TIGER BRANDS
Medical Scheme

2024 Tiger Brands Medical Scheme

Why choose Tiger Brands Medical Scheme

You cannot put a foot wrong with Tiger Brands Medical Scheme (TBMS), the dedicated medical aid scheme for employees of Tiger Brands Limited, Spar, Adcock Ingram and Sea Harvest. TBMS is committed to providing high- value quality healthcare cover and service to members and their families. The Scheme is administered by Universal Healthcare, which ensures that members benefit from care that is not only cost-effective but also appropriate, effective, and highly compassionate.

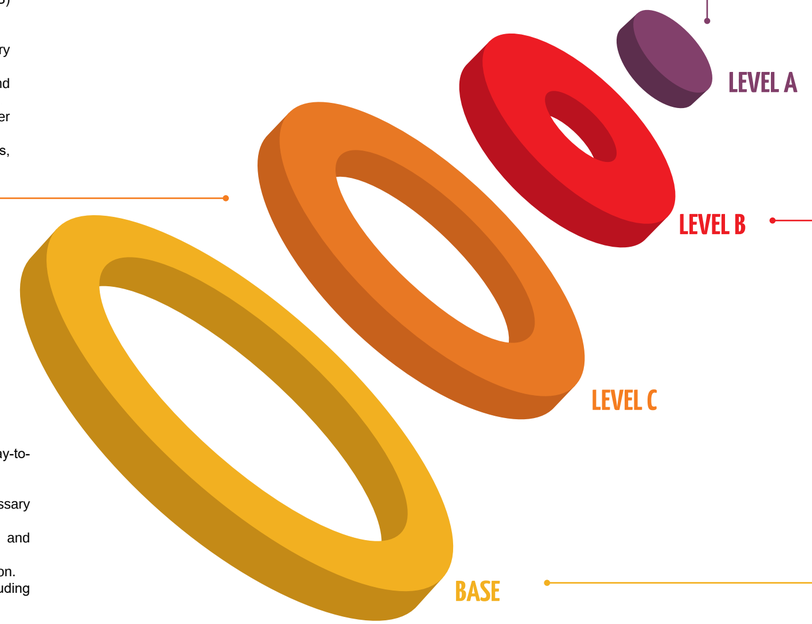
- Affordable, quality healthcare for you and your family.
- A range of options: traditional and income-based network options.
- Separate benefits for chronic medication.
- Complete care and support for families including a 24-hour “Ask the Nurse” Health Line.
- Medical Information and Assistance Line.
- Managed care programmes to help you manage your mental health and chronic conditions such as cancer, HIV/AIDS and diabetes.
- Extensive GP network to give you more value for money.
- Access to quality service providers and healthcare professionals so you get the best care.
- Preventative care and wellness benefits paid from risk.

LEVEL A

- Generous Annual Routine Care Benefit (ARCB) for day-to-day expenses.
- Separate Chronic Medicine Benefit.
- Access to any private hospital for all necessary medical procedures.
- In-hospital specialist consultations, visits and procedures paid at 150% of the Scheme rate.
- Freedom of choice in health service provider selection.
- Wellness Benefit paid from risk benefits, including flu vaccinations and mammograms.

LEVEL C

- Annual Routine Care Benefit (ARCB) for day-to-day expenses.
- Separate Chronic Medicine Benefit
- Access to any private hospital for all necessary medical procedures.
- In-hospital specialist consultations, visits and procedures paid at 100% of Scheme rate.
- Freedom of choice in service provider selection.
- Wellness Benefit paid from risk benefits, including flu vaccinations and mammograms.



LEVEL B

- Rich Annual Routine Care Benefit (ARCB) for day-to-day expenses.
- Separate Chronic Medicine Benefit.
- Access to any private hospital for all necessary medical procedures.
- In-hospital specialist consultations, visits and procedures paid at 125% of Scheme rate.
- Freedom of choice in service provider selection.
- Wellness Benefit paid from risk benefits, including flu vaccinations and mammograms.

BASE

- Unlimited primary care benefits, including GP consultations, acute and chronic medication from our network of healthcare providers.
- The Universal Network provides members with a national network of private practitioners that provide quality healthcare.
- Access to any private hospital for all medically necessary medical procedures,
- Annual Flexi Benefit for day-to-day expenditure for dentistry, optometry, and specialist consultations.

How to choose the right plan for you

We provide a list of the plans on offer through TBMS, as well as a brief description of the benefits on each option, below. So how do you know which benefit plan will be right for you?

1. What are your healthcare needs?

Completing a quick personal healthcare needs analysis can help you to determine what level of health cover you need. If you are going to have any dependants on your plan, you will also need to check that their needs are adequately covered too. Consider how much you and your dependants have spent on medical expenses over the last year to help guide you.

To assist in determining your healthcare cover requirements you need to ask yourself:

- How often do you or your dependants visit the doctor?
- Do you or your dependants require medicine often?
- Do you and your dependants need to visit specialists?
- Do you and your dependants need extra cover for cancer, renal dialysis, HIV or any other medical conditions?

2. Check how much cover you need

If you find that you hardly ever claim or have very few medical expenses, then you may consider a plan that offers a lower level of cover.

If you have had a lot of medical expenses in the past, or foresee additional healthcare expenses into the near future, then you should consider a plan that offers a higher level of cover.

3. Decide if you are comfortable to use a network of healthcare providers

An option such as Base requires that you use a specific GP from a selection of preferred doctors (Network Providers) with whom we have negotiated special rates and services. If you are happy to use these selected GPs, you can minimise your healthcare costs and maximise the value of your hard-earned rand, Base may be for you. Should you wish to use a doctor of your own choice, on the other hand, you may want to look at one of the higher levels of TBMS options.

4. Get expert advice

If you are still unsure about what plan to choose, you can contact the TBMS call centre on **0800 002 636** for further information on the plans and assistance.

Contributions

LEVEL A

Principal Member	Adult	Child
R6 678	R4 386	R1 740

LEVEL B

Principal Member	Adult	Child
R5 520	R3 420	R1 356

LEVEL C

Principal Member	Adult	Child
R4 218	R2 658	R1 206

Annual Routine Care Benefit (ARCB):
Day-To-Day: Out of Hospital Benefit Limits

	Level A	Level B	Level C
Principal Member	R19 200	R14 580	R9 624
Adult	R11 424	R8 220	R5 910
Child	R3 624	R2 448	R1 416

Your medical scheme funds become available upfront at the beginning of each new calendar year and are then used throughout the year. The full Annual Routine Care Benefit (ARCB) is allocated to the whole family. The Scheme does not differentiate between a member and his/her dependants. So if one person in the family has high-cost medical needs, it is possible that the ARCB could be depleted.

ARC Benefits:
Day-to-Day: Out of Hospital

	Level A	Level B	Level C
Consultations and Visits			
General Practitioners	Paid from ARCB, 100% of Scheme rate.	Paid from ARCB, 100% of Scheme rate.	Paid from ARCB, 100% of Scheme rate.
Specialists	Paid from ARCB 100% of Scheme rate. Subject to a General Practitioner referral and pre-authorisation.	Paid from ARCB 100% of Scheme rate. Subject to a General Practitioner referral and pre-authorisation.	Paid from ARCB 100% of Scheme rate. Subject to a General Practitioner referral and pre-authorisation.
	Includes Emergency room visits.		
Medicine			
Medicine	Paid from Sub-limit within ARCB, 20% Co-payment subject to MMAP.	Paid from Sub-limit within ARCB, 20% Co-payment subject to MMAP.	Paid from Sub-limit within ARCB, 20% Co-payment subject to MMAP.
Pharmacy advised therapy/ Over-the-counter medication	**R300** per script, paid from acute medicine limit.	**R280** per script, paid from acute medicine limit.	**R260** per script, paid from acute medicine limit.
Acute Medication			
Principal Member	R6 546	R4 602	R2 835
Adult	R3 720	R2 838	R1 764
Child	R2 550	R1 494	R966
	The full acute medicine limit is allocated to the whole family. The Scheme does not differentiate between a member and his/her dependants.		
Oral contraceptives and devices - female	R2 202	R2 202	R2 202

ABBREVIATIONS

ARCB	Annual Routine Care Benefit	**PMB**	Prescribed Minimum Benefit
Auxiliary services	Associated medical services, e.g. speech therapy.	**TBMS**	Tiger Brands Medical Scheme
CDL	Chronic Disease List		
MMAP	Maximum Medical Aid Price		
MRP	Medicine Reference Price		

*Scheme Rate: The rules of the Scheme make provision for benefits to be paid at a specific tariff, or rate, known as 'the Scheme Rate'.

