



MARCH MEDIFLASH

2026 is well underway and with it comes some new and exciting Scheme benefits and offerings. You will have received your year-end communication outlining the 2026 benefit updates at the end of the year. We hope you have familiarised yourself with your Option details for this year. You can review all the 2026 Benefit Option information in the latest [Benefit Guide](#).

Please note: the deadline for submitting an [Option change](#) was 16 March 2026. Any requests made thereafter will not be accommodated.

Frequently Asked Questions – 2026 Benefits and Contributions

We have included some common questions that might assist you in understanding your 2026 Option benefits and contributions:

1. What are the main changes for 2026?

- Introduction of a new benefit option:
Option B Classic
- **Option C** is now a network option
- Contribution increases across all options
- Updated **medicine formulary**

2. What is Option B Classic?

Option B Classic is a new option that offers the same core benefits as Option B, with a few important requirements:

- **All planned hospital admissions must be done at a network hospital.**
- **You must nominate a network GP as your Primary Care Provider** (at dependant level) for chronic care
- **Chronic medication to be dispensed via MediRite pharmacies.**

State facilities (local clinics and government hospitals) are also covered.

There is no change to your other benefits, including optometry, dental care, and prescribed medication (excluding chronic medicine).

- **New Designated Service Providers (DSPs) – MediRite Pharmacies and hospital networks**
- Enrolment in Member Care Programmes for full benefits
- Expanded GP networks are available for all options
- Expanded preferred specialist network for all options

3. What changes have been made to Option C?

Option C is now a network option.

- **All planned hospital admissions must be done at a network hospital.**
- **You must nominate a network GP as your Primary Care Provider** (at dependant level) for chronic care
- **Members must follow DSP rules to avoid co-payments**

There is no change to your other benefits, including optometry, dental care, and prescribed medication (excluding chronic medication).

4. When do these changes take effect?

You can change your option once a year, during January.

5. When was the deadline for changing my option?

The deadline for 2026 option changes was 16 March 2026.

6. Can I change my option more than once a year?

No. Option changes are only allowed **once per year** during the designated period. Any changes submitted after the deadline will not be processed unless exceptional circumstances apply, and the Scheme approves the request.

7. What are the contributions for 2026?

- **Option A:** R9 604 for a main member
- **Option B:** From R3 867 (income-based)
- **Option B Classic:** From R2 867 (income-based)
- **Option C:** From R1 782 (income-based)

8. What are Prescribed Minimum Benefits (PMBs)?

PMBs are a set of defined healthcare conditions and treatments that all registered medical schemes in South Africa are legally required to cover in full. (PMBs) include:

- Essential healthcare services for emergencies
- 271 listed medical conditions
- 27 chronic conditions.

Full cover is dependent on using DSPs, adhering to formulary requirements, and following the Scheme's treatment protocols.

9. What is a DSP?

A healthcare provider (e.g. doctor, hospital, or pharmacy) that has an agreement with the medical scheme to provide medical services at negotiated rates for specific medical conditions or treatment.

10. What is a formulary?

A formulary, or medicine list, is a defined list of approved medicines that a medical scheme covers for specific conditions on different benefit options.

11. Why do I need to follow DSP and formulary rules?

To help control healthcare costs while ensuring appropriate and effective treatment. Using a DSP allows the Scheme to pay negotiated rates and often prevents co-payments. Following the formulary ensures that approved, cost-effective medicines are used. These rules help keep contributions affordable and maintain the financial sustainability of the Scheme.

12. What are the Scheme's DSPs?

- **GP Networks:** Applicable to Option A, Option B, Option B Classic, and Option C
- **Hospital Networks:** Applicable to Option B Classic and Option C
- **MediRite Pharmacies:** Used for chronic medication on Option B Classic and Option C

NB: If a service is obtained at a State facility (such as a local clinic and government hospital), it will be covered in full.

13. What happens if I use a non-DSP pharmacy for chronic medication?

For **Option B Classic** and **Option C**, you will incur co-payments if you do not use MediRite or State facilities for chronic medication.

14. Do I need to nominate a GP?

Yes, members on **Option B Classic** and **Option C** nominate a network GP as their Primary Care Provider. However, members on Option A and B do not need to nominate a GP. They can use any doctor on the network and it will be paid in full.



15. Will my current GP automatically become my Primary Care Provider in 2026?

No, you will be required to nominate your GP.

16. How do I choose a Primary Care Provider for myself and my dependants?

Log in to www.medipos.co.za and navigate to **Hospital and doctor visits** → **Nominate a Primary Care Provider**, then click **Nominate Now**. You can also ask your doctor to nominate themselves as your PCP via Discovery HealthID, provided you give consent.

You can nominate a PCP for each dependant. Make sure the doctor you choose is on the GP Network.

