MEMBER GUIDE
Summary • 2022/23

CONTACT DETAILS

Claims and Benefits Enquiries
Tel: 0860 100 076 or +27 11 208 1021 **Hours:** 7:00 to 19:00 Monday – Friday and 8:00 to 13:00 on Saturdays, excluding Public Holidays **Fax:** 0864 647 808 **Email:** enquiries@omsmaf.co.za **Website:** www.omsmaf.co.za
Online Communication Tools
Website: www.omsmaf.co.za
Current First-Time Claims
Email: claims@omsmaf.co.za **For claims refunds Email:** refundme@omsmaf.co.za **Fax:** 0864 647 808 **Post:** OMSMAF (Claims), PO Box 1411, Rivonia, 2128
Claims for services rendered outside RSA
Email: foreignclaims@omsmaf.co.za
Membership, Contributions and enquiries pertaining to Plan selections
Tel: 0860 100 076 or +27 11 208 1021 **Fax:** 0862 106 635 **Email:** membership@omsmaf.co.za

Pre-authorisation: Hospital Benefit Management

Tel: 0860 100 076 or +27 11 208 1021 and follow the voice prompts for hospital pre-authorisations

Hours: 24-hour service

Fax: 0862 957 355

Email: authorisations@omsmaf.co.za
Emails and Faxes will be responded to during office hours

Pre-authorisation: Chronic Medicine Management

Tel: 0860 100 076 or +27 11 208 1021 and follow the voice prompts for chronic medicine

Hours: 8:00 to 17:00 Monday – Friday only

Email: chronic@omsmaf.co.za

Fax: 0864 613 913

Pre-authorisation: Oncology case manager (patients diagnosed with cancer)

Tel: 0860 100 076 or +27 11 208 1021 and follow the voice prompts for oncology

Hours: 8:00 to 17:00 Monday – Friday only

Fax: 0864 613 917

Email: oncology@omsmaf.co.za

Independent Clinical Oncology Network (ICON)

Website: www.cancernet.co.za

Email: oncology@omsmaf.co.za

Out-of-Hospital PMB Care Plans

Fax: 0864 647 808

Email: pmb@omsmaf.co.za

Dental Authorisation

Email: dental@omsmaf.co.za

Tel: 0860 100 076

Specialist Authorisation

Network and Network *SELECT* Plans

Email: authorisations@omsmaf.co.za

Traditional and Traditional Plus Plans (Including *SELECT*)

Email: spec.auth@omsmaf.co.za

Contributions

Email: contributions@omsmaf.co.za

Tel: 0860 100 076

Healthcare Professionals Contact Centre

Tel: 0860 100 076

Fax: 0864 647 808

HIV and AIDS Management Programme

Universal Healthcare HIV/AIDS Management Programme

Tel: 0860 378 800

Hours: 8:00 to 17:00 Monday – Friday only

Fax: 0864 613 921

Email: hivprogramme@omsmaf.co.za

Website: www.omsmaf.co.za

Mental Health Programme

Universal Healthcare Mental Health Programme

Tel: 0860 100 076

Hours: 8:00 to 17:00 Monday – Friday only

Email: mentalhealth@omsmaf.co.za

Back and Neck Programme

Tel: 0860 100 076 or +27 11 208 1021

Hours: 8:00 to 17:00 Monday – Friday only

Fax: 0862 957 355

Email: backandneck@omsmaf.co.za

Active Disease Risk Management Programme

Universal Healthcare Disease Management Programme

Tel: 0860 100 076

Hours: 8:00 to 17:00 Monday – Friday only

Fax: 0864 613 918

Email: diseasemanagement@omsmaf.co.za

Mother and Baby Programme

Tel: 0860 100 076 or +27 11 208 1021

Hours: 8:00 to 17:00 Monday – Friday only

Fax: 0862 957 355

Email: maternity@omsmaf.co.za

PAED-IQ's Babyline

Tel: 0860 666 110

For further details refer to **page 39** of the full Member Guide

Universal Healthcare Network Providers

Email: network.accounts@omsmaf.co.za

Escalations (for members)

Please refer to **page 120** of the full Member Guide for detailed escalation process

Whistle Blowers – Fraud Hotline

Tel: 080 111 4447 (Toll free number)

Fax: 086 672 1681

Email: fraud@omsmaf.co.za

Website: www.thehotline.co.za

WebApp: www.thehotlineapp.co.za

Callback: (Please call me) 072 595 9139

GAP Claims (use this email address for notifying the Fund to pay at Medical Scheme Rate)

Please refer to **page 52** of the full Member Guide for more detail on the Gap Claims process

Council for Medical Schemes (if you cannot resolve a query with the Fund)

Tel: 0861 123 267 or +27 12 431 0500

Email: complaints@medicalschemes.co.za

Disclaimer: Every effort has been made to ensure that this guide is an accurate explanation of the benefits offered by the Old Mutual Staff Medical Aid Fund. Please note that this document does not replace the Rules of the Fund, which take precedence over any wording in this guide, and is subject to approval from the Council for Medical Schemes. To obtain a copy of the Fund Rules, please log into the OMSMAF member portal, via the Fund's website www.omsmaf.co.za where you will find a link to the Fund Rules or send an email to OMSMAF_Office@oldmutual.com.

IN SUMMARY

IN THIS SECTION

- Can I have a quick overview of the Plans?
- What do I need to know about the *SELECT* Plans?
- What are the monthly contributions for 2022/23?
- What is the annual healthcare spend available for day-to-day medical expenses?
- What must I consider before making a choice?
- Who are the Fund's contracted providers, and what co-payments could I incur?

Can I have a quick overview of the Plans?

The Fund continues to offer as much choice to its members as possible, with a total of eight Plans to choose from.

The Plans range from lower cost options that offer lower cover, to higher cost options that offer more comprehensive cover.

In addition, members can also choose one of the *SELECT* Plans, which offer a reduced contribution rate in return for access to selected hospitals only. See page 21 for important information on these Plans.

The Plans differ quite extensively, both in terms of benefits In-Hospital and Out-of-Hospital, as can be seen from the graphic on the next page. Please refer to the summary tables on the next pages, as well as the detailed tables in other sections of this member guide, for more information.

