions even when scheme exclusions or waiting periods apply, or when the member has reached the limit for a benefit.

How PMB claims are paid

Your cover depends on whether you choose to use the Malcor Medical Aid Scheme's Designated Service Providers (DSPs) or not.

The Malcor Medical Aid Scheme has selected MediClinic facilities Busamed Gateway, Busamed Hillcrest (in KZN), Life East London (East London) and Life St George's (Port Elizabeth) as the Scheme's in-hospital Designated Service Provider (DSP) or 'network'. The latest list of hospitals and other service providers is available at **www.malcormedicalaid.co.za > Doctor visits > Find a healthcare professional**

What we cover as a prescribed minimum benefit

The Prescribed Minimum Benefits make provision for the cover of the diagnosis, treatment and ongoing care of:

- 270 diagnoses and their associated treatment
- 27 chronic conditions
- Emergency treatment.

Remember

Your hospital admission is subject to approval and pre-authorisation. If you need to be admitted for emergency medical treatment, please arrange for authorisation 72 hours after your admission or have a family member contact us to arrange this.

Out-of-hospital PMB cover is subject to approval and pre-authorisation. The application form can be downloaded from **www.malcormedicalaid.co.za > Find a document** or by calling the Scheme on **0860 100 698.**

Benefit tip

If you choose to use the Malcor Medical Aid Scheme's DSPs, the Scheme will pay your medical expenses in full, from your Hospital Benefit. If you choose not to use a DSP, the Scheme will pay for medical expenses incurred while you are admitted to hospital at up to the Scheme Rate. You will be responsible for the balance as a co-payment.

Cover for **EMERGENCIES**

Your health benefits also include cover for medical emergencies in South Africa.

Emergencies in South Africa

In an emergency, call Discovery **911** on **0860 999 911** – this number is displayed on your membership card for easy reference.

Cover while travelling overseas

If you require emergency medical services while overseas, that would normally be covered by the Malcor Medical Aid Scheme, you can claim the reimbursement of the cost of these services back from the Malcor Medical Aid Scheme on your return. The Malcor Medical Aid Scheme will refund you at the Malcor Rate that would have been paid if emergency medical services had been obtained in South Africa.

Please download the international claim form from the website and send it to us with the detailed claim so that we can review the claims for payment.

Malcor medical aid scheme emergency service

Cover is provided for emergency medical evacuations. The Discovery Medicopters, supported by ground staff, provide medical support and air evacuation in extreme critical cases. The emergency helicopters operate from Johannesburg, Cape Town and Durban.

Motor vehicle accidents

The member must inform the Scheme about the accident as soon as possible. Discovery Health will assist with the Road Accident Fund claim in the following ways:

- Discovery Health will refer the member to a Discovery Health approved attorney who will assist the member with their claim against the Road Accident Fund (the member may however make use of their own attorney).
- If the member uses one of Discovery Health's approved attorneys, those attorneys will analyse the member's accident (at no cost to the member) to determine whether the member has a valid claim.
- If the member chooses to use their own attorney, the member should ask their attorney to contact the Scheme in order to assist the member's attorneys with the accident-related accounts and any fee-related queries which the attorneys may have.

The Scheme will pay for accident-related healthcare expenses in accordance with the rules of the Scheme and the member's plan type.

If the Road Accident Fund pays for medical expenses which were also paid by the Scheme, the Scheme must be reimbursed in accordance with the amount paid by the Road Accident Fund.

In an emergency, please call the Discovery 911 emergency services number which you will find on your membership card and the car sticker that has been provided (Plan A, B and C only).

ADVANCED TECHNOLOGY and convenience

When you're at the doctor – health ID

HealthID, Discovery Health's application for healthcare professionals, is the first of its kind in South Africa. Many doctors in the network will be able to access your health records with your consent. Remember that member confidentiality will be protected at all times and your information can only be accessed with your consent.

Online bookings:

You can conveniently use the Discovery app to make real time online bookings. You can download the Discovery app by going to the Apple AppStore or Google Play.

Managing diabetes digitally

The Malcor Medical Aid Scheme will fund a telemetric glucometer for all members registered for diabetes. These devices provide an efficient and simple user interface for capturing blood glucose readings and insulin levels, and for logging exercise and meals – all in real time.

The data captured through this device integrates seamlessly with HealthID (an application that doctors can download) to access members' information remotely and identify risks in a timely manner.

These benefits allow doctors to spend less time downloading data and more time focusing on the health of patients, making diabetes management easier for members of the Malcor Medical Aid Scheme. These benefits are provided through Dis-Chem pharmacies and will be funded subject to your external medical appliances limit and overall out-of-hospital limit.

The Malcor Medical Aid Scheme **BENEFIT TABLES**

Hospital benefits: Plans A, B and C

Benefit limits are prorated if a member joins the Malcor Medical Aid Scheme during the year unless otherwise stated. Pre-authorisation required, except in the case of an emergency.

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	**BASIS OF COVER**	**ANNUAL LIMITS**	**ANNUAL LIMITS**	**ANNUAL LIMITS**
Statutory Prescribed Minimum Benefits	Services rendered by public hospitals/DSP at 100% of cost or 100% of the Scheme Rate in a private hospital where the beneficiary voluntarily elects another service provider	Unlimited	Unlimited	Unlimited
	Where PMB performed in a private hospital involuntarily such procedure will be paid at 100% of cost			
	All Prescribed Minimum Benefits are paid at cost, subject to requirements as set out in the Scheme Rules			
Overall annual limit for in-hospital expenses	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	R1 000 000 per family per annum
Accommodation, materials, theatre fees	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Blood transfusions	100% of the Scheme Rate funded from overall annual in-hospital benefit	Unlimited	Unlimited	Overall annual in-hospital limit
Ambulance (local emergency evacuation)	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies	Unlimited	Unlimited	Overall annual in-hospital limit
Specialists	100% of the Scheme Rate funded from overall annual in-hospital benefit Specialist Network applies as DSP Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
GP	100% of the Scheme Rate funded from overall annual in-hospital benefit GP Network applies as DSP Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Comprehensive Maternity benefits Antenatal consultations, Antenatal classes, Ultrasound scans and prenatal screening, Blood tests, Private ward, Essential registered devices	100% of the Scheme Rate funded from overall annual in-hospital benefit	Antenatal consultations are limited to 12 visits. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of 2 Ultrasound scans and one nuchal translucency or NIPT or down syndrome screening test are covered. Blood tests are limited to a defined basket. Private ward cover is limited to R2 070 per day. Cover on essential registered devices is limited to R4 000	Antenatal consultations are limited to 12 visits. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of 2 Ultrasound scans and one nuchal translucency or NIPT or down syndrome screening test are covered. Blood tests are limited to a defined basket. No benefit for private ward cover. Cover on essential registered devices is limited to R2 000	Refer to Maternity Out-of-hospital benefits