17. What if I want to change my Primary Care Provider (PCP) during the year?

You may change your PCP once per calendar year, at the beginning of the year. You may still be granted an opportunity to change your nominated PCP on a case-by-case basis for valid reasons, including:

- Moving to a new area (change of residence)
- Dissatisfaction with the current provider with proper motivation
- Doctor closed practice / incapacitated / retired
- Doctor left the network
- Doctor changed specialisation or moved practices

18. What happens if there is no network hospital in my area if I am on Option B Classic or Option C?

If there is no network hospital available in your area (within a 30km radius) you may attend a non-network hospital and no co-payment will be applied to your hospital claim. Be sure to review the Scheme's list of network hospitals. If none exists near you, you may need to consider changing your benefit option in the next year.

Members on Option B Classic and Option C are required to use the Scheme's designated hospital network. To avoid co-payments, ensure that your treating specialist admits you to one of the network hospitals. If you choose to use a non-network facility, **a R10 000 co-payment** will be applied to your hospital claim. Please remember that all planned hospital admissions **must be pre-authorised**.

19. Why are we using networks?

By adopting networks and network-based options, MEDiPOS can better manage healthcare costs, improve long-term sustainability and ensure members receive care through providers who meet agreed-upon quality and pricing standards. Networks are being introduced to help support MEDiPOS's overall recovery and stabilisation plan after the operational and financial problems that the Options experienced.

20. Can my Personal Medical Savings Account balance be transferred into my personal bank account?

No, your Personal Medical Savings Account (PMSA) cannot be transferred into your personal bank account. Savings may only be used to fund eligible medical claims in line with Scheme Rules, and/or the PMSA is intended exclusively for defined claim types, not for personal withdrawals. A PMSA refund will only be paid into the main member's personal bank account if the member resigns from the Scheme or moves to a benefit option that does not offer a PMSA.

21. What are Disease Management Programmes?

These programmes provide additional support for managing chronic conditions and improving health outcomes. Enrolment is required to access full benefits.

22. How do I register for the Spinal Conservative Care Programme?

To register for the Spinal Conservative Care Programme, you must first consult your GP or Primary Care Provider for back or neck pain. If your GP is part of the spinal network, they can assess you and refer you via Discovery HealthID – a digital platform used by Providers – to a network physiotherapist, chiropractor, or virtual partner for a full assessment. If they are not on the network, they must refer you to a network spinal surgeon, who will determine whether surgery or conservative treatment is appropriate. The network allied professional or virtual partner will then conduct clinical assessments, including disability scoring and a Patient Health Questionnaire-2 (PHQ2).

PHQ-2 is a short, two-question screening tool used to quickly check for possible depressive symptoms, to determine if you meet the Spinal Conservative Care Programme's entry criteria. If you qualify, they will complete the registration through HealthID, giving you access to a conservative care treatment basket. You can't register yourself, and the programme will only accept referrals done through the Provider, on HealthID. You will be enrolled only if you meet all the clinical requirements.

23. Where can I find more details about my benefits?

Refer to the **2026 Benefit Guide** included in your Year-End communications and available on the MEDiPOS website under: **Find a Document** → **Benefit Guides** or contact **Client Services** at **0860 100 078** or enquiries@medipos.co.za.

24. Who do I contact for queries?

Client Services: enquiries@medipos.co.za | 0860 100 078



NETWORK HOSPITALS **AND** PHARMACIES



A reminder that if you are on Option B Classic or Option C, you need to nominate a network GP as your Primary Care Provider. In addition to this, you must make use of [hospital networks](#) to ensure you don't have to pay for treatment out of your own pocket. You can also make use of the [medical and provider search tool](#) to find your nearest GP or specialist.

Please remember that on all options, you need to be referred by your GP to visit a specialist of any kind. If there is no referral your claim will not be paid. You need to provide your referral when you visit the specialist, and they will then include the referral when they invoice you so that your claim is paid correctly. For ongoing specialist care, you do not need a referral every time, the specialist must just include the original referral.

Members who require chronic medication must obtain this through a MediRite pharmacy. A simple and convenient way to obtain your medication is to scan the QR code below and submit your script directly to MediRite. Please be aware that, should you have any issues with your pharmacy orders or deliveries, the Scheme is unable to assist you. You will need to liaise with MediRite directly on 0800 222 6161.

UPDATE YOUR CHRONIC SCRIPT

Please remember to contact us with an updated script for your chronic medications so that we can load it onto the system. Please send your **script** to cib.app.forms@medipos.co.za



Medirite+

SCAN
HERE

to upload your
prescription



COME AND MEET WITH US!

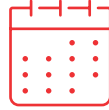
Keep an eye out for our onsite MEDiPOS consultants who will be visiting these locations in March between 08:00 and 12:30:

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24 MARCH 2026

Tshwane



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Germiston Mail



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