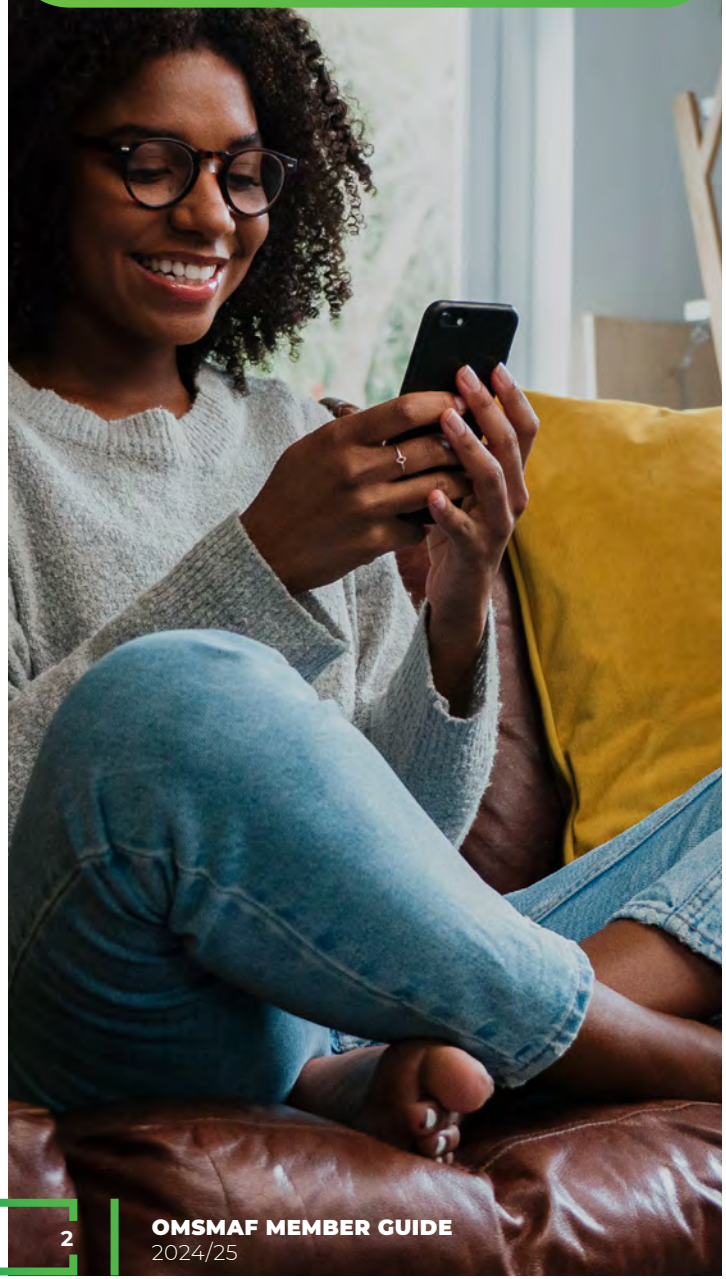
MEMBER GUIDE

2024/25

EFFECTIVE 1 APRIL 2024

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
EMAIL: enquiries@omsmaf.co.za
WEBSITE: www.omsmaf.co.za

CURRENT FIRST-TIME CLAIMS

EMAIL: claims@omsmaf.co.za
FOR CLAIMS REFUNDS EMAIL: refundme@omsmaf.co.za
POST: OMSMAF (Claims), PO Box 1411, Rivonia, 2128

CLAIMS FOR SERVICES RENDERED OUTSIDE RSA

EMAIL: foreignclaims@omsmaf.co.za

MEMBERSHIP AND ENQUIRIES PERTAINING TO PLAN SELECTIONS

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 08:00 to 17:00 Monday - Friday
EMAIL: membership@omsmaf.co.za
WEBSITE: www.omsmaf.co.za

ER24 Medical Emergencies: **084 124**

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 (Call Centre)
EMAIL: authorisations@omsmaf.co.za
Emails 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

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
EMAIL: oncology@omsmaf.co.za

INDEPENDENT CLINICAL ONCOLOGY NETWORK (ICON)

WEBSITE: www.cancernet.co.za
EMAIL: oncology@omsmaf.co.za

CHRONIC PMB TREATMENT PLAN

EMAIL: pmb@omsmaf.co.za

DENTAL AUTHORISATION

TEL: 0860 100 076
EMAIL: dental@omsmaf.co.za

SPECIALIST AUTHORISATION

Network and Network *SELECT* Plans
EMAIL: authorisations@omsmaf.co.za
Traditional and Traditional Plus Plans
EMAIL: spec.auth@omsmaf.co.za

CONTRIBUTIONS

TEL: 0860 100 076
EMAIL: contributions@omsmaf.co.za

HIV AND AIDS MANAGEMENT PROGRAMME

TEL: 0860 378 800
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: hivprogramme@omsmaf.co.za

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
EMAIL: backandneck@omsmaf.co.za

ACTIVE DISEASE RISK MANAGEMENT PROGRAMME

TEL: 0860 100 076
HOURS: 8:00 to 17:00 Monday – Friday only
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
EMAIL: maternity@omsmaf.co.za

PAED-IQ'S BABYLINE

TEL: 0860 666 110
For further details refer to **page 22**

UNIVERSAL HEALTHCARE NETWORK PROVIDERS

EMAIL: network.accounts@omsmaf.co.za

ESCALATIONS (FOR MEMBERS)

Refer to the OMSMAF website for the Escalations process: **www.omsmaf.co.za**

WHISTLE BLOWERS – FRAUD HOTLINE

TEL: 080 111 4447 (Toll free number)
EMAIL: fraud@omsmaf.co.za
WEBSITE: www.thehotline.co.za
WEBAPP: www.thehotlineapp.co.za
CALLBACK: (Please call me) 072 595 9139

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.**

DIGITAL TOOLS

www.omsmaf.co.za	OMSMAF Website, for all your latest Fund information, Forms and News
www.omsmaf.co.za	OMSMAF Member Portal, where you can view your claims, statements, and personal details.

Universal.one Mobile App , OMSMAF members can access their virtual membership card, view available benefits, find a provider, submit claims, view their statements and chat to a consultant.

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1 WELCOME TO YOUR MEMBER GUIDE

IN THIS SECTION

Why have a medical scheme?

You never know when you or one of your family members may need medical care, which could cost a substantial amount. The Fund provides medical cover to you and your dependants for a wide range of medical services, prescribed medicine and medical events, such as hospitalisation and surgery.

How can this Member Guide help me?

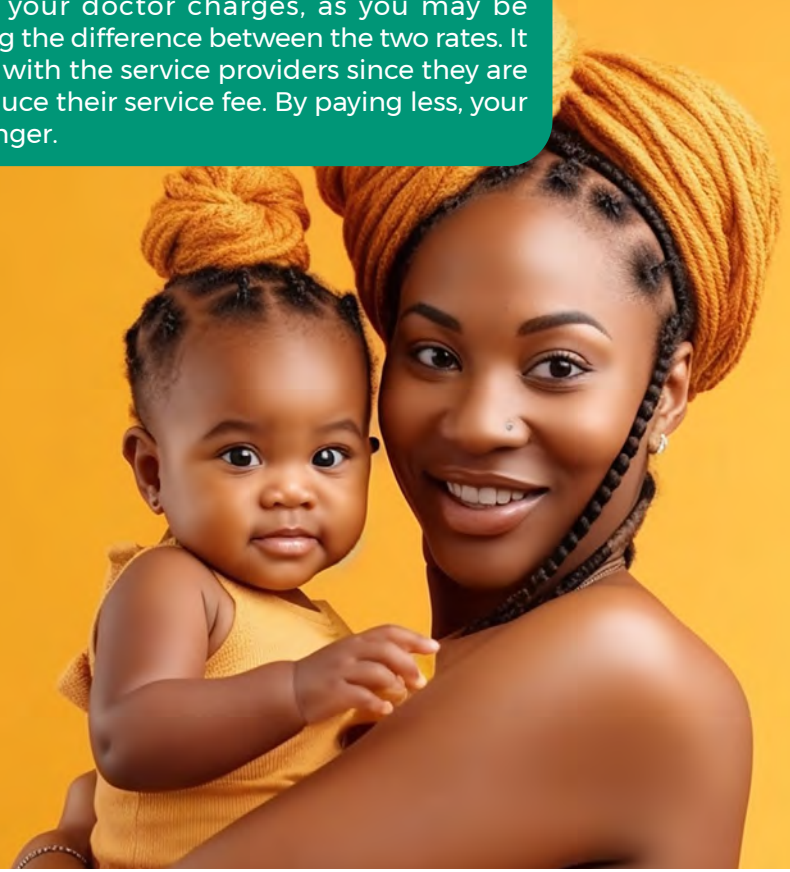
All your benefits and related conditions and limits are explained in a summarised form in this guide. This guide is designed to answer most of the general questions you may have. Read it carefully and keep it for future reference. You are also encouraged to visit the OMSMAF website for additional information www.omsmaf.co.za.

What are my responsibilities as a member?

- Understand how the Fund and your specific Plan works.
- Keep the Fund up to date on any changes to your membership details including your banking details.
- In order to assist the Fund in combatting the impact of fraudulent claims, please:
  - **check the accounts you receive from medical service providers for errors or inconsistencies,**
  - **check your member statement, SMS notifications and emails from the Fund to make sure that any claims that have been processed are correct and that there are no claims for services not provided,**
  - **report any suspicions of fraud by calling the Fraud Hotline on 080 111 4447, or emailing fraud@omsmaf.co.za.**
- Before having any medical procedures, please request quotes from providers and submit to Universal Healthcare, so that you can find out the difference between what the Fund will pay and what you will have to pay directly to the service providers.
- Contact the Fund before you are admitted to hospital to pre-authorise your admission.
- File all your documentation regarding the Fund so that you can refer to it if necessary.
- Keep your membership card in a safe place so that no one else can use it fraudulently.
- An electronic membership card can be downloaded via the universal.one mobile app.

- If you are an employee, ensure that your home address, email address, and any relevant changes, are captured on the Human Capital management system, and if you are on disability or a pensioner, inform the Fund of any changes, in order to receive all communication.
- If you retire and continue to belong to the Fund, you must ensure that you notify the Fund of your updated postal address, email address and banking details, if applicable.
- If you are a pensioner, ensure that you notify the Fund of your valid postal address and current email address in order to ensure that you receive your communication.

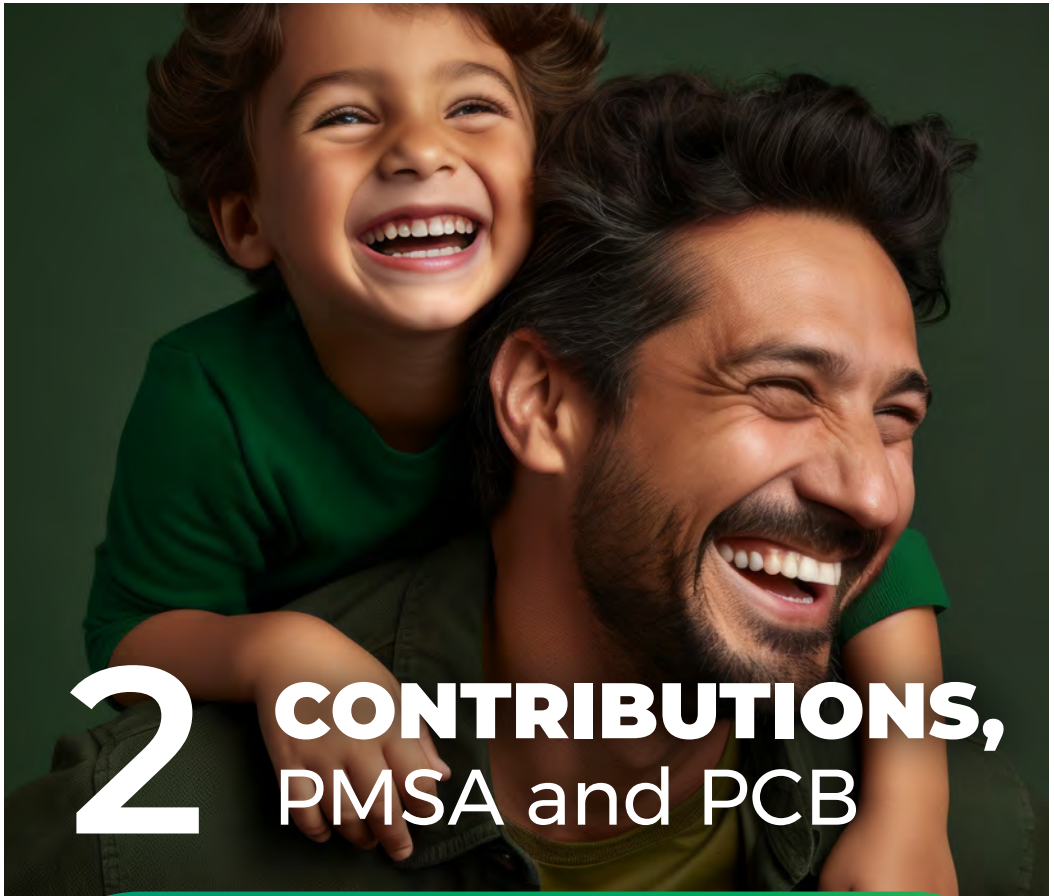
IMPORTANT NOTE: Medical practitioners are under no obligation to charge MSR. Due to the substantial difference between MSR and private provider rates, you should find out what rate your doctor charges, as you may be responsible for paying the difference between the two rates. It is worth negotiating with the service providers since they are usually willing to reduce their service fee. By paying less, your benefits will last longer.



ABBREVIATIONS

The following abbreviations appear in this guide:

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, by the Board of Trustees.
PCB	Primary Care Benefit
PET	Positron Emission Tomography
PMB	Prescribed Minimum Benefits
PMSA	Personal Medical Savings Account
SEP	Single Exit Price (for medicines)
TTO	To-take-out (medicine to take home from hospital event)



2 CONTRIBUTIONS, PMSA and PCB

IN THIS SECTION

- What are my monthly contributions?
- PMSA and PCB

What are my monthly contributions?

Hospital Plan

An entry-level Plan that offers Hospital benefits, Basic Chronic Benefits and Wellness Screenings.

Hospital Plan

Income band	Member	Adult	Child (max 3)
R0 - R5 870	R1 219	R975	R244
R5 871 - R8 800	R1 318	R1 054	R264
R8 801 - R11 740	R1 453	R1 191	R319
R11 741 - R23 240	R1 977	R1 680	R495
R23 241 +	R2 317	R1 970	R579

Network and Network SELECT Plans

A value-for-money Plan that offers Hospital benefits, Primary Care Benefits at a Network Provider, Wellness Screenings, and an enhanced benefit to manage chronic conditions, among others, all at an affordable rate for those in lower income groups. The non-PMB chronic conditions were reduced and are now aligned to the Hospital Plan. Only mental-health related conditions are covered.

Network Plan

Income band	Member	Adult	Child (max 3)
R0 - R5 870	R1 800	R1 531	R451
R5 871 - R8 800	R2 244	R1 908	R562
R8 801 - R11 740	R2 384	R2 027	R597
R11 741 - R15 680	R2 796	R2 376	R699
R15 681 - R23 240	R2 966	R2 521	R742
R23 241 +	R3 154	R2 681	R788

Network *SELECT* Plan

Income band	Member	Adult	Child (max 3)
R0 - R5 870	R1 275	R1 084	R319
R5 871 - R8 800	R1 589	R1 351	R397
R8 801 - R11 740	R1 969	R1 673	R492
R11 741 – R15 680	R2 522	R2 144	R631
R15 681 - R23 240	R2 675	R2 274	R669
R23 241 +	R2 845	R2 418	R711

Savings Plan

A Plan that offers a flexible Day-to-day Benefit, Hospital Benefits, Basic Chronic Benefits, Wellness Screenings and an enhanced Supplementary Benefit that includes maternity.