This scheme rate is in line with the industry benchmark tariff.

** Agreed tariff: This is a rate negotiated between the Scheme and certain healthcare providers.

ARC Benefits:
Day-to-Day: Out of Hospital

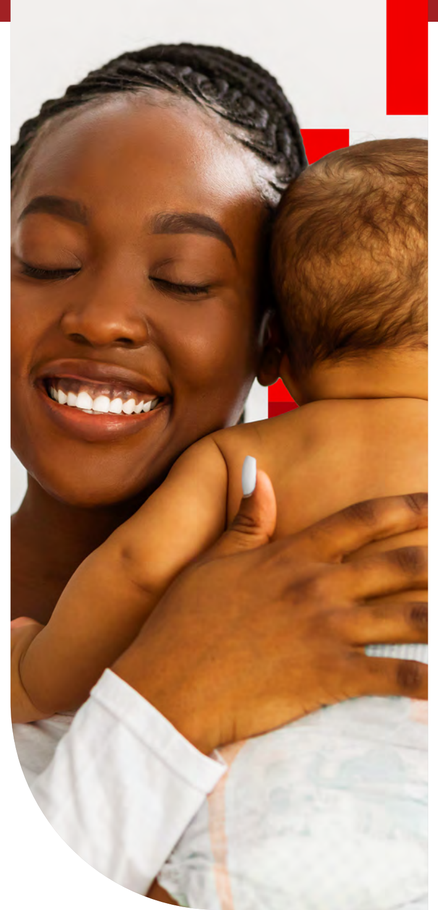
	Level A	Level B	Level C
Optical			
Optical	Paid from ARCB 100% of Scheme tariff.	Paid from ARCB 100% of Scheme tariff.	Paid from ARCB 100% of Scheme tariff.
Frames	**R1 272**	**R1 182**	**R1 074**
Lens Enhancement	**R2 160 o**ne set of lenses per beneficiary in a 24 month period.	**R1 806** one set of lenses per beneficiary in a 24 month period.	**R1 470** one set of lenses per beneficiary in a 24 month period.
Contact Lenses	**R4 584** annual benefit.	**R4 242** annual benefit.	**R3 876** annual benefit.
	Beneficiary can either have glasses or contact lenses, but not both		
Eye Test	One per beneficiary per annum.	One per beneficiary per annum.	One per beneficiary per annum.
Radial Keratotomy	**R8 052** combined family benefit for in and out of hospital, paid from ARCB 100% of Scheme rate.	**R8 052** combined family benefit for in and out of hospital, paid from ARCB 100% of Scheme rate.	**R8 052** combined family benefit for in and out of hospital, paid from ARCB 100% of Scheme rate.
Dentistry			
Basic Dentistry	Paid from ARCB limit 100% of Scheme rate.	Paid from ARCB limit 100% of Scheme rate.	Paid from ARCB limit 100% of Scheme rate.
Specialised Dentistry	**R13 488** per beneficiary and **R28 554** per family paid from ARCB limit, 100% of Scheme rate.	**R12 804** per beneficiary and **R27 150** per family paid from ARCB limit, 100% of Scheme rate.	**R12 744** per beneficiary and **R26 904** per family paid from ARCB limit, 100% of Scheme rate.
Mental Health			
Clinical Psychologist	Paid from ARCB limit, 100% of Scheme rate.	Paid from ARCB limit, 100% of Scheme rate.	Paid from ARCB limit, 100% of Scheme rate.
Psychiatry	Paid from ARCB limit, 100% of Scheme rate.	Paid from ARCB limit, 100% of Scheme rate.	Paid from ARCB limit, 100% of Scheme rate.
Radiology			
Basic Radiology	**R4 764** per single member limited to **R10 494** per family, paid from ARCB limit 100% of Scheme rate.	**R3 534** per single member limited to **R7 770** per family, paid from ARCB limit 100% of Scheme rate.	**R2 544** per single member limited to **R5 607** per family paid from ARCB limit 100% of Scheme rate.

ARC Benefits:
Day-to-Day: Out of Hospital

	Level A	Level B	Level C
Pathology			
Basic Pathology	**R4 764** per single member limited to **R10 494** per family, paid from ARCB limit 100% of Scheme rate.	**R3 534** per single member limited to **R7 770** per family, paid from ARCB limit 100% of Scheme rate.	**R2 544** per single member limited to **R5 607** per family, paid from ARCB limit 100% of Scheme rate.
Auxiliary Services			
Auxiliary services (i.e. speech therapy, social workers, occupational therapy etc.)	Out of hospital, paid from ARCB limit, 100% of Scheme rate.	Out of hospital, paid from ARCB limit, 100% of Scheme rate.	Out of hospital, paid from ARCB limit, 100% of Scheme rate.
Appliances			
Appliances	Paid from ARCB limit, limited to sub-limits detailed below, 100% of Scheme rate	Paid from ARCB limit, limited to sub-limits detailed below, 100% of Scheme rate	Paid from ARCB limit, limited to sub-limits detailed below, 100% of Scheme rate
External Fixator	R24 372	R24 372	R24 372
BP Monitor	R1 050	R1 050	R1 050
Glucometer	R1 050	R1 050	R1 050
Humidifier	R474	R474	R474
Nebulizer	R1 674	R1 674	R1 674
Elastic stocking	R1 224	R1 224	R1 224
Foot arch support	R5 160	R5 160	R5 160
Elbow crutch	R582	R582	R582
CPAP machine	R16 200	R16 200	R16 200
Foam walker	R3 024	R3 024	R3 024

ARC Benefits:
Day-to-Day: Out of Hospital

	Level A	Level B	Level C
Appliances (continues...)			
Walker	R534	R534	R534
Braces & Calliper	R1 050	R1 050	R1 050
Commode	R1 674	R1 674	R1 674
Stocking (thigh)	R1 224	R1 224	R1 224
Anti Embolic Stocking	R1 224	R1 224	R1 224
Sling Clavic Brace	R294	R294	R294
Wig	R3 180	R3 180	R3 180
Bra	R2 112	R2 112	R2 112