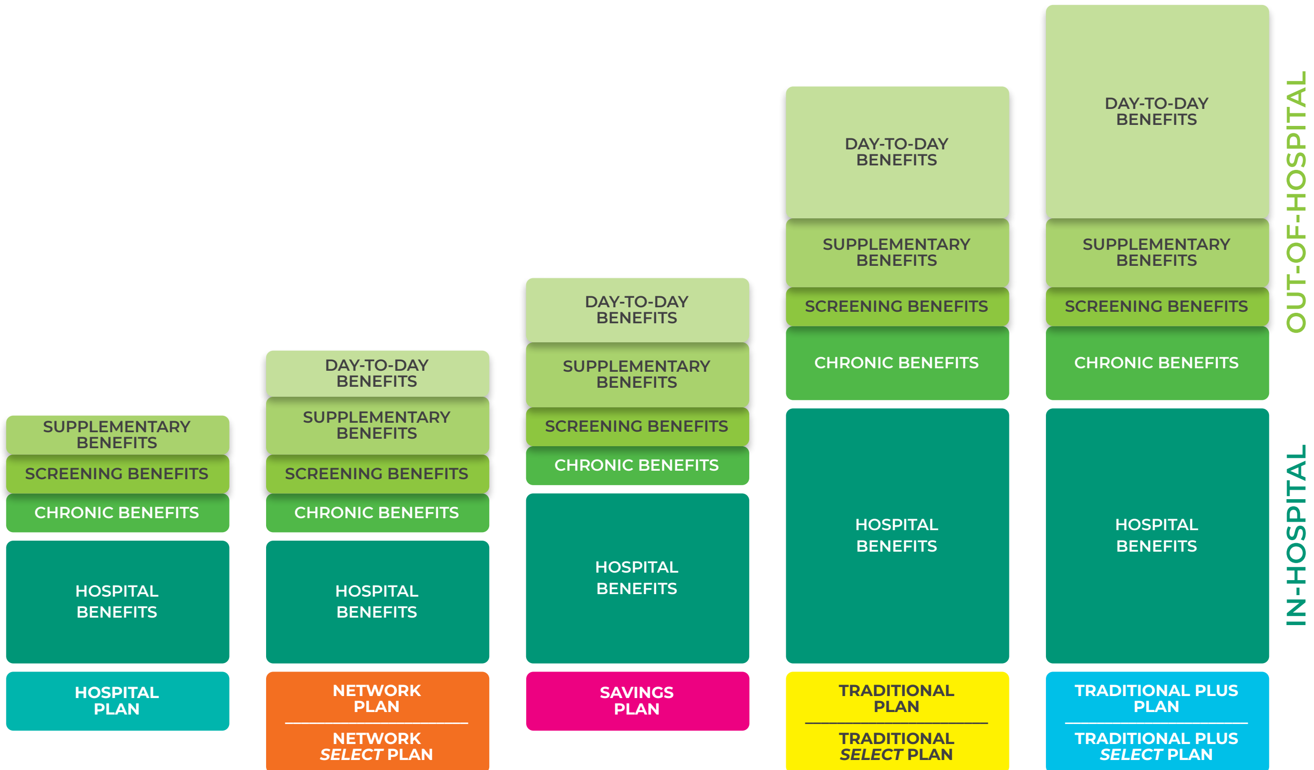
The 2022/23 benefit year will commence on the 1st of April 2022 and run to the 31st of March 2023. All benefits reflected in this member guide will apply for the benefit year, unless stated otherwise. If a person joins the Fund during the benefit year they will receive pro rata benefits. The same applies if there is a movement in membership for example the addition or removal of a dependent, benefits will be adjusted and prorated accordingly.

Abbreviations

The following abbreviations appear in this guide:

Abbreviation	Meaning
AFB	Annual Flexi Benefit
CDL	Chronic Disease List
DSP	Designated Service Provider
GP	General Practitioner
HB	Hospital Benefits
ICON	Independent Clinical Oncology Network
LJP	Late Joiner Penalty
MEL	Medicine Exclusion List
MMAP	Maximum Medical Aid Price
MRI	Magnetic Resonance Imaging
MSR	Medical Scheme Rates is the rate at which the Fund will pay for relevant health services. This is adjusted from time to time, following consultation with suppliers in the industry.
PCB	Primary Care Benefit
PET	Positron Emission Tomography
PMB	Prescribed Minimum Benefit
PMSA	Personal Medical Savings Account
SEP	Single Exit Price (for medicines)
TTO	To-Take-Out (medicine to take home from hospital event)

A GRAPHIC OVERVIEW OF **THE PLANS**



	Hospital Plan	Network Plan Network *SELECT* Plan*	Savings Plan	Traditional Plan Traditional *SELECT* Plan*	Traditional Plus Plan Traditional Plus *SELECT* Plan*
DAY-TO-DAY BENEFITS	✓Limited Primary Care Benefits for specified procedures only. ✓No Personal Medical Savings Account.	✓Primary healthcare benefits via Universal Healthcare Network GP. ✓No Personal Medical Savings Account. ✓Annual Flexi Benefit (AFB) for pathology, radiology, psychology, physiotherapy, optometry and auxiliary services. ✓Specialist consultations.	✓Limited to Personal Medical Savings Account only; no PCB limits.	✓Comprehensive; from Personal Medical Savings Account at cost; then from PCB at MSR.	✓Very comprehensive; from Personal Medical Savings Account at cost; then from PCB up to 300% of MSR.
SUPPLEMENTARY BENEFITS	✓Limited, paid at MSR*.	✓Limited, paid at MSR.	✓Limited, paid at MSR.	✓Comprehensive, paid at MSR.	✓Comprehensive, paid at MSR.
SCREENING BENEFITS	✓Standard	✓Standard	✓Standard	✓Standard + Fitness Assessment and Exercise Prescription benefit.	✓Standard + Fitness Assessment and Exercise Prescription benefit.
CHRONIC BENEFITS	✓Limited	✓Via Universal Healthcare Network GPs.	✓Limited	✓Comprehensive	✓Comprehensive

*MSR. Refer to page 6 for all definitions regarding the Fund Acronyms and Terms

<table>
<tr><th></th><th>Hospital Plan</th><th>Network Plan
Network SELECT Plan*</th><th>Savings Plan</th><th>Traditional Plan
Traditional SELECT Plan*</th><th>Traditional Plus Plan
Traditional Plus SELECT Plan*</th></tr>
<tr><td rowspan="5">HOSPITAL BENEFITS</td><td>✓ Unlimited Overall Annual Limit (OAL): (subject to certain sub-limits). Certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. Refer to detailed table under Hospital Benefits.</td><td>✓ Overall Annual Limit (OAL): R1 000 000 per beneficiary per benefit year (subject to certain sub-limits). Certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. See page 65 of the full Member Guide for more information.</td><td>✓ Unlimited Overall Annual Limit (OAL): (subject to certain sub-limits).</td><td>✓ Comprehensive, with unlimited overall annual limit (subject to certain sub-limits).</td><td>✓ Comprehensive, with unlimited overall annual limit (subject to certain sub-limits).</td></tr>
<tr><td colspan="5">A Doula (birthing coach) on all the plans as part of the In-Hospital maternity benefits, subject to a limit of R2 730 per pregnancy, specifically for the confinement (delivery). No post-natal follow-ups.</td></tr>
<tr><td colspan="3">✓ - Subject to the Overall Annual Limit and Managed Care protocols.
- Physiotherapy: R6 050 per family per benefit year.</td><td colspan="2">✓ Subject to the Overall Annual Limit and Managed Care protocols.</td></tr>
<tr><td rowspan="2">✓ Oncology covered within ICON Essential Protocols.</td><td rowspan="2">✓ Oncology covered within ICON Essential Protocols.