Savings Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 870	RISK	R1 784	R1 516	R356
	PMSA	R340	R289	R68
	TOTAL	**R2 124**	**R1 805**	**R424**
R5 871 - R11 740	RISK	R2 238	R1 678	R448
	PMSA	R426	R320	R85
	TOTAL	**R2 664**	**R1 998**	**R533**
R11 741 - R23 240	RISK	R2 638	R2 243	R660
	PMSA	R503	R427	R126
	TOTAL	**R3 141**	**R2 670**	**R786**
R23 241 +	RISK	R2 740	R2 329	R685
	PMSA	R522	R444	R131
	TOTAL	**R3 262**	**R2 773**	**R816**

Traditional and Traditional SELECT Plans

Offers Comprehensive Benefits for a variety of Healthcare Services including Hospital Benefits, Day-to-day, a wide-range of Chronic conditions, an extensive Supplementary Benefit and Wellness Screenings.

Traditional Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 870	RISK	R3 829	R2 987	R957
	PMSA	R426	R332	R106
	TOTAL	**R4 255**	**R3 319**	**R1 063**
R5 871 - R11 740	RISK	R4 179	R2 925	R1 045
	PMSA	R464	R325	R116
	TOTAL	**R4 643**	**R3 250**	**R1 161**
R11 741+	RISK	R5 088	R4 194	R1 414
	PMSA	R565	R466	R157
	TOTAL	**R5 653**	**R4 660**	**R1 571**

Traditional *SELECT* Plan

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 870	RISK	R3 454	R2 695	R863
	PMSA	R384	R299	R96
	TOTAL	**R3 838**	**R2 994**	**R959**
R5 871 - R11 740	RISK	R3 766	R2 636	R941
	PMSA	R418	R293	R105
	TOTAL	**R4 184**	**R2 929**	**R1 046**
R11 741+	RISK	R4 588	R3 783	R1 275
	PMSA	R510	R420	R142
	TOTAL	**R5 098**	**R4 203**	**R1 417**

Traditional Plus Plan

Offers Comprehensive Benefits for a variety of Healthcare Services including Hospital Benefits, Day-to-day, a wide-range of Chronic conditions, an extensive Supplementary Benefit and Wellness Screenings.

Traditional Plus Plan

Income band	Contribution	Member	Adult	Child (max 3)
All income bands	RISK	R8 425	R6 741	R2 107
	PMSA	R933	R746	R233
	TOTAL	**R9 358**	**R7 487**	**R2 340**

PMSA and PCB

Savings Plan

PMSA Only

Income band		Member	Adult	Child (max 3)
R0 - R5 870	Annual PMSA	R4 080	R3 468	R816
R5 871 - R11 740		R5 112	R3 840	R1 020
R11 741 - R23 240		R6 036	R5 124	R1 512
R23 241 +		R6 264	R5 328	R1 572

Traditional Plan

PMSA and PCB

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 870	Annual PMSA	R5 112	R3 984	R1 272
	Annual PCB	R5 390	R4 570	R1 620
	Overall Day to Day	**R10 502**	**R8 554**	**R2 892**
R5 871 - R11 740	Annual PMSA	R5 568	R3 900	R1 392
	Annual PCB	R5 390	R4 570	R1 620
	Overall Day to Day	**R10 958**	**R8 470**	**R3 012**
R11 741 +	Annual PMSA	R6 780	R5 592	R1 884
	Annual PCB	R5 390	R4 570	R1 620
	Overall Day to Day	**R12 170**	**R10 162**	**R3 504**

Traditional *SELECT* Plan

PMSA and PCB

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R5 870	Annual PMSA	R4 608	R3 588	R1 152
	Annual PCB	R5 390	R4 570	R1 620
	Overall Day to Day	**R9 998**	**R8 158**	**R2 772**
R5 871 - R11 740	Annual PMSA	R5 016	R3 516	R1 260
	Annual PCB	R5 390	R4 570	R1 620
	Overall Day to Day	**R10 406**	**R8 086**	**R2 880**
R11 741 +	Annual PMSA	R6 120	R5 040	R1 704
	Annual PCB	R5 390	R4 570	R1 620
	Overall Day to Day	**R11 510**	**R9 610**	**R3 324**

Traditional Plus Plan

PMSA and PCB

Income band	Contribution	Member	Adult	Child (max 3)
All income bands	Annual PMSA	R11 196	R8 952	R2 796
	Annual PCB	R10 800	R8 610	R2 710
	Overall Day to Day	**R21 996**	**R17 562**	**R5 506**

3 OVERVIEW OF BENEFITS

Hospital Plan

Simple, cost-effective cover

An entry-level Plan that offers Hospital benefits, Basic Chronic Benefits and Wellness Screenings.

Savings Plan

Simple cover with savings

A Plan that offers a flexible Day-to-day Benefit, Hospital Benefits, Basic Chronic Benefits, Wellness Screenings and an enhanced Supplementary Benefit that includes maternity.

Network Plan

Simple cover with benefits

A value-for-money Plan that offers Hospital benefits, Primary Care Benefits at a Network Provider, Wellness Screenings, Basic Chronic Benefits, among others, all at an affordable rate for those in lower income groups.

Network *SELECT* Plan

Simple cover with benefits at a lower cost

Get all the cover of the Network Plan for a more cost-effective monthly contribution, based on a restriction to select hospital providers.

Traditional Plan

Complete cover

Offers Comprehensive Benefits for a variety of Healthcare Services including Hospital Benefits, Day-to-day, a wide-range of Chronic conditions, an extensive Supplementary Benefit and Wellness Screenings.

Traditional *SELECT* Plan

Complete cover at a lower cost

Get all the cover of the Traditional Plan for a more cost-effective monthly contribution based on a restriction to select hospital providers.

Traditional Plus Plan

Full cover and total peace of mind

Offers Comprehensive Benefits for a variety of Healthcare Services including Hospital Benefits, Day-to-day, a wide-range of Chronic conditions, an extensive Supplementary Benefit and Wellness Screenings.

How do these benefits compare across Plans?

	Hospital Plan	Network Plan Network *SELECT* Plan*	Savings Plan	Traditional Plan Traditional *SELECT* Plan*	Traditional Plus Plan
DAY-TO-DAY BENEFITS	✓ 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. ✓ Limited Specialist consultations. ✓ 2 Out of network visits, event limit is R1 400	✓ 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.

*MSR. Refer to page 7 for all definitions regarding the Fund Acronyms.

How do these benefits compare across Plans?

	Hospital Plan	Network Plan Network *SELECT* Plan*	Savings Plan	Traditional Plan Traditional *SELECT* Plan*	Traditional Plus Plan
CHRONIC BENEFITS	✓ Limited	✓ Via Universal Healthcare Network GPs.	✓ Limited	✓ Comprehensive	✓ Comprehensive
HOSPITAL BENEFITS	✓ 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.	✓ 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.	✓ Unlimited Overall Annual Limit (OAL): (subject to certain sub-limits).	✓ Comprehensive, with unlimited Overall Annual Limit (subject to certain sub-limits).	✓ Comprehensive, with unlimited Overall Annual Limit (subject to certain sub-limits).
	A Doula (birthing coach) on all the plans as part of the In-Hospital maternity benefits, subject to a limit of **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.				
	✓ - Subject to the Overall Annual Limit and Managed Care protocols. - Physiotherapy: **R6 710** per family per benefit year.			✓ Subject to the Overall Annual Limit and Managed Care protocols.	
	✓ Oncology covered within ICON Essential Protocols. PMB only	✓ Oncology covered within ICON Essential Protocols. PMB only *Please note that under the ***SELECT*** Plan, members' choice of hospitals is restricted, and your doctor needs to work at the network hospital – refer to the OMSMAF website at www.omsmaf.co.za for a list of SELECT facilities.	✓ Oncology covered within ICON Enhanced Protocols. PMB only	✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit). *Please note that under the SELECT Plan, members' choice of hospitals is restricted, and your doctor needs to work at the network hospital – refer to the OMSMAF website at www.omsmaf.co.za for a list of SELECT facilities.	✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit).

4 OUT-OF-HOSPITAL DAY-TO-DAY BENEFITS

The level of Day-to-Day Benefits you receive will depend on the Plan you select. The tables below provide you with an overview of your Day-to-Day Benefits.

		Network Plan		Traditional Plan	
	Hospital Plan	**Network *SELECT* Plan***	**Savings Plan**	**Traditional *SELECT* Plan***	**Traditional Plus Plan**
Rate payable	Paid at Medical Schemes Rates (MSR) unless stated otherwise.				Paid up to 300% of MSR.
Personal Medical Savings Account (PMSA)	No	No	Yes, depends on your income band and family size - see page 10.	Yes, depends on your income band and family size - see page 10.	Yes, depends on your family size – see page 10
Annual Flexi Benefit (AFB)	No	Annual Flexi Benefit (AFB), subject to **R7 740** per beneficiary per benefit year and **R12 900** per family per benefit year.	No	No	No
Primary Care Benefit (PCB) Limit	No	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 10.	Depends on your family size – see page 10.

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
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, - Dermatologist (for lives >35 years) - 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, - Dermatologist (for lives >35 years) - 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	No benefit.	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
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: **R2 360** per beneficiary per benefit year; **R3 960** 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. (Medicine exclusion list may apply).	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).	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).
Pharmacy-Advised Therapy (PAT)		Over-the-counter medication available at your Universal Healthcare Pharmacy Network, subject to Network formulary, MMAP and limited to **R400** per family and **R110** per event.			
Auxiliary Services					
Physiotherapy		Auxiliary services limited to available AFB, subject to sub-limits: **R2 360** per beneficiary per benefit year; **R3 960** per family per benefit year.	At cost from PMSA and then from accumulated savings, subject to available funds. Limited to 1 pair of glasses, lenses and frames every 24 months, per beneficiary.	At cost from PMSA, then at MSR from PCB, up to overall Day-to-Day limit. Thereafter, accumulated savings can be used. Limited to 1 pair of glasses, lenses and frames every 24 months, per beneficiary.	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. Limited to 1 pair of glasses, lenses and frames every 24 months, per beneficiary.
Optical benefits ▸ Eye tests ▸ Spectacles, Frames, Readers, Contact Lenses (including fitting consultation for Contact Lenses)		Subject to AFB and to Universal Healthcare Optometry Network protocols and to be obtained from Universal Healthcare Optometry Network providers. No benefit for readers. Limited to 1 pair of glasses, lenses and frames every 24 months, per beneficiary.			

5 SUPPLEMENTARY BENEFITS

(These benefits differ across Plans.)

IN THIS SECTION

What are Supplementary Benefits?

On most open medical schemes, the benefits listed below are usually payable from Day-to-Day Benefits. However, to help you stretch your Day-to-Day Benefits as far as possible, the Fund will cover certain benefits in the same way as your Hospital Benefits, instead.

What is covered under Supplementary Benefits?

The following benefits are specifically covered under the various Plans, and are payable where applicable at MSR or cost, whichever is the lesser:

Maternity Benefits*	All pregnant beneficiaries have to register on the Mother and Baby Care Programme. If you are on the **Hospital** Plan, you will not have additional benefits. **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.** **Members on the Network and Network *SELECT* Plans: Specialist visits are subject to referral from a Universal Healthcare Network GP and authorisation.**
Antenatal classes	**Educational and support services and antenatal classes by a registered midwife, subject to the following limits per Plan:** **Hospital** Plan: No benefit. **Network** (including *SELECT*) and **Savings** Plans: **R1 620** per family per benefit year, paid at MSR. **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **R2 540** per family per benefit year, paid at MSR.
Antenatal visits	**Hospital** Plan: No benefit. **Network** (including *SELECT*) Plan: May also choose to consult with an obstetrician for up to 8 visits per pregnancy, paid at MSR, subject to referral by a Universal Healthcare Network GP and authorisation. Telephone: 0860 100 076 **Savings** Plan: 8 visits per pregnancy, paid at MSR. **Traditional** (including *SELECT*) and **Traditional Plus** Plans: 12 visits per pregnancy, paid at MSR.
Ultrasound scans (pregnancy)	**Hospital** Plan: No benefit. **Network** (including *SELECT*) Plan: Two 2D scans per pregnancy, if done, or referred by a Universal Healthcare Network GP or specialist. **Savings**, **Traditional** (including *SELECT*) and **Traditional Plus** Plans: Two 2D scans per pregnancy per beneficiary, Paid at MSR or cost, whichever is lesser.

Out-of-Hospital pathology tests (pregnancy)	Hospital Plan: No benefit. Network (including *SELECT*) and Savings Plans: **R3 150** per family. Traditional (including *SELECT*) and Traditional Plus Plans: **R3 940** per family. This benefit is dependent on the patient registering on the Mother and Baby Care Programme. Pathology testing (or blood tests) plays a very important role in the lives of patients. The Administrator has therefore adopted a sound policy of achieving maximum benefits for members of the Fund, both In-and-Out-of-Hospital, through partnerships with acknowledged experts in certain fields of medical care provision. You can assist the Fund by doing the following when blood tests are required: ▸ Ask your doctor about the need for specific tests in aiding medical diagnosis. Perhaps you can suggest single tests rather than multiple tests for every possible condition. ▸ Ask your doctor about the cost of the tests you are due to have done. ▸ Ensure that the doctor uses the correct ICD-10 code so that the claim comes off the correct benefit.
Antenatal vitamins	Hospital Plan: No benefit. Network (including *SELECT*) and Savings, Traditional (including *SELECT*) and Traditional Plus Plans: MMAP or medicine price, whichever is the lesser, subject to prescription and formulary.
Lactation Consultation	Hospital Plan: No benefit Network (including SELECT), Savings, Traditional (including SELECT) and Traditional Plus Plans: *NEW! provides mothers with one lactation consultation (breast feeding help) after discharge from hospital with a registered nurse.
Ultrasound scans In-and-Out-of-Hospital – combined benefit limit	**(All scans other than for pregnancy.)** **MSR or cost, whichever is the lesser,** subject to the following sub-limits per Plan: Network (including *SELECT*), Hospital and Savings Plans: **R6 080** per family. Traditional (including *SELECT*) and Traditional Plus Plans: **R9 040** per family.
Specialised Radiology* In-and-Out-of-Hospital – combined benefit limit (Including MRI, CT and Radio-isotope Scans and Nuclear Medicine. Excluding PET scans.) Unless pre-authorised, benefits will be subject to the relevant available Day-to-Day Benefits.	**MSR or cost, whichever is the lesser,** subject to the following combined benefit limits per Plan as well as co-payments applicable to specialised radiology In-and-Out-of-Hospital. Also see page 37, 'Specialised Radiology In-hospital'. Network (including *SELECT*), Hospital and Savings Plans: **R17 900** per family, with a co-payment of **R1 500** per authorisation. Traditional (including *SELECT*) and Traditional Plus Plans: **R22 100** per family, with a co-payment of **R1 500** per authorisation. This benefit excludes Oncology and Organ transplant-related MRI, CAT, PET and radio-isotope scans.
Dental implants*	Subject to pre-authorisation and only available on application prior to obtaining the service. Network (including *SELECT*) and Hospital Plans: No benefit. Savings Plan: PMSA, subject to available funds. Traditional (including *SELECT*) and Traditional Plus Plans: **R18 400** per family. All other associated costs, i.e. anaesthetic fees and hospitalisation, will not accumulate to this limit, and are subject to the Hospital Benefit at MSR. A **R1 500** co-payment will apply for all Fund-approved dental admissions to hospital. You will need to submit a quotation for every phase of treatment. If not approved, all costs will be covered from your available Day-to-Day Benefit, which is subject to available PMSA, PCB and accumulated savings.