Hospital/Risk Benefits:
Hospital

	Level A	Level B	Level C
Hospital Benefits	Unlimited, 100% of Scheme rate. Pre-authorisation required.	Unlimited, 100% of Scheme rate. Pre-authorisation required.	Unlimited, 100% of Scheme rate. Pre-authorisation required.
Surgical Procedure Co-Payments	Scopes: R1 500 Laparoscopic surgical procedures: R2 500 No co-payment if done in a Day Clinic Hip replacement: R5 000 Knee replacement: R5 000 Shoulder joint replacement: R5 000 Spinal surgery: R5 000 Arthroscopy: R5 000	Scopes: R2 250 Laparoscopic surgical procedures: R2 500 No co-payment if done in Day Clinic. Hip replacement: R5 000 Knee replacement: R5 000 Shoulder joint replacement: R5 000 Spinal surgery: R5 000 Arthroscopy: R5 000	Scopes: R3 250 Laparoscopic surgical procedures: R2 500 No co-payment if done in Day Clinic. Hip replacement: R5 000 Knee replacement: R5 000 Shoulder joint replacement: R5 000 Spinal surgery: R5 000 Arthroscopy: R5 000
Consultations: **General Practitioners** **Specialists**	Unlimited 100% of Scheme rate. Unlimited 150% of Scheme rate.	Unlimited 100% of Scheme rate. Unlimited 125% of Scheme rate.	Unlimited 100% of Scheme rate. Unlimited 100% of Scheme rate.
Auxiliary Benefits	Unlimited 100% of Scheme rate pre-authorisation required.	Unlimited 100% of Scheme rate pre-authorisation required.	Unlimited 100% of Scheme rate pre-authorisation required.
Pathology and Radiology	Unlimited, 100% of Scheme rate.	Unlimited, 100% of Scheme rate.	Unlimited, 100% of Scheme rate.
Physiotherapy	R5 900 per single member limited to R8 460 per family, Paid from ARCB limit, combined in and out of hospital limit, 100% of Scheme rate.	R4 500 per single member limited to R6 400 per family, Paid from ARCB limit, combined in and out of hospital limit, 100% of Scheme rate.	R2 800 per single member limited to R4 350 per family, Paid from ARCB limit, combined in and out of hospital limit, 100% of Scheme rate.
Blood Transfusions	Unlimited, 100% of Cost.	Unlimited, 100% of Cost.	Unlimited, 100% of Cost.
Confinement	Unlimited, pre-authorisation required, 100% of Scheme rate.	Unlimited, pre-authorisation required, 100% of Scheme rate.	Unlimited, pre-authorisation required, 100% of Scheme rate.
Mental Health	**R27 144** per family, pre-authorisation required, 100% of Scheme rate.	**R21 636** per family, pre-authorisation required, 100% of Scheme rate.	**R18 048** per family, pre-authorisation required, 100% of Scheme rate.
Organ Transplants	**R540 480** per family, pre-authorisation required, 100% of Scheme rate.	**R540 480** per family, pre-authorisation required, 100% of Scheme rate.	**R540 480** per family, pre-authorisation required, 100% of Scheme rate.
Oncology	**R763 932** per beneficiary, pre-authorisation required 100% of Scheme rate.	**R383 050** per beneficiary, pre-authorisation required 100% of Scheme rate.	**R191 580** per beneficiary, pre-authorisation required 100% of Scheme rate.
Biological Medication	**R216 150 p**er beneficiary included in limit above, pre-authorisation required 100% of Scheme rate.	**R216 150 p**er beneficiary included in limit above, pre-authorisation required 100% of Scheme rate.	**R216 150 p**er beneficiary included in limit above, pre-authorisation required 100% of Scheme rate.
Renal Dialysis	**R426 816** per family, pre-authorisation required 100% of Scheme rate.	**R426 816** per family, pre-authorisation required 100% of Scheme rate.	**R426 816** per family, pre-authorisation required 100% of Scheme rate.

Additional Risk

	Level A	Level B	Level C
Benefits Paid from Risk			
Wheelchairs	**R23 940 every 5 years.**	**R23 940 every 5 years.**	**R23 940 every 5 years.**
Hearing Aids	**R22 140 every 5 years.**	**R22 140 every 5 years.**	**R22 140 every 5 years.**
Other High Cost Appliances	**R23 940 every 5 years.**	**R23 940 every 5 years.**	**R23 940 every 5 years.**
Stoma Bags	Unlimited. 100% of Scheme rate, pre-authorisation required and managed care protocols apply.	Unlimited. 100% of Scheme rate, pre-authorisation required and managed care protocols apply.	Unlimited. 100% of Scheme rate, pre-authorisation required and managed care protocols apply.
COVID-19 Benefit	COVID-19 patients who have tested positive per family: **R895** pulse oximeter; **R1 674** nebuliser; **R615** thermal thermometer.	COVID-19 patients who have tested positive per family: **R895** pulse oximeter; **R1 674** nebuliser; **R615** thermal thermometer.	COVID-19 patients who have tested positive per family: **R895** pulse oximeter; **R1 674** nebuliser; **R615** thermal thermometer.
Intra-ocular Lenses	**R6 504** per eye, pre-authorisation required 100% of Scheme rate.	**R6 504** per eye, pre-authorisation required 100% of Scheme rate.	**R6 504** per eye, pre-authorisation required 100% of Scheme rate.
Ambulance	Unlimited emergency transport at ER24.	Unlimited emergency transport at ER24.	Unlimited emergency transport at ER24.
Convalescent Homes	10 days per event, pre-authorisation required, 100% of Scheme rate.	10 days per event, pre-authorisation required, 100% of Scheme rate.	10 days per event, pre-authorisation required, 100% of Scheme rate.
Private Nursing	**R32 256** per family, pre-authorisation required 100% of Scheme rate.	**R32 256** per family, pre-authorisation required 100% of Scheme rate.	**R32 256** per family, pre-authorisation required 100% of Scheme rate.
Frail Care	**R305** per day maximum of 45 days 100% of Scheme rate, pre-authorisation required and managed care protocols apply.	**R305** per day maximum of 45 days 100% of Scheme rate, pre-authorisation required and managed care protocols apply.	**R305** per day maximum of 45 days 100% of Scheme rate, pre-authorisation required and managed care protocols apply.
Back and Neck Rehabilitation Programme	100% Scheme rate, Subject to the relevant managed healthcare programme and authorisation. A **R5 400** co-payment may be imposed, should an eligible member decline to follow the managed care protocol before going for non PMB or non-emergency PMB spinal surgery.	100% Scheme rate, Subject to the relevant managed healthcare programme and authorisation. A **R5 400** co-payment may be imposed, should an eligible member decline to follow the managed care protocol before going for non PMB or non-emergency PMB spinal surgery.	100% Scheme rate, Subject to the relevant managed healthcare programme and authorisation. A **R5 400** co-payment may be imposed, should an eligible member decline to follow the managed care protocol before going for non PMB or non-emergency PMB spinal surgery.
Surgical Prosthesis			
Stent	R22 416	R22 416	R22 416
Medical Stent	R34 680	R34 680	R34 680
Renal Stent	R5 000	R5 000	R5 000
Abdominal Aortic Aneurysm Stent	R101 760	R101 760	R101 760
Hip Prosthesis	R40 008	R40 008	R40 008
Knee Prosthesis	R40 008	R40 008	R40 008
Shoulder Prosthesis	R40 008	R40 008	R40 008
Spinal Instrumentation	R32 004	R32 004	R32 004
Spinal Cage	R22 416	R22 416	R22 416
Heart Valve	R44 784	R44 784	R44 784
Hernia Mesh	R9 800	R9 800	R9 800
Normal bladder sling	R16 128	R16 128	R16 128

Additional Risk

	Level A	Level B	Level C
Electronic and Nuclear Devices			
Defibrillator	R243 948	R243 948	R243 948
Single pace maker	R91 512	R91 512	R91 512
Dual pace maker	R111 864	R111 864	R111 864
Internal nerve stimulator	R203 640	R203 640	R203 640
Cochlear implant	R257 640	R257 640	R257 640
Insulin pump	R44 784	R44 784	R44 784
Artificial Limbs			
Through knee prosthesis	R101 760	R101 760	R101 760
Below knee prosthesis	R77 448	R77 448	R77 448
Above knee prosthesis	R89 088	R89 088	R89 088
Partial foot prosthesis	R38 910	R38 910	R38 910
Wellness Benefit			
Flu Vaccine	One per beneficiary per year.	One per beneficiary per year.	One per beneficiary per year.
Pneumococcal vaccine	One per beneficiary per year older than 65.	One per beneficiary per year older than 65.	One per beneficiary per year older than 65.
Mammogram	One per annum per female beneficiary over the age of 40.	One per annum per female beneficiary over the age of 40.	One per annum per female beneficiary over the age of 40.
Pap smear	One per annum per female beneficiary over the age of 18.	One per annum per female beneficiary over the age of 18.	One per annum per female beneficiary over the age of 18.
HPV (cervical cancer) vaccine	One course (3 doses) per female beneficiary between the ages 12 and 18.	One course (3 doses) per female beneficiary between the ages 12 and 18.	One course (3 doses) per female beneficiary between the ages 12 and 18.
PSA (Prostate Specific Antigen)	One per annum per male beneficiary over the age of 40.	One per annum per male beneficiary over the age of 40.	One per annum per male beneficiary over the age of 40.