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	**BASIS OF COVER**	**ANNUAL LIMITS**	**ANNUAL LIMITS**	**ANNUAL LIMITS**
Post-birth benefits GP and specialist visits, Post natal consultations, Six week post-birth consultation, Nutrition assessment, Mental health consultation, Lactation consultation	100% of the Scheme Rate funded from overall annual in-hospital benefit	Consultations with a GP, paediatrician or an ENT is limited to 2 visits for your baby. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of one six-week post-birth consultation with a GP, midwife or gynaecologist is covered. A limit of one nutrition assessment with a dietician is covered. Mental health consultations with a GP, gynaecologist or psychologist is limited to 2 visits. A limit of one lactation consultation with a nurse or lactation specialist is covered	Consultations with a GP, paediatrician or an ENT is limited to 2 visits for your baby. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of one six-week post-birth consultation with a GP, midwife or gynaecologist is covered. A limit of one nutrition assessment with a dietician is covered. Mental health consultations a GP, gynaecologist or psychologist is limited to 2 visits. A limit of one lactation consultation with a nurse or lactation specialist is covered	Refer to Maternity Out-of-hospital benefits
Organ transplants	100% of the Scheme Rate funded from overall annual in-hospital benefit. PMB at cost Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Internal prosthesis (hip, knee, shoulder joints,artificial eyes, intraocular lenses, defibrillators, pacemakers, stents, spinal items, etc.)	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required Sub-limits: Hip Knee Pacemakers Stents	R116 600 per beneficiary per annum R58 300 R58 300 R58 300 R25 440	R81 620 per beneficiary per annum R40 810 R40 810 R40 810 R23 320	R40 810 per beneficiary per annum No sub-limits. Subject to overall internal prothesis limit.
Cardiac stents (limited to the internal prosthesis sub-limit for stents for Plan A and Plan B. For Plan C it is subject to the internal prosthesis sub-limit)	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	3 stents per beneficiary per annum	3 stents per beneficiary per annum	3 stents per beneficiary per annum
Bone-anchored hearing aid	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Subject to internal prosthesis limit	Subject to internal prosthesis limit	Subject to internal prosthesis limit
Spinal prosthesis	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Subject to internal prosthesis limit	Subject to internal prosthesis limit	Subject to internal prosthesis limit
External medical items (HALO traction, embolytic stockings, certain back braces)	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Pathology	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Radiology	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Endoscopies	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	ANNUAL LIMITS	ANNUAL LIMITS
Specialised radiology (MRI, CT scans, PET scans, nuclear medicine studies, angiograms, arthrograms)	100% of the Scheme Rate funded from overall annual in-hospital benefit regardless of setting (out-of-hospital or in-hospital) Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Dentistry (maxilla-facial procedures)	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required Conservative dentistry and specialised dentistry not covered in-hospital unless pre-authorised	Unlimited	Unlimited	Overall annual in-hospital limit
Ophthalmologic procedures (corneal crosslinking included)	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Mental health	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	21 days per beneficiary per annum	21 days per beneficiary per annum	21 days per beneficiary per annum
Drug and alcohol rehabilitation	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Pre-authorisation required	21 days per beneficiary per annum	21 days per beneficiary per annum	21 days per beneficiary per annum
Detoxification for substance dependency	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Pre-authorisation required	Three days per beneficiary per approved event	Three days per beneficiary per approved event	Three days per beneficiary per approved event
Allied professionals (acousticians, biokineticists, chiropractors, dietitians, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, social workers, speech and hearing therapists)	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Private nursing	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Compassionate care	100% of the Scheme Rate funded from overall annual in-hospital benefit. PMB at Cost DSP applies Pre-authorisation required	Unlimited	Unlimited	Unlimited
Renal dialysis	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
Medication supplied in-hospital	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit
To-take-out (TTO) medication	100% of the Scheme Rate funded from overall annual in-hospital benefit Pre-authorisation required	Limited to seven days	Limited to seven days	Limited to seven days
International travel	100% of claim funded from the overall annual in-hospital benefit Pre-authorisation required	R500 000 per beneficiary per journey, 90 days from departure date	R500 000 per beneficiary per journey, 90 days from departure date	R500 000 per beneficiary per journey, 90 days from departure date
Home oxygen	100% of the Scheme Rate funded from overall annual in-hospital benefit DSP applies Pre-authorisation required	Unlimited	Unlimited	Overall annual in-hospital limit

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	ANNUAL LIMITS	ANNUAL LIMITS
HIV and AIDS-related treatment	100% of the Scheme Rate funded from overall-annual in-hospital benefit PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
Post-exposure HIV prophylaxis following occupational exposure, traumatic exposure or sexual assault	100% of scheme rate PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
HIV prophylaxis to prevent mother-to-child transmission	100% of scheme rate PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
Prescribed antiretroviral medication for HIV/AIDS and medication to treat opportunistic infections such as tuberculosis and pneumonia	100% of scheme rate PMB criteria apply	Unlimited	Unlimited	Overall annual out-of-hospital limit. Approved PMB's will fund through the limit
Oncology	100% of the Scheme Rate funded from the oncology limit Subject to ICON and SAOC guidelines and pre-authorisation by Scheme. Wigs are covered from the overall out-of-hospital benefits, subject to the external medical items limit	R500 000 per family per annum	R300 000 per family per annum	R200 000 per family per annum
Advanced Illness Benefit (end-of-life care at home for members registered on the Oncology Benefit)	100% of the Scheme Rate funded from the overall annual in-hospital benefit DSP applies	Unlimited	Unlimited	Unlimited
Stem cell transplants	100% of the Scheme Rate funded from overall annual in-hospital benefit	R500 000 per family per annum (part of the Oncology Benefit)	R300 000 per family per annum (part of the Oncology Benefit)	R200 000 per family per annum (part of the Oncology Benefit)