Refractive Procedures* (including all related costs)	Subject to pre-authorisation. Network (including *SELECT*) and Hospital Plans: PMB only. Savings Plan: Subject to PMSA. Traditional (including *SELECT*) and Traditional Plus Plans: MSR or cost, whichever is the lesser, up to a sub-limit of **R19 400** per beneficiary. No benefits shall be paid unless the refraction of the eye is within the guidelines set by the Fund from time to time. The member must submit all relevant medical reports required by the Fund in order to consider the request.
Medical Appliances (External)* (e.g. wheelchair, crutches, baumanometer, as well as CPAP machines subject to managed care protocols) plus Foot Orthotics	**MSR** for hiring or purchasing a medical appliance. This benefit is subject to prior application and approval. Provided that no benefit shall be available for Action Potential Simulation (APS) Machines unless approved by the Fund. **Limits per Plan:** Network (including *SELECT*) and Hospital Plans: No benefit, unless a PMB. Savings: PMSA, subject to available funds. Traditional (including *SELECT*) and Traditional Plus Plans: Sub-limit of **R12 200** per family. Repairs are subject to approval and service rendered by an accredited supplier. If not approved, the benefit will be paid from available PMSA. Foot orthotics: **R5 520** per family on Traditional (including *SELECT*) and Traditional Plus Plans, subject to the overall Medical Appliances benefit, subject to motivation and authorisation.
Hearing Aids*	MSR or cost, whichever is the lesser. **Sub-limits per Plan:** Network (including *SELECT*) and Hospital Plans: No benefit. Savings Plan: PMSA, subject to available funds. Traditional (including *SELECT*) and Traditional Plus Plans: **R21 700** per ear per beneficiary, subject to a **co-payment of 10%**. Benefit is available every 3 years for those under the age of 7 and those over 85 years and every 5 years for beneficiaries between the ages of 7 and 84 years. This benefit excludes consultations and associated tests. Benefit is subject to the submission of a motivation by the treating doctor to the Fund and approval of the purchase of the devices prior to the acquisition of the device. Repairs are subject to approval and service rendered by an accredited supplier. If not approved, the benefit will be paid from available PMSA.
Mental Health Programme*	Limited to **R15 800** per beneficiary, subject to pre-authorisation and relevant managed healthcare protocols. Please see page 52 for more information.
Back and Neck Rehabilitation Programme*	Please see page 48 for more information on this programme.

* Subject to pre-authorisation - call 0860 100 076.

6 SCREENING AND WELLNESS BENEFITS

(These benefits may differ across Plans.)

IN THIS SECTION

Why should I go for screening tests?

Getting screening tests is one of the most important things you can do for your health. Screenings are medical tests that check for diseases before there are any symptoms. Screenings can help doctors find diseases early, when the diseases may be easier to treat.

How can the Screening Benefits help me?

These preventative benefits are available on all Plans and consists of two types of Screening Benefits: a Pharmacy Screening Benefit, plus certain tests that can be conducted by a GP or specialist.

This benefit is separate from the Day-to-Day Benefit and is not paid from these limits, but subject to the use of the correct diagnostic and tariff codes and covered at Medical Scheme Rate. *NEW! Non-pharmacy wellness consultations are paid at 200% of MSR for Specialists and 100% of MSR for GPs.

The aim of this benefit is to encourage beneficiaries to take care of their health and wellbeing by going for a general health consultation once a year and to keep track of their results.

What is available under the Pharmacy Screening Benefit?

The Pharmacy Screening Benefits are available from any of the Fund's preferred provider pharmacy clinics with a qualified nurse. The Fund will cover one visit per beneficiary per benefit year, to assess your state of health and to give advice as tools on how to improve your health.

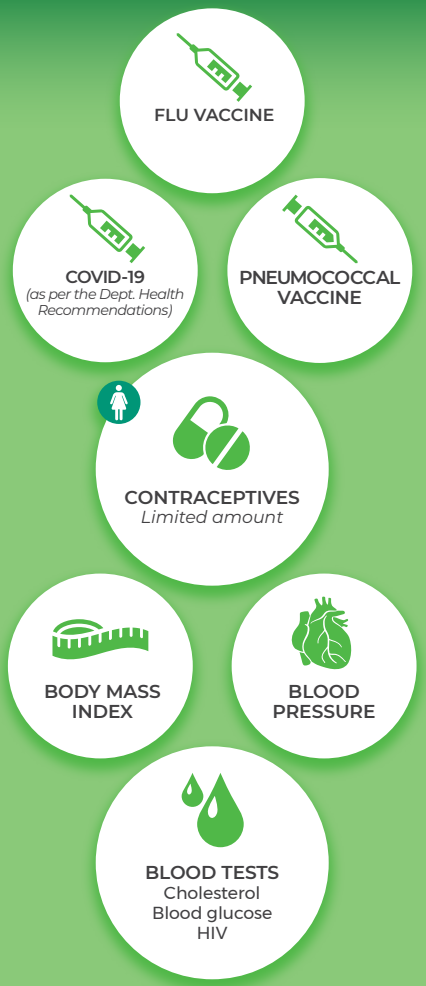
At the clinic they can offer the following tests, measurements and services:

- **Blood pressure** – Limited to 1 test per beneficiary.
- **Blood glucose** – Limited to 1 test per beneficiary.
- **Cholesterol** – Limited to 1 test per beneficiary.
- **HIV/AIDS Test** – Limited to 1 test per beneficiary.
- **Body Mass Index (BMI)** – Limited to 1 test per beneficiary.
- **Flu vaccine – Limited to 1 vaccination per beneficiary.** (The cost of a visit to a General Practitioner is subject to the Day-to-Day Benefit.)
- **Pneumococcal vaccine** – Limited to 1 vaccination per beneficiary per lifetime. (The cost of a visit to a General Practitioner is subject to the available Day-to-Day Benefit.)
- **COVID-19 vaccine** - for all eligible beneficiaries in accordance with the Department of Health recommendation.
- **Contraceptives – R3 780** per beneficiary. **R2 370** sub-limit for oral contraceptives. (Products must be prescribed in accordance with the prescribed list for contraception and not for the treatment of acne or skin conditions, unless otherwise specified as per managed care protocols.) The cost of a visit to a General Practitioner or Gynaecologist will not be covered under this benefit.

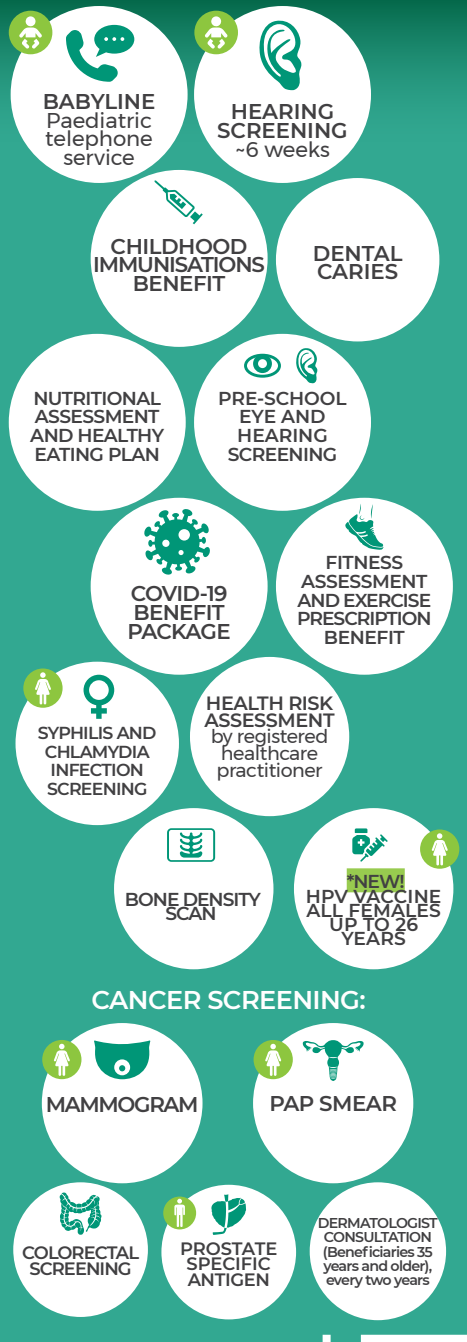
IMPORTANT: Please ask the General Practitioner or Gynaecologist or Urologist or Dermatologist (whichever is applicable) to submit the wellness consultation claim using the following primary ICD-10 code: Z00.0. If this code is not used, the benefit will be paid from your available Day-to-Day Benefits.

Members on the Network and Network *SELECT* Plans:
Specialist visits are subject to referral from a Universal Healthcare Network GP and authorisation, except in instances where the consultation forms part of the chronic PMB treatment plan, registration on the Mother and Baby Programme or is for a wellness consultation.

Pharmacy-based



Non-pharmacy-based



TIP: Discuss your contraceptive options with your healthcare provider when you have your pap smear.

In addition to having your blood pressure, cholesterol, blood sugar, height, weight and body mass index measured and monitored, you can also ask the clinic staff for advice on how to improve your health through basic exercise and healthy eating plans.

Please contact your nearest pharmacy clinic to make an appointment.

What is available under the non-pharmacy-based Screening Benefit?

*NEW! One consultation per beneficiary per benefit year with a GP paid at 100% of MSR or a Gynaecologist or a Urologist or a Dermatologist paid at 200% of MSR from the Wellness benefit for any of the following non-pharmacy screenings benefits:

- **Pap smear** – limited to 1 test per female beneficiary, including consultation with Registered Nurse, General Practitioner or Gynaecologist. This will also be an opportunity to discuss contraceptive options and get a script, if relevant.
- **Mammogram** – limited to 1 test per female beneficiary, including consultation with a Gynaecologist or GP. (Please note for the above Pap smear and Mammogram, only one Gynaecologist or GP consultation per benefit year will be funded from the Screening benefit).
- **Syphilis and Chlamydia infection screening** – limited to 1 test per female beneficiary, 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).
- **Prostate Specific Antigen** – limited to 1 test per male beneficiary, including consultation with General Practitioner or Urologist.
- **Colorectal screening** – limited to 1 test per beneficiary.
- **Health Risk assessment** – limited to 1 test per beneficiary. Only for services rendered by a registered healthcare practitioner (for example, a General Practitioner).
- **Audiology screening** – limited to 1 test per beneficiary up to the age of 6 weeks.
- **PAED-IQ's Babyline** – A 24/7, paediatric telephone service, whereby parents or caregivers of children from birth to three years of age, who are registered on the Fund, can phone in and get up-to-date child healthcare advice and reassurance.
- **Nutritional assessment and healthy eating plan** – Access to Universal network of dieticians - subject to pre-authorisation and registration - for annual assessment, healthy eating plan prescription and regular monitoring. An additional assessment for pregnant beneficiaries.
- **Pre-School readiness** – Eye and hearing screening for children aged 5 and 6.
- **Dental caries** (prevention and oral fluoride supplementation) – limited to beneficiaries up to age 6 years, subject to Managed Care Protocols, by oral-hygienist consultation.
- **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 and Chest physiotherapy. Pre-authorisation and managed care protocols apply. *COVID-19 Vaccinations for all eligible beneficiaries in accordance with the Department of Health recommendation.
- **Fitness Assessment and Exercise Prescription benefit** – Only available on the **Traditional** (including *SELECT*) 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.
- **Childhood immunisations** – Children up to the age of 12-years, as per recommendation by the Department of Health.
- *NEW! **HPV vaccine** has been extended to all females up to the age of 26 years.
- **Dermatologist Consultation** – limited to 1 consultation for cancer screening per beneficiary every 2 years, for beneficiaries 35-years and older.
- **Bone Density Scan** - limited to 1 bone density scan per beneficiary, per annum.

Any medical expenses not covered under the Screening Benefit will be paid from your available Day-to-Day Benefits.

7 MEDICINE BENEFITS

(These benefits may differ across Plans.)

IN THIS SECTION

What is a chronic condition?

A chronic condition is a condition that requires ongoing long-term or continuous medical treatment. However, not all of these conditions are necessarily covered by the Fund's Chronic Medicine Benefit. The Fund specifies a list of chronic diseases that qualify for this benefit.

Which chronic conditions are covered by all Plans?

All five Plans (including *SELECT*) have an unlimited chronic medicine benefit for Prescribed Minimum Benefits (PMB) conditions specified in the Government Gazette by the Minister of Health. (In addition, you qualify for certain additional Fund approved chronic conditions, depending on the Plan you have selected. Please see page 26-27 for more information.) To better understand this benefit, it helps to be familiar with the following terms and what they mean:

Chronic Medicine Formularies

A formulary is a list of cost effective evidence-based medicines that the Fund will cover for the treatment of your chronic condition. These lists are compiled by the Universal Healthcare Chronic Medicine Programme and are constantly reviewed.

Reimbursement is subject to the following Universal Healthcare Chronic Medicine Programme clinical guidelines and protocols, and the MMAP. The Fund applies an **Universal Healthcare Restrictive Formulary** and **Comprehensive Formulary** as part of the guidelines.

- **The Universal Healthcare Restrictive Formulary,** applicable to the Hospital and Savings Plans, contains a list of medicines for the covered chronic conditions.
- **The Universal Healthcare Comprehensive Formulary,** applicable to the Traditional (including *SELECT*) and Traditional Plus Plans, provides access to a wider range of medicines than the Universal Healthcare Restrictive Formulary.
- **The Universal Healthcare Network Formulary,** applicable to the Network (including *SELECT*) Plan.

If you choose to use a medicine that is not in your Plan's formulary, you will have to pay a 25% co-payment. The formularies are updated throughout the benefit year. It is important for you to discuss changing to an alternative medicine with your treating doctor or you will have to make co-payments.

Maximum Medical Aid Price (MMAP)

All medicine claims are paid at medicine price or the MMAP, whichever is the lesser.

MMAP is a reference pricing system that uses a benchmark or reference price for generically similar products. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicines, but instead limits the amount that will be paid. The MMAP is updated regularly and there may be a change to the amount your Fund will pay for your medicine. Check in with your pharmacist regularly to keep up to date with the MMAP changes.

Speak to your pharmacist or consult with your treating doctor about an alternative treatment. A clinical motivation from your doctor, requesting the Fund to cover a non-MMAP medicine in full, may be considered if criteria are met.

Medicine Exclusion List (MEL)

The Fund makes use of a MEL, which excludes medicines from payment from the Acute Medicine Benefit for a number of reasons. These include:

- medicines not proven to have relevant clinical value;
- medicines more expensive compared to equally effective and safe cheaper alternatives;
- some expensive chronic medicines that require pre-authorisation;
- some combination products, where it is more appropriate to use single ingredient products; and
- newly registered products under review.

MMAP co-payments

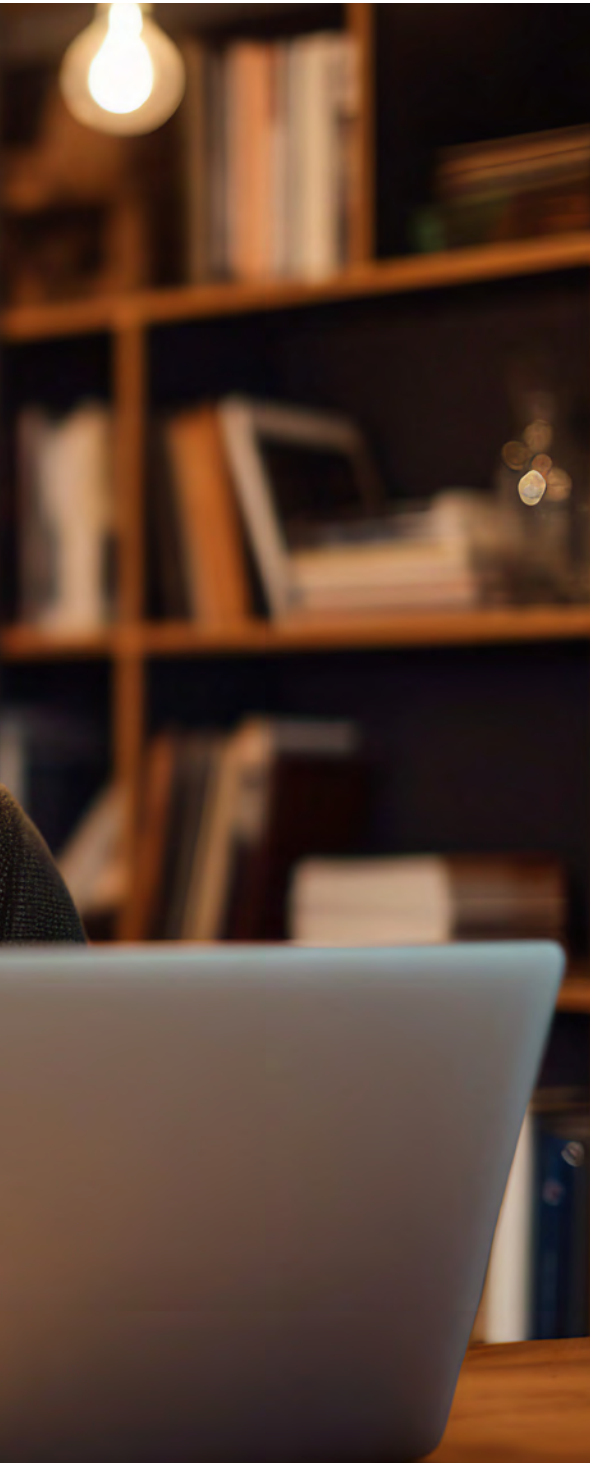
A MMAP co-payment is the difference between the cost of the medicine and the reference price. These co-payments will be payable if you claim for chronic medicine that is not within the MMAP instead of choosing an alternative from the list, e.g. an appropriate generic equivalent.

