The Maternity Benefit in 2020

The Maternity Benefit covers in-hospital and day-to-day medical expenses for expecting mothers and their newborns.

Overview

This document tells you about how Malcor Medical Aid Scheme covers pregnancy and childbirth. Read further to understand what we include for your specific Plan and how to get the most out of your maternity benefits.

Terms we use in this document

There may be some terms we refer to in the document that you may not be familiar with. We give you the meaning of these terms in the table below.

Terminology	Description
Prescribed Minimum Benefits (PMBs)	A set of conditions that all medical schemes must provide a basic level of cover for. This basic level of cover includes the diagnosis, treatment and costs of the ongoing care of these conditions.
Related accounts	Any account other than the hospital account for in-hospital care.
Scheme Rate	This is how much the Scheme will pay, and is based either on a rate determined by the Scheme or a specific negotiated rate with the healthcare professional.
Board of Healthcare Funders (BHF)	Board of Healthcare Funders (BHF) is the representative organisation for the majority of medical schemes throughout South Africa.
Shortfall	Malcor Medical Aid Scheme pays designated service providers at the Malcor Scheme Rate. If the doctor's rates are higher than the Scheme Rate, the member will have to pay the outstanding amount.

In hospital cover

We need to be made aware if your delivery date changes in order for us to manage your costs in the best way. Claims received related to the confinement for dates different to what has been originally authorised may lead to claims being rejected or paid from the incorrect benefit. **Kindly update your confinement date if it changes to prevent unnecessary delays in having claims paid correctly.**

The Maternity Benefit – Plan A and B

During your pregnancy

You get comprehensive maternity and post-birth benefits

The Maternity Benefit is available from 2019 per pregnancy per child up to two years after birth.

The healthcare services are covered from the **Maternity Benefit at the Scheme Rate**. **This cover does not affect your day-to-day benefit.** Once you have used up your maternity benefit, we pay for out-of-hospital healthcare expenses related to your pregnancy from your available day-to-day benefits. If you do not have day-to-day benefits, or if you have run out of funds, you must pay for these costs yourself.

Benefits will be activated when:

- your pregnancy or baby profile is created on www.malcormedicalaid.co.za
- when you preauthorise your pregnancy, (preauthorise the procedure with us by calling on 0860 100 698), or
- when you register your baby onto the Scheme (for new members).

Antenatal consultations

You are covered for up to 12 visits (including the urine dipstick) at your gynaecologist, GP or midwife.

Ultrasound scans and prenatal screening

You are covered for up to two 2D ultrasound scans including one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans. You are also covered for one Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria. We pay for Non-Invasive Prenatal Test (NIPT) screening up to 100% of the Scheme Rate from the Maternity Benefit, subject to clinical entry criteria and if you use one of our preferred providers, Genesis Genetics (a Next Biosciences company), Ampath Laboratories or Lancet Laboratories. If you use any other provider, you will be responsible for the difference between what is charged and what we pay. If you do not meet the clinical entry criteria for NIPT, the test will be covered from your available day-to-day benefits, up to 100% of the Scheme Rate.

We have added a **new chromosome test** for Downs Syndrome screening in **2020**. The chromosome test has been **added** to **Maternity screening** on the same basket as the prenatal screening basket.

Members will have the option to **choose** between **one chromosome test or Non-Invasive Prenatal Test (NIPT)**, subject to clinical entry criteria.Any additional costs such as consultations with a genetic counsellor or any other healthcare provider, and additional tests that might be needed, will be covered according to the Scheme benefits.

Blood tests

You have cover for a defined basket of blood tests per pregnancy from the Maternity Benefit. These tests include:

- **To confirm pregnancy (bHCG)**
- **HIV (Elisa)**
- **Syphilis (RPR and TPHA)**
- **German Measles (Rubella)**
- **Glucose**
- **Blood cross-matching (Rh antigen)**
- **Anaemia (Haemoglobin)**
- **Blood group (A, B and O antigen)**

Pre – and postnatal benefits

Antenatal classes or consultations with a nurse

You are covered for up to five pre- or postnatal classes up until two years after birth, or consultations with a registered nurse.