Additional Risk

	Level A	Level B	Level C
Wellness Benefit (continues...)			
Fitness Assessment and Exercise Prescription	Access to Universal Network Biokineticists for an annual assessment, exercise programme prescription and monthly monitoring.	Access to Universal Network Biokineticists for an annual assessment, exercise programme prescription and monthly monitoring.	Access to Universal Network Biokineticists for an annual assessment, exercise programme prescription and monthly monitoring.
Nutritional Assessment and Healthy Eating Plan	Access to Universal Network Dieticians for an annual assessment, healthy eating plan and monthly monitoring.	Access to Universal Network Dieticians for an annual assessment, healthy eating plan and monthly monitoring.	Access to Universal Network Dieticians for an annual assessment, healthy eating plan and monthly monitoring.
Chronic Medication			
Chronic Medicine	**R11 040** Subject to approval on the Chronic Medicine Programme 27 listed PMB Chronic Disease List (CDL) including additional conditions listed below.	**R9 222** Subject to approval on the Chronic Medicine Programme 27 listed PMB Chronic Disease List (CDL) including additional conditions listed below.	**R7 524** Subject to approval on the Chronic Medicine Programme 27 listed PMB Chronic Disease List (CDL).
HIV/Aids	Unlimited, subject to registration on the Universal HIV/Aids programme		

Chronic medication covers the 27 listed **PMB Chronic Disease List (CDL)** conditions below, subject to authorisation.
These conditions are legislated. Chronic medication is subject to the basic formulary and reference pricing.

Non-PMB Chronic medication is subject to the basic formulary, reference pricing and a 15% co-payment.

Beneficiaries must apply for authorisation for chronic medication benefits by submitting their prescription to **chronicmedicine@universal.co.za**, or by calling **0860 111 900**.
Please note if there are any changes made to your chronic medicine prescription, even if it is just an adjustment to the dosage, you will need to update your authorisation.

PMB Chronic Disease List Level A,B And C

Addison's disease	Crohn's disease	Hyperlipidaemia
Asthma	Diabetes mellitus type 1 and 2	Hypothyroidism
Bipolar mood disorder	Diabetes Insipidus	Multiple sclerosis
Bronchiectasis	Dysrhythmias	Parkinson's disease
Cardiac failure	Epilepsy	Rheumatoid arthritis
Cardiomyopathy	Glaucoma	Schizophrenia
Chronic renal disease	Haemophilia	Systemic lupus erythematosus
Chronic obstructive pulmonary disorder	HIV	Ulcerative colitis
Coronary artery disease	Hypertension	

Additional Chronic Conditions

Tiger Brands Medical Scheme also offers cover for additional non-PMB chronic conditions on Level A and B respectively, subject to available limit.

Level A		Level B
• Ankylosing spondylitis	• Osteoporosis	• Attention deficit hyperactivity disorder
• Attention deficit hyperactivity disorder	• Osteopenia	• Allergic rhinitis
• Allergic rhinitis	• Psoriasis and eczema	• Depression
• Depression	• Vertigo	• Gastro-oesophageal reflux disease
• Gout		• Gout
• Incontinence		• Osteoarthritis
• Myasthenia gravis		• Osteoporosis
• Osteoarthritis		• Psoriasis and eczema

BASE

Income Bands/R	Principal Member	Adult	Child
R0 – R5 200	846	846	354
R5 201 - R6 800	966	966	450
R6 801 - R10 600	1 158	1 158	510
R10 601 - R12 300	1 614	1 614	564
R12 301 - R14 200	1 758	1 758	576
R14 201 - R15 700	1 980	1 980	582
R15 701 – R20 200	2 388	2 388	588
R20 201 - R24 300	3 234	3 234	612
R24 301 - R29 500	3 642	3 642	612
R29 501 - R33 300	3 864	3 864	612
R33 301 +	4 068	4 068	612

Annual Flexi Benefit (AFB) :
Day-to-Day: Out of Hospital Benefit Limits

Base (Network Option)	
Principal Member	R3 264
Adult	R4 764 per family
Child	N/A

Your medical scheme funds become available upfront at the beginning of each new calendar year and are then used throughout the year. The full Annual Flexi Benefit (AFB) is allocated to the whole family. The Scheme does not differentiate between a member and his/her dependants. So if one person in the family has high-cost medical needs, it is possible that the AFB could be depleted.

AFB Benefits:
Day-to-Day: Out of Hospital

Base (Network Option)	
Consultations and Visits	
General Practitioners	Unlimited, subject to clinical necessity. Each beneficiary must select a contracted **Universal Network GP** for day-to-day care, 100% of Agreed Tariff. Two out-of-area visits per beneficiary, per year. Member required to pay the out-of-area provider in cash and claim back. Limited to R1 248 per event including the GP consultation and all related costs.
Specialists	No cover in cases of voluntary use of a **non-Universal Network Provider**, or voluntary use of a specialist without referral by a **Universal Network GP**.
	Emergency room visits no benefit, unless for a bona-fide emergency that results in a hospital admission.
Medicine	
Medicine	Unlimited if prescribed by a **Universal Network GP**, or by a specialist provided the member is referred by a **Universal Network GP, 100% of Agreed Tariff**.
Pharmacy advised therapy/ Over-the-counter medication	No Benefit
Acute Medication	
Principal Member	Subject to medicine formulary. No cover for non-formulary medicines, unless otherwise pre-authorised.
Adult	No cover in cases of voluntary use of a non-Universal Network Provider, or voluntary use of a specialist without referral by a Universal Network GP.
Oral contraceptives and devices - female	No Benefit

ABBREVIATIONS

AFB	Annual Flexi Benefit	**PMB**	Prescribed Minimum Benefit
Auxiliary services	Associated medical services, e.g. speech therapy.	**TBMS**	Tiger Brands Medical Scheme
		SAOS	South African Optometry Society
CDL	Chronic Disease List		
MMAP	Maximum Medical Aid Price		
MRP	Medicine Reference Price		

*Scheme Rate: The rules of the Scheme make provision for benefits to be paid at a specific tariff, or rate, known as 'the Scheme Rate'.

This scheme rate is in line with the industry benchmark tariff.