Out-of-formulary co-payments

These co-payments will be payable whenever you claim for chronic medicine that is not in your Plan formulary.

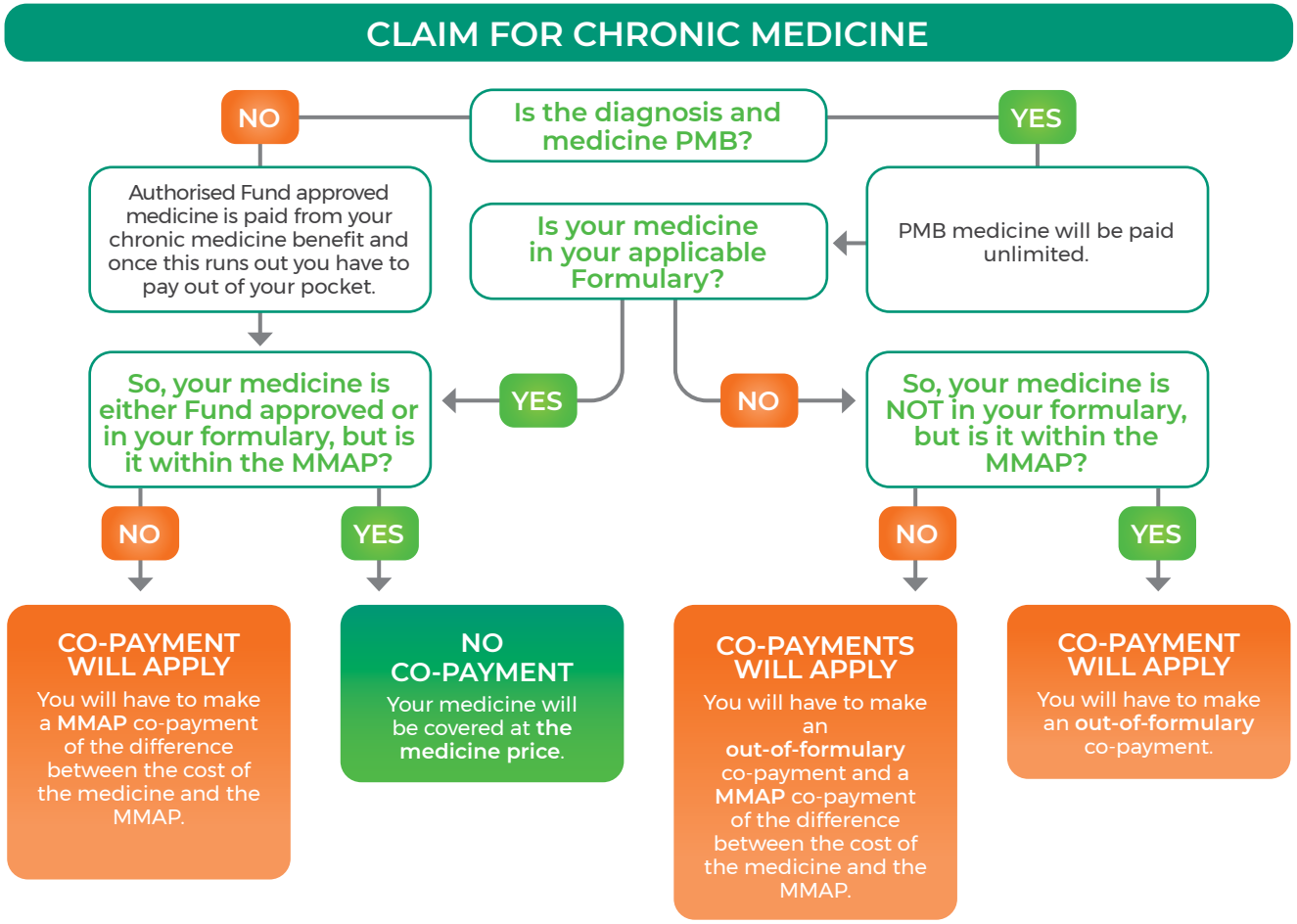
If you are unsure of which medicine is in or out of formulary and the effect this will have on your chronic medicine benefits, please contact us. To avoid co-payments, discuss alternative therapies with your treating doctor or pharmacist and ensure that you obtain your medicine through the appropriate source.

Please note that the Fund has appointed preferred providers that have contracted to dispense medicine at the Fund's agreed dispensing fees.



Co-payments

Co-payments are payable at the point of dispensing and can be attracted in one of two ways, as set out in the diagram below:



More information on the chronic registration process, chronic conditions and the formularies is available over the next few pages of the guide. If you need more information, contact the Fund on 0860 100 076 or email chronic@omsmaf.co.za.

PMB Chronic medicine

MMAP or the medicine price, whichever is the lesser, for medicine prescribed in respect of PMB chronic conditions, unlimited.

On the **Network** (including *SELECT*) Plan the Universal Healthcare Network Formulary will apply.

On the **Hospital** and **Savings** Plans the Universal Healthcare Restrictive Formulary will apply.

On the **Traditional** (including SELECT) and **Traditional Plus** Plans the Universal Healthcare Comprehensive Formulary will apply.

PMB Chronic Disease List (CDL) conditions - All Plans

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic obstructive pulmonary disease (emphysema)
- Chronic renal disease
- Coronary artery disease (angina pectoris and ischaemic heart disease)
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension (high blood pressure)
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

Additional PMB Conditions Covered (DTP)

- Chronic Hepatitis
- Cushing's syndrome
- Cystic fibrosis
- Deep vein thrombosis
- Hyperfunction of the pituitary gland
- Hyperthyroidism
- Hypofunction of the pituitary gland
- Hypoparathyroidism
- Menopause
- Myasthenia gravis

Additional Chronic Conditions

In addition to the chronic conditions covered as PMBs, the Fund offers chronic medicine benefit cover for certain additional conditions and up to different limit amounts, depending on the Plan you are on.

Did you know?
OMSMAF offers more non- PMB Chronic conditions on ALL Plans than many open schemes out there!

	Hospital Plan	Network Plan: Network *SELECT* Plan*	Savings Plan	Traditional Plan: Traditional *SELECT* Plan*	Traditional Plus Plan
PMB Chronic Disease List (CDL)	Covered on **ALL** plans.				
Additional List of non-PMB Chronic limit	**R7 880** per family.	Registration and approval required and medicine subject to the Universal Healthcare Network Formulary.	**R7 880** per family.	**R15 500** per family.	**R18 600** per family.
Additional Conditions Covered	Anxiety | Depression | General Anxiety Disorder | Obsessive Compulsive Disorder | Panic Disorder | Post-Traumatic Stress Disorder				
	Only the above listed additional mental health related conditions, which apply to all plans.	Only the above listed additional mental health related conditions, which apply to all plans.	Anorexia nervosa | Bulimia nervosa | Cardiac Arrhythmia | Acne | Allergic rhinitis | Migraine	Alzheimer's disease | Attention deficit hyperactivity disorder (ADHD) | GORD (if linked to one of the following PMB conditions: asthma, Crohn's Disease, rheumatoid arthritis or ulcerative colitis)| Myoneural disorders | Osteoporosis | Psoriasis | Cushing's disease | Cystic fibrosis | Allergic dermatitis/Eczema | Ankylosing spondylitis | Anorexia nervosa | Bulimia nervosa | Neuropathies | Systemic sclerosis | Acne | Allergic rhinitis | Migraine | Gout | Osteoarthritis | Macular Degeneration | Macular Odema | Cardiac Arrhythmia	Alzheimer's disease | Attention deficit hyperactivity disorder (ADHD) | GORD (if linked to one of the following PMB conditions: asthma, Crohn's Disease, rheumatoid arthritis or ulcerative colitis)| Myoneural disorders | Osteoporosis | Psoriasis | Cushing's disease | Cystic fibrosis | Allergic dermatitis/ Eczema | Ankylosing spondylitis | Anorexia nervosa | Bulimia nervosa | Neuropathies | Systemic sclerosis | Acne | Allergic rhinitis | Migraine | Gout | Osteoarthritis | Macular Degeneration | Macular Odema | Cardiac Arrhythmia

*Prescribed Minimum Benefits (PMBs) are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. This includes any emergency medical condition; a limited set of 271 medical conditions (defined in the Diagnosis Treatment Pairs); and 26 chronic conditions (defined in the Chronic Disease List).

Specialised drugs for non-Oncology (The non-oncology specialised drug list is a continuously evolving list of high-cost drugs used for the treatment of chronic conditions. This list includes but is not limited to biological drugs (biological therapy for inflammatory arthritis, inflammatory bowel disease, chronic demyelainating polyneuropathies, chronic hepatitis, botulinum toxin, palivizumab). Unless otherwise stated, for any other diseases where the use of the drug is deemed appropriate by the managed health care organisation, drugs will be funded from this benefit. Subject to a published list that can be obtained by logging into www.omsmaf.co.za.	Network (including *SELECT*), Hospital and Savings Plans: PMB only (only Multiple Sclerosis is covered). Traditional (including *SELECT*) and Traditional Plus Plans: **MMAP or medicine price, whichever is the lesser, limited to R247 000** per beneficiary per benefit year, included in the overall annual limit. **Subject to the relevant managed healthcare programme and to pre-authorisation.**
Drugs applicable for treatment of Macular degeneration and macular oedema	Network (including *SELECT*), Hospital and Savings Plans: PMB only. Traditional (including *SELECT*) and Traditional Plus Plans: **MMAP or medicine price, whichever is the lesser, limited to R78 300** per beneficiary and included in the specialised drugs for non-oncology benefit. Subject to approval and pre-authorisation by the managed healthcare programme.
Drugs for the treatment of MDR and XDR-TB	**MMAP or medicine price, whichever is the lesser**, subject to the relevant managed healthcare programme and pre-authorisation.

How do I apply for the Chronic Medicine Benefit?

To register for treatment of your chronic condition, your pharmacist, your doctor, or you can follow the telephonic process shown below.

Have the following information on hand:

- a copy of your current prescription.
- your membership number.
- the date of birth of the person applying.
- the ICD-10 code.
- doctor's practice number.
- medicine details.

To authorise certain medicine you may also need to supply:

- the clinical examination data, e.g. weight, height, BP. readings, smoking status, allergy information.
- test results, e.g. lipogram results, Hba1c, lung function tests.
- motivation provided by your prescribing doctor.

Telephonic process:

- Call Universal Healthcare Chronic Medicine Programme between 08:00 and 17:00 at 0860 100 076 and follow the voice prompts for chronic medicine.
- Once you select the appropriate option your call will be routed through to a consultant who will guide you through the process.

Where more clinical information is needed, members of the clinical team will review the information supplied and correspond with you and your doctor either telephonically or in writing.

The outcome of your application will be communicated to you in writing by means of an authorisation letter. The letter lists the medicines authorised as chronic medication for you. The authorisation letter, together with a valid prescription, must be presented to your pharmacist. Pharmacies will not dispense your chronic medicines without a valid prescription.

MMAP and out-of-formulary co-payments will still apply to medicine that is pre-approved. Contact the Universal Healthcare Chronic Medicine Programme on 0860 100 076 to check for medicines that may have a co-payment. Formularies and MMAP information are available on www.omsmaf.co.za.

How do I update my chronic medication if my doctor prescribes a new medicine?

If your doctor provides you with a new script or a change in your current treatment, it is best to go straight to your pharmacy to update your medicine there. Your pharmacist can simply submit the claim. Ask your pharmacist to inform you of any co-payments or additional costs. He or she can also recommend a generic alternative, if needed.

An updated script will only be needed if:

- your medicine is not in the formulary; or
- you are diagnosed with a new chronic condition.

Important to note: Authorisation of your chronic medicine on all Plans

- Each beneficiary needs to be registered individually on the programme.
- Clinical Entry Criteria will be applied. This means that your application must meet certain clinical criteria before chronic medicine benefits will be authorised. This step ensures the cost-effective and sustainable funding of chronic medicine, without compromising the quality of care.
- Medicines for PMB will be covered without a co-payment if they are on your Plan-specific Formulary and you obtain your medicine from a Preferred Provider. A MMAP co-payment may still apply. This can be avoided by choosing an appropriate generic equivalent.

Please note: If your medicine or condition does not meet the required criteria, your claims will be subject to the available Day-to-Day Benefits (where applicable).

How does the Chronic PMB Treatment Plan work?

If your application for a PMB CDL condition is approved, you will receive a PMB Care Plan for the chronic disease for which you are being treated. The Care Plan has been set up to ensure that members receive sufficient benefits to control their PMB chronic conditions and improve their quality of life. No Care Plans will be allocated for Fund approved chronic conditions.

Your Care Plan assigns you a basket of care specific to your PMB condition. Chronic medicine is not included in the Care Plan and is covered by your chronic medicine limit, where appropriate. Your Care Plan is a list of the type and number of services that are likely to be needed by a patient with your diagnosis and that the Fund will cover. It includes Out-of-Hospital treatment such as doctor consultations, radiology and pathology tests. If you need treatment and care in excess of your Care Plan, a clinical motivation needs to be provided and approved before more services will be covered.

Which service providers should I use?

Although you are free to use any service provider, the Fund has appointed a Universal Healthcare Preferred Provider network contracted to dispense acute and chronic medicine at the Fund's agreed dispensing fees. This is a comprehensive network consisting of more than 1800 pharmacies and includes independent community pharmacies, big retail groups as well as courier pharmacies.

A list of the preferred provider network pharmacies is available on the member portal, and can also be obtained by contacting the Universal Healthcare contact centre on 0860 100 076.

Contact details for Chronic Medicine Management

Telephone:	0860 100 076 (Members) 0860 100 076 (Doctors & pharmacists)
Email:	chronic@omsmaf.co.za
Business hours:	Monday - Friday, 08:00 – 17:00

8 HOSPITAL BENEFITS

(These benefits may differ across Plans.)

IN THIS SECTION

What are Hospital Benefits?

Hospital Benefits generally cover the major medical expenses that you would incur when undergoing surgery or while in hospital. In most cases, the services that would normally be provided in doctors' rooms, dental surgeries, etc. are excluded. **Please note that a visit to a hospital's Emergency Room does not qualify to be paid from your Hospital Benefits, unless the incident is of such a serious nature that you are admitted to a ward in the hospital itself, for further treatment.**

If your treating doctor charges you more than the sub-limit available for that service, you will have to pay the difference.

The difference can be paid from your PMSA or accumulated savings, if any. Please note that you may not use your PMSA or accumulated savings to pay for PMB in part or in full.

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

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*** and **Traditional *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 (refer to the website for a list of the *SELECT* hospitals).

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.

What if I am on a *SELECT* Plan, but voluntarily get admitted to a non-*SELECT* hospital?

A co-payment of 20% of the total hospital bill will apply if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals (Refer to the list on the website).

How does pre-authorisation before hospitalisation work?

What to do before you are hospitalised

Before having any medical procedures, please request quotes from providers and submit it to enquiries@omsmaf.co.za so that you can find out the difference between what the Fund will pay and what you will have to pay directly to the service providers.

Before you are admitted to any hospital you or your doctor must pre-authorise with the Fund. Pre-authorisation is informing the Fund of your hospital admission and obtaining approval for your hospital stay.

We highly recommend that you or your doctor contact the Fund at least five (5) working days before every planned admission. It is recommended that you or your doctor obtain authorisation at least 10 days before your hospitalisation for a procedure where an implant or an internal prosthesis will be necessary, for example, a hip, knee, shoulder or elbow replacement or spinal surgery. Please ensure that your doctor provides a comprehensive quote.

An authorisation will not be provided unless all of the following information is available:

- Member or dependant number: Who is being admitted?
- Place of service practice number: Where is the person being admitted to?
- Treating healthcare professional practice number: Who is the doctor admitting the person?
- Treatment date: When is the person being admitted?
- Relevant diagnosis and/or procedure codes: Why is the person being admitted?