Out-of-hospital benefits: Plans A, B and C

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	ANNUAL LIMITS	ANNUAL LIMITS
Overall annual limit for out-of-hospital expenses	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	R116 600 per family per annum	R72 290 per family per annum	Annual limit per family based on number of dependants: M – R7 815 M1 – R14 055 M2 – R17 180 M3 – R20 285 M4+ – R23 415
GPs and homeopaths	100% of the Scheme Rate funded from overall annual out-of-hospital benefit DSP for GPs: GP Network	Overall annual out-of-hospital benefit limit	Annual limit per family based on number of dependants: M – 6 visits M1 – 12 visits M2 – 16 visits M3 – 20 visits M4+ – 24 visits When the limit is reached, claims are funded at 50% of the Scheme Rate from the overall out-of-hospital benefit.	Overall annual out-of-hospital benefit limit
Specialists (cardiologist, paediatrician, gynaecologist, specialist physician, oncologist, etc.)	Plan A: 120% of the Scheme Rate funded from overall annual out-of-hospital benefit (excluding dental specialists and anesthetist funded at 100% of the Scheme Rate). Plans B and C: 100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Annual limit per family based on number of dependants: M – 7 visits M1 – 12 visits M2 – 17 visits M3 – 24 visits M4+ – 26 visits	Annual limit per family based on number of dependants: M – 4 visits M1 – 8 visits M2 – 11 visits M3 – 14 visits M4+ – 17 visits	Overall annual out-of-hospital benefit limit
Maternity consultations (gynaecologist and GPs)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Refer to the Comprehensive Maternity and Post birth benefit	Refer to the Comprehensive Maternity and Post birth benefit	Overall annual out-of-hospital benefit limit
Endoscopies	100% of the Scheme Rate funded from overall annual out-of-hospital benefit if not pre-authorised	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit
External medical items (walking sticks, commodes, bed pans, toilet seat raisers, crutches, glucometers, foot orthotics and shoe innersoles, etc)	100% of cost funded from overall annual out-of-hospital benefit	R4 080 per family per annum	R2 715 per family per annum	Overall annual out-of-hospital benefit limit
Walkers	100% of cost funded from overall annual out-of-hospital benefit	R670 per family per annum	R455 per family per annum	Overall annual out-of-hospital benefit limit
Wheelchairs (including buggies and carts)	100% of cost funded from overall annual out-of-hospital benefit	R4 000 per family per annum	R2 670 per family per annum	Overall annual out-of-hospital benefit limit
Hearing aids	100% of cost funded from overall annual out-of-hospital benefit	R20 395 per family per annum	R14 835 per family per annum	Overall annual out-of-hospital benefit limit
Pathology	100% of the Scheme Rate funded from overall annual out-of-hospital benefit. When the limit is reached, claims are funded at 80% of the Scheme Rate from the overall annual out-of-hospital benefit	Annual limit per family based on number of dependants: M – R3 405 M1 – R5 955 M2 – R7 670 M3 – R9 370 M4+ – R11 065	Annual limit per family based on number of dependants: M – R1 659 M1 – R2 905 M2 – R3 725 M3 – R4 560 M4+ – R5 385	Overall annual out-of-hospital benefit limit

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	ANNUAL LIMITS	ANNUAL LIMITS
Radiology	100% of the Scheme Rate funded from overall annual out-of-hospital benefit. When the limit is reached, claims are funded at 80% of the Scheme Rate from the overall annual out-of-hospital benefit	Annual limit per family based on number of dependants: M – R3 405 M1 – R5 955 M2 – R7 670 M3 – R9 370 M4+ – R11 065	Annual limit per family based on number of dependants: M – R1 659 M1 – R2 905 M2 – R3 725 M3 – R4 560 M4+ – R5 385	Overall annual out-of-hospital benefit limit
Pregnancy scans	100% of the Scheme Rate funded from overall annual out-of-hospital benefit. When the limit is reached, claims are funded at 80% of the Scheme Rate from the overall annual out-of-hospital benefit Claims accumulate to the out-of-hospital radiology limit	Refer to the Comprehensive Maternity and Post birth benefit	Refer to the Comprehensive Maternity and Post birth benefit	Overall annual out-of-hospital benefit limit
Dentistry (conservative dentistry and specialised dentistry, inclusive of osseo-integrated implants)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Annual limit per family based on number of dependants: M – R10 945 M1 – R18 235 M2 – R23 705 M3 – R29 190 M4+ – R34 656	Annual limit per family based on number of dependants: M – R5 025 M1 – R8 375 M2 – R10 875 M3 – R13 385 M4+ – R14 220	Overall annual out-of-hospital benefit limit
Dental therapy	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	R1 390 per family per annum	R985 per family per annum	Overall annual out-of-hospital benefit limit
Radial Keratotomy and Excimer laser treatment (performed in hospital or out-of-hospital setting)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	R17 490 per beneficiary per annum	No benefit	No benefit
Optical benefits (spectacles, contact lenses, frames and all add-ons)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit Optometry Network applies: members will receive discounts as negotiated (discount applies to frames, eyeglass lenses and add-on components but excludes contact lenses and professional services)	Annual limit per family based on dependants: M – R5 000 M1+ – R10 000	Annual limit per family based on dependants: M – R2 500 M1+ – R5 640	Overall annual out-of-hospital benefit limit
Eye tests	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	One test per beneficiary per annum	One test per beneficiary per annum	One test per beneficiary per annum
Allied professionals (acousticians, biokineticists, chiropractors, dietitians, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, social workers, speech and hearing therapists)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit, subject to the Allied Professionals limit	R16 515 per family per annum	R11 450 per family per annum	Overall annual out-of-hospital benefit limit
Mental health (psychologist and counsellor)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit, subject to the Allied Professionals limit	15 consultations per beneficiary per annum	15 consultations per beneficiary per annum	Overall annual out-of-hospital benefit limit
Drug and alcohol rehabilitation, detox and substance abuse	No benefit	No benefit	No benefit	No benefit