** Agreed tariff: This is a rate negotiated between the Scheme and certain healthcare providers.

AFB Benefits:
Day-to-Day: Out of Hospital

Base (Network Option)

Optical

Optical	Paid from the AFB, 100% of Scheme Tariff.
Frames	Combined benefit for lenses, frames - clear plastic single vision OR bifocal lenses every second year. Basic range of frames.
Lens Enhancement	No Benefit
Contact Lenses	No benefit for contact lenses.
Eye Test	One per beneficiary, every second year. Subject to use of a Universal Network Optometrist.
Radial Keratotomy	No Benefit

Dentistry

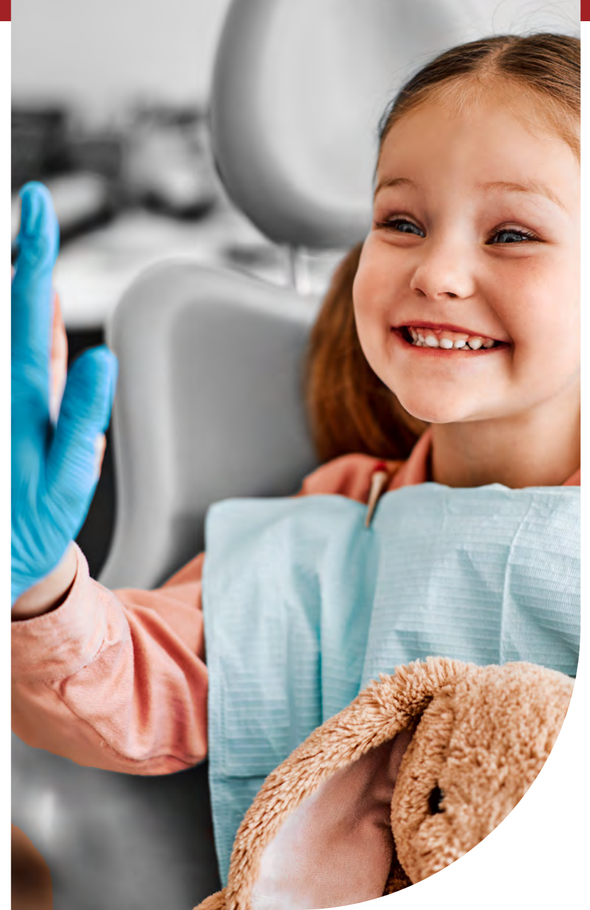
Basic Dentistry	Paid from AFB limit, subject to use of a Universal Network Dentist, 100% of the negotiated tariff.
Specialised Dentistry	PMB rules apply, subject to protocols.

Mental Health

Clinical Psychologist	PMB rules apply, subject to protocols.
Psychiatry	PMB rules apply, subject to protocols.

Radiology

Basic Radiology	Unlimited when clinically appropriate within the **Universal Network** and subject to referral by a **Universal Network GP**. Limited to list of codes. Subject to case management. No benefit if not referred by a **Universal Network Provider**, or by a specialist following referral by a **Universal Network GP** (except when involuntary). 100% of Agreed Tariff.



AFB Benefits:
Day-to-Day: Out of Hospital

Base (Network Option)

Pathology

Basic Pathology	Unlimited when clinically appropriate within the **Universal Network** and subject to referral by a **Universal Network GP**. Limited to list of codes. Subject to case management. No benefit if not referred by a **Universal Network Provider**, or by a specialist following referral by a **Universal Network GP** (except when involuntary). 100% of Agreed Tariff.

Auxiliary Services

Auxiliary services (i.e. physiotherapy, speech therapy, social workers, occupational therapy etc.)	PMB rules apply, subject to protocols.

Appliances

Appliances	
External Fixator	
BP Monitor	
Glucometer	
Humidifier	
Nebulizer	PMB rules apply, subject to protocols.
Elastic stocking	
Foot arch support	
Elbow crutch	
CPAP machine	
Foam walker	

Hospital/Risk Benefits

Base (Network Option)	
Hospital Benefits	Unlimited, 100% of Scheme rate, PMB rules apply. Cataract Lenses: Cataract limit of R3 900 per lens; this excludes other costs associated with the procedure.
Consultations: General Practitioners and Specialists	Unlimited, 100% of Scheme rate.
Auxiliary Benefits	PMB rules apply, subject to protocols.
Pathology and Radiology	Unlimited, 100% of Scheme rate, subject to protocols.
Physiotherapy	PMB rules apply, subject to protocols.
Principal Member	
Adult	
Child	
Blood Transfusions	Unlimited, 100% of Scheme rate.
Confinement	Unlimited, pre-authorisation required, 100% of Scheme rate.
Mental Health	PMB rules apply, subject to protocols.
Organ Transplants	PMB rules apply, subject to protocols.
Oncology	PMB rules apply, subject to protocols.
Biological Medication	PMB rules apply, subject to protocols.
Renal Dialysis	PMB rules apply, subject to protocols.

Additional Risk

Base (Network Option)	
Benefits Paid from Risk	
Wheelchairs	No Benefit.
Hearing Aids	No Benefit.
Stoma Bags	No Benefit.
COVID-19 Benefit	COVID-19 patients who have tested positive per family: **R895** pulse oximeter; **R1 674** nebuliser; **R585** thermal thermometer.
Intra-ocular Lenses	No Benefit.
Ambulance	PMB rules apply, subject to protocols.
Convalescent Homes	PMB rules apply, subject to protocols.
Private Nursing	PMB rules apply, subject to protocols.
Frail Care	PMB rules apply, subject to protocols.
Back and Neck Rehabilitation Programme	Not applicable.
Surgical Prosthesis	
Stent	PMB rules apply, subject to protocols.
Medical Stent	
Abdominal Aortic Aneurysm Stent	
Hip Prosthesis	
Knee Prosthesis	
Shoulder Prosthesis	
Spinal Instrumentation	
Spinal Cage	
Heart Valve	
Normal Bladder Sling	

Additional Risk

Base (Network Option)	
Electronic and Nuclear Devices	
Defibrillator	PMB rules apply, subject to protocols.
Single pace maker	
Dual pace maker	
Internal nerve stimulator	
Cochlear implant	
Insulin pump	
Artificial Limbs	
Through knee prosthesis	PMB rules apply, subject to protocols.
Below knee prosthesis	
Above knee prosthesis	
Partial foot prosthesis	
Wellness Benefit	
Flu Vaccine	One per beneficiary per year.
Mammogram	One per annum per female beneficiary over the age of 40.
Pap smear	One per annum per female beneficiary over the age of 18.
PSA (Prostate Specific Antigen)	One per annum per male beneficiary over the age of 40.

Base (Network Option)	
Chronic Medication	
Chronic Medicine	Only medication prescribed by a Universal Network General Practitioner or accredited designated service provider/pharmacy will be covered. Subject to approval on the Chronic Medicine Programme 27 listed PMB Chronic Disease List (CDL).
HIV/Aids	PMB rules apply, subject to protocols.

Chronic medication is subject to the basic formulary and reference pricing. No co-payment is payable.

Managed Care Programmes

We offer a range of managed care programmes to support you and help you on your path to good health. These programmes empower you to manage your condition effectively and in the most clinically proven way, and also ensure your benefits last longer.

Hospital Utilisation Management

TBMS provides a full hospital management service to its members. Certain systems have been put in place in order to ensure that you experience the highest possible levels of service. This enables us to meet the needs of our members efficiently and effectively.

For non-emergency admissions members must contact the Scheme at least two working days in advance for a hospital authorisation. In the case of an emergency admission, the Scheme should be contacted on the first working day following hospital admission. Please note that failure to obtain authorisation will result in non-payment of the account and/or a R1 000 penalty. Please take note that members are responsible for ensuring that all hospital admissions are authorised. However, the hospital or healthcare provider may assist you with obtaining an authorisation.

What information should you have ready when you apply for an authorisation?

- TBMS membership number.
- The name and date of birth of the patient.
- Date of admission and procedure.
- Name and practice number of the treating healthcare provider.
- Name and practice number of the hospital.
- Reason for the admission, treatment and diagnosis.
- Tariff codes and the ICD 10 codes for the procedure/treatment.