You will receive an authorisation letter to advise you of the status of the authorisation. It is still your responsibility to ensure that you have received an authorisation. You may contact the OMSMAF Contact Centre on 0860 100 076 if you have any queries.

How do I pre-authorise for hospital admission?

Contact Hospital Benefit Management at 0860 100 076 and follow the voice prompts for hospital pre-authorisations, or email: authorisations@omsmaf.co.za at least five working days (where possible) before being admitted to hospital.

What if there is no pre-authorisation?

A R500 co-payment may apply when a treatment is not pre-authorised. This will be in addition to any other co-payments that may apply. If there is a change to your original pre-authorisation, this may be subject to additional approval.

Why it's important to pre-authorise

If authorisation has been granted it is payable from the relevant benefit subject to the Fund's rules and limits. Additional pre-authorisations, over and above the hospital admission pre-authorisation, may be required in certain instances during your hospital stay, e.g. for MRI scans.

Please note:

- You or your doctor has to pre-authorise every admission to hospital, even if you are re-admitted the next day.
- Authorisation is not a guarantee of payment. Payment will depend on your membership being active and benefits being available on the date of treatment.

In the case of a major hospitalisation event, a case manager from Hospital Benefit Management will monitor the patient's progress, including their stay in high care and intensive care. This will ensure that he/she does not have to stay in hospital any longer than necessary. They may also arrange, in consultation with the doctor, that the patient recuperates at home, under the care of professionals.

Remember that it is your responsibility to ensure that the doctor's rooms have obtained pre-authorisation where required.

What about emergencies?

In the case of an emergency, you or a family member must ensure that the doctor's rooms have notified Hospital Benefit Management on the first working day after being admitted. If not, you may have to pay a co-payment of R500.

What if my hospitalisation is postponed after I have already received pre-authorisation?

Please ensure that the doctor's rooms contact the Contact Centre to update your admission dates.

What if I am re-admitted?

Your doctor's rooms will have to pre-authorise your hospital admission again, before you are admitted, even if you are being re-admitted for the same condition.

What about extended stays?

The hospital must obtain approval from the Fund via the case manager for stays that exceed the number of days that were initially pre-authorised.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

What about procedures in General Practitioners' and Specialists' rooms?

You must obtain a pre-authorisation number for procedures that are undertaken in doctors' rooms to be funded from your Hospital Benefits at MSR or cost, whichever is the lesser, subject to Managed Care protocols. These include, but are not limited to, the following:

- Bone marrow biopsy
- Colonoscopy
- Cystoscopy
- Gastroscopy
- Hysteroscopy
- Intravenous therapy
- Keloids (subject to motivation)
- Laser to scars (subject to motivation)
- Sclerotherapy
- Flexible sigmoidoscopy
- Surgical biopsies (needle biopsies) (subject to motivation)
- Tonsillectomy (laser)
- Upper Glendoscopy
- Vasectomy
- **Tariff Code** 0307 Excision and repair
- **Tariff Code** 0255 Drainage of subcutaneous abscess & avulsion of nail
- **Tariff Code** 0259 Removal of foreign body superficial to deep fascia
- Any other minor procedures
- Excision of lymphoma
- Biopsy of skin

Your doctor can still authorise your treatment on the first working day after the procedure, if your circumstances do not allow you to do so beforehand. These procedures are more cost effective when performed in a doctor's room and will be paid from your Hospital Benefits, provided the procedure is authorised.

What do I need to know before I go for a knee or hip replacement?

If you are on the **Savings**, **Traditional** (including SELECT) or **Traditional Plus** Plans* and meet the necessary criteria on examination by the orthopaedic surgeon, you can use the Fund's Designated Service Provider (DSP) for knee and hip replacements to ensure that you do not incur a co-payment for your surgery.

The DSP, ICPS (Improved Clinical Pathway Services), is a group of orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways. These care pathways have been developed in accordance with evidence-based outcomes to ensure that the quality of the hip and/or knee replacement is of the highest standard and to ensure the best health outcomes.

They use multidisciplinary teams dedicated to assist with rapid and successful recovery, keeping the patient as comfortable as possible during the healing period.

If you need a hip or knee replacement:

- Call the Contact Centre on 0860 100 076 and you will be given the details of a DSP orthopaedic surgeon closest to you.
- Consult with the DSP orthopaedic surgeon to see whether you meet the criteria for their clinical care pathway.
- If you meet the criteria, an application for an authorisation number will be arranged on your behalf by the practice. This will ensure payment in full, with no co-payment for the procedure.

To alleviate the administrative burden of submitting accounts, the DSP will submit one account to the Fund for payment that will include:

- All hospital costs.
- Surgeons' and anaesthetists' fees.
- Prosthesis (subject to your prosthesis benefit).
- Physiotherapist (pre-, intra- and post-operative).

For further enquiries regarding the DSPs for hip and knee replacements, please call the Contact Centre on 0860 100 076.

Members on the **Hospital or **Network** (including SELECT) Plans are not covered for procedures such as hip, knee, shoulder and elbow replacements, other than in accordance with Prescribed Minimum Benefits.*

What if I have multiple procedures under the same anaesthetic?

Sometimes multiple procedures are done during the same operation. In some cases, these are planned and pre-authorised, while in some cases these are not planned, but are necessary and will therefore be authorised. There are also cases where additional procedures will not be covered at all. The following are some typical examples of the three possibilities above.

- A typical case of multiple procedures being planned and pre-authorised would be a child having a tonsillectomy, adenoidectomy, grommets insertion and removal of warts in one theatre event. These codes as well as the full theatre time will be approved, if clinically indicated. Using an industry 'modifier code', **the procedures will be covered at a sliding scale,** with the first procedure covered at 100% and the rest at a lesser percentage.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

- The second scenario is where a patient complains of abdominal pain, for which the doctor books a diagnostic laparoscopy. The doctor then finds that the appendix is inflamed and that the member has endometriosis on the ovaries. The doctor may then, without pre-authorisation, do a laparoscopic appendectomy and laparoscopic ovarian cystectomy. These procedures, as well as the full theatre time, will be updated by the hospital case managers and be approved retrospectively by the Fund. These procedures will then be covered the same as if pre-authorisation had been obtained.
- Multiple procedures will not be covered, for example, where a patient has a laparotomy for the removal of the colon (hemicolectomy) due to cancer, but is overweight and asks the doctor to also do a lipectomy (removal of excess abdominal fat) while he/she is in theatre. The hemicolectomy and the theatre time for the hemicolectomy will be covered, but the member will be liable for the lipectomy as well as for the additional theatre time in which this was performed, as a lipectomy is a Fund exclusion.

What is important to know is that even when authorised, not all procedures should be claimed at 100%, as, for example, the same incision is used and cannot be claimed as a separate 'code'. These reimbursement rules are in accordance with guidelines set up by professional medical associations.

What services and procedures are covered during hospitalisation?

The following services and procedures are covered at MSR or cost, whichever is the lesser, unless otherwise stated. You will find a list of the services and procedures covered under Hospital Benefits, as well as the sub-limits that apply, in the tables on the following pages.

Quro Medical - The technology-enabled Hospital at Home (HAH) gives patients the option to receive active treatment for a specified period at home instead of a general hospital ward, without compromising on the quality of care. Subject to referral from treating doctor.

Please note that you need to pre-authorise for services marked with an asterisk or risk having them paid from your Day-to-Day benefits (*). All authorisations are subject to managed healthcare protocols and guidelines. Please note that authorisation is not a guarantee of payment.

If you are uncertain about any of these benefits, and would like to find out more, please call 0860 100 076.

Terms used in the table:

- **Designated Service Prover (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 (including *SELECT*) and Traditional Plus 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.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
Unless otherwise stated, benefits will be paid at MSR or cost, whichever is the lesser.	
OVERALL ANNUAL LIMIT:	**Network** (including *SELECT*) Plan: **R1 000 000** per beneficiary per benefit year. **Hospital**, **Savings**, **Traditional** (including *SELECT*) and **Traditional Plus** Plans: Unlimited.
Prescribed Minimum Benefits (PMBs)	**Cost** for services received in accordance with State hospital level of care. Refer to the OMSMAF website for more information on PMBs.
Co-Payments	Co-payments may apply to certain procedures – these procedures and co-payments are listed under this section in the member guide. Please note that these are some of the most common co-payments, there may be specific co-payments related to your authorisation. Your pre-authorisation letter will also provide you with the details of your co-payments applicable to your authorisation. You may submit a quotation prior to your admission, to find out if there is a difference between what your specialist has quoted and what the Fund will cover at MSR. ***SELECT* Plans: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and are voluntarily admitted to hospital not on the *SELECT* list of hospitals. The co-payment is payable to the hospital either upfront or at the time of discharge.**
1. Hospital Services* If you are hospitalised, your stay will be subject to the period that was pre-authorised and any additional days that may be further authorised by the case manager. No further benefits will be paid unless such a stay is further authorised.	**Subject to managed healthcare protocols and guidelines and pre-authorisation, MSR** in respect of the following: • Wards - unless otherwise specified, general ward on all options • Intensive and high care units • Surgical and theatre fees • Labour and recovery wards • Hospital procedures Private wards are paid at general ward rates unless pre-authorised and subject to clinical protocols. On the day of discharge, you should arrange to leave the hospital **before 12h00** wherever possible. If scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you **after 12h00**. In this way, you can avoid incurring additional hospital costs.
2. Maternity Benefits*	All pregnant beneficiaries have to register on the Mother and Baby Care Programme except beneficiaries on the Hospital Plan.
Confinement **in-hospital** Please note that, if your newborn baby needs phototherapy for jaundice an authorisation can be issued for the treatment to be performed at your home by a registered nurse. This treatment, if authorised, will be funded from your Hospital Benefits.	**MSR or cost, whichever is the lesser,** in respect of the following, subject to the overall annual limit: • Medical practitioner services whilst hospitalised. • Theatre and recovery rooms. • Normal delivery limited based on protocols. • Caesarean delivery limited based on protocols. • Material used in-hospital. • Medicine price for medicines. • Medicine taken on discharge from hospital, limited to **R690** per beneficiary per admission. • A Doula (birthing coach) benefit limited to **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Confinement in **a registered birthing unit**	**Society for Private Nurse Practitioners of South Africa (SPNP) rate (for midwife or home delivery). Midwife must be registered with the BHF and the Nursing Council.** **Limited to and including the following Maternity Benefits:** • Delivery by a midwife; • Hire of water bath included in Maternity Benefit; • 4 Post-natal midwife consultations per event if a gynaecologist is not used. • A Doula (birthing coach) benefit limited to **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.

Confinement **Out-of-Hospital**	**Negotiated fee, the Society for Private Nurse Practitioners of South Africa (SPNP) rates, or in the absence of such fee, the lower of MSR or cost, or Uniform Patient Fee Schedule for public hospital for the delivery by a general practitioner or midwife. Midwife must be registered with the BHF and the Nursing Council.** **Limited to and included in the Maternity Benefit:** ▸ Hire of water bath and oxygen cylinder included in the Maternity Benefit. ▸ 4 Post-natal midwife consultations per event if a Gynaecologist is not used. ▸ A Doula (birthing coach) benefit limited to **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Service category	**Benefit**
3. Medical Services Refer to page 32 for details on the pre-authorisation process.	**MSR or cost, whichever is the lesser**, in respect of the following: ▸ Visits and consultations by a GP or specialist during hospitalisation. ▸ Surgery and medical procedures that require hospitalisation. ▸ Anaesthetics. ▸ Perfusion services. ▸ Pathology during hospitalisation. ▸ Radiology during hospitalisation. ▸ Physiotherapy during hospitalisation. ▸ Clinical technology during hospitalisation. ▸ Speech therapy during hospitalisation. ▸ Occupational therapy during hospitalisation. ▸ Dietetic services during hospitalisation. ▸ Social worker services during hospitalisation. ▸ Other services performed by registered medical practitioners. ▸ Cost of blood. ▸ Certain services related to the initial pre-authorised hospitalisation may be covered by Hospital Benefits, subject to approval. **PLEASE NOTE: Cover for claims for auxiliary medical services in-hospital, such as physiotherapy, occupational therapy, speech therapy and dietetics, will be subject to referral by the treating healthcare professional.** The following in-hospital sub-limit applies to the Savings, Network (including *SELECT*) and Hospital Plans: ▸ Physiotherapy: **R6 710** per family
4. Ultrasound scans - in-hospital	(All scans other than for pregnancy) **MSR or cost, whichever is the lesser.** Limited to the overall combined benefit amount for ultrasound scans - please see page 18.
5. Basic Dentistry - in-hospital* (performed by a dental practitioner, including minor oral surgery)	Network (including *SELECT*) and Hospital: No benefit Savings, Traditional (including *SELECT*) and Traditional Plus Plans: **MSR or cost, whichever is the lesser.** Subject to the relevant managed healthcare programme and pre-authorisation. General anaesthetic, conscious sedation, theatre fees and hospitalisation for dental work will only be granted for: ▸ Beneficiaries under the age of 8 years. In such a case the hospital and anaesthetist's account will be covered under your Hospital Benefits, **while the dentist's account will be paid from your Day-to-Day Benefits.** ▸ Bony impactions of the third molars. In such a case the hospital, anaesthetist's and dentist's accounts will be covered under your Hospital Benefits. ▸ Lingual and labial frenectomies under general anaesthesia granted for beneficiaries under the age of 8 years, subject to the relevant managed healthcare programme and pre-authorisation, will be covered from your Hospital Benefits. All dental-related cases requiring surgery need to be motivated by the attending dental practitioner and are subject to approval. This includes simple extractions. **A R1 500 co-payment will apply for Fund-approved dental admissions to hospitals.**

6. Maxillo-facial and oral surgery (including orthognathic surgery where clinically appropriate)*	Network (including *SELECT*) and Hospital Plans: Limited to PMB admissions only. Savings, Traditional (including *SELECT*) and Traditional Plus Plans: **MSR or cost, whichever is the lesser,** subject to the relevant managed healthcare programme and pre-authorisation. Dentist/ Maxillo-facial account will be paid from your Day-to-Day benefits, for Savings, Traditional (including *SELECT*) and Traditional Plus Plans. This benefit excludes the following for the Network (including *SELECT*) and Hospital Plans: ▸ Orthognathic surgery. ▸ Osseo-integrated implants. ▸ Advanced dentistry. ▸ Oral surgery not applicable to dental PMB. ▸ Removal of impacted wisdom teeth. **A R1 500 co-payment will apply for Fund-approved dental admissions to hospitals.**
Service category	**Benefit**
7. Physiotherapy – after hospitalisation	**MSR or cost, whichever is the lesser,** provided that physiotherapy is related to the relevant hospital admission. Limited to 10 appointments per beneficiary per hospital admission.
8. Procedures in Doctors' Rooms*	**MSR or cost, whichever is the lesser,** subject to pre-authorisation. Major Medical Procedures (normally performed in-hospital) performed in doctors' rooms.
9. Drugs and medicine (other than chronic)	**Cost or medicine price** for the following: ▸ Material used during hospitalisation. ▸ Theatre drugs. ▸ Medicine price for medicines supplied during hospitalisation.
10. Medicines dispensed on discharge from hospital [to-take-out medicine (TTO)]	**MMAP or medicine price limited to R690 per beneficiary per admission.** Subject to the overall annual limit, **excluding anti-coagulants after surgery,** which are subject to the managed healthcare programme protocols. This medicine may also be provided by any other pharmacy on the day of discharge from the hospital, if not provided by the hospital at the time of discharge.
11. Specialised Radiology including MRI, CT and Radio-isotope Scans and Nuclear Medicine* Unless pre-authorised, benefits will be subject to the relevant available day-to-day benefit.	**In-hospital** **MSR or cost, whichever is the lesser,** limited to the overall combined benefit amount for specialised radiology (please see page 18). A **R1 500** co-payment per authorisation for Fund-approved Specialised Radiology services rendered In-and-Out-of-Hospital. This benefit excludes Oncology and Organ transplant-related MRI, CAT, PET and radio-isotope scans.
12. Intra-ocular Lenses*	Subject to a sub-limit of **R4 370** per lens per beneficiary.

Please note: Reference to a general practitioner, midwife, medical practitioner, specialist, surgeon, anaesthetist, pharmacist or medical auxiliary means a person who is registered as such with the relevant professional body.