*Please note that under the SELECT Plan, members' choice of hospitals is restricted, and your doctor needs to work at the network hospital – see page 22 for more information.</td><td rowspan="2">✓ Oncology covered within ICON Enhanced Protocols.</td><td>✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit).</td><td>✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit).</td></tr>
<tr><td colspan="2">*Please note that under the SELECT Plan, members' choice of hospitals is restricted, and your doctor needs to work at the network hospital – see page 22 for more information.</td></tr>
</table>

The tables below highlight the differences between the Plans in more detail.

OUT-OF-HOSPITAL: Day-to-Day Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 14-36 OF THE FULL MEMBER GUIDE FOR MORE INFORMATION

	Hospital Plan	Network Plan / Network *SELECT* Plan	Savings Plan	Traditional Plan / Traditional *SELECT* Plan	Traditional Plus Plan / Traditional Plus *SELECT* Plan
Rate payable	Paid at Medical Schemes Rates (MSR) unless stated otherwise.				Paid up to 300% of MSR
Overall Day-to-Day Limit - see page 14 of the full Member Guide.	No	No	No	Yes	Yes
Personal Medical Savings Account (PMSA) - see page 91 of the full Member Guide.	No	No	Yes, depends on your income band and family size - see page 28.	Yes, depends on your income band and family size - see page 29.	Yes, depends on your income band and family size - see page 30.
Annual Flexi Benefit (AFB)	No	Annual Flexi Benefit (AFB), subject to **R5 820** per beneficiary per benefit year and **R9 700** per family per benefit year.	No	No	No
Primary Care Benefit (PCB) Limit	**R2 230** per family for specified procedures in doctors' rooms only.	At Universal Healthcare Network Provider.	No PCB benefit; benefits are payable from available PMSA or, thereafter, accumulated savings.	Depends on your family size- see page 26 of the full Member Guide.	Depends on your family size- see page 29 of the full Member Guide.

uConsult™ Virtual Consultation

Paying the doctor a visit is being revolutionised with the introduction of uConsult, a virtual consultation platform making home-based care far more accessible in South Africa. Patients are able to use this simple, streamlined platform to search for general practitioners by name or geolocation, and will soon be able to connect with providers from other medical disciplines. Best of all, virtual consultations can take place from anywhere and any smart device like laptops, tablets, mobile phones and desktops.

uConsult™ securely connects patients with providers using safe, scalable technology that enables video chat, screen sharing, electronic prescriptions, specialist referral letters, lab test forms and radiology request forms, all on one platform that works on any device. Just another innovative solution from Universal to bring you closer to world-class healthcare experiences.

	Hospital Plan	Network Plan Network *SELECT* Plan*	Savings Plan	Traditional Plan Traditional *SELECT* Plan*	Traditional Plus Plan Traditional Plus *SELECT* Plan*
GPs and Specialists	No benefit.	Medically necessary visits to Universal Healthcare Network GPs, subject to Universal Healthcare Network benefits. Specialist consultations subject to referral from a Universal Healthcare Network GP and authorisation. Limited to two consultations per beneficiary per benefit year; four consultations per family per benefit year.	At cost from PMSA, thereafter from available accumulated savings.	At cost from PMSA, thereafter at MSR from PCB up to overall Day-to-Day limit. Thereafter, accumulated savings can be used. Members are required to consult with their GP first, to obtain a referral to a specialist. Specialist claims without a referral will have a 25% co-payment levied on the total specialist bill. This will exclude consultations relating to your registered PMB chronic conditions as per your PMB treatment plan and the following practice types listed below: - Ophthalmologist, - Psychiatrist, - Gynaecologist, - Oncologist, - Haematologist, - Urologist (for lives > 40 years) and - Paediatrician (for lives < 2 years) Payable at MSR or cost, whichever is lesser. Subject to PMSA and PCB.	At cost from PMSA, thereafter up to 300% of MSR from PCB up to overall Day-to-Day limit. Thereafter, accumulated savings can be used. Members are required to consult with their GP first, to obtain a referral to a specialist. Specialist claims without a referral will have 25% co-payment levied on the total specialist bill. This will exclude consultations relating to your registered PMB chronic conditions as per your PMB treatment plan and the following practice types listed below: - Ophthalmologist, - Psychiatrist, - Gynaecologist, - Oncologist, - Haematologist, - Urologist (for lives > 40 years) and - Paediatrician (for lives < 2 years) Payable at MSR or cost, whichever is lesser from PMSA, then up to 300% of MSR from PCB.
Specified procedures in doctors' rooms	Subject to PCB limit.	Covers minor trauma treatment and small procedures in Universal Healthcare Network GPs' rooms.			

	Hospital Plan	Network Plan Network ***SELECT*** **Plan**	Savings Plan	Traditional Plan Traditional ***SELECT*** **Plan**	Traditional Plus Plan Traditional Plus ***SELECT*** **Plan**
Dentistry	No benefit.	Covers fillings, primary extractions, scaling, polishing and **one pair of plastic dentures** per beneficiary per three-year period at a Universal Healthcare Network provider (dentists only).	At cost from PMSA and then from accumulated savings, subject to available funds.	At cost from PMSA, then at MSR from PCB, up to overall Day-to-Day limit. Thereafter, accumulated savings can be used.	At cost from PMSA, then up to 300% of MSR from PCB, up to overall Day-to-Day limit. Thereafter, accumulated savings can be used.
Radiology		Specified black and white X-rays as requested by Universal Healthcare Network GP and subject to Universal Healthcare protocols and limited to available AFB.			
Pathology		Blood tests according to an approved tariff list requested by an Universal Healthcare Network GP and subject to Universal Healthcare protocols and limited to available AFB.			
Psychology		Limited to AFB, subject to sub-limits: **R1 940** per beneficiary per benefit year; **R3 250** per family per benefit year			
Prescribed (acute) medicines		Acute medicines on the Universal Healthcare Network Acute Medicine Formulary as prescribed by Universal Healthcare Network GP and dispensed by Universal Healthcare Network Dispensing GP or Universal Healthcare Network Pharmacy.	At MMAP or medicine price, whichever is the lesser from PMSA, thereafter from available accumulated savings.	At MMAP or medicine price, whichever is lesser from PMSA, thereafter from PCB up to overall Day-to-Day limit. Thereafter accumulated savings can be used.	At MMAP or medicine price, whichever is lesser from PMSA, thereafter from PCB up to overall Day-to-Day limit. Thereafter accumulated savings can be used.