Please contact Universal Healthcare on **0860 102 312** to apply for authorisation for a hospital admission.

Please take note:

- The Scheme has the right to apply managed care principles, protocols and exclusions.
- While the Scheme may authorise the hospital stay and procedure, this is not a guarantee of payment.
- All claims will be paid at Scheme tariffs. In order to avoid co-payments, members are advised to enquire in advance whether their healthcare provider charges at the Scheme tariff or above.

Authorisation for Specialised Radiology

When a patient requires specialised radiology, such as an MRI scan, PET scan or a CT scan, he or she must contact TBMS for authorisation. An appropriate motivation must accompany the request for the scan. This is a requirement for both in- and out-of- hospital patients.

Please contact us on **0860 102 312** for further information.

Oncology Management Programme

At TBMS we understand that being diagnosed with cancer is both a difficult and emotional experience. Our Oncology Management Programme offers members with cancer the support they need to manage this condition efficiently and effectively.

It is important that your treating doctor contacts the Scheme as soon as you are diagnosed with cancer and that he or she registers you on the TBMS Oncology Management Programme. Your doctor will devise a proposed treatment plan for your condition, which should be sent to TBMS as soon as possible.

A medical professional will review the treatment plan according to accepted treatment guidelines and protocols. If necessary, your doctor will be contacted to discuss more appropriate treatments. Once the treatment plan has been approved, treatment can commence. You will not have to obtain a separate medicine authorisation, as this will form part of your approved oncology treatment plan. Most oncology treatment takes place on an outpatient basis. Please remember to get a separate authorisation if you require hospitalisation during your oncology treatment period.

To find out more please contact us on **0860 111 900.**

HIV/AIDS Management Programme

As with any chronic condition, a holistic healthcare management approach can help to ensure that an HIV-positive person enjoys a healthy and fulfilled life. It is important for you to know your status. Only when you know that you are HIV-positive you can take the necessary steps to protect your partner and family, and effectively manage your own health and wellness for the future.

TBMS has the utmost respect for patient confidentiality and will not disclose any information about your status to anyone but yourself.

If your tests show that you are HIV-positive, you or your treating doctor should contact us to register you on the TBMS HIV/AIDS Management Programme.

The programme is coordinated through highly skilled and dedicated nurses. These nurses are trained and experienced in assisting people to develop life skills for the optimal management of HIV and Aids and ensure that effective and appropriate medical care is provided. The nurses provide ongoing telephonic support and counselling to HIV-positive individuals. The sooner the HIV-positive individual is registered, the quicker appropriate treatment can commence.

Please contact us on **0860 111 900** for further information.

Disease Management Programme

All TBMS members with a chronic disease condition such as asthma, cardiac failure, chronic obstructive pulmonary disease (COPD), or diabetes mellitus will be contacted by Universal Healthcare to enrol on the TBMS Disease Management Programme.

This programme provides telephonic support and personalised health and wellness information to assist you in managing your chronic condition. If you have been diagnosed with one of these chronic conditions, you may enrol on the programme or have your doctor enrol you. Alternatively, the Scheme may identify you as having a chronic condition through your claims, chronic medicine registrations or hospital admissions, and get in touch. Members are also invited to contact the Disease Management Call Centre should they wish to speak to a nursing counsellor.

Back and Neck Rehabilitation programme (This applies to Level A, B and C members only)

Back and neck pain is the most common form of pain which can cause ill health and incapacity. In order to assist in reducing pain and a possible need for invasive surgery, the Scheme is offering access to a conservative Back and Neck Rehabilitation programme. Members enrolled on the programme will be identified for either an intensive multidisciplinary or physiotherapy programme. This programme is provided either at a contracted Document Based Care (DBC) Clinic or at a physiotherapy practice accredited by the South African Association of Physiotherapists, which are the preferred providers for this programme.

How does it benefit you?

By participating in the Back and Neck rehabilitation programme, your quality of life will improve and your pain may be reduced. The programme is based on internationally recognised care pathways that reduces pain and improves flexibility. It has been proven to reduce the need for or even avoid surgery. Should you require surgery, following assessment by the programme, this will be funded in accordance with the scheme's rules and protocols. The Scheme will impose a R5 000 hospital co-payment should an eligible member or beneficiary decline to participate in the Back and Neck rehabilitation programme prior to going for non PMB or non-emergency surgery.

How to access this programme

- Your family practitioner or specialist may refer you.
- If you are diagnosed with a back or neck problem, you can contact Universal on **0860 102 312** or e-mail **preauthorisation@universal.co.za** who will refer you to a practice near you.
- Once you have had an initial assessment at the healthcare provider, they will advise you as to the duration of the treatment. Either the practice or you can contact Universal for an authorisation number in order to ensure that the treatment will be covered from your risk benefits.

For more information, you can contact us on **0860 102 312.**

What do I need to know?

Specialist Referral Authorisation

Members should please make sure that they are aware of the specialist referral and authorisation process for out-of-hospital procedures. The specialist referral and authorisation process is for out-of-hospital only.

You and your beneficiaries are required to obtain a referral from a GP before seeing a medical specialist for a consultation and treatment. This is only necessary for out-of-hospital consultations.

The authorisation process will support the process that is used by your GP. When you obtain the referral letter from your GP, the referral letter should be submitted to Universal Healthcare. Based on the referral letter, an authorisation will be created in the administration system. If a referral has been obtained the claim will be paid, subject to available limits and Scheme Rate.

The referral letter can be submitted via:

- E-mail: **specauth@universal.co.za**
- Fax: **086 503 8038**
- Call centre: **0800 002 636**

The authorisation will be:

- Granted for a period of three months in order to give the member a chance to obtain an appointment with a specialist
- Limited to one consultation
- The authorisation will be for a speciality rather than for a particular specialist

The following will be excluded from the specialist authorisation requirement process:

1. One gynaecologist visit per female over the age of 16 per annum
2. One urologist visit per male beneficiary over the age of 40 per annum
3. Paediatrician consultations for children under the age of three
4. Pregnancy
5. Oncology will be approved as part of the Oncology Management Programme
6. Ophthalmologist
7. Orthodontists

Emergency Transport Services

ER24 offers a 24-hour/7 days a week integrated service to all Tiger Brands Medical Scheme members. The clinical staff are all highly specialised in emergency care. The service is provided through professional and friendly nurses and paramedics.

What to do in the case of an emergency

- Call **084 124**.
- If someone else is calling on your behalf, tell them to call **084 124**.
- Tell the ER24 operator that you are a Tiger Brands Medical Scheme member. They will prompt you or the caller to obtain all the information they require to get help to you.

Medical Information and Assistance Line

Call **084 124** for medical information and assistance. ER24 medical personnel, including doctors, paramedics and nurses, are available 24 hours a day to provide general medical information and advice. Please note that this is an advisory and information service only, as a telephonic conversation does not permit an accurate diagnosis.

24-hour "Ask the Nurse" Health Line

Members are encouraged to utilise this 24-hour cost saving service.
Our trained medical staff use documented medical algorithms and protocols to advise members on health related problems they may be experiencing.

Members can first seek advice to ascertain:

1. The urgency of medical attention required (for example whether to visit a doctor, dispatch an ambulance, or go to the hospital);
2. General medication advice - whether you should go to the pharmacy for over-the-counter medication, or can self-medicate from home.