Where multiple procedures are performed during the same procedures or operation, these may be covered at different percentages. See page 33 for more information.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

13. Psychiatric Treatment & Psychotherapy* Members on *SELECT* Plans will need to ensure they are admitted to one of the *SELECT* facilities. A list of the *SELECT* facilities can be found on the OMSMAF website at www.omsmaf.co.za.	Subject to pre-authorisation. **MSR or cost, whichever is the lesser,** up to a maximum of 21 days per beneficiary or outpatient psychotherapy, up to 15 (fifteen) contacts. Only at registered psychiatric treatment facilities or at facilities of healthcare providers registered to provide psychotherapy. This benefit includes accommodation, medicine, anaesthetics, dieticians, general practitioners, occupational therapists, pathology, psychiatrists, psychologists, radiologists and social workers. Maximum of three days' hospitalisation for beneficiaries admitted by a general practitioner or specialist. Members with a psychiatric illness must be admitted to a registered psychiatric unit or hospital, where they will benefit from the normal case management process or will be able to benefit from out-patient psychotherapy for up to 15 contacts. If a member is admitted to a hospital that does not have a registered psychiatric unit, the authorisation will be subject to the relevant Managed Healthcare Programme. For example, if a member is not stable enough to be moved to a hospital with a psychiatric unit, the stay will be authorised. However if the member elects to stay in a hospital without a psychiatric facility, claims could be paid from Day-to-Day Benefits, subject to the Fund Rules. **Remember that**, as an employee, you and your household dependants have access to short-term counselling and support on Old Mutual's Employee Wellbeing Programme. Call the Helpline on 0800 006 068. (You also have access to the Fund's Mental Health Programme, as part of the Fund's Managed Care Programmes. See page 52 for more information.)
Service category	**Benefit**
14. Drug and Alcohol Abuse Rehabilitation*	Subject to pre-authorisation. **MSR or cost, whichever is the lesser,** up to a maximum of 21 days per beneficiary. (You also have access to the Fund's Mental Health Programme, as part of the Fund's Managed Care Programmes. See page 52 for more information.)

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

15. Surgical Implants (Internal Prostheses)* [Prostheses and internal devices (surgically implanted), including all temporary prostheses, or/and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices]	Internal prostheses are fabricated or artificial substitutes, which are surgically implanted for a diseased or missing part of the body, or to improve the function of a diseased or damaged organ. The list is constantly reviewed and updated. Where new products or technology are considered, these should be motivated by a medical practitioner. Application for or use of any item not on the list must always be submitted with a motivation from the treating practitioner to the Fund's medical adviser. In the case of hip, knee, elbow or shoulder replacement and spinal fusion, it is recommended that you pre-authorise 10 days before the operation so that the case manager has enough time to negotiate discounts with the service provider. It is in your best interest to get a quotation from the treating doctor to ensure that the benefit limit is enough to cover the cost of the prosthesis. On application and approval, cost subject to the following sub-limits (which include bone cement and antibiotic cement, where applicable): **INTERNAL PROSTHESES COVERED THE SAME ON ALL PLANS:** ▸ **Aortic stents: R192 000** per stent (including the delivery system) per beneficiary, limited to one stent per beneficiary. ▸ **Carotid stents: R27 700** per stent per beneficiary. ▸ **Detachable platinum coils: R69 000** per beneficiary. ▸ **Embolic protection devices: R68 700** per beneficiary. ▸ **Peripheral arterial stent grafts: R56 800** per beneficiary. ▸ **Cardiac Stents: R40 200** per stent per beneficiary. Limited to three stents per beneficiary. ▸ **Cardiac Pacemakers** [including Implantable Cardioverter Defibrillators (ICDs)]: **R94 200** per beneficiary. ▸ **Cardiac Valves: R55 800** per valve per beneficiary. Limited to two valves per beneficiary. Included in this benefit are percutaneous valve replacements, including transcatheter aortic valve implantation (TAVI). ▸ **Neuro-stimulation/ ablation devices for Parkinson's:** R62 600 per beneficiary. ▸ **Vagal stimulator** (for intractable epilepsy): **R53 100** per beneficiary. ▸ **Bone lengthening devices:** R61 800 per beneficiary ▸ **Any other prosthesis,** including total ankle replacement: **R72 800** per beneficiary.
Service category	**Benefit**
NOTE: Under the **Hospital** and **Network** (including *SELECT*) Plans, elective procedures will only be covered in accordance with PMB. This means that procedures such as hip, knee, shoulder or elbow replacements will typically only be approved in the case of a fracture (normal wear and tear and arthritis of a joint would not qualify as PMB). An emergency admission where loss of limb has to be prevented will also qualify as PMB. For members on the **Savings**, **Traditional** (including *SELECT*) and **Traditional Plus** Plans, ICPS will be the Designated Service Providers (DSPs) for Fund approved hip and knee replacements. **A R5 000 co-payment will apply if the DSP is not used.** Members on *SELECT* Plans will not incur a 20% hospital bill co-payment if they use the DSP, but not one of the *SELECT* list of hospitals. Please refer to the OMSMAF website for a list of the *SELECT* facilities.	**INTERNAL PROSTHESES NOT COVERED ON THE NETWORK (INCLUDING *SELECT*) AND HOSPITAL PLANS (EXCEPT FOR PMB), BUT ON THE OTHER PLANS:** ▸ Hip replacement subject to the following limits: – **Network (including SELECT) and Hospital Plans: PMB only (see note to the left).** – **Savings Plan: R67 900 per hip per beneficiary.** – **Traditional (including SELECT) and Traditional Plus Plans: R73 300 per hip per beneficiary.** ▸ Knee replacement subject to the following limits: – **Network (including SELECT) and Hospital Plans: PMB only (see note to the left).** – **Savings Plan: R67 900 per knee per beneficiary.** – **Traditional (including SELECT) and Traditional Plus Plans: R73 300 per knee per beneficiary.** ▸ Shoulder replacement subject to the following limits: – **Network (including SELECT) and Hospital Plans: PMB only (see note to the left).** – **Savings Plan: R67 900 per shoulder per beneficiary.** – **Traditional (including SELECT) and Traditional Plus Plans: R73 300 per shoulder per beneficiary.** ▸ Elbow replacement subject to the following limits: – **Network (including SELECT) and Hospital Plans: PMB only (see note to the left).** – **Savings, Traditional (including SELECT) and Traditional Plus Plans: R60 900 per elbow per beneficiary.**

NOTE: An initial assessment is compulsory for Fund approved cases. Please see page 48 for more information on the Back and Neck Rehabilitation Programme.	SPINAL DEVICES COVERED ON ALL PLANS ▸ **Spinal plates and screws: R50 500** per beneficiary. ▸ **Other approved spinal implantable devices and intervertebral discs: R69 000** per beneficiary. **A R5 000 co-payment on spinal surgery will apply to beneficiaries who declined to follow the Back and Neck Rehabilitation Programme before going for spinal surgery.** **Non-PMB spinal surgery is only covered on the Savings, Traditional (incl. *SELECT*) and Traditional Plus Plans. It is not covered on the Hospital and Network (incl. *SELECT*) Plans, these Plans only cover PMB spinal surgery.**
16. Artificial limbs & artificial eyes*	**Cost subject to the following sub-limits:** ▸ **Artificial leg: R100 000** per leg per beneficiary. ▸ **Artificial arm: R100 000** per arm per beneficiary. ▸ **Artificial eye: R34 500** per eye per beneficiary. Benefit is available every 2-5 years. Subject to application and approval prior to the service.
17. Home Oxygen Therapy (including cylinders and home concentrators)* (CPAP machines and portable concentrators are excluded)	**MSR or cost, whichever is the lesser.** Sub-limit of **R26 000** per beneficiary. This benefit is subject to pre-authorisation. This includes the cost of the appliance, provided that the appliance is obtained from a preferred provider.
18. Bariatric (obesity) surgery* (including all related costs)	**MSR or cost, whichever is the lesser,** subject to pre-authorisation and clinical guidelines and protocols. **Network** (including *SELECT*) and **Hospital** Plans: No benefit **Savings** Plan: PMSA, subject to available funds. **Traditional** (including SELECT) and **Traditional Plus** Plans: **R139 000** per beneficiary.
19. Paramedical and auxiliary services in-hospital*	**MSR or cost, whichever is the lesser,** of certain services related to the initial pre-authorised hospitalisation will be covered, subject to referral by the treating healthcare professional. Otherwise, these services will be covered from Day-to-Day Benefits.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

20. ER24 Ambulance

MSR or cost, whichever is the lesser for travelling expenses of a medical practitioner and/or ambulance and/or emergency service provider, up to a maximum sub-limit of **R12 100** per family.

Provided that no benefit shall be available in respect of travel in urban areas other than in respect of ambulance charges where the patient's physical condition precludes the use of any other means of transport.

Keep in mind that if you are transported to hospital by an ER24 ambulance (even though approved), and on examination you are found to be fit enough to return home, you will be responsible for arranging your own transport home.

Unfortunately, due to the high number of attacks on emergency staff, ER24 has taken several measures to ensure the safety of their staff. Some of these measures include requesting the aid of security services and local authorities when responding to incidents in high-risk areas. This can have an impact on the response times in certain areas. ER24 strives to maintain prompt response times to various incidents, even when utilising the services of security and local authorities.

What should we do in an emergency situation?

You and your registered dependants have access to emergency medical transportation 24 hours a day, 7 days a week via **084 124** (within South Africa) or /+27 10 205 3052 for members outside the borders of South Africa.

ER24's trained staff will note the details of your condition and immediately authorise the dispatch of the closest appropriate Emergency Medical Services provider to assist you.

Services offered by ER24 include:

- 24-hour access to the ER24 Emergency Call Centre.
- Dispatch of emergency response.
- Medical transportation by ambulance or aircraft.
- Authorised inter-facility transfers.

In addition to emergency transportation, you will also receive emergency medical advice and assistance. ER24's operators will guide you through a medical crisis situation, provide emergency advice and organise for you to receive the support you need – available at all times.

Emergency services outside the borders of South Africa

Members outside the borders of South Africa (members in Namibia, Lesotho and Swaziland) may call ER24 by dialling +27 10 205 3052 for the following services:

- Life-threatening emergency (primary).
- For primary service, but not life-threatening.
- Any inter-facility transfers.

Remember that, in the case of an emergency where you (or your dependants) are admitted to hospital, you must arrange to notify the Fund on the first working day after being admitted.

Once you have exhausted your annual sub-limit for ambulance services, or if you need additional funding for this service, you can apply to the Fund for approval by submitting a clinical letter of motivation.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
21. Nursing Services* (excluding long-term care or chronic care)	**MSR or cost, whichever is the lesser,** for nursing services by registered nurses or nurse aids for the acute phase after hospitalisation or in lieu of hospitalisation up to a sub-limit of **R23 100** per beneficiary. Benefits are subject to prior application and approval. **Network** (including *SELECT*) Plan: Benefits are subject to obtaining a Universal Healthcare Network provider's report. This benefit includes private nursing (not for general or chronic care).
22. Hospice* (excluding long-term care or chronic care)	**MSR or cost, whichever is the lesser,** for hospice services for end-of-life care in lieu of hospitalisation up to a sub-limit of **R44 200** per beneficiary for non-PMBs. PMBs are unlimited. Benefits are subject to prior application and approval. **Network** (including *SELECT*) Plan: Benefits are subject to obtaining a Universal Healthcare Network provider's report.
23. Oncology Cancer treatment, including pathology, X-rays, MRI, Cat and Radio-isotope scans, Chemotherapy, drugs associated with Chemotherapy, medicine for terminal illness, Oncologist consultations, radiotherapy, mammograms and nutritional supplements. Subject to registration on the Oncology Benefit Management Programme, and the sub-limits indicated below:	
General Oncology*	**Cost at DSP, or negotiated fee, or, in the absence of such fee, 100% of the lower of the MSR or cost, or Uniform Patients Fee Schedule for public hospitals for Oncologists, haematologists, and credentialed medical practitioners.** **Limits per Plan:** **Network** (including *SELECT*) and **Hospital** Plans: PMB only ICON Essential Protocols **Savings** Plan: PMB only and subject to the ICON Enhanced Protocol. **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **R783 000** per beneficiary within ICON Enhanced Protocols. Benefit is subject to pre-authorisation and is available upon diagnosis and the submission of a treatment plan by the treating Oncologist to the case manager before treatment begins.
General Oncology* (continued)	Subject to pre-authorisation, medicine price for medicine and drugs, subject to the appropriate ICON protocols per Plan. Where MMAP is applicable, medicine will be reimbursed up to a maximum of the MMAP. **A 20% co-payment for consultation will apply if service is obtained from a non-ICON Oncologist.** Approved related medicine and nutritional supplements subject to the above limits per Plan. Vitamins, antibiotics, alternative medicine, sleeping tablets, anti-anxiety medicine and medicines for depression are subject to applicable and available Day-to-Day Benefits.
Specialised drugs for Oncology*	**Network** (including *SELECT*), **Hospital** and **Savings** Plans: PMB only **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **MMAP or medicine price, whichever is the lesser, limited to R247 000** per beneficiary, included in the Oncology benefit. Subject to the relevant managed healthcare programme and to pre-authorisation. The Oncology Specialised Drug List is a continuously evolving list of drugs used for the treatment of cancers and certain haematological conditions. This list includes but is not limited to targeted therapies e.g. biologicals, tyrosine kinase inhibitors and other non-genericised chemotherapeutic agents. Subject to a published list. Please access the oncology drug list via www.omsmaf.co.za.
PET Scans*	**Subject to the Oncology limit, PET Scans are covered up to the following sub-limits per Plan:** **Network** (including *SELECT*), **Hospital** and **Savings** Plans: PMB only. **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **R41 100** per beneficiary. This benefit is subject to the submission of a motivation by the treating Oncologist and approval by the Case Manager.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
Brachytherapy materials* (including seeds and disposables) and equipment	**Traditional (including *SELECT*) and Traditional Plus Plans: limited to R62 500 per beneficiary.** **Hospital, Network (including *SELECT*) and Savings Plans: PMB only**
Terminal illness benefit for all terminally ill patients, including cancer patients	**Cost or MSR, whichever is the lesser** for consultations with a registered psycho-social practitioner such as a social worker, up to a sub-limit of **R4 370** per family. This benefit is subject to referral from the treating healthcare provider and managed care protocols.
24. Renal dialysis*	**MSR or cost, whichever is the lesser.** Automated Peritoneal Dialysis will only be approved subject to the Fund's criteria. Subject to pre-authorisation, **medicine price** for all related approved medicine provided that medicine from an approved provider is used.
25. Acute Rehabilitation*	Subject to pre-authorisation and the submission of a motivation by the treating medical practitioner to the case manager. **MSR or cost, whichever is the lesser,** up to a sub-limit of **R105 000** per beneficiary provided that treatment is at a registered facility. The condition must be non-progressive. The acute conditions which are covered are as follows: severe motor vehicle accidents, strokes, brain injuries, spinal cord injuries, debilitating bacterial illnesses, debilitating viral neurological illnesses and amputations. Progressive neurological conditions are excluded.
26. Organ Transplants*	**MSR or cost, whichever is the lesser,** in respect of the transportation of the organ needed for the transplant, as well as hospital accommodation and surgically related services and procedures. The transplant and the relevant treatment plan must be pre-authorised and are subject to clinical guidelines and protocols. Organ harvesting is limited to the Republic of South Africa. Non-PMB Organ Transplant is only covered on the **Traditional** (incl. *SELECT*) and the **Traditional Plus** Plans, and not on the **Hospital**, **Network** (incl. *SELECT*) and **Savings** Plans.
Anti-rejection drugs*	**MMAP or medicine price** of anti-rejection drugs provided that drugs from an approved provider are used. Subject to pre-authorisation.
Organ donor*	**MSR or cost, whichever is the lesser** for the work up and harvesting of the organ/s or Haemopoietic stem cells (bone marrow) and the transplantation thereof. Organ harvesting is limited to the Republic of South Africa.
27. Corneal graft (local or imported)*	Subject to pre-authorisation. **MSR or cost, whichever is the lesser,** up to a sub-limit of **R42 100** per eye per beneficiary.
28. Hyperbaric Oxygen Therapy*	**MSR or cost, whichever is the lesser.** Exclusively for anaerobic life-threatening infections and specific conditions, subject to pre-authorisation and clinical guidelines and protocols.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