<table>
<tr><th></th><th>Hospital Plan</th><th>Network Plan
Network SELECT Plan</th><th>Savings Plan</th><th>Traditional Plan
Traditional SELECT Plan</th><th>Traditional Plus Plan
Traditional Plus SELECT Plan</th></tr>
<tr><td>Pharmacy-Advised Therapy (PAT)</td><td rowspan="4">No benefit.</td><td>No benefit.</td><td>At MMAP or medicine price, whichever is the lesser from PMSA, thereafter from available accumulated savings.
(Medicine exclusion list may apply).</td><td>At MMAP or medicine price, whichever is lesser from PMSA, thereafter from PCB up to overall Day-to-Day limit. Thereafter accumulated savings can be used.
(Medicine exclusion list may apply).</td><td>At MMAP or medicine price, whichever is lesser from PMSA, thereafter from PCB up to overall Day-to-Day limit. Thereafter accumulated savings can be used.
(Medicine exclusion list may apply).</td></tr>
<tr><td>Auxiliary Services</td><td rowspan="2">Auxiliary services limited to available AFB, subject to sub-limits: R1 940 per beneficiary per benefit year; R3 250 per family per benefit year.</td><td rowspan="3">At cost from PMSA and then from accumulated savings, subject to available funds.</td><td rowspan="3">At cost from PMSA, then at MSR from PCB, up to overall Day-to-Day limit.
Thereafter, accumulated savings can be used.</td><td rowspan="3">At cost from PMSA, then up to 300% of MSR from PCB, up to overall Day-to-Day limit.
Thereafter, accumulated savings can be used.</td></tr>
<tr><td>Physiotherapy</td></tr>
<tr><td>Optical benefits
▸ Eye tests
▸ Spectacles, Frames, Contact Lenses and Readers (including fitting consultation for contact lenses)</td><td>Subject to AFB and to Universal Healthcare Optometry Network protocols and to be obtained from Universal Healthcare Optometry Network providers. See page 15 of the full Member Guide for more information.</td></tr>
</table>

OUT-OF-HOSPITAL: Supplementary Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 32-36 OF THE FULL MEMBER GUIDE FOR MORE INFORMATION.

	Hospital Plan	Network Plan / Network *SELECT* Plan	Savings Plan	Traditional Plan / Traditional *SELECT* Plan	Traditional Plus Plan / Traditional Plus *SELECT* Plan
Maternity benefits (dependent on registration on the Mother and Baby Care Programme) **Members expecting a baby and considering a *SELECT* Plan must please make sure that their specialist is at one of the *SELECT* list of hospitals.**					
A Doula (birthing coach) benefit on all the options as part of the In-Hospital maternity benefits, subject to a limit of **R2 730** per pregnancy, specifically for the confinement (delivery). No post-natal follow-ups. **Note: Paid from In-Hospital benefit.**					
Antenatal classes	No benefit.	**R1 460** per family.	**R1 460** per family.	**R2 290** per family.	**R2 290** per family.
Antenatal visits	No benefit.	**R3 450** per pregnancy.	**R3 450** per pregnancy.	**R5 750** per pregnancy.	**R5 750** per pregnancy.
Ultrasound scans (pregnancy) Tariff codes 3615 and 3617	No benefit.	Two 2D scans per pregnancy at a Universal Healthcare Network GP or treating specialist. OR Referral by Universal Healthcare Network GP or treating specialist to a radiologist.	Two 2D scans per beneficiary.	Two 2D scans per beneficiary.	Two 2D scans per beneficiary.
Out-of-Hospital pathology tests	No benefit.	**R2 840** per family.	**R2 840** per family.	**R3 550** per family.	**R3 550** per family.

	Hospital Plan	Network Plan Network *SELECT* Plan	Savings Plan	Traditional Plan Traditional *SELECT* Plan	Traditional Plus Plan Traditional Plus *SELECT* Plan
Antenatal vitamins	No benefit.	MMAP or medicine price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit.	MMAP or medicine price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit.	MMAP or medicine price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit.	MMAP or medicine price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit.
Ultrasound scans In and Out-of-Hospital (other than for pregnancy) – combined benefit limit	**R5 480** per family.	**R5 480** per family.	**R5 480** per family.	**R8 150** per family.	**R8 150** per family.
Specialised Radiology In and Out-of-Hospital (including MRI, CT and Radio-isotope Scans and Nuclear Medicine) - combined benefit limit	**R16 100** per family, with a co-payment of **R1 500** per authorisation.	**R16 100** per family, with a co-payment of **R1 500** per authorisation.	**R16 100** per family, with a co-payment of **R1 500** per authorisation.	**R19 900** per family, with a co-payment of **R1 500** per authorisation.	**R19 900** per family, with a co-payment of **R1 500** per authorisation.
Dental implants	No benefit, except for Prescribed Minimum Benefits.	No benefit, except for Prescribed Minimum Benefits.	At cost from PMSA, thereafter from available accumulated savings, subject to pre-approval.	**R16 600** per family, subject to pre-approval.	**R16 600** per family, subject to pre-approval.
Medical Appliances				**R11 000** per family, subject to approval.	**R11 000** per family, subject to approval.
Foot Orthotics				**R4 980** per family and included in the appliance limit of **R11 000** per family above.	**R4 980** per family and included in the appliance limit of **R11 000** per family above.

	Hospital Plan	Network Plan / Network *SELECT* Plan	Savings Plan	Traditional Plan / Traditional *SELECT* Plan	Traditional Plus Plan / Traditional Plus *SELECT* Plan
Hearing Aids (including repairs – see page 36 of the full Member Guide)	No benefit, except for Prescribed Minimum Benefits.	No benefit, except for Prescribed Minimum Benefits.	At cost from PMSA and then from accumulated savings, subject to available funds.	**R19 600** per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for beneficiaries under age 7, and every 5 years for beneficiaries older than 7 years. The benefit excludes consultations and associated tests. Subject to pre-approval.	**R19 600** per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for beneficiaries under age 7, and every 5 years for beneficiaries older than 7 years. The benefit excludes consultations and associated tests. Subject to pre-approval.
Refractive procedures				MSR or cost, whichever is the lesser, up to a sub-limit of **R17 500** per beneficiary. See page 36 of the full Member Guide for more information. Subject to pre-approval.	MSR or cost, whichever is the lesser, up to a sub-limit of **R17 500** per beneficiary. See page 36 of the full Member Guide for more information. Subject to pre-approval.
Back and Neck Rehabilitation Programme	Please see page 72 of the full Member Guide for more information.				
Mental Health Programme	**R12 000** per beneficiary. Please see page 78 of the full Member Guide for more information.				

OUT-OF-HOSPITAL: Screening Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 33-35 OF THE FULL MEMBER GUIDE FOR MORE INFORMATION.