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	**BASIS OF COVER**	**ANNUAL LIMITS**	**ANNUAL LIMITS**	**ANNUAL LIMITS**
Acute medication (includes homeopathic medication, vaccines*, pharmacy assisted treatment, TTO obtained at a pharmacy and over-the-counter medication)	100% of the Malcor Medication Rate funded from overall annual out-of-hospital benefit DSP applies *Vaccines and immunisation to be funded based on State EPI vaccines for infants and children up to the age of 12 years	Annual limit per family based on number of dependants: M – R12 740 M1 – R18 210 M2 – R23 665 M3 – R30 960 M4+ – R34 600	Annual limit per family based on number of dependants: M – R6 200 M1 – R8 845 M2 – R11 500 M3 – R15 050 M4+ – R16 830	Overall annual out-of-hospital benefit limit
	Over-the-counter sub limits	M – R3 180 M1+ – R9 540	M – R2 120 M1+ – R6 360	No sub-limit. Subject to overall annual out-of-hospital benefit limit
Chronic Illness Benefit	**Chronic Disease List**			
	Maximum Medical Aid Price (MMAP) Subject to medicine list (formulary). DSP applies Subject to pre-authorisation and benefit entry criteria	Funded from the overall annual in-hospital benefit	Funded from the overall annual in-hospital benefit	Funded from the overall annual out-of-hospital benefit limit
	Additional Disease List			
	Maximum Medical Aid Price (MMAP) Subject to medicine list (formulary). DSP applies Subject to pre-authorisation and benefit entry criteria	Overall annual out-of-hospital benefit limit	No benefit	No benefit
Contraceptives	**Oral contraceptives**			
	100% of the Malcor Medication Rate funded from the overall annual out-of-hospital benefit, subject to the acute medicine limit DSP applies	R159 per beneficiary per month	R159 per beneficiary per month	R159 per beneficiary per month
	Mirena device			
	100% of the Scheme Rate funded from the overall annual out-of-hospital benefit Subject to the acute medicine limit DSP applies	One every 5 years	One every 5 years	One every 5 years
	Associated gynaecology costs for insertion and removal in the doctor's rooms			
	Plan A: 120% of the Scheme Rate funded from the overall annual out-of-hospital benefit Plan B and C: 100% of the Scheme Rate funded from the overall annual out-of-hospital benefit	Subject to the specialist annual limit per family	Subject to the specialist annual limit per family	Overall annual out-of-hospital benefit
	Associated gynaecology costs for Mirena insertion and removal in theatre			
	100% of the Scheme Rate Subject to pre-authorisation and benefit entry criteria	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit	Overall annual out-of-hospital benefit limit
	Implanon nxt			
	100% of the Scheme Rate funded from the overall annual out-of-hospital benefit Subject to the acute medicine limit DSP applies	One every 3 years	One every 3 years	One every 3 years
	Associated gynaecology cost for Implanon nxt implant or removal			
	Plan A: 120% of the Scheme Rate funded from the overall annual out-of-hospital benefit Plan B and C: 100% of the Scheme Rate funded from the overall annual out-of-hospital benefit Subject to the specialist annual limit per family	Subject to the specialist annual limit per family	Subject to the specialist annual limit per family	Overall annual out-of-hospital benefit

		Plan A	Plan B	Plan C
HEALTHCARE SERVICE	**BASIS OF COVER**	**ANNUAL LIMITS**	**ANNUAL LIMITS**	**ANNUAL LIMITS**
Musculo-skeletal topical agents (Topical Analgesic Agents)	100% of the Malcor Medication Rate funded from overall annual out-of-hospital benefit, subject to the acute medicine limit DSP applies	65g per fill, limited to two fills per beneficiary per annum	65g per fill, limited to two fills per beneficiary per annum	65g per fill, limited to two fills per annum
Screening Benefit Dis-Chem WellScreen	100% of the Scheme Rate funded from the overall annual out-of-hospital benefit	Combined benefit of two screening tests per beneficiary per annum*	Combined benefit of one screening test per beneficiary per annum**	Combined benefit of one screening test per beneficiary per annum**
Screening Benefit	100% of the Scheme Rate funded from overall annual out-of-hospital benefit	Combined benefit of two screening tests per beneficiary per annum*	Combined benefit of one screening test per beneficiary per annum**	Combined benefit of one screening test per beneficiary per annum**
Annual health check (blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI))	Annual health check to be carried out at the Wellness network pharmacy/provider			
Screening Benefit - Children's screening check. Applies to children between the ages of two years and 18 years (Body Mass Index and counselling, where appropriate, hearing screening, dental screening and milestone tracking for children under the age of eight)	100% of the Scheme Rate funded from overall annual out-of-hospital benefit Children's screening tests to be carried out at a network pharmacy/provider	One test per qualifying child per annum	One test per qualifying child per annum	One test per qualifying child per annum

* Member may claim for a maximum of two screening tests per annum and may choose to use either the Dis-Chem WellScreen test or the Health Check or both.

** Member may claim for a maximum of one screening test per annum and may choose to use either the Dis-Chem WellScreen test or the Health Check.

The Malcor Medical Aid Scheme **BENEFIT TABLES**

Hospital benefits: plan D

Benefit limits are prorated if a member joins the Malcor Medical Aid Scheme during the year unless otherwise stated. Pre-authorisation required, except in the case of an emergency. In all instances, Prescribed Minimum Benefits (PMBs) are paid at cost and are unlimited.