29. HIV/AIDS*	Subject to pre-authorisation and clinical guidelines and protocols. **MMAP or medicine price** for HIV-related chronic medicine. **MSR or cost, whichever is the lesser,** for the medical management and related pathology tests and doctors' visits as required. **Tariff code 4766** (HIV drug-resistance testing) excluded unless pre-authorised on the relevant HIV Disease Management Programme. **Tariff code 3974** - Polymerase chain reaction to be paid from Hospital Benefits for babies < 18 months where the diagnosis refers to HIV testing. For members on the Network (including *SELECT*) Plan only cover for PMBs is applicable at cost or MSR, whichever is the lesser, for the medical management and the related pathology tests required. Medicine price for HIV related chronic medicine for PMB only.
30. Stoma Care Products	**100% of cost, or MSR, whichever is the lesser,** subject to pre-authorisation.
31. Cochlear Implants*	**R401 000** per beneficiary. Subject to managed healthcare protocols and pre-authorisation. Amounts in excess of the Cochlear Implants limit may, at the discretion of the Medical Advisor be paid as part of the Overall Annual Limit. Repairs to and replacement of the external components of the Cochlear Implant will be limited as below: Network (including *SELECT*) and Hospital Plans: No benefit. Savings: Subject to the Personal Medical Savings Account. Traditional (including *SELECT*) and Traditional Plus Plans: Limited to R21 700 per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for lives under 7 years and lives 85 years and older. Benefit is available every 5 years for lives aged 7 to 84 years.
32. Poloysomnograms (Sleep Studies): Diagnostic Polysomnograms (whether In or Out-of-Hospital)	Network (including *SELECT*) and Hospital Plans: No benefit. Savings, Traditional (including SELECT) and Traditional Plus Plans: PMSA, subject to available funds.
CPAP titration in-hospital*	**Cost or MSR,** whichever is the lesser, subject to pre-authorisation and clinical guidelines and protocols. Network (including *SELECT*) Plan: PMB only.
33. Laparoscopic procedures	Laparoscopic procedures are subject to prior authorisation and a **R2 500** co-payment will apply.
34. Scopes	Scopes are subject to prior authorisation and a **R1 500** co-payment will apply for procedures performed in an acute hospital. **For the scope done in a day hospital no co-payment will apply**.
35. Breast Reduction	Subject to submission of a motivation by the treating provider and submission of medical reports as required by the Fund. Benefits are subject to the approval by the Fund's medical advisor on the ground that the patient meets the clinical critera (e.g. Body Mass Index) applied by the Fund ito the Fund's managed care protocols.

9 MANAGED CARE PROGRAMMES

(These benefits may differ across Plans.)

IN THIS SECTION

As part of the Fund's aim of identifying and managing beneficiaries' disease risks in good time, there are a number of programmes that form part of the Fund's Managed Care approach.

Back and Neck Rehabilitation Programme

A description of the programme

Second only to headaches in the ranking of painful disorders that affect humans, back and neck pain is a common cause of ill health and incapacity and is associated with significant social and financial problems. To reduce your suffering and possible need for invasive surgery, the Fund offers a conservative Back and Neck Rehabilitation Programme.

Members enrolled on the programme will be identified for either a physiotherapy programme or an intensive six-week multidisciplinary programme where a medical doctor, biokineticist and physiotherapist are involved in the assessment and treatment of your condition. This intensive programme is provided at a DBC (Document Based Care) Clinic, which is one of the Designated Service Providers (DSPs) for this programme.

How does it benefit you?

The successful management of back and neck pain via the Fund's conservative back and neck programme will improve your quality of life and reduce your pain and suffering. The programme is based on internationally successful care pathways that reduces pain and stiffness and improve flexibility. It is also proven to limit, avoid or postpone surgery. Where surgery is truly warranted, this will be permitted within Fund rules.

It is important that you understand that since the success rate of this programme is very high, **there will be a R5 000 co-payment on spinal surgery if you decline participation in the conservative back and neck programme prior to surgery.** This co-payment will not apply to emergency admissions/PMB.

How can you access the benefit?

To ensure that all eligible members are enrolled, there are a number of ways to access the programme:

- The telephonic helpline on 0860 100 076.

- Intervention prior to pre-authorisation of back and neck surgery.
- For employees, your line manager may refer you to Universal Healthcare to assess your eligibility for one of the programmes.
- Referral from your family practitioner or specialist.

Oncology Benefit Management Programme for cancer patients

If you are diagnosed with cancer, the Oncology Benefit Management Programme will not only help you to manage your Oncology Benefits in relation to the high costs associated with treatment, but you will also receive support and education on your condition.

By joining the Programme when you are diagnosed with cancer, you will qualify for the Oncology Benefit. This benefit forms part of your Hospital Benefits, subject to the Oncology sub-limit.

How do I apply for this benefit?

If you are diagnosed with cancer, your treating Oncologist must submit a proposed Care Plan for pre-authorisation before your treatment can begin. This Care Plan should provide information such as the date of diagnosis, ICD-10 code, the area to be treated, any prior surgery or treatment plus history, new treatment requested, as well as approximate costs.

The Care Plan must be submitted to Oncology Benefit Management by sending an email to oncology@omsmaf.co.za.

Your Care Plan will be evaluated and, where necessary, discussed with the treating Oncologist in order to manage your condition in relation to the benefits available to you. If this Care Plan changes at any time, your Oncologist must inform the Oncology case manager by submitting a revised Care Plan before beginning the new treatment.

What services are covered?

The Oncology Benefit will cover:

- Pathology.
- BRCA gene testing.
- MRI, radio-isotope, CAT and PET scans (the latter to be motivated and approved).
- Radiotherapy.
- Chemotherapy and drugs associated with chemotherapy (e.g. anti-nausea).
- Approved related medicine.
- Radiology.
- Oncologists' consultations.
- Consultations with a social worker.
- Mammograms (if it forms part of your Care Plan).
- Medicine for terminal illness.
- Approved nutritional supplements.

The following will be covered under your Day-to-Day Benefits, provided you have enough benefits available. You should therefore take this into account when choosing a new Plan:

- Prescribed vitamins.
- Antibiotics.
- Alternative medicine.
- Sleeping tablets.

What is the role of the Oncology case manager?

You can contact the case manager with any queries you may have regarding the Oncology Benefit Management Programme or your condition. The case manager can also provide support and education on your condition.

The case manager does not handle account queries. For this you must contact the OMSMAF Contact Centre at 0860 100 076.

Designated Service Provider (DSP) for Oncology Treatment

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.

The Fund subscribes to the following ICON protocols:

- **Network** (including *SELECT*) and **Hospital** Plans: PMB only
- **Savings** Plan: PMB only and subject to the ICON Enhanced Protocol.
- **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **R783 000** per beneficiary with ICON Enhanced Protocols.

The ICON Essential Protocols would typically be based on what is available from the State, whereas the ICON Enhanced Protocols will have a wider range of treatments for the Oncologist to choose from.

These protocols apply irrespective of the patient's treating Oncologist (DSP and non-DSP Oncologist). If service is obtained from a non-DSP, a 20% co-payment for consultation will be applicable.

Oncology claims will be covered as follows:

- If you consult with a non-ICON Oncologist a **co-payment** will be imposed on the Oncologist account. The Fund will cover 80% of the claim and you will be liable for the other **20% of the claim**. This is applicable to the consultations performed by a non-ICON Oncologist only.
- If you are currently on the Oncology Programme and you want to find out if your treating Oncologist is part of ICON, contact Oncology Benefit Management by visiting www.cancernet.co.za or calling the Contact Centre on 0860 100 076.

Can I upgrade to another Plan to enjoy more benefits?

If you or one of your dependants is diagnosed with cancer or has to undergo oncology treatment and your Plan does not provide adequately for the cancer treatment, you can apply to upgrade to a more comprehensive Plan within two months (60 days) after the date of the first diagnosis of cancer, or having had to undergo oncology treatment.

To upgrade Plans, the following guidelines are important:

- The application to upgrade your Plan must reach the Fund within 60 days after the first diagnosis;
- Upgrading is only allowed to the Savings, Traditional (including *SELECT*) or Traditional Plus Plans;
- The member and all his/her dependants must upgrade to the new Plan;
- Upgrading requests will be considered in consultation with the Fund's medical adviser, who will decide if the cancer meets the criteria according to the Fund's Rules;

NOTE: Please remember to renew your care plan well in advance of its end date, to avoid interrupting your treatment while your care plan is being evaluated.

- All existing waiting periods and late-joiner penalties will still apply; and
- Upgrading will be effective from the month after the month in which the Fund approves your application to upgrade Plans.

HIV and AIDS Management Programme

For most people HIV and AIDS is a frightening disease, but today effective treatment is available that allows the majority of people living with HIV to lead healthy and productive lives for many years.

Action and information

The first step is to find out whether you have been infected with HIV and what you can do to protect your loved ones and stay healthy. Medicines called antiretroviral therapy are available to suppress the virus, while good nutrition and exercise can play a critical role in keeping your body strong and healthy. Starting treatment at the right time and taking them correctly ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infections or other complications. Our HIV/AIDS Management Programme can help you access benefits to assist you in managing HIV and AIDS. Members must register on the Fund's HIV/AIDS Management Programme.

Contact details for the HIV/AIDS Programme
Tel: 0860 378 800; follow prompts for HIV/AIDS programme

We can help you to manage your condition

The Fund has a benefit in place specifically for HIV/AIDS related medicines and tests. This benefit is used to pay for medicines to suppress the virus and medicines to protect against illnesses such as TB and serious pneumonia and regular monitoring tests. The Fund will also pay for one HIV test per beneficiary.

Your condition will stay confidential

HIV is a sensitive matter and every effort is made to keep your condition confidential. They use separate contact details (please see details at the front of this guide). Patients need to use these facilities to maintain confidentiality.

Nobody, not even your Employer or the Board of Trustees of the Fund, is notified about a member's enrolment on the Programme or the HIV status of the member.

You must register on the HIV/AIDS Management Programme

If a test shows you are HIV positive you must register with the HIV/AIDS Management Programme as soon as possible to make use of this benefit.

Telephone them in confidence on 0860 378 800, follow the prompts for HIV Disease Management team.

Your doctor can also contact the HIV/AIDS Management Programme on your behalf and may also contact the medical team for advice.

After you have registered

After you receive the application form, you and your doctor must complete it and return it to the HIV/AIDS Management Programme by using the confidential fax line number on the form. A highly qualified medical team will review the information provided and, if necessary, discuss cost-effective and appropriate treatment with your doctor.

Once treatment has been agreed upon, you and your doctor will be sent a detailed Treatment Plan, which lists the approved medicines and how to take them, as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

If you are exposed to HIV infection through sexual assault or needle-stick injury, please ask your doctor to contact the HIV/AIDS Management Programme to authorise special antiretroviral medicine to help prevent possible HIV infection.

It is best to take this medicine as soon as possible (within hours) after exposure. If the incident putting you at risk occurs over the weekend, make sure you get the necessary medicine on time.

You or your doctor can contact the HIV/AIDS Management Programme on the Monday morning to arrange authorisation of the drugs for payment by the Fund.

Remember that, as an employee, you and your household dependants have access to short-term counselling and support on Old Mutual's Wellbeing Programme. Call the Helpline on 0800 006 068.

The HIV/AIDS Management Programme is available for telephonic nurse support, education and monitoring of patients who have been diagnosed with HIV to ensure that an HIV-positive person enjoys a healthy and fulfilled life.

It is operated by highly skilled, dedicated nurses who provide regular telephonic support and counselling to HIV-positive beneficiaries. The nurses are trained and experienced in assisting people to develop life skills for the optimal management of HIV and in ensuring that effective, appropriate medical care is provided.

What benefits are available for HIV and AIDS?

If you have been diagnosed with HIV you have access to the following benefits for HIV:

- Regular, ongoing, HIV Disease Management nurse telephonic HIV support and counselling.
- Regular visits to your doctor for your condition. Network (including *SELECT*) Plan members should visit their Universal Healthcare Network doctor.
- Regular pathology testing to monitor your health and immune status.
- Antiretroviral treatment prescribed by your doctor to suppress the HI virus.
- Multivitamins to aid in strengthening your immune status.
- Access to vaccines to protect against pneumonia, flu etc.
- PreP treatment for serodiscordant couples and conception planning.
- Post-exposure prophylaxis (PEP) for exposure through sexual assault or needle-stick injury.

What services does the HIV and AIDS Programme offer?

- The HIV nurse counsellors provide regular telephonic counselling, support and personalised health and wellness education to assist you in the management of your condition.
- The nurses will work with you and your GP to ensure you receive the appropriate care for the management of your condition.
- The nurses will provide information to you on the benefits available, and how to utilise these benefits, for the appropriate management of your condition according to evidence based treatment guidelines and protocols.
- The nurses will contact you regularly to monitor your condition.
- The nurses will obtain clinical information on the tests conducted and use it to monitor the progress of your condition.
- Together with you, the nurse will recommend lifestyle and /or behavioural changes to enhance your quality of life for your condition.
- Medicine to treat HIV (including medicines to prevent mother-to-child transmission and infection after sexual assault or occupational exposure) at the most appropriate time.

- Treatment to prevent opportunistic infections like serious pneumonias and TB.
- Best practice clinical guidelines and support from experienced HIV clinical experts.

Mental Health Programme

A description of the programme

The Mental Health Programme can support you with mental health conditions or substance-abuse issues that you may have, such as Depression, General Anxiety, Bipolar Mood Disorder or Post-Traumatic Stress Disorder.

Did you know that one in three South Africans will suffer from a mental health disorder in his or her lifetime and that a person's physical, social and financial wellbeing is closely tied to their mental health? Our Mental Health Programme has been built around the principle of providing support to both you and your family practitioner to promote access to the best quality primary mental healthcare that is available.

How does it benefit you?

The programme provides effective collaboration between family practitioners, psychiatrists and other healthcare professionals, for example, psychologists and social workers and a Care Manager, who will work together to ensure that you are supported in a way that suits your individual needs. Your adherence and active participation in treatment is required to achieve the desired outcomes and we encourage you to make the most of the opportunities and support with which this programme will provide you. While enrolled on the programme you can expect to receive the following support:

- Education for you and your family.
- Access to community support groups.
- A listening ear to provide support and guidance.

A telephonic helpline is available to any beneficiary suffering from a mental health condition or problems with substance (drug and alcohol) abuse. This provides you with direct access to a Care Manager who will assess your eligibility for enrolment on the programme, explain the programme and inform you about the benefits available to manage your condition.

How can you access the benefit?

There are a number of ways to access the programme:

- The Contact Centre is one way to contact us – simply call 0860 100 076 and speak to a consultant.
- You can also email mentalhealth@omsmaf.co.za.
- Referral from Old Mutual's Wellbeing Programme (with your consent).

You can be contacted to enrol on the programme by the Fund's administrator.

Active Disease Risk Management Programme

The Active Disease Risk Management Programme is a co-ordinated system of health care interventions aimed at supporting members with chronic conditions with the emphasis on preventing exacerbation and/or complications utilising evidence based protocols, formularies and care plans.

The service applies to beneficiaries with the following chronic conditions:

- Asthma.
- Cardiovascular Disease i.e. Cardiac Failure, Coronary Artery Disease.
- Chronic Obstructive Pulmonary Disease.
- Chronic Renal Disease.
- Diabetes Mellitus Type 1 and 2.
- Hypertension.
- Hyperlipidaemia.

The Programme provides support and guidance to assist with managing your health. A team of care managers will provide you with relevant information and advice regarding your chronic condition.

The Active Disease Risk Management Programme is a telephonic nurse based support program for patients diagnosed with chronic conditions. The program is staffed by specially trained nurses and care managers who will:

- provide telephonic support to you in order to monitor your compliance to the treatment plan your healthcare provider has recommended.
- provide further health education and guidance regarding your chronic condition and other supportive care you may require.
- ensure that you understand your own role in the management of your condition and support you in order to prevent any unnecessary hospitalisation.

Contact details for the Active Disease Risk Management Programme:
Tel: 0860 100 076
Email: diseasemanagement@omsmaf.co.za

Mother and Baby Care Programme

This Programme is available to members and their dependants during their pregnancy, the birth and after the birth. The Programme, which falls under your Supplementary Benefits, offers education and support to all pregnant mothers, with special emphasis on high-risk pregnancies. You need to register on the Programme as early as possible in your pregnancy and your additional benefits will automatically be activated.