Trauma Lines

Keep in mind that our members have access to a 24-hour Crisis Counselling line where trained healthcare professionals can telephonically assist you with advice or provide counselling services for any of the following:

• Domestic violence • Family, domestic and child abuse • Bereavement • Hijacking	• Armed robbery • Assault • Kidnapping • HIV/AIDS information • Trauma counselling	• Rape/referral to rape centres • Substance abuse • Poison advice • Suicide hotline

Useful tips

- Teach your family members to call **084 124** in the event of an emergency.
- If you are in an accident, take note of road names and numbers, as this will ensure that emergency medical help will reach you sooner.

Preferred Service Providers

In an effort to assist members with the management of their medicine benefits, the following pharmacies have offered the Scheme a favourable dispensing fee for medicines. These pharmacies have also agreed to dispense generic equivalents that fall within the Scheme's maximum reference price limit where generic products are available:

- Clicks, Dis-Chem, Link, MediRite, ScriptSaver, Optipharm, Optime and Chronic Medicine Dispensar

This means that you may obtain your acute and chronic medicines from any of the above pharmacies without having to make an additional co-payment for dispensing fees or generic equivalents. The arrangement with the above pharmacies relates specifically to the dispensing fee and generic equivalents. It is possible that you may have a co-payment should your doctor prescribe medicines that do not appear on the Scheme's medicine formulary.

You may continue to obtain your medicine from the pharmacy of your choice. It should, however, be noted that different dispensing fees are charged by the various pharmacies and this may result in a co-payment if the dispensing fee charged by your pharmacy is higher than that of one of our preferred provider pharmacies.

The Scheme will pay in full for the diagnosis, treatment and care of the Prescribed Minimum Benefits (PMBs) as per Regulation 8 of the Medical Schemes Act.

It should be noted that where a medicine/treatment protocol or a formulary drug that is preferred by the Scheme has been ineffective, or would potentially cause harm to a beneficiary, based on clinical evidence, the Scheme will fund the cost of the appropriate substitution treatment, without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

Generic medicine

What are generic medicines?

A generic drug is a medication created to be the same as an already marketed brand-name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. These similarities help to demonstrate bioequivalence, which means that **a generic medicine works in the same way and provides the same clinical benefit as the brand-name medicine**. In other words, you can take a generic medicine as an equal substitute for its brand-name counterpart.

Are generic medicines as effective as brand-name medicines?

There are stringent regulations around the registration of generic medicine in South Africa. The (SAHPRA) South African Health Products Regulatory Authority requires that generic medicines have the same high quality, strength, purity and stability as brand-name medicines. They also require post-registration testing and assurance of maintained stability and as such quality, safety and efficacy over the entire shelf-life period of the product.

SAHPRA inspects the manufacturing and packaging facilities of generic companies for compliance to international standards. Therefore generics sold in South Africa comply with good manufacturing practices.

Why are generics cheaper or why do generics cost less?

Generic drugs are usually sold for significantly lower prices than their branded equivalents and at lower profit margins. One reason for this is that competition increases among producers when a drug is no longer protected by patents. Generic companies incur fewer costs in creating generic drugs - only the cost of manufacturing, without the costs of drug discovery and drug development - and are therefore able to maintain profitability at a lower price.

What is the difference between a generic medicine and a brand name medicine?

The generic medicine can have a different shape, colour, coating or flavouring than the original brand name version due to the non-active ingredients used such as the dyes, fillers and preservatives.

How do I switch to a generic medicine?
If you would like to save money by buying generic medicines instead of brand medicines, ask your doctor or pharmacist if there are generic medicines that can be used to substitute your current medication.

Any time you replace one medicine with another, for any reason, make sure you learn what the new medicine looks like and which one it is replacing. This is to avoid accidentally taking the same medicine twice because the brand name and generic pills look different.

Do non-prescription medicines also have brand and generic names?
A medicine you buy without a prescription can be sold under many different brand names and many different store brands, even though it has the same medicine in it. For example Aspirin can be sold as Disprin® or Ecotrin®

Maximum medical aid price (MMAP) - applies to all medicines

MMAP is a reference price limit that TBMS pays for generically similar medicines. MMAP does not restrict your choice of medicine but limits the amount the scheme will pay for each. If you choose to use a medicine that costs more than the MMAP price, this will incur an MMAP co-payment which is the difference between your chosen product and the MMAP price limit.

TBMS has implemented a short message service (SMS) functionality to provide you with instant notifications regarding pharmacy medicine claims. This SMS will inform you when you have exceeded your chronic medicine benefit limit or if the medicine being claimed has a less expensive generic alternative.

Should you wish to change to a more cost-effective generic medication, then you can discuss the alternatives with the pharmacist.

Medicine Co-payment structure
Co-payments apply to the purchase of most medicines, excluding registered PMB chronic medicines. This will result in TBMS paying 80% of the cost of your medicine, with the remaining 20% having to be paid by you.

Example: Acute medicine - MMAP and co-payment.

Your doctor prescribes a specific medication that costs R250. The MMAP set for this medication is R150.

The cost covered by TBMS will be R120. You will have to carry the remaining cost of R130, being the excess of R100 above the MMAP and the co-payment of R30 (20% of R150).

This example illustrates just how important it is for you to use a less expensive alternative.

What is an ICD-10 code?

ICD-10 stands for International Classification of Diseases and Related Health Problems - 10th revision. This is a set of codes developed by the World Health Organization (WHO), which translates the written description of medical and health information into codes in a standardised format, e.g. J03.9 = acute tonsillitis, unspecified and G41.0 = grand mal status epilepticus. This set of codes forms part of an international standard, with which South Africa is required to comply in accordance with the Medical Schemes Act. The ICD-10 code is used to supply the diagnosis or medical condition.

Using ICD-10 codes has the following benefits:
- Reliable statistics for medical and health conditions are obtained, which means that your scheme can plan the correct management of your medical services and benefits.
- Faster payment of your claims.
- Correct coding of PMB conditions ensures payment from the appropriate benefit pool.
- Ensuring confidentiality of your condition/illness, since that information is now supplied to your medical scheme in coded form.

uConsult™ online healthcare consultation platform

All TBMS members can consult with a healthcare provider online without leaving the comfort and safety of their own home. uConsult™ is a secure, user-friendly online healthcare consultation platform that guides TBMS members through a hassle-free appointment booking and confidential online healthcare consultation experience.

- **App-free accessibility** - you can simply connect with your healthcare provider from your browser on any phone, tablet or computer with an internet connection.
- **All-in-one functionality** - video chat, screen sharing, electronic prescriptions, specialist referral letters, lab test forms, radiology request forms, multiple provider payment options and more.
- **Total confidentiality** - personal information is always kept safe, including encrypted medical documents. This system is fully compliant with the Protection of Personal Information Act.

How to access this benefit:
1. Visit www.u-consult.co.za.
2. Register as a patient by following the prompts - you will need your ID number, scheme membership details, and an electronic photo of yourself for identification purposes.
3. Enter your personal details and select your user preferences.
4. Add your dependants, should you wish to do so - you may opt to have this information imported automatically from the information TBMS has on record.
5. Search for your preferred healthcare provider to make an appointment.

Rules of the Scheme

The Scheme is governed by a set of rules, submitted to and approved by the Registrar for Medical Schemes. All terms and conditions are set out in detail in the Rules of the Scheme, which can be viewed at the office of the healthcare administrator. Please note that the Rules of the Scheme always take precedence during a dispute resolution.

Membership

Membership is restricted to all eligible employees.

Registration of dependants
A member may apply for the registration of his or her dependants at the time of applying for membership. The following persons qualify as dependants:
- A spouse or partner (please note that a divorced spouse cannot stay on the Scheme as a dependant);
- Dependant children under the age of 25;
- Disabled/mentally-challenged children.

Child dependants
Membership for child dependants will be cancelled at the end of the year in which he or she turns 25 years old. This does not apply to disabled or mentally challenged dependants. A child who turns 21 years old will be charged at adult contribution rates in the month of their birthday. Unless proof of study is provided annually.