Service	Benefits/annual limits	Benefit requirements/conditions
Overall annual limit	No annual limit	Subject to protocols and sub-limits not being exceeded
Statutory Prescribed Minimum Benefit services rendered by public hospitals payable at 100% of cost	No annual limit	
Emergency medical cover while travelling outside of South Africa	100% of SA tariff rates payable in RSA currency	

	Service	Benefits	Annual limits	Benefit requirements/ conditions
1. HOSPITALISATION AND ASSOCIATED COSTS - PROVINCIAL AND PRIVATE				
Items 1.01 – 1.21: All admissions to hospitals and services listed below must be pre-authorised by the Designated Service Provider. Tel: 0860 00 24 02.				
The Scheme will pay the costs of Prescribed Minimum Benefits in full for the involuntary use of a non-Designated Service Provider and 100% of the Scheme Rate for services obtained from a Designated Service Provider.				
	Overall annual limit	R600 000 per family per annum	Subject to sub-limits not being exceeded	
1.01	**Accommodation, theatre fees medicines, intensive care**	100% of Managed Care Rate	Subject to PMBs as prescribed	Medicine dispensed on discharge limited to a five-day supply
1.02	**Surgical procedures in hospital** including GP and specialist consultations	100% of Managed Care Rate Hip Arthroscopy not covered	Subject to PMBs as prescribed Private wards not covered	
1.03	**Diagnostic investigations** e.g. Radiology, Pathology, MRI/CAT scans etc.	100% of Managed Care Rate	Authorisation must be obtained prior to the examination or within 24 hours in case of an emergency Limited to R9 240 per family per annum	Subject to clinical protocols and PMBs as prescribed MRI and CT Scans must be authorised by the Scheme, or the Managed Health Care Organisation
1.04	**Blood transfusions**	100% of cost		
1.05	**Oncology treatment**	100% of Managed Care Rate Subject to ICON protocols	Limit of R216 000 per family per annum	Subject to PMBs as prescribed
1.06	**Accommodation for confinements** Note: Waiting period may be applied, subject to the rights of interchangeability	100% of Managed Care Rate	NVD – Limited to two days Caesar – Limited to three days Limited to two sonars per confinement	Subject to PMBs as prescribed
1.07	**Psychiatric treatment and clinical psychology**	No benefit		Subject to PMBs as prescribed Drug and alcohol treatment at SANCA affiliated facilities only

Service		Benefits	Annual limits	Benefit requirements/ conditions
1.08	**Organ transplants**	100% of Managed Care Rate	Limited to R99 840 per family per annum Cornea transplants: only locally harvested corneas will be covered	Subject to PMBs as prescribed and pre-authorisation. Only locally harvested corneas will be covered
1.09	**Renal dialysis**	100% of Managed Care Rate	Subject to PMBs as prescribed.	Subject to pre-authorisation from the Scheme's designated Managed Health Care Service Provider
1.10	**Dental hospitalisation**	No benefit		
1.11	**Sterilisation / vasectomy**	No benefit		(Revisions excluded)
1.12	**Internal prosthesis**	100% of cost	Limited to R21 620 per case per annum Cardiac stents – one per lesion, maximum three lesions Aphakic Lenses – R4 320 per lens	Subject to PMBs as prescribed and pre-authorisation Cardiac stents are reimbursed at the cost of bare metal stents (BMS) and not drug eluting stents (DES). (Revisions excluded)
1.13	**Physiotherapy**	100% of Managed Care Rate		Subject to PMBs as prescribed and pre-authorisation
1.14	**Step down facilities** Instead of hospitalisation	100% of Managed Care Rate	Limited to a maximum of two weeks per person per annum	Subject to PMBs as prescribed and pre-authorisation
1.15	**Private nursing** Instead of hospitalisation	100% of Managed Care Rate	Limited to a maximum of two weeks per person per annum	Subject to PMBs as prescribed and pre-authorisation
1.16	**Rehabilitation facilities**	100% of Managed Care Rate	Limited to a maximum of two weeks per person per annum	Subject to PMBs as prescribed and pre-authorisation
1.17	**Circumcision** In- and out-of-hospital	100% of Managed Care Rate	Limited to R1 130 per person per annum	
1.18	**Hyperbaric Oxygen Therapy**	No benefit		
1.19	**Back surgery**	100% of Managed Care Rate	Refer to the limit as per item 1.12	Subject to PMBs as prescribed and pre-authorisation Subject to back treatment protocols
1.20	**Stereotactic Radiosurgery**	No benefit		
1.21	**Laparoscopic Procedures**	No benefit		Subject to PMBs as prescribed and pre-authorisation

Out-of-hospital benefits: Plan D

Benefit limits are prorated if a member joins the Malcor Medical Aid Scheme during the year unless otherwise stated. In all instances, PMBs are paid at cost and are unlimited.

Service		Benefits	Annual limits	Benefit requirements/ conditions
2. GENERAL PRACTITIONERS AND SPECIALISTS				
2.01	**Consultations** General Practitioners	100% of Managed Care Rate	No annual limit	Subject to member's choice of nominated GP
	Specialists	100% of Managed Care Rate	Limited to four visits per family per annum	Subject to referral from nominated GP
	Outpatient facilities	100% of Managed Care Rate	Two visits per family per annum	
2.02	**Antenatal care** Included in sub limits for consultations and medication	100% of Managed Care Rate	Limited to two sonars per pregnancy	Note: waiting periods may apply subject to the rights of interchangeability
2.03	**Diagnostic investigations** Pathology	100% of Managed Care Rate	Limited to R925 per person per annum	Subject to PMBs as prescribed
	Radiology	100% of Managed Care Rate	Limited to R925 per person per annum	
	MRI/Cat Scans	No benefits		
3. MEDICINES				
3.01	**Acute medicines** (including homeopathic medicine)	100% of Designated Service Provider reference price	Unlimited subject to medicine dispensed by the nominated GP and medicine formulary	
3.02	**PMB Chronic Disease List (CDL) medicines**	100% of Designated Service Provider reference price	Unlimited, but subject to Designated Service Providers' treatment protocols and medicine formulary	PMBs subject to registration and pre-authorisation of the medicine with the Scheme's Preferred Provider Tel: 0860 00 24 02
3.03	**Other chronic (non-CDL) medicines**	100% of Designated Service Provider reference price	Unlimited, but subject to Designated Services Providers' treatment protocols and medicine formulary	Non-CDL PMBs subject to registration and pre-authorisation of the medicine with the Scheme's Preferred Provider, Tel: 0860 00 24 02
3.04	**Pharmacy Advised Treatment (PAT)** Over the counter medication. In consultation with pharmacist, restricted to schedule 0, 1 and 2 medicines	100% of Managed Care Rate	R347 per family per annum at R115 per event	
4. OPTICAL BENEFITS				
Contact the Designated Service Provider for availability of contracted optometrists. Tel: 0860 00 24 02				
4.01	**Spectacle lenses** In Network Benefits	100% of cost	Limited to R937 per person payable every 24 months	Subject to using the Scheme's Designated Service Provider
4.02	**Spectacle lenses** Out of Network Benefits Applicable to members who choose to utilise a non-Preferred Provider Network Optometrists	Included in limit 4.01 above		
4.03	**Contact lenses** In and Out of Network	No benefit		
4.04	**Frames** In and Out of Network	Included in limit 4.01 above		
4.05	**Eye tests** In and out of Network	Included in limit 4.01 above		