	Hospital Plan	Network Plan / Network *SELECT* Plan	Savings Plan	Traditional Plan / Traditional *SELECT* Plan	Traditional Plus Plan / Traditional Plus *SELECT* Plan
Screening Benefit (1 per beneficiary per benefit year)	▸ **Pharmacy-based health-screening tests:** Blood pressure, blood glucose, cholesterol, HIV/AIDS, BMI. One of each screening test per beneficiary per benefit year. ▸ **Pharmacy-based vaccines:** One flu vaccine per beneficiary per benefit year, one pneumococcal vaccine per lifetime. ▸ **Contraceptive benefit: R3 410** per beneficiary per benefit year. **R2 140** sub-limit per beneficiary for oral contraceptives. ▸ **Non-pharmacy based benefits** consist of one pap smear and mammogram per female beneficiary per benefit year and one prostate test per male beneficiary, as well as colorectal screening, limited to one test per beneficiary per benefit year including the consultation at the GP or gynaecologist (for female beneficiaries) or urologist (for male beneficiaries), paid up to the Medical Scheme Rates for a visit to a GP, gynaecologist or urologist, plus one health risk assessment per beneficiary per benefit year for services rendered by a registered healthcare practitioner (such as a General Practitioner). **It is very important that your service provider uses the correct ICD-10 code to claim for these benefits - see the green note on page 38 of the full Member Guide for more information.** ▸ **Nutritional assessment and healthy eating plan:** Access to the Universal Healthcare network of dieticians for annual assessment, healthy eating plan prescription and regular monitoring. An additional assessment for pregnant beneficiaries. ▸ **Childhood immunisations** for children up to the age of 12 years, as per recommendation of the Department of Health. ▸ **Pre-school eye and hearing screening** for children aged 5 and 6. ▸ **Hearing screening** for newborns up to six weeks. ▸ **PAED-IQ's Babyline** - A 24/7, paediatric telephone service, whereby parents or caregivers of children from birth to three years of age registered on the Fund can phone in and get up-to-date child healthcare advice and reassurance. ▸ **Fitness Assessment and Exercise Prescription Benefit:** Only available on the Traditional and Traditional Plus Plans, members will have access to the Universal Healthcare network of Biokineticists, who will assess the members' needs and prescribe a relevant exercise plan that can be filled at a contracted fitness facility. This benefit will be paid from the Screening Benefit. It is subject to registration on the program and Universal Healthcare protocols. ▸ **COVID-19 Benefit Package:** Any beneficiary who tested positive for COVID-19 will be able to access the following: Pulse oximeter, Nebuliser, Oxygenator, Thermometer, 2 GP consultations, 2 PCR tests and Chest physiotherapy. Pre-authorisation and managed care protocols apply. ▸ ***COVID-19 Vaccine** for all eligible beneficiaries in accordance with the Department of Health recommendation. ▸ **NEW!** Syphilis and Chlamydia infection screening - limited to 1 test per benefit year, per female beneficiary who is at risk or who is pregnant, including consultation with a Gynaecologist or General Practitioner. (Please note for the Pap smear, Mammogram and Syphilis and Chlamydia screening, only one Gynaecologist consultation per benefit year will be funded from the Screening benefit). ▸ **NEW!** Dental caries (prevention and oral fluoride supplementation) - limited to beneficiaries up to age 6 years, subject to Managed Care Protocols, including oral-hygienist consultation.				

OUT-OF-HOSPITAL: Chronic Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 40-50 OF THE FULL MEMBER GUIDE FOR MORE INFORMATION.

	Hospital Plan	Network Plan Network *SELECT* Plan	Savings Plan	Traditional Plan Traditional *SELECT* Plan	Traditional Plus Plan Traditional Plus *SELECT* Plan
Additional Fund approved chronic conditions	A limit of **R5 750** per family, subject to Maximum Medical Aid Price (MMAP) or the medicine price, whichever is the lesser. Anxiety, Chronic Hepatitis, Depression, Macular Degeneration, Oedema and Post-Traumatic Stress Disorder.	Subject to the Universal Healthcare Network Formulary and approval. Pre-authorised by Universal Healthcare Chronic Medicine Management. Acne, Allergic rhinitis, Anxiety, Dysrhythmias, Chronic Hepatitis, Depression, Gout, Female Hormone Replacement Therapy, Macular Degeneration, Migraine, Oedema, Osteoarthritis, and Post Traumatic Stress Disorder.	A limit of **R5 750** per family, Subject to Maximum Medical Aid Price (MMAP) or the medicine price, whichever is the lesser. For other conditions, subject to available PMSA or, thereafter, accumulated savings. Acne, Allergic rhinitis, Anxiety, Dysrhythmias, Chronic Hepatitis, Depression, Gout, Female Hormone Replacement Therapy, Macular Degeneration, Migraine, Oedema, Osteoarthritis and Post Traumatic Stress Disorder.	A limit of **R14 000** per family. For other conditions, subject to available PMSA, PCB or, thereafter, accumulated savings. Acne, Allergic rhinitis, Alzheimer Disease, Anxiety, Attention Deficit Hyperactivity Disorder, Chronic Hepatitis, Cushing disease, Cystic fibrosis, Deep vein thrombosis, Depression, Female Hormone Therapy, GORD, Gout, Hypoparathyroidism, Macular Degeneration, Myasthenia gravis, Myoneural disorders, Migraine, Neuropathies, Oedema, Osteoarthritis, Osteoporosis, Post-traumatic Stress Disorder, Psoriasis.	A limit of **R16 700** per family. For other conditions, subject to available PMSA, PCB or, thereafter, accumulated savings. Acne, Allergic rhinitis, Alzheimer Disease, Anxiety, Attention Deficit Hyperactivity Disorder, Chronic Hepatitis, Cushing disease, Cystic fibrosis, Deep vein thrombosis, Depression, Female Hormone Therapy, GORD, Gout, Hypoparathyroidism, Macular Degeneration, Myasthenia gravis, Myoneural disorders, Migraine, Neuropathies, Oedema, Osteoarthritis, Osteoporosis, Post-traumatic Stress Disorder, Psoriasis.

	Hospital Plan	Network Plan Network *SELECT* Plan	Savings Plan	Traditional Plan Traditional *SELECT* Plan	Traditional Plus Plan Traditional Plus *SELECT* Plan
Additional Fund approved chronic conditions (continued)	**NEW!** General Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorders.	**NEW!** General Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorders.	**NEW!** Anorexia nervosa, Bulimia nervosa, General Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorders.	**NEW!** Allergic dermatitis / Eczema, Ankylosing spondylitis, Anorexia nervosa, Bulimia nervosa, General Anxiety Disorder, Neuropathies, Obsessive Compulsive Disorder, Panic Disorders, Systemic sclerosis.	**NEW!** Allergic dermatitis / Eczema, Ankylosing spondylitis, Anorexia nervosa, Bulimia nervosa, General Anxiety Disorder, Neuropathies, Obsessive Compulsive Disorder, Panic Disorders, Systemic sclerosis.
PMB Conditions	Unlimited, subject to the **Universal Healthcare restrictive formulary** and approval.	Unlimited, subject to **Universal Healthcare Network Formulary** and approval.	Unlimited, subject to the **Universal Healthcare restrictive formulary** and approval.	Unlimited, subject to the **Universal Healthcare comprehensive formulary** and approval.	Unlimited, subject to the **Universal Healthcare comprehensive formulary** and approval.

IN-HOSPITAL: Hospital Benefits (HB)

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 51-71 OF THE FULL MEMBER GUIDE FOR MORE INFORMATION.