Waiting Periods

Prospective members are required to disclose to the Scheme on the application form details of any sickness or medical condition for which medical advice, diagnosis, care, or treatment was recommended and/or received prior to the 12-month period ending on the date on which application for membership was made.
The Scheme may impose waiting periods and late joiner penalties. Please contact the Scheme to confirm if this will be applicable to your membership.

Membership Card

Every member will be provided with a membership card. This card must be presented to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership. Members may apply for additional membership cards or replacement cards.

Change of Address

A member must notify the scheme within 30 days of any change of address, including his or her domicilium citandi et executandi (i.e. address at which legal proceedings may be instituted). The scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member neglecting to comply with the requirements of this rule.

Deceased Members

The dependants of a deceased member, who are registered with the Scheme as his/her dependants at the time of the member's death, shall be entitled to continued membership of the Scheme without any new restrictions, limitations or waiting periods. Where a child dependant has been orphaned, the eldest child may be deemed to be the member, and any younger siblings as the dependants.

Benefits

Choosing a benefit level

Members are entitled to benefits during a financial year, as per the rules of the Scheme, and such benefits extend from the member to his/her registered dependants. A member must, on admission, elect to participate in any one of the available levels, detailed in the Rules of the Scheme.

Level Changes

A member is entitled to change from one benefit level to another, subject to the following conditions:

- The change may be made only with effect from 1 January of any financial year;
- Application to change from one benefit level to another must be in writing and lodged with the Scheme within the period notified by the Scheme.

Pro-rating Benefits

If members join the Scheme later than 1 January during a specific year, pro-rata annual benefits will apply until the end of the year. From 1 January the following year, members will qualify for the full annual benefit.

Exclusions

Unless otherwise provided for or decided by the Board of Trustees, expenses incurred in connection with any of the following will not be paid by the Scheme:

1. Where a member has recourse in terms of a third-party claim, the member must refund the Scheme for payments received from third parties in lieu of claims paid by the Scheme for the injury/event. Where the member refuses to refund the Scheme, it constitutes unlawful enrichment and the Scheme will reverse claims payments made in respect of the injury/event.

2. Claims and expenses incurred by a member or dependant of a member in the case of, or arising out of wilful self-inflicted injury, professional sport, speed contests and speed trials will be paid subject to PMBs only. Any treatment that does not fall within the scope of level of care for PMBs will be for the member's own account.

3. Consultations, visits, examinations and tests for insurance, school camps, visas, employment or similar purposes.

4. Cosmetic and treatment for obesity:
   - All costs for operations, medicines, treatment and procedures for cosmetic purposes and obesity, e.g. bariatric surgery, gastric bypass, slimming preparations and appetite suppressants; including tonics, slimming products. Consultations and treatments as provided by general practitioners and dieticians as part of a conservative lifestyle-based protocol will however be paid subject to the ARCB.
   - Keloid and scar revisions, excluding PMBs.
   - Sclerotherapy

5. Dental:
   - Bone augmentations
   - Bone and tissue regeneration procedures
   - Crowns and bridges for cosmetic reasons and associated laboratory costs
   - Enamel micro-abrasion
   - Fillings: the cost of gold, precious metal, semi-precious metal and platinum foil
   - Laboratory delivery fees
   - Orthogenetic surgery
   - Sinus lift
   - Gum guards or mouth protectors

6. Holidays for recuperative purposes, accommodation and/or treatment in headache and stress relieve clinics, spas and resorts for health, slimming, and recuperative or similar purposes.

7. Infertility:
   Investigations, operations and/or treatment whether advised for psychiatric or similar reasons in respect of artificial insemination and treatment for infertility. Including but not limited to: assisted reproductive technology, in-vitro fertilisation, Gamete intrafallopian tube transfer, vasovasostomy (reversal of vasectomy) and salpingectomy (reversal of tubal ligation), subject to PMBs, that will be covered as per PMB regulation.

8. Medicine:
   - Medicines not registered with the South African Health Products Regulatory Authority (formerly known as the Medicines Control Council) and proprietary preparations.
   - The purchase of medicine prescribed by a person not legally entitled to prescribe medicine.
   - Purchase of chemist supplies not included in the prescription from a medical practitioner or any other person who is legally entitled to prescribe medicine; provided that this excludes benefits payable under Pharmacy Advisory Therapy.
   - Applications, toiletries and beauty preparations.
   - Aphrodisiacs and/or any products to induce, enhance, maintain and promote penile erection or to address erectile dysfunction such as erectile appliances and drugs, including but not limited to Viagra, unless pre-authorised on the Chronic Disease Management programme according to PMB guidelines.
   - Anabolic steroids such as, but not limited to Deca Durabolin.
   - Bandages, cotton wool and similar aids, unless prescribed by a general practitioner or specialist.
   - Non-scheduled soaps, shampoos and other topical applications.
   - Stop smoking products, such as but not limited to Nicorette, Nicoblock, unless the member can prove that they have stopped smoking. Member must apply before use of products start and claim will be paid after member has tested negative for nicotine.
   - Sunscreens and tanning agents.
   - Household and biochemical remedies.
   - Vitamins and minerals (excluding pregnancy-specific supplements).
   - Homemade remedies.
   - Alternative medicines.
   - Patent foods, including baby food, unless prescribed by a general practitioner or specialist, subject to PMB guidelines.

9. Mental health:
   Sleep therapy and hypnotherapy

10. Optical:
    - Sunglasses (lenses with a tint greater than 35%)
    - Coloured contact lenses
    - Corneal collagen cross-linking
    - Phakic implants

11. Radiology and radiography:
    - PET scans, unless pre-authorised by oncology management for the appropriate diagnosis, staging, the monitoring of response to treatment and investigation of residual tumour or suspected recurrence (restaging) of metastatic breast cancer.
    - CT colonoscopy

12. All costs in respect of sickness conditions that were specifically excluded from benefits when the member joined the Scheme; as per waiting periods and exclusions applied as per the Medical Schemes Act.

13. In cases of illness of a protracted nature, the Board of Trustees shall have the right to insist upon a member or dependant of a member consulting a particular specialist. The Board may nominate in consultation with the attending medical practitioner. In such a case, if the medical specialist's proposed treatment is not acted upon, no further benefits will be allowed for that particular illness.

14. All costs that are more than the Annual Routine Care Benefit to which a beneficiary is entitled in terms of the Rules of the Scheme, the payment of PMB claims will accumulate to, but exceed any benefit limit as stipulated in these rules and annexures.

15. Cost of accommodation in respect of old age homes, and other custodial care facilities.

16. No member shall be entitled to any benefits or portion thereof, payable in terms of these rules, where such benefit or portion thereof is recoverable by such member:
    - Under the Compensation for Occupational Injuries and Diseases Act; or
    - Are invalidated as claims under the Compensation for Occupational Injuries and Diseases Act through failure of the member to report the accident in the manner required; or
    - Would have arisen if the member had been able to, and had made use of the facilities provided by the Employer at factories to treat the results of accidents at work, or
    - Are covered by any ex-gratia compensation from the Employer; or
    - From third party (including an insurance company registered under Act 29 of 1942) who is liable therefore;
    - The member of the Scheme must disclose any amount recovered or recoverable by the member or dependant as aforesaid in respect of any illness or accident.

17. Prosthesis and appliances:
    - Where not introduced as an integral part of a surgical operation, Trans-catheter Aortic Valve Implantation (TAVI) or replacement batteries for hearing aids or other devices.

How do I claim?

Electronic claims

Most suppliers and providers, including hospitals, pharmacies, general practitioners, etc., will submit