Service		Benefits	Annual limits	Benefit requirements/ conditions
5. DENTISTRY				
5.01	**Conservative dentistry** (e.g. fillings, extractions and X-rays)	100% of Managed Care Rate	Subject to overall annual limit	Pre-authorisation required from Designated Service Provider Tel: 0860 10 49 25
5.02	**Specialised dentistry** (e.g. crowns, bridge-work, dentures, orthodontics and periodontics)	No benefit		
5.03	**Maxillo facial and oral surgery** (consultations, surgical procedures and operations)	No benefit		
6. ALTERNATIVE SERVICES				
6.01	**Chiropractic, homeopathy, podiatry and naturopathy**	No benefit		
7. REMEDIAL AND OTHER THERAPIES				
7.01	**Audiology, dietitians, hearing aid acousticians, occupational therapy, orthoptics, social workers and speech therapy**	No benefit		
8. APPLIANCES				
8.01	**Appliances** (e.g. hearing aids, wheelchairs, calipers etc.)	No benefit		Subject to PMBs as prescribed
9. EXTERNAL PROSTHESIS				
9.01	**External prosthesis** (e.g. artificial limbs, eyes, etc.)	No benefit	Subject to overall annual limit	Subject to PMBs as prescribed Pre-authorisation required from Designated Service Provider Tel: 0860 10 49 25
10. PHYSIOTHERAPY (out of hospital)				
10.01	**Physiotherapy** (out-of-hospital)	No benefit		Subject to PMBs as prescribed
11. OTHER BENEFITS				
11.01	**Ambulance services** **LifeMed 0861 086 911** (air/road ambulance and emergency services)	100% of cost		Non-emergency: Subject to pre-authorisation beforehand. Failure to do this could result in the member being liable for the costs incurred Emergency: Subject to authorisation within 72 hours after the emergency Inter-hospital transfers: must be done by the Designated Service Provider only
11.02	**HIV/AIDS and sexually transmitted diseases**	100% of Managed Care Rate	Hospitalisation payable as a PMB.	Subject to Regulation 8(3) Subject to treatment protocols, medicine formulary and registration of chronic medicine by the member's nominated GP
11.03	**Infertility**	100% of Cost	Subject to PMBs as prescribed	

Reporting **FRAUD** or **MALPRACTICE**

Be part of the solution and not the problem. Report any fraudulent or unethical practice to us and take an active role in combating crime.

Fraud hotline (anonymous)

To report any crime related activity, call anonymously on the toll-free number 0800 004 500 or SMS your report to 43477. This is a totally independent, professional hotline service.

Key **INFORMATION**

The Scheme pays the applicable Malcor Rate directly to providers as standard practice. If medical providers charge in excess of Malcor Rates, the member will then have to settle the balance with the relevant provider.

Should a member pay a provider directly and submit his claim with proof of receipt, the Scheme will refund the Malcor Rate to the member.

NB! All medical aid refunds are done electronically and members are urged to ensure their banking details with the Scheme are always updated.

Important tips when claiming

When claiming from the Scheme for your medical costs, whether these are hospital, chronic or out-of-hospital, these steps apply:

- When sending claims, please make sure the following details are clear:
  - Your membership number
  - The service date
  - Your doctor's details and practice number
  - The amount charged
  - The relevant consultation, procedure or NAPPI codes and diagnostic (ICD-10) codes
  - The name and birth date of the dependant for whom the service performed
  - If paid, attach your receipt or make sure the claim says 'paid'.
- Check with your healthcare providers if they have sent your claims to us to avoid duplicates.
- Send your claims within four months of the date of service, otherwise they will be treated as expired and will not be paid.
- Always remember to keep copies of your claims for your records.
- To see the status of your claim, you can go to **www.malcormedicalaid.co.za**

Important notes

1. Healthcare practices must be appropriately registered with the Board of Healthcare Funders (BHF) and must have a valid practice number in order for claims to be considered.
2. The Scheme Rate is set by the Scheme for reimbursement or it is the rate agreed between the Scheme and the provider. Discovery Health has been mandated to negotiate certain rates on behalf of the Scheme.

How to claim

Email and fax

You can fax your claims to us on 0860 FAX CLAIMS (0860 329 252), or scan and email your claim to **claims@malcormedicalaid.co.za**

Post

You can post your claims to the following address:

PO Box 8012
Greenstone
1616

Claim drop-off boxes

You can drop your claims in the Discovery Health claims drop-off boxes situated around the country, in convenient places such as pharmacies and medical practices, as well as most Virgin Active or Planet Fitness gyms.

The Malcor Medical Aid Scheme claims boxes will remain in place at the various employer groups and you may continue to use these.

Claim queries

For any claim queries, call the Scheme on **0860 100 698** or email service@malcormedicalaid.co.za. Note this email address should not be used to submit your claims.

Changing plans

Members have freedom of choice between the four plans. Members may change plans with effect from January each year. Members may request a plan change at the end of the year when the year-end communication is sent out by the Scheme.