Hospital Plan	Network Plan / Network *SELECT* Plan	Savings Plan	Traditional Plan / Traditional *SELECT* Plan	Traditional Plus Plan / Traditional Plus *SELECT* Plan
Unlimited cover for Hospital Benefits (HB), subject to certain sub-limits. **Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP).	Annual limit of **R1 000 000** per beneficiary for Hospital Benefits (HB), subject to certain sub-limits. **Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP).	Unlimited cover for Hospital Benefits (HB), subject to certain sub-limits. **Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP).	Unlimited cover for Hospital Benefits (HB), subject to certain sub-limits. **Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP).	Unlimited cover for Hospital Benefits (HB), subject to certain sub-limits. **Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP).

NOTE: Under the Hospital, Network and Network *SELECT* Plans, certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. See page 65 of the full Member Guide for more information.

Terms used in the table:

- **DSP** – a healthcare provider selected and formally contracted by the Fund as its preferred service provider to provide diagnosis, treatment and care in respect of one or more conditions.
- **Maximum Medical Aid Price (MMAP)** – a reference pricing system that uses a benchmark or reference price for generically similar products.
- **Medicine Exclusion List (MEL)** – exclusion list used by the Fund, which excludes medicines from payment from the Acute Medicine Benefit for a number of reasons.
- **Universal Healthcare Restrictive Medicine Formulary** – Applicable to the Hospital and Savings Plans. Contains a list of medicines that provide cover for the listed chronic conditions.
- **Universal Healthcare Comprehensive Medicine Formulary** – Applicable to the Traditional and Traditional Plus (including *SELECT*) Plans. It provides access to a wider range of medicines than the restrictive formulary.
- **Universal Healthcare Network Formulary** - Applicable to the Network (including *SELECT*) Plan.

What do I need to know about the *SELECT* Plans?

Why have the *SELECT* Plans been introduced?

Healthcare costs rise at a faster rate than inflation each year and impact member contributions. The Fund is therefore always exploring ways to contain costs without compromising quality.

One such measure is the **Network *SELECT***, **Traditional *SELECT*** and **Traditional Plus *SELECT*** Plans, where the Fund negotiated discounted rates with certain hospitals.

The *SELECT* Plans are based on offering the same benefits as those on the standard Plans, but at a reduced contribution – in return for members then using the *SELECT* list of hospitals (see page 126 of the full Member Guide).

For example:

A **Traditional** Plan member moving to the **Traditional *SELECT*** Plan -

- pays a reduced contribution; and
- retains the same benefits;

by using one of our *SELECT* list of hospitals.

How were the hospitals for *SELECT* Plans chosen?

Apart from the level of discount being offered, the Fund more importantly considered the quality and accessibility of care to most members.

Are there any differences in the benefits between the standard and *SELECT* Plans?

The benefits are the same. The only small difference between the standard and *SELECT* Plans can be seen in the Day-to-Day Benefits on the **Traditional** and **Traditional Plus** Plans and their *SELECT* counterparts. As the *SELECT* Plans have lower contributions, this will slightly reduce the amount members on these Plans pay towards their Personal Medical Savings Account (PMSA), since both Plans contribute the same percentage of contributions.

What if I choose a *SELECT* Plan and then visit a hospital not on the *SELECT* list of hospitals?

Unless it is a legitimate emergency (see 'What if there is an emergency?'), members on *SELECT* who use a hospital that is not on the *SELECT* list will incur a co-payment of 20% of the total hospital bill.

This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

What if my specialist is not at one of the *SELECT* list of hospitals?

If your specialist does not practise at one of the listed hospitals, you should probably not consider choosing a *SELECT* Plan, unless you are willing to move to a specialist who is based at one of the *SELECT* list of hospitals. You can check this with your doctor.

What if there is an emergency?

An emergency medical condition is defined as *"the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy."*

If you experience such an emergency, you will not incur a 20% co-payment for being on a *SELECT* Plan and using a hospital that is not on the *SELECT* list of hospitals.

Pensioners

Employees who joined Old Mutual on or before 31 July 1998 and who were members of the Fund on 1 June 2007, and continue as members of the Fund after retirement, qualify to receive a subsidy from Old Mutual during retirement. However, employees who joined Old Mutual from 1 August 1998 do not qualify to receive a subsidy from Old Mutual during retirement. They will therefore be responsible for the full monthly contribution to the Fund after retirement.

Please see page 124 of the full Member Guide for the definition of income.

What are the monthly contributions for 2022/23?

The total monthly contribution to the Fund is based on the Plan you have chosen, the number of your dependants and your income (see following tables). You can find a definition of income on page 124 of the full Member Guide.

The compulsory Personal Medical Savings Account (PMSA) contributions on the **Savings**, **Traditional** and **Traditional Plus** (including *SELECT*) Plans are included in the amounts shown in the tables (The **Hospital**, **Network** and **Network *SELECT*** Plans have no savings portion).

Please note that contributions are charged in respect of the first three child dependants only.

Any subsidies paid to non-TGP members and qualifying pensioners are included in the monthly contributions. Where the subsidy is higher than the contribution on the Plan you have chosen, you will not be required to make monthly contributions to the Fund.

Late Joiner Penalties will be imposed in accordance with the Rules of the Fund (please see page 103 of the full Member Guide for more information).

Hospital Plan

Income band	Member	Adult	Child (max 3)
R0 - R5 510	**R944**	**R774**	**R207**
R5 511 - R8 260	**R1 020**	**R836**	**R225**
R8 261 - R11 020	**R1 207**	**R990**	**R265**
R11 021 - R21 820	**R1 658**	**R1 409**	**R415**
R21 821 +	**R1 943**	**R1 652**	**R486**

Please see page 124 of the full Member Guide for the definition of income.

Network Plan

Income band	Member	Adult	Child (max 3)
R0 - R5 510	**R1 510**	**R1 284**	**R378**
R5 511 - R8 260	**R1 882**	**R1 600**	**R471**
R8 261 - R11 020	**R1 999**	**R1 639**	**R500**
R11 021 – R14 720	**R2 345**	**R1 993**	**R586**
R14 721 - R21 820	**R2 488**	**R2 115**	**R622**
R21 821 +	**R2 621**	**R2 228**	**R655**

Network *SELECT* Plan

Income band	Member	Adult	Child (max 3)
R0 - R5 510	**R1 069**	**R909**	**R267**
R5 511 - R8 260	**R1 333**	**R1 133**	**R333**
R8 261 - R11 020	**R1 652**	**R1 355**	**R413**
R11 021 – R14 720	**R2 115**	**R1 798**	**R529**
R14 721 - R21 820	**R2 243**	**R1 907**	**R561**
R21 821 +	**R2 364**	**R2 009**	**R591**

See page 21 for important information on this option.

Please see page 124 of the full Member Guide for the definition of income.