If you are on the **Hospital** Plan, you will be covered for your confinement and delivery from your Hospital Benefits, but you will not qualify for the additional maternity benefits that form part of the Fund's Supplementary Benefits (see page 17-18).

Who can join the Programme and when?

All pregnant members or their dependants must register on the Programme. Early registration gives the Programme an opportunity to identity high-risk conditions. It also allows enough time to find out about benefits, antenatal classes and other information, depending which Plan you are on.

You are entitled to certain vitamins that are registered as antenatal supplements. Once registered on the Programme you will receive a list of those antenatal vitamins that are covered by this benefit. Vitamins not covered on this benefit will be paid from your available PMSA or accumulated savings.

Please take the vitamin prescription from your doctor to your pharmacy, where your claim will be processed electronically, at MMAP or the medicine price, whichever is the lesser.

A maternity booklet is available on the OMSMAF website, www.omsmaf.co.za.

What services are covered?

The following services are covered:

- SPNP rate for midwives (for midwife delivery or home delivery).
- Education and support services.
- Care after the birth services, e.g. home visits by a registered nurse and phototherapy treatment for your baby at home, if required, subject to managed healthcare protocols and pre-authorisation.
- **A Doula (birthing coach) on all the options** as part of the in-hospital maternity benefits, subject to a limit of **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.

In addition, the following services are available to members on the **Network**, **Savings**, **Traditional** (including *SELECT*) and **Traditional Plus** Plans (not available to members on the **Hospital** Plan).

- Antenatal visits subject to the sub-limits per pregnancy.
- Medicine price or MMAP for antenatal vitamins, subject to prescription and Formulary.
- Antenatal classes performed by a registered midwife (services of a physiotherapist or aerobics instructor are not covered) for the registered beneficiary.
- Out-of-Hospital pathology tests subject to the sub-limits per family.

You can register on the Programme by contacting the Contact Centre:
Telephone: 0860 100 076 (Follow the voice prompts.)
Fax: 0862 957 355
Email: maternity@omsmaf.co.za

The following benefits are all paid at MSR, up to the specified limits:

Maternity Benefits	Paid from	All pregnant beneficiaries have to register on the Mother and Baby Care Programme.
Antenatal classes	Supplementary benefits	**Educational and support services and antenatal classes by a registered midwife, subject to the following limits per Plan:** ▸ **Hospital** Plan: No benefit, but education and support is available via the Mother and Baby Care Programme and website (www.omsmaf.co.za). ▸ **Network** (including *SELECT*) and **Savings** Plans: **R1 620** per family. ▸ **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **R2 540** per family.
Antenatal visits	Supplementary benefits	▸ **Hospital** Plan: No benefit. ▸ **Network** (including *SELECT*) Plan: May also choose to consult with an obstetrician for up to 8 visit per pregnancy, paid at MSR, subject to referral by a Universal Healthcare Network GP and authorisation. ▸ **Savings** Plan: 8 visits per pregnancy, paid at MSR. ▸ **Traditional** (including *SELECT*) and **Traditional Plus** Plans: 12 visits per pregnancy, paid at MSR.
Ultrasound scans (pregnancy)	Supplementary benefits	**Limits per Plan per benefit year:** ▸ **Hospital** Plan: No benefit. ▸ **Network** (including *SELECT*) Plan: Two 2D scans per pregnancy, if done, or referred by Universal Healthcare Network GP or specialist. ▸ **Savings**, **Traditional** (including *SELECT*) and **Traditional Plus** Plans: Two 2D scans per beneficiary.
Hospital benefits	Supplementary benefits	▸ **A Doula (birthing coach) on all the options** as part of the In-Hospital maternity benefits, subject to a limit of **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Out-of-Hospital pathology tests (pregnancy)	Supplementary benefits	▸ **Hospital** Plan: No benefit. ▸ **Network** (including *SELECT*) Plan: Basic blood tests, if requested by Universal Healthcare Network GP or specialist and on the approved tariff list. **R3 150** per family. ▸ **Savings** Plan: **R3 150** per family per benefit year. ▸ **Traditional** (including *SELECT*) and **Traditional Plus** Plans: **R3 940** per family. This benefit is dependent on the patient registering on the maternity programme (not available to members on the **Hospital** Plan).
Antenatal vitamins	Supplementary benefits	**Hospital** Plan: No benefit. **Network**, **Savings**, **Traditional** (including *SELECT*) and **Traditional Plus** Plans: MMAP or medicine price, subject to prescription from an approved list and Formulary and included in the Overall Annual Limit.
Lactation Consultation		**Hospital** Plan: No benefit **Network** (including SELECT), **Savings**, **Traditional** (including SELECT) and **Traditional Plus** Plans: ***NEW!** provides mothers with one lactation consultation (breast feeding help) after discharge from hospital with a registered nurse.

In addition to the benefits above, the Fund offers the following confinement benefits as part of its Hospital Benefits:

Confinement	Paid from	

Confinement In-Hospital	Hospital benefits	**MSR or cost, whichever is the lesser,** in respect of the following, subject to the overall annual limit: ▸ Medical practitioner services whilst hospitalised. ▸ Theatre and recovery rooms. ▸ Normal delivery limited based on protocols. ▸ Caesarean delivery limited based on protocols. ▸ Material used In-Hospital. ▸ Medicine price for medicines. ▸ Medicine taken on discharge from hospital, limited to **R690.** ▸ Doula (birthing coach) on all the options as part of the In-Hospital maternity benefits, subject to a limit of **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Confinement in a registered birthing unit	Hospital benefits	**Society for Private Nurse Practitioners of South Africa (SPNP) rate (for midwife or home delivery). Midwife must be registered with the BHF and the Nursing Council. Limited to and including the following confinement benefits:** ▸ Delivery by a midwife; ▸ Hire of water bath included in confinement benefits; ▸ 4 Post-natal midwife consultations per event if a gynaecologist is not used. ▸ Doula (birthing coach) as part of the maternity benefit, limited to **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Confinement Out-of-Hospital	Hospital benefits	**Negotiated fee, or Society for Private Nurse Practitioners of South Africa (SPNP) rates, or in the absence of such fee, the lower of MSR or cost, or Uniform Patient Fee Schedule for public hospital for the delivery by a general practitioner or midwife. Midwife must be registered with the BHF and the Nursing Council.** ▸ Limited to and included in the Maternity Benefit: ▸ Hire of water bath and oxygen cylinder included in the Maternity Benefit. ▸ 4 Post-natal midwife consultations per event if a gynaecologist is not used. ▸ Doula (birthing coach) as part of the maternity benefit, limited to **R3 030** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.

Please note that, if your newborn baby needs phototherapy for jaundice an authorisation can be issued for the treatment to be performed at your home by a registered nurse. This treatment, if authorised, will be funded from your Hospital benefits.

NOTE: 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.

What if I do not register on the Programme?

Depending on the Plan you have chosen, benefits such as antenatal classes and antenatal vitamins are payable from your Supplementary Benefits only if you register on the Programme. If not, these benefits will be paid from your available PMSA or accumulated savings. Members on the **Hospital** Plan can also access education and support via the Mother and Baby Programme.

Do I need a pre-authorisation number for my stay in hospital?

Yes, please pre-authorise your stay five days before (or, in an emergency, within one working day after) your date of admission. Remember that if you do not pre-authorise your stay in-hospital, you may have to pay a co-payment on your hospital account.

To pre-authorise:
Call 0860 100 076 or email maternity@omsmaf.co.za.

***SELECT* members: Please ensure that for a booked admission you make use of one of the *SELECT* Hospitals that are listed on www.omsmaf.co.za.**

Must I register my baby as a dependant?

Yes, even though you have pre-authorised your confinement, members on all OMSMAF Plans still have to notify the Fund of the birth of your baby, and arrange for him/her to be registered as a dependant on the Fund. This must happen within 30 days of birth. Your newborn baby can also be registered telephonically by calling 0860 100 076. We will require the full name, surname and date of birth of the baby.

If you do not register the baby as a dependant within 30 days of birth, the Fund will not register your baby from date of birth and therefore will not pay for any medical claims incurred for the baby during that time. Refer to www.omsmaf.co.za for the procedure to register a dependant.

10 EXPLANATION OF TERMS

Term	Explanation
Accumulated savings	Savings that build up in the PMSA from previous years and can then be used to cover certain expenses (such as expenses beyond the PCB limit on **Traditional** (including *SELECT*) and **Traditional Plus** Plans).

Annual Flexi Benefit (AFB)	An Out-of-Hospital Annual Flexi Benefit (AFB) on the **Network** and **Network *SELECT*** Plans, subject to beneficiary and family limits per benefit year, covering the following benefits:
	▸ Blood tests according to an approved tariff list
	▸ Specified black and white X-rays
	▸ Optometry
	▸ Auxiliary services, subject to the following sub-limits: **R2 360** per beneficiary and **R3 960** per family.
	  ▸ Psychology
	  ▸ Physiotherapy

Auxiliary (and paramedical) services	Acupuncture, anthroposophical treatment, applied kinesiology, audiometry/audiology, autologous donation of blood, ayurvedic treatment, biokinetics, chiropody, chiropractic services, clinical technology, dieticians, herbalists, genetic counselling, homeopathy, naturopathy, occupational therapy, orthoptic treatment, osteopathy, phytotherapy, podiatry, private nursing services, reflexology, speech therapy and social work. **PLEASE NOTE:** Cover for claims for auxiliary medical services In-Hospital, such as physiotherapy, occupational therapy, speech therapy and dietetics, will be subject to referral by the treating healthcare professional.
Beneficiary	A member and/or dependant registered with the Fund.
Benefit year	The period for which benefits and contributions apply, in this case 1 April to 31 March. If you join the Fund during a benefit year, you are only entitled to a pro rata portion of the benefits and limits for that year.
Child dependant	"CHILD", shall mean a member's or a member's spouse's or partner's: (a) natural child and/or (b) grandchild and/or (c) great grandchild and/or (d) stepchild of the member and/or (e) a foster child or a child in the process of being placed in foster care; who has been placed by order of the court in the custody of the member or his spouse or partner, as defined Section 1 of the Children's Act, 20015 (Act No. 38 of 2005); and/or (f) a child for whom the member has a duty of support; and/or (g) a child who is factually being cared for by the member including an orphaned child and/or (h) a legally adopted child or a child in the process of being adopted and who has been placed in the custody of the member or his spouse or partner, as defined in Section 1 of the Children's Act, 2005 (Act No. 38 of 2005).
Day-to-Day Benefits	These cover smaller medical expenses that occur more frequently, e.g. GP or dentist consultations and prescribed medicines. Treatment is usually received Out-of-Hospital or at the outpatient facility of a hospital. A visit to a hospital's Emergency Rooms (ER) would also be covered from this benefit, unless the patient was admitted to the hospital itself for further treatment.

Term	Explanation
Designated Service Provider (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. The Fund's current DSPs include the *SELECT* list of hospitals, ICON, ICPS and DBC.
Dispensing fee	Fee to be charged by pharmacies when dispensing medicine to members of the Fund.
Exclusions	Services that are not covered in terms of the Rules of the Fund.
Hospital Benefits	These generally cover the major medical expenses that you would incur when undergoing surgery or while in hospital. This does not include a visit to a hospital's emergency rooms (ER), unless the condition warrants admission to hospital.
ICD-10 code	International Classification of Diseases (ICD)-10 coding is a system that classifies diseases and the complications connected to these diseases according to a specific category.
Income	▸ For employees whose remuneration is structured as a total guaranteed package received from the Employer: Income = Total Guaranteed Package received from the Employer. ▸ For employees whose remuneration is pensionable remuneration received from the Employer: Income = Pensionable Remuneration divided by 90%. ▸ For employees whose remuneration is deemed commission received from the Employer: Income = deemed commission received from the Employer. ▸ For employees who earn a fixed income and commission, the medical scheme contribution will be based on the fixed income only. ▸ For any members other than retirees: Income = their gross monthly income. ▸ For retirees: Income will be your gross annual income as taxable by SARS in terms of the Income Tax Act. However, during the first year of retirement, income will be based on the value of the last monthly salary received from the employer or your gross income, whichever is the greater, until such time that the member provides proof of their gross income post-retirement. Confirmation of income may be required annually from time to time, through the provision of a copy of the South African Revenue Service tax return. ▸ For members who are on disability, the medical scheme contribution will be based on the monthly disability income benefit.
ICON Protocols	A protocol is a plan for a course of medical treatment. ICON, the service provider for oncology care, offers two protocols to Fund members, depending on the Plan they are on. The ICON Essential Protocols would typically be based on what is available from the State, whereas the ICON Enhanced Protocols will have a wider range of treatments for the Oncologist to choose from.
Late Joiner Penalty	A penalty imposed on members (or dependants) who join a medical scheme after the age of 35, or who have never been medical scheme members, or who have not belonged to a medical scheme for a specified period of time. The penalty aims to compensate for potentially increased claims by people who join a medical scheme when they are already older or infirm, and range from 5% to 75% of contributions.
Medical Scheme Rates (MSR)	The rate at which the Fund will pay for relevant health services, as determined by the Board of Trustees from time to time.
Medicine Exclusion List (MEL)	The list of medicines used by the Fund, which excludes medicines from payment from the Acute Medicine Benefit for a number of reasons.
Medicine price	Amount payable by the Fund in respect of medicines. This amount is the sum of the Single Exit Price and dispensing fee.
Member portion	Any amount paid by the Fund on your behalf that exceeds the amount to which you are entitled.
Maximum Medical Aid Price (MMAP)	MMAP is a reference pricing system that uses a benchmark or reference price for generically similar products. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicines, but instead limits the amount that will be paid.
Overall Annual Limit (OAL)	An Overall Annual Limit per beneficiary and per family per benefit year, applicable to all Plans.
Personal Medical Savings Account (PMSA)	A savings account held by a member's medical scheme to which a certain percentage of a member's contribution is paid on a monthly basis. These funds can only be used to defray health care expenditure and are trust monies held on behalf of the member by the medical scheme and do not form part of scheme assets. From the beginning of each benefit year, the personal medical savings account is credited with a percentage of a member's contribution, as determined in the medical scheme rules. This savings fund is made available prospectively to a member; in other words, the full year's savings funds are made available at the beginning of each benefit year.
Pre-authorisation	The process whereby a member applies for approval for a procedure or treatment from the Fund. This may include the submission of quotations. Co-payments may be payable if you do not pre-authorise.

Term	Explanation
Preferred provider	A provider of a healthcare service contracted to the Fund to deliver quality healthcare services and to participate in the managed healthcare programme. The Fund has the following preferred providers: ER24 for emergency services, and any Pharmacy appointed as a Preferred Provider by the Fund.
Prescribed Minimum Benefits (PMB)	The unlimited benefit to which all members are entitled, for treatment related to the conditions specified in the Medical Schemes Act, provided that this treatment is obtained at a DSP. The Fund's current DSPs include the *SELECT* list of hospitals, ICON.
Universal Healthcare Comprehensive Formulary	Applicable to the **Traditional** (including *SELECT*) and **Traditional Plus** Plans. It provides access to a wider range of medicines than the Universal Healthcare Restrictive Formulary.
Universal Healthcare Restrictive Formulary	Applicable to the **Hospital** and **Savings** Plans. Contains a list of medicines that provide cover for the listed chronic conditions.
Single Exit Price (SEP)	Price of medicine as determined by the State, and the manufacturer, at which it is marketed and purchased by the pharmacist.
SPNP	Society of Private Nursing Practitioners of South Africa.
Sub-limit	The maximum amount of cover you have for specified medical expenses during the benefit year.
Supplementary benefits	A list of benefits offered by the Fund that are paid from the Hospital Benefits limit, although they are, strictly speaking, Out-of-Hospital benefits.
Waiting period	The period during which you will not be covered for any medical expenses incurred, even though you may be making contributions to the Fund. There are two types of waiting periods: ▸ **Condition-specific waiting period:** A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. This will also apply to PMB if there is a break in membership of 90 days. ▸ **General waiting period:** A period not exceeding 3 months during which a beneficiary is not entitled to claim any benefits. This will also apply to PMB if there is a break in membership of 90 days.

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