Essential registered devices

Members on Plan A have cover for up to R4 000 and members on Plan B have cover up to R2 000 for essential registered devices from the Maternity Benefit eg breast pumps and smart thermometers. These items must be registered products that are bought from registered providers.

If your plan does not have available day-to-day benefits or you have run out of funds, you need to pay these costs yourself.

Birth-related benefits

Your cover for your hospital stay depends on the type of delivery

You have cover for your delivery from your Hospital Benefit, once approved. Where we confirm cover, we will give you an authorisation number to use when booking your bed at the hospital.

You can benefit by using healthcare professionals with admitting rights to Network Hospitals and/or that are on our GP network, subject to the relevant limit on your plan option as we will cover their approved procedures in full. You have cover for three (3) days and two (2) nights for a normal delivery and four (4) days and three (3) nights for a caesarean section, if approved. The day of the delivery is counted as day one. If you need to stay in hospital longer than the number of days we approved, your doctor will need to send a letter to motivate why you need to stay in hospital longer.

We cover home births with a registered midwife

Home births are covered from the Hospital Benefit. We will cover the cost of a midwife who is registered with BHF and has a valid practice number up to the maximum Scheme Rate that the limit on your plan option covers, for up to three days after the delivery.

We cover water births in hospital or at home

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

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

Private ward cover

Members on Plan A have private ward cover up to **R2 070** per day for their approved hospital stay for the delivery. Plan B does not have access to private ward cover. If you require an extended length of stay it will be covered in a general ward, once approved.

GP and Specialist visits

Your baby is covered for up to two visits with a GP, paediatrician or an ENT from the Maternity Benefit over the two-year period.

Post-natal consultation

Pre or post-natal classes are limited to 5 consultations with a registered nurse.

Lactation consultation

You are covered for one lactation consultation with a registered nurse or lactation specialist at the Scheme Rate. Benefit is available from the date of activation.

Nutrition assessment

You are covered for one nutrition assessment with a dietitian at the Scheme Rate. Benefit is available from the date of activation.

Mental Health

You are covered for up to two mental health consultations with a counsellor or psychologist at the Scheme Rate. Benefit is available from the date of activation.

The Maternity Benefit – Plan C

During your pregnancy

We cover out-of-hospital consultations and tests from your day-to-day benefits

We pay all healthcare services related to your pregnancy, like scans, blood tests and antenatal consultations with a GP, midwife or gynaecologist during your pregnancy from your available day-to- day benefits.

We cover healthcare professionals who we do not have a payment arrangement with up to 100% of the Scheme Rate.

We cover specialists and GP's for pregnancy according to your plan type and subject to a set amount of visits.

We pay for three (3) 2D pregnancy scans from available day-to-day benefits. Any 3D and 4D scans will add up to this limit and will be paid up to the rate of a 2D scan only.

Private ward cover

Members on Plan C does not have access to private ward cover

Ultrasound scans and prenatal screening

You are covered for up to two 2D ultrasound scans including one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans. You are also covered for one Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria. We pay for Non-Invasive Prenatal Test (NIPT) screening up to 100% of the Scheme Rate from the Maternity Benefit, subject to clinical entry criteria and if you use one of our preferred providers, Genesis Genetics (a Next Biosciences company), Ampath Laboratories or Lancet Laboratories. If you use any other provider, you will be responsible for the difference between what is charged and what we pay. If you do not meet the clinical entry criteria for NIPT, the test will be covered from your available day-to-day benefits, up to 100% of the Scheme Rate.

Any additional costs such as consultations with a genetic counsellor or any other healthcare provider, and additional tests that might be needed, will be covered according to the Scheme benefits.

Blood tests

You have cover for a defined basket of blood tests per pregnancy from the overall annual out-of-hospital benefit. These tests include:

- To confirm pregnancy (bHCG)
- HIV (Elisa)
- Syphilis (RPR and TPHA)
- German Measles (Rubella)
- Glucose
- Blood cross-matching (Rh antigen)
- Anaemia (Haemoglobin)
- Blood group (A, B and O antigen)

Pre – and postnatal benefits

Essential registered devices

Members on Plan C have access to external medical items provided that members buy it from appropriately registered providers with a valid BHF practice number. We cover these items at 100% of the Scheme Rate, subject to available funds in your overall annual out-of-hospital benefit.