General **EXCLUSIONS**

1. Prescribed minimum benefits

The Scheme shall pay in full, without any co-payment or use of deductibles, the diagnosis, treatment and care costs of the Prescribed Minimum Benefits as per Regulation 8 of the Act. Furthermore, where a protocol or formulary drug preferred by the Scheme has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act.

2. Limitations and restrictions of benefits

Unless otherwise decided by the Trustees, the following limitations and restrictions will be applied to the application of benefits:

2.1. The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme.

2.2. In cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.

2.3. Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest broken pack) for every such prescription or repeat thereof.

2.4. If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its managed healthcare organisation may impose.

2.5. The Scheme reserves the right not to pay for any new technology. Coverage of new technology will be assessed by the Scheme with due consideration given to:

2.5.1. medical necessity

2.5.2. clinical evidence of its use in clinical medicine including outcome studies

2.5.3. its cost-effectiveness

2.5.4. its affordability

2.5.5. its value relative to existing services or supplies;

2.5.6. its safety.

2.6. New technology is defined as any clinical intervention of a novel nature as well as those with which the Scheme has not had previous experience.

2.7. The Scheme reserves the right to impose and apply exclusions and limits to the benefits that will be paid for medicines/procedures/interventions which have been accepted into the practice of clinical medicine through a process of health technology.

2.8. Benefits in respect of the cost of emergency medical treatment whilst abroad are covered at the applicable Malcor Rate using the then prevailing exchange rate into RSA currency.

3. Benefits Excluded

General exclusions mentioned in this paragraph are not affected by medicines or treatment approved and authorised in terms of any Scheme approved managed healthcare programme. Expenses incurred in connection with any of the following will not be paid by the Scheme:

3.1. all costs that exceed the maximum allowed for benefits to which the member is entitled in terms of the rules

3.2. all costs for operations, medicines, and procedures for cosmetic purposes or for non-clinical reasons

3.3. if, in the opinion of the medical advisor, the healthcare service in respect of which a claim is made is not appropriate and necessary for any aspect of the management of the medical condition

3.4. all costs for treatment, if the efficacy and safety of such treatment cannot be proved

3.5. purchase of the following:

- homemade remedies; and
- alternative medicines.

3.6. beneficiaries admitted during the course of a financial year are entitled to the benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year

3.7. all costs for services rendered by:

3.7.1. persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

3.7.2. any institution, nursing home or similar institution, not registered in terms of the applicable law

3.8. abdominoplasties (including the repair of divarication of the abdominal muscles)

3.9. accommodation and services provided in a geriatric hospital, old age home, frail care facility, or the like

3.10. acupuncture

3.11. anabolic steroids, immunostimulants (except for immunoglobulin and growth hormones, which are subject to pre-authorisation by the relevant managed healthcare programme)

3.12. ante and postnatal exercises

3.13. appointments which a beneficiary fails to keep

3.14. appliances, devices and procedures not scientifically proven or appropriate

3.15. aromatherapy

3.16. autopsies

3.17. ayurvedics

3.18. leg rests, back rests and chair sets

3.19. bandages and dressings (except medicated dressings subject to authorisation by the relevant managed healthcare programme)

3.20. beds and mattresses

3.21. bilateral gynaecomastia in beneficiaries under the age of 18 years (in beneficiaries over 18 years Scheme protocols will apply)

3.22. blepharoplasties

3.23. breast augmentation

3.24. breast reconstruction (unless necessitated by pre-authorised surgical mastectomy, traumatic mastectomy or congenital unilateral absence of a breast which is subject to Scheme protocols)

3.25. breast reductions

3.26. nasal surgery done by a plastic surgeon, nasal cautery (procedure code 1069) if done with other intranasal procedures

3.27. external cardiac assistive devices

3.28. coloured or cosmetic effect contact lenses, and contact lens accessories and contact lens solutions

3.29. cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, not including coal tar products and the treatment of lice infestation, scabies and other microbial infections

3.30. dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable; and costs for

3.30.1. anaesthetics in respect of dental services, except where approved by the Scheme's dental advisor

3.30.2. general anaesthetics, conscious analog-sedation and hospitalisation for dental work except in the case of patients under the age of 12 years and bony impaction of third molars.

3.31. labial frenectomies in respect of beneficiaries under the age of 12 years

3.32. orthodontic treatment over the age of 21 years

3.33. use of high impact acrylic and precious metal in dentures or the cost of precious metal as an alternative to semi-precious or non-precious metal in dental prosthesis

3.34. osseo-integrated tooth implants in a hospital setting, except where approved by the Scheme's dental advisor

3.35. diagnostic kits, agents and appliances except for diabetic accessories

3.36. sleep therapy

3.37. treatment for erectile dysfunction and loss of libido

3.38. tonics, evening primrose oil, fish liver oils, nutritional supplements, minerals and food and nutritional supplements including baby food and special milk preparations unless usage is specifically recommended by a Scheme approved managed healthcare programme of which the beneficiary is a member or allowed by Scheme (benefit is confined to single and multivitamins and iron prescribed by a doctor and vitamins for members receiving authorised HIV and Oncology treatment and/or vitamins for women that are pregnant)

3.39. gender reassignment treatment

3.40. genioplasties

3.41. oral appliances and the ligation of temporal artery and its branches for the treatment of headaches

3.42. hirsutism

3.43. HIV resistance testing unless registered on a Scheme approved managed healthcare programme in which case Scheme protocols will apply

3.44. holidays for recuperative purposes

3.45. humidifiers

3.46. hyperbaric oxygen therapy

3.47. infertility treatment

3.48. ionisers and air purifiers

3.49. iridology

3.50. surrogate pregnancy

3.51. keloid surgery, except for burns and functional impairment deemed by the Scheme to be medically necessary

3.52. laxatives

3.53. medication in connection with substance abuse treatment unless specifically authorised by the relevant managed healthcare programme

3.54. medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines

3.55. medicine not approved by the Medicine Control Council or other statutory body empowered to approve/register medicine