Savings Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 510	RISK	R1 424	R1 210	R284
	PMSA	R294	R250	R59
	TOTAL	**R1 718**	**R1 460**	**R343**
R5 511 – R11 020	RISK	R1 852	R1 354	R337
	PMSA	R382	R280	R69
	TOTAL	**R2 234**	**R1 634**	**R406**
R11 021 - R21 820	RISK	R2 183	R1 856	R546
	PMSA	R451	R383	R113
	TOTAL	**R2 634**	**R2 239**	**R659**
R21 821 +	RISK	R2 289	R1 945	R572
	PMSA	R472	R402	R118
	TOTAL	**R2 761**	**R2 347**	**R690**

Please see page 124 of the full Member Guide for the definition of income.

Traditional Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 510	RISK	R2 663	R2 024	R646
	PMSA	R345	R262	R84
	TOTAL	**R3 008**	**R2 286**	**R730**
R5 511 – R11 020	RISK	R3 210	R2 129	R724
	PMSA	R416	R276	R94
	TOTAL	**R3 626**	**R2 405**	**R818**
R11 021+	RISK	R3 926	R3 236	R1 221
	PMSA	R509	R420	R158
	TOTAL	**R4 435**	**R3 656**	**R1 379**

Traditional *SELECT* Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 510	RISK	R2 402	R1 825	R583
	PMSA	R311	R236	R75
	TOTAL	**R2 713**	**R2 061**	**R658**
R5 511 – R11 020	RISK	R2 894	R1 920	R653
	PMSA	R374	R248	R84
	TOTAL	**R3 268**	**R2 168**	**R737**
R11 021+	RISK	R3 542	R2 920	R1 102
	PMSA	R458	R378	R142
	TOTAL	**R4 000**	**R3 298**	**R1 244**

See page 21 for important information on this option.

Traditional Plus Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0+	RISK	R6 610	R5 288	R1 652
	PMSA	R759	R607	R190
	TOTAL	**R7 369**	**R5 895**	**R1 842**

Traditional Plus *SELECT* Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0+	RISK	R5 852	R4 682	R1 463
	PMSA	R675	R540	R169
	TOTAL	**R6 527**	**R5 222**	**R1 632**

See page 21 for important information on this option.

Please see page 124 of the full Member Guide for the definition of income.

What is the annual healthcare spend available for day-to-day medical expenses?

Hospital Plan

Maximum annual PCB limit of **R2 230** per family for specified procedures.

Network Plan

Subject to Universal Healthcare Network benefits.

Savings Plan

Income band		Member	Adult	Child (max 3)
R0 - R5 510	Annual PMSA	R3 528	R3 000	R708
R5 511 – R11 020		R4 584	R3 360	R828
R11 021 - R21 820		R5 412	R4 596	R1 356
R21 821 +		R5 664	R4 824	R1 416

Please see page 124 of the full Member Guide for the definition of income.

Traditional Plan

Income band		Member	Adult	Child (max 3)
R0 - R5 510	Annual PMSA	R4 140	R3 144	R1 008
	Annual PCB	R4 850	R4 120	R1 460
	Overall Day-to-Day	**R8 990**	**R7 264**	**R2 468**
R5 511 – R11 020	Annual PMSA	R4 992	R3 312	R1 128
	Annual PCB	R4 850	R4 120	R1 460
	Overall Day-to-Day	**R9 842**	**R7 432**	**R2 588**
R11 021+	Annual PMSA	R6 108	R5 040	R1 896
	Annual PCB	R4 850	R4 120	R1 460
	Overall Day-to-Day	**R10 958**	**R9 160**	**R3 356**

Traditional *SELECT* Plan

Income band		Member	Adult	Child (max 3)
R0 - R5 510	Annual PMSA	R3 732	R2 832	R900
	Annual PCB	R4 850	R4 120	R1 460
	Overall Day-to-Day	**R8 582**	**R6 952**	**R2 360**
R5 511 – R11 020	Annual PMSA	R4 488	R2 976	R1 008
	Annual PCB	R4 850	R4 120	R1 460
	Overall Day-to-Day	**R9 338**	**R7 096**	**R2 468**
R11 021+	Annual PMSA	R5 496	R4 536	R1 704
	Annual PCB	R4 850	R4 120	R1 460
	Overall Day-to-Day	**R10 346**	**R8 656**	**R3 164**

As the ***SELECT*** Plans have lower contributions, this will reduce the amount you pay towards your Personal Medical Savings Account (shown as Annual PMSA above).

Please see page 124 of the full Member Guide for the definition of income.

Traditional Plus Plan

Income band		Member	Adult	Child (max 3)
R0+	Annual PMSA	R9 108	R7 284	R2 280
	Annual PCB	R9 700	R7 760	R2 440
	Overall Day-to-Day	**R18 808**	**R15 044**	**R4 720**

Traditional Plus *SELECT* Plan

Income band		Member	Adult	Child (max 3)
R0+	Annual PMSA	R8 100	R6 480	R2 028
	Annual PCB	R9 700	R7 760	R2 440
	Overall Day-to-Day	**R17 800**	**R14 240**	**R4 468**

REMEMBER THAT YOU CANNOT CHANGE PLANS AT ANY TIME OTHER THAN AT THE BEGINNING OF THE BENEFIT YEAR.*

*Unless you retire or you (or a beneficiary) are newly registered on the Oncology Programme, or following the death of a member. If defaulted/auto-enrolled you have 30 days to change plans.

As the ***SELECT*** Plans have lower contributions, this will reduce the amount you pay towards your Personal Medical Savings Account (shown as Annual PMSA above).

What must I consider before making a choice?

Before you select your Plan for the coming benefit year, take the following factors into consideration:

- The monthly contributions of each Plan to ensure that you can afford the Plan you select.
- Whether the Plan you are considering offers adequate benefits most suited to your medical needs.
- Your health history or what your medical expenses were during the previous benefit year.
- Your anticipated healthcare needs during the next benefit year.
- The number of dependants you have and whether this may change in the next benefit year.
- If you have a chronic condition, whether the Plan you choose covers your condition, and whether you are comfortable with the formulary that is applicable to your Plan (more information on pages 40-50 of the full Member Guide).

What must I consider before choosing a *SELECT* Plan?

A *SELECT* Plan should be considered:

- If you are considering the **Network**, **Traditional** or **Traditional Plus** Plan and would like to maintain those benefits, but at a lower contribution rate;
- If you are looking for more affordable options;
- If you are comfortable using only the *SELECT* hospitals;
- If you are within comfortable travelling distance of one of the *SELECT* list of hospitals; and/or
- If your specialist works at one of the *SELECT* list of hospitals, or if you are willing to move to a specialist who does work at one of the *SELECT* list of hospitals.