Birth-related benefits

Your cover for your hospital stay depends on the type of delivery

You have cover for your delivery from your Hospital Benefit, once approved. Where we confirm cover, we will give you an authorisation number to use when booking your bed at the hospital.

You can benefit by using healthcare professionals with admitting rights to Network Hospitals and/or that are on our GP network, subject to the relevant limit on your plan option as we will cover their approved procedures in full. You have cover for three (3) days and two (2) nights for a normal delivery and four (4) days and three (3) nights for a caesarean section, if approved. The day of the delivery is counted as day one. If you need to stay in hospital longer than the number of days we approved, your doctor will need to send a letter to motivate why you need to stay in hospital longer.

We cover home births with a registered midwife

Home births are covered from the Hospital Benefit. We will cover the cost of a midwife who is registered with BHF and has a valid practice number up to the maximum Scheme Rate that the limit on your plan option covers, for up to three days after the delivery.

We cover water births in hospital or at home

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

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

General information applicable to all Plans

Antiretrovirals to prevent mother-to-child transmission

We fund HIV medicine to prevent mother-to-child transmission of HIV from the in-hospital overall annual limit. Please refer to the HIV*Care* brochure or call the HIV*Care* team on 0860 100 698 for more information.

We pay for medicine and supplements for pregnancy from your day-to-day benefits

We pay for medicine and supplements that you may use during your pregnancy, like medicines for morning sickness, iron supplements and folic acid, up to 100% of the Scheme Rate for medicine if you make use of a Dis-Chem pharmacy, which is the Scheme's Designated Service Provider.

Treatment for neonatal jaundice

If your baby needs phototherapy for neonatal jaundice, we will cover the phototherapy lights from the day-to-day benefit.

We cover circumcisions from the Hospital Benefit

Please preauthorise the procedure with us by calling on 0860 100 698.

There are certain items we do not cover

We do not cover these items:

- Mother and baby packs that hospitals supply
- The bed-booking fee that some hospitals may require you to pay for
- Your lodger or border fees if your baby needs to stay in hospital for longer, and you choose to stay on
- Pre- and postnatal exercises

Getting the most out of your maternity benefits

Tell us about your pregnancy

Malcor Medical Aid Scheme covers the birth of your baby either in hospital or clinic with a doctor or a midwife or at home with the help of a midwife. It is important to call us when you are between 12 to 24 weeks pregnant to inform us of your pregnancy. You can call us on 0860 100 698.

Understand your benefits

The Prescribed Minimum Benefits is a set of conditions which all medical schemes must provide a basic level of cover for. The Prescribed Minimum Benefit (PMB) regulations include funding for antenatal care where it is necessary to hospitalise the mother before she gives birth. We will pay in hospital accounts in full if you receive treatment from one of our designated service providers.

What are designated service providers (DSPs) and how to find them

A designated service provider (DSP) is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have a payment arrangement with. According to this arrangement, they will provide treatment or services at a contracted rate. This will make sure that you do not have any shortfalls when you use their services.

If you do not use healthcare providers who we have a DSP payment arrangement with, you will have to pay part of the treatment costs yourself. This amount you have to pay is called shortfall.

Pregnant mothers who need to be admitted during their pregnancy can call us on **0860 100 698**. For more information on PMBs go to our website at www.malcormedicalaid.co.za.

Register your baby within 30 days of the birth

We automatically cover newborns under the parent's name up to the last day of the calendar month that he or she is born. For example, if your baby is born on 20 May, he or she will have automatic cover from 20 May until 31 May under your name.

To continue cover, the baby must be registered from the next calendar month and we must receive a contribution made by the main member on their behalf as a dependant. Please note we may underwrite the application to enrol your baby and apply waiting periods if you do not register your baby within 30 days of the date of birth.

To register your newborn on the Scheme, you must inform your employer.

Contact us

Tel: 0860 100 698• P O Box 8012, Greenstone, 1616• www.malcormedicalaid.co.za