3.56. MRI, CT scans and PET scans ordered by a general practitioner

3.57. obesity treatment

3.58. orthopaedic shoes and boots

3.59. osteopathy

3.60. otoplasties

3.61. pain relieving machines, e.g. TENS, APS machines

3.62. refractive eye surgery/excimer laser treatment except on Plan A

3.63. reflexology

3.64. revision of scars

3.65. rhinoplasties

3.66. smoking cessation treatment and anti-smoking preparations

3.67. stethoscopes

3.68. sphygmomanometers/blood pressure monitors

3.69. sunglasses

3.70. travelling expenses

3.71. uvulopalatalpharyngoplasty (UPPP) and laser – assisted uvuloplatoplasty (LAUP)

3.72. pharmacy service and facility fees

3.73. services rendered during any waiting periods that are imposed on a member or any dependant joining the Scheme

3.74. all claims where ICD10 codes are missing on the related account or are, invalid or incomplete

3.75. Rhizotomy and/or facet joint injections of the spine, except where approved by the Scheme's medical advisor.

CONTACT us

How to contact the scheme (plan A, B and C)

For any queries, call the Scheme on **0860 100 698** or visit the Scheme's website **www.malcormedicalaid.co.za.** Visit the Discovery Store at the following places:

Sandton

1 Discovery Place, Sandton
Telephone: 011 529 4483
Opening hours:
Monday – Friday: 08:00 – 17:00
Saturday: 08:00 to 15:00
Sunday: Closed
Public holidays: Closed

Pretoria

Menlyn Maine Central Square, Shop 35, Corner of Dallas Ave and Aramist Ave, Menlyn
Telephone: 012 676 4221 | 012 676 4222
Opening hours:
Monday – Saturday: 09:00 – 18:00
Sunday and public holidays: 09:00-14:00

Cape Town

Sable Park, Bridgeways Precinct, Century City 7446
Telephone: 021 527 1262
Opening hours:
Monday – Friday: 08:00 – 17:00
Saturdays: 08:00 to 13:00
Public Holidays: 08:00 to 13:00
Sundays: Closed

The Point shopping centre,
76 Regent Road, Sea Point
Telephone: 021 527 1073
Opening hours:
Monday – Friday: 09:00 – 18:00
Saturday and Sundays : 09:00 – 14:00
Public holidays: Closed

Durban

Shop 7, 16 Chartwell Drive,
Granada Square, Umhlanga
Telephone: 031 576 7308 | 031 576 7276
Opening hours:
Monday – Friday: 08:00 – 17:00
Saturday: 09:00 – 14:00
Sunday and public holidays: 09:00 -14:00

How to contact enablemed (plan D)

24 hour pre-authorisations: 0860 002 402
Dentistry: 0860 104 925
24 hour medical emergency: 0861 086 911

Abbreviations and definitions

The following is a list of abbreviations used in the booklet:

Term	What
Scheme or Malcor	The Malcor Medical Aid Scheme
Trustees	The Board of Trustees of the Scheme
Hospital/s	Hospitals, Private Nursing Homes, and Day Clinics
CDL	Chronic Disease List – A legislated list of 27 chronic diseases forming part of the Prescribed Minimum Benefits
MMAP®	Maximum Medical Aid Price
Scheme Rate / Tariff	The rate at which the Scheme reimburses claims
Malcor Medication Rate	The Malcor Medication Rate is MMAP® reference pricing. In the absence of MMAP®, the single exit price plus the appropriate professional fee as determined by the Scheme, will be applied
PMB	Prescribed Minimum Benefit

The Council for **MEDICAL SCHEMES**

For you, for health, for life.

What?

The Council for Medical Schemes (CMS) is a statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical scheme industry. The CMS' vision is to promote vibrant and affordable healthcare cover for all.

Why?

It is our mission to regulate the medical schemes industry in a fair and transparent manner.

- We protect the public, informing them about their rights, obligations and other matters, in respect of medical schemes;
- We ensure that complaints raised by members of the public are handled appropriately and speedily;
- We ensure that all entities conducting the business of medical schemes, and other regulated entities, comply with the Medical Schemes Act;
- We ensure the improved management and governance of medical schemes;
- We advise the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- We collaborate with other entities in executing our regulatory mandate.

Who?

The CMS governs the medical schemes industry and therefore your complaint should be related to your medical scheme. Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.

It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme before approaching the CMS for assistance.

You can contact your scheme by phone or if not satisfied with the outcome, in writing to the Principal Officer of the scheme, giving her/him full details of your complaint. If you are not satisfied with the response from your Principal Officer, you can ask the matter to be referred to the Disputes Committee of your scheme.

If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within 3 months of the date of the decision to the CMS. The appeal should be in the form of an affidavit directed to the CMS.
We are for you.

When?

When you need us! The CMS protects and informs the public about their medical scheme rights and obligations, ensuring that complaints raised are handled appropriately and speedily. We are for health.

How?

Complaints against your medical scheme can be submitted by letter, fax, email or in person at our Offices from Mondays to Fridays (08:00-17:00).The complaint form is available from www.medicalschemes.com

Your complaints should be in writing, detailing the following: Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiate the complaint.

The CMS' Customer Care Centre and Complaints Adjudication Unit also provides telephonic advice and personal consultations, when necessary.

Our aim is to provide a transparent, equitable, accessible, expeditious, as well as a reasonable and procedurally fair dispute resolution process. The CMS will send a written acknowledgement of a complaint within three working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with a complaint.

In terms of Section 47 of the Medical Schemes Act 131 of 1998, a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the CMS within 30 days.

The CMS shall within four days of receiving the complaint from the scheme or its administrator, analyse the complaint and refer the complaint to the relevant medical scheme for comments.

You can contact the CMS

Customer Care Centre

0861 123 267
0861 123 CMS

Reception

Tel: 012 431 0500
Fax: 012 430 7644

General enquiries

Email enquiries: information@medicalschemes.com
www.medicalschemes.com

Complaints

Fax: (086) 673 2466
Email: complaints@medicalschemes.com

Postal address
Private Bag X34
Hatfield
0028

Physical address
Block A, Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157

MALCOR
MEDICAL AID SCHEME
Administered by Discovery

Call Centre 0860 100 698 | service@malcormedicalaid.co.za | www.malcormedicalaid.co.za

GM_60767DIH_10/09/19_V5