If you are thinking of joining the Network or Network *SELECT* Plan:

- Check whether any additional Fund approved chronic medicine you may be on is covered.
- Consider if there is a Universal Healthcare Network doctor within easy reach of your home or work. Please contact Universal Healthcare by emailing network.accounts@omsmaf.co.za or calling 0860 100 076 for comprehensive lists of the nearest Universal Healthcare Network provider.
- Take note that Universal Healthcare Network providers are mainly based within Southern Africa, therefore the **Network** or **Network *SELECT*** Plan may not be appropriate for members who live in Namibia or other outlying countries.
- Your savings credit balance (if applicable) will be paid out to you after 5 months.

If you are thinking of joining the Hospital Plan:

- Your savings credit balance (if applicable) will be paid out to you after 5 months.

Who are the Fund's contracted providers, and what co-payments could I incur?

Why does the Fund make use of contracted providers?

The Fund contracts with certain providers to obtain efficient, cost effective healthcare services with quality outcomes for members. Depending on how the contract has been set up, these contracted providers are known as either designated service providers (DSPs) or preferred providers.

Why does the Fund make use of co-payments?

In an effort to manage escalating healthcare costs and over-utilisation of benefits, the Fund has implemented certain co-payments that would apply under certain circumstances.

For ease of reference, this section gives an overview of all the co-payments that you may incur. Depending on your decisions, you may incur one or a combination of these.

GENERAL – MEDICAL SCHEME RATES (MSR) VS ACTUAL COSTS

Medical practitioners are under no obligation to charge MSR and often charge more. That means...

If you ...	... you will have to pay
claim for Hospital, Supplementary or Screening Benefits (unless it is in accordance with Prescribed Minimum Benefits), your claim will be covered at MSR and...	the difference between what you are charged by the medical service provider and MSR.
are on the **Traditional** or **Traditional *SELECT*** Plan and claim for Day-to-Day Benefits after exhausting your PMSA portion, your claim will be covered at MSR and...	the difference between what you are charged by the medical service provider and MSR.
are on the **Traditional Plus** or **Traditional Plus *SELECT*** Plan and claim for Day-to-Day Benefits after exhausting your PMSA portion, your claim will be covered up to 300% of MSR and...	the difference between what you are charged by the medical service provider and 300% of MSR.

APPLIANCES, TESTS, CONSULTATIONS

If you claim for ...	... you will have a co-payment of	Is there a contracted provider you can use to avoid the co-payment on the left?
a consultation with a non-ICON oncologist	20% of the consultation claim.	YES. The Fund has appointed the Independent Clinical Oncology Network (ICON) as the DSP for Oncology treatment. ICON is a dedicated network of oncologists committed to the comprehensive management of members with cancer.
a hearing aid	10% of the cost of such hearing aid.	NO
specialised radiology In or Out-of-Hospital	R1 500 per authorisation.	NO
Out-of-Hospital specialist referral on the **Traditional Plus** and **Traditional** (including *SELECT*) Plans. Beneficiaries will be subject to a 25% co-payment on Out-of-Hospital non-referred specialist claims. This will exclude the following practice types: Ophthalmologist, Psychiatrist, Gynaecologist, Oncologist, Haematologist, Urologist (for beneficiaries > 40 years) and Paediatrician (for beneficiaries < 2 years). Members registered on a PMB treatment plan who are required to visit a specialist in accordance to their approved treatment plan.		

CHRONIC MEDICINES

If you claim for a medicine that is ...	... you will have a co-payment of	Is there a contracted provider you can use to avoid the co-payment on the left?
not in your Plan Formulary.	25% of the cost of such medicine.	NO. If you do not want to incur the co-payment, use medicine in your Plan Formulary.
not within the MMAP.	the difference between the cost of the medicine and MMAP. See page 41 of the full Member Guide.	NO. If you do not want to incur the co-payment, use medicine within MMAP.

See page 40 of the full Member Guide for more information.

PHARMACY CLAIMS

If you claim for ...	... then	Is there a contracted provider you can use to avoid this?
chronic medicine from a pharmacy that is not part of the Preferred Provider network of the Fund.	you may have a co-payment of the difference between the Fund's agreed Preferred Provider dispensing rate and what the non-Preferred Provider pharmacy charges you.	YES. There is a Universal Healthcare pharmacy network. To find a provider, call 0860 100 076 or by logging into www.omsmaf.co.za

HOSPITALISATION

If you ...	... you will have a co-payment of	Is there a contracted provider you can use to avoid the co-payment on the left?
are a member of the **Network *SELECT***, **Traditional *SELECT*** or **Traditional Plus *SELECT*** Plan and use a hospital that is not on the *SELECT* list of hospitals*.	20% of the total hospital bill*	YES. The *SELECT* list of hospitals, which have been chosen for both their efficiency and value for money (see page 126 of the full Member Guide).

If you ...	... you may have a co-payment of	Is there a contracted provider you can use to avoid the co-payment on the left?
do not contact the Fund before you are admitted to hospital to pre-authorise your admission (unless it is a valid emergency).	R500	NO

This does not apply to members on the* **Savings, **Traditional**, **Traditional *SELECT***, **Traditional Plus** *and* **Traditional Plus *SELECT*** *Plans for an admission for hip or knee surgery through ICPS.*

PROCEDURES IN-HOSPITAL

If you have any of the following procedures*...		... you will have a co-payment of	Is there a contracted provider you can use to avoid the co-payment on the left?
ALL Plans	Fund approved dental procedures In-Hospital	R1 500	No, the co-payment will apply if covered on your Plan.
	Gastroscopy / colonoscopy / arthroscopy In-Hospital; cystoscopy, facet joint injections, flexible sigmoidoscopy, functional nasal surgery, hysteroscopy (not endometrial ablation), myringotomy, tonsillectomy and adenoidectomy, varicose vein surgery.	R1 500	**NEW!** YES. A co-payment will not apply if done at a day hospital.
	Specialised radiology.	R1 500 per authorisation	No, the co-payment will apply for non-PMB specialised radiology.
	Spinal surgery, if you decline participation in the Back and Neck Rehabilitation Programme before surgery.	R5 000	YES. Document Based Care (DBC) and physiotherapists following the South African Society of Physiotherapy defined care pathways are the Fund's DSPs for the Back and Neck Rehabilitation Programme.
	Laparoscopic appendectomy, laparoscopic hernia repair (for inguinal or femoral hernias: funding only if the hernia is bilateral or recurrent), laparoscopic hysterectomy, laparoscopic radical prostatectomy, balloon sinuplasty, diagnostic laparoscopy, percutaneous radiofrequency ablations (percutaneous rhizotomies), laparoscopic pyeloplasty, Nissen Fundoplication (reflux surgery).	R2 500	NO. The alternative, if you do not want to incur the co-payment, would be to undergo open surgery.
Savings, Traditional, Traditional *SELECT*, Traditional Plus and Traditional Plus *SELECT* Plans	Hip or knee replacements not undertaken by the Fund's Designated Service Providers.	R5 000	ICPS is a group of orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways.

**These co-payments will not apply if the procedure is in accordance with Prescribed Minimum Benefits. Please see page 86 of the full Member Guide, Prescribed Minimum Benefits, for more information.*

OLDMUTUAL