cmp medical aid

MyHealth 200

Adults	**R3 577**	**Minor dependents**	**R631**

Benefits Overview

HOSPITALISATION At Life Health, Mediclinic or Netcare hospitals and any doctor/specialist of your choice	**JOINT REPLACEMENTS**
PATHOLOGY In- and out-of-hospital	**BONE DENSITY TEST**
MAJOR MEDICAL ILLNESS COVER	**MAMMOGRAMS**
RADIOLOGY	**LAPAROSCOPIC AND ENDOSCOPIC PROCEDURES**

In-hospital cover

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Overall annual limit Benefits must be authorised	Unlimited authorised admission to hospital.
Hospital accommodation Ward fees, operating theatres, unattached theatres and day hospitals	Up to 100% of the CMP tariff or Agreed Tariff in intensive care, specialised intensive care, high care and general wards.
Emergency room treatment Outpatient services	No cover – except for PMBs.
Hospitalisation/institutionalisation for the treatment of mental illnesses, and alcoholism and drug addiction	No cover – except for PMBs.
Treatment in lieu of hospitalisation Registered step-down facilities, hospices, registered nurses and rehabilitation centres when hospitalisation is not clinically appropriate	100% of the CMP tariff for hospices and registered nurses, limited to 15 days per beneficiary per year.
Emergency services Provided by a registered ambulance service	100% of the CMP tariff – except for PMBs.
Blood transfusions In-hospital	100% of cost, up to 100% of the CMP tariff.
Materials and devices Used in-hospital	100% of cost, up to the SEP/Agreed Tariff/pre-authorised tariff.
Medicines Dispensed and used in-hospital	100% of cost, up to the SEP for approved medicines.
Supplementary services Refer to page 11 for more information	100% of the CMP tariff.
Joint replacements	200% of the CMP tariff.
Consultations, procedures and operations performed by General Practitioners	200% of the CMP tariff.
Consultations, procedures and operations performed by registered medical specialists Written referral required	200% of the CMP tariff.
Laparoscopic and endoscopic procedures performed in hospital Written referral required	200% of the CMP tariff with a co-payment of R1 500 per scope used, per procedure.

Out-of-hospital cover

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CONSULTATIONS AND PROCEDURES	
General Practitioner consultations and procedures Any procedure performed by a General Practitioner requires pre-authorisation	One GP consultation per beneficiary, per year, at 100% of the CMP tariff – except for PMBs.
Registered medical specialist consultations and procedures Written referral required	No cover – except for PMBs.
Laparoscopic and endoscopic procedures Written referral required	200% of the CMP tariff with a co-payment of R1 500 per scope used, per procedure.
Supplementary services e.g. physio-, occupational-and speech therapists, and dieticians	No cover – except for PMBs.
DENTISTRY, ORTHODONTICS AND ORAL SURGERY	
General dental practitioner consultation	No cover.
General dental practitioner procedures In-hospital, and according to Dental Protocols	100% of cost, up to 120% of the CMP tariff for procedures and operations which require hospitalisation – except for PMBs.
Orthodontic treatment	No cover.
Maxillo-facial surgeons In-hospital procedures Written referral required	120% of the CMP tariff – except for PMBs.
Maxillo-facial surgeons and orthodontists Dental implants, general dental treatment, orthodontic treatment, orthognathic procedures, periodontic and prosthodontic treatment, and according to Dental Protocols	No cover.

Out-of-hospital cover

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MATERNITY AND PAEDIATRICS	
Maternity confinements Birth or delivery	200% of the CMP tariff (only medically necessary caesareans are covered) – except for PMBs.
Antenatal consultations and foetal scans In- or out-of-hospital Provided by a registered gynaecological or radiology practice	200% of the CMP tariff, limited to R2 950 per family per year – except PMBs.
Paediatrician consultations	200% of the CMP tariff, limited to R2 498 per child per year – except for PMBs.
Paediatrician procedures and operations	200% of the CMP tariff.
DIAGNOSTICS – X-RAYS, RADIOLOGY AND PATHOLOGY	
Radiologist procedures Angiograms, CT scans, duplex doppler scans, interventional radiology, MRI scans and nuclear medical investigations Written referral required	100% of the CMP tariff, limited to R15 425 per beneficiary per year, with a co-payment of R1 700 per event (on all procedures) – except for PMBs.
Black and white x-rays In-hospital	100% of the CMP tariff.
Black and white x-rays Out-of-hospital	No cover – except for PMBs.
Mammograms Provided by a registered radiology practice	100% of the CMP tariff, with a co-payment of R300, per female beneficiary over the age of 49 years, once every 24 months, limited to R1 987 – except for PMBs.
Bone density benefit Provided by a registered radiology practice	100% of the CMP tariff, per beneficiary, over the age of 50, once every five years – except for PMBs.
Pathology services In- and out-of-hospital With Pathcare and Lancet Laboratories and must be SANAS-accredited Written referral required	In- and out-of-hospital pathology is covered in full as long as you use Pathcare or Lancet Laboratories, who are SANAS-accredited. In-hospital pathology services performed by a service provider other than Pathcare or Lancet Laboratories will only be covered from your insured benefits during the first 24 hours of an emergency admission, and only when approved by CMP and performed by a SANAS-accredited pathologist. Any out-of-hospital pathology will be for your own account if you don't use a Preferred Provider (Pathcare or Lancet Laboratories).

Out-of-hospital cover

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PROSTHESES, DIALYSIS, ORGAN TRANSPLANTS AND ONCOLOGY (MUST BE AUTHORISED)	
Prostheses and implants excluding hearing devices and dental implants Refer to Prostheses and Implants price list on page 10.	If introduced internally as an integral part of an operation, 100% of the cost, limited to R56 538 per beneficiary per year.
External prostheses and surgical appliances	Payable from MSA – except for PMBs.
Chronic renal dialysis	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.
Organ transplants	Provided that PMB level of care criteria are met, covered at 100% of the CMP tariff.
Oncology treatment	Provided the formularies and treatment protocols of CMP and the SA Oncology Consortium's (SAOC) tier guidelines are applied in accordance with an agreed treatment plan, covered at 100% of the CMP tariff, as per the SAOC's Primary Level of Care treatment guidelines.
Anti-emetics, vitamins and cosmetic and prosthetic appliances forming part of oncology treatment	No cover – except for PMBs.
PRESCRIBED MEDICATION	
Chronic medication Subject to authorisation	100% of cost, to a maximum of SEP, plus the agreed Preferred Provider dispensing fee.
Conditions covered by the chronic medicine benefit	Refer to the chronic medicine benefit under additional notes and terminologies on page 8.
Take-home medication	Payable from MSA – except for PMBs.
SPECTACLES, CONTACT LENSES AND SUPPLEMENTARY SERVICES	
Spectacles and contact lenses	No benefit.
Supplementary services Refer to additional notes and terminologies	No benefit.

What doesn't CMP cover

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As with any medical scheme, we are unable to cover certain procedures, products and services. These are listed as exclusions across all our products and may never be paid for from insured benefits, subject to PMB rules. They may, however, be paid for from the MSA if funds are available. The following exclusions apply:

- COVID-19 testing that is in place of a vaccination or for travel or leisure purposes
- Blepharoplasties, or any procedure to correct eye refraction errors including, but not limited to an excimer laser/Lasik
- Treatment for sexual dysfunction (male and female)
- Infertility treatment, unless authorised within PMB level of care criteria
- Breast reductions, including scar revision, Botox, breast augmentation and gynaecomastia
- Mammaprint genetic testing and any other type of genetic testing
- Non-diseased breast reconstruction, nipple reconstruction and symmetry, unless authorised within PMB level of care criteria
- Any cosmetic surgery
- Long-term nursing care (such as frail care nursing)
- Non-PMB treatment relating to alcohol or substance abuse, wilful self-injury or attempted suicide
- Non-PMB psychological and psychiatric treatment, including sleep studies
- Treatment and/or surgery for obesity
- Educational and group therapy
- Protective gear
- Treatment relating to or forming part of organ transplants that does not fall within the PMB level of care criteria
- Non-PMB external devices (including crutches, commodes, nebulisers, pronator boots, bed pans, raised toilet seats, wheelchairs, and CPAP machines)
- Non-PMB hearing devices and cochlear implants (or the maintenance thereof)
- Artificial and synthetic blood products
- Dental implants, orthodontic treatment, prosthodontic treatment, orthognathic procedures, periodontic treatment

What doesn't CMP cover

- General dentistry performed under general anaesthetic or conscious sedation for minor beneficiaries over the age of 7 years
- Experimental or unproven treatments, procedures, devices, unregistered medicines and Section 21 medicines, as per the Medicines Control Council
- Household medicinal remedies, contraceptives, patent medicines, non-ethical and all proprietary preparations (including vitamins, supplements, minerals, medical creams, soaps, shampoos, and laxatives)
- Medical examinations for insurance, school, association, emigration, visa, employment or other applications
- Any treatments or costs not specifically provided for
- Deep brain implants for medical and surgical conditions
- Internal nerve pain stimulators for medical and surgical conditions – this includes both temporary and permanent implants

Important Notes

Agreed tariffs

CMP has negotiated fixed tariffs with the major hospital groups in South Africa, namely Life Healthcare, Mediclinic and Netcare. These agreed tariffs, which are not necessarily linked to the CMP tariff, are applicable to all CMP members requiring hospitalisation. There are a few specific hospitals that don't fall into these major groupings and in those instances, claims will only be paid at the CMP tariff, which may result in payment shortfalls.

Chronic Medication benefit

Conditions that are covered on the chronic medicine benefit and make up our Chronic Disease List (CDL) are:

- Addison's Disease
- Anti-coagulating therapy
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic Obstructive Pulmonary Disease
- Chronic Renal Disease
- Coronary Artery Disease
- Crohn's Disease
- Cushing's Disease
- Diabetes Insipidus
- Diabetes Mellitus Type 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- HIV
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis
- Multiple Sclerosis
- Parkinson's Disease
- Schizophrenia
- Systemic Lupus Erythematosis
- Ulcerative Colitis

Access to the Chronic Medication benefit is subject to registration and authorisation. To register for the Chronic Disease Management programme, please contact our Customer Care division at 021 937 8300 or email chronic@cmp.co.za.

Claims

All claims must be submitted within four months of the date of treatment. In order for members to claim reimbursement from CMP, the service provider must have an active Board of Healthcare Funders (BHF) practice number.

CMP tariff

This tariff represents the maximum amount CMP will pay to service providers on behalf of its members. The 2025 CMP tariff is the 2024 CMP tariff + 4.7%.

Co-payments

In some cases, a specific pre-determined amount of the cost of the procedure or service in question will be for members' own account, as per our benefit rules. A co-payment is not the same as a payment shortfall.

Dental procedures (in- and out-of-hospital)

Dental work is only covered as per the CMP Dental Protocol.

Emergency services

If you need the use of emergency road transport services, you must obtain authorisation within 72 hours of the event and the service must be provided by a registered service provider.

Any airlifting services must be pre-authorised prior to take off, and there must be proof of a life-threatening emergency.

In-excess tariffs

If a service provider charges in excess of the CMP tariff.

Medical emergency

The sudden, unexpected onset of a health condition that requires immediate medical attention. Where treatment is not available, the condition could result in serious harm or even death.

Payment of benefits

If a member requests that benefits are paid directly to them, we will oblige at our discretion. CMP reserves the right to withhold payment of claims referred to the HPCSA for investigation.

Payment shortfalls

When there are not enough insured benefits or savings to pay for a medical account, the amount owing is called a payment shortfall. This often happens when a service provider charges more than what a member's product provides for. A shortfall may be paid from a member's savings account (MSA). However, if savings are depleted, members become personally liable for the amount. A payment shortfall is not the same as a co-payment.

Important Notes

Prescribed Minimum Benefits (PMBs)

PMBs are the minimum benefits that all medical schemes are legally required to cover so that members are always covered in life-threatening situations. A set of about 270 medical conditions, 29 chronic conditions and all genuine emergency medical conditions are classified as PMBs.

To ensure payment of PMB claims, PMB treatment must conform to CMP's formularies and protocols, and all ICD-10 and PMB codes must be recorded on a claim.

CMP reserves the right to investigate all PMB claims, and to request supporting documentation. PMBs will be paid in accordance with current legislation if services are obtained from a Preferred Provider, or involuntarily obtained from any other service provider. This condition is subject to pre-authorisation, as well as rules 17.9 and 17.10 of the full benefit sets.

Pro-rated benefits

Any member who joins CMP after 1 January will receive out-of-hospital benefits in proportion to the number of contributions they will pay for the remainder of the year.

Prostheses and implants

If introduced internally as an integral part of an operation, 100% of the cost, limited to R56 538 per beneficiary per year.

PROSTHETIC AND IMPLANTS PRICE LIST **– cover is subject to these limits**	
DEVICE	**SUB-LIMIT**
Cardiac stents	R17 668 per stent
Trans-vaginal tape	R12 077
Intra-ocular lenses	R3 547 per lens
Patches used in incisional hernia repairs	R4 830
Patches used in groin hernia repairs	R1 618
Pacemakers, including leads	R56 538
Joint replacements	R56 538
Bi-lateral joint replacements	R113 076

Referral of accounts

If an account submitted to CMP appears to be invalid for whatever reason, we reserve the right to scrutinise the account and, if necessary, take further action on a member's behalf. If necessary, the account will be referred to the HPCSA for further investigation. Until the grievance is resolved, CMP may withhold payment of that claim.

Referral to a specialist

In the interests of better co-ordinated care and the management of costs, members must have a written motivation from preferably their general practitioner (GP) or family physician before seeing a specialist, should they require any form of hospitalisation or procedure.

Registered practitioner

A registered practitioner is one who is registered with the Health Professionals Council of South Africa (HPCSA). The HPCSA is a statutory body established to serve and protect the public and provide guidance to registered healthcare practitioners and medical schemes. Cover is subject to instruction by a HPCSA-registered medical practitioner (including a paramedic). Cover is subject to services received from registered medical specialists, limited to anaesthetists, dermatologists, gynaecologists, paediatric cardiologists, paediatric surgeons, cardiothoracic surgeons, general surgeons, neurologists, neurosurgeons, otorhinolaryngologist (ear, nose and throat specialists), urologists, clinical haematologists, gastroenterologists, nuclear medicine practitioners, ophthalmologists, orthopaedic surgeons, physicians, plastic & reconstructive surgeons, and pulmonologists.

Single Exit Price (SEP)

A SEP is the price charged for drugs by drug manufacturers to service providers (pharmacies, hospitals and practices, for example). This price, as well as the dispensing fee charged by service providers, is regulated by government.

Supplementary services

This includes aromatherapists, chiropodists, chiropractors, dieticians, hearing aid acousticians, homeopaths, herbalists, naturopaths, occupational therapists, orthotists, orthoptists, physiotherapists, podiatrists, psychiatrists, psychologists, physical medicine practitioners, reflexologists, social workers, speech therapists and sexologists. **Separate authorisation is required for these services in-hospital.**

Written referral

This is a referral from a registered General Practitioner or family physician. The referral must be in the form of a clinically appropriate medical report/referral letter. This report must indicate why a beneficiary needs to be referred, what conservative treatment has been followed and the beneficiary's recent medical history. This is in accordance with rule 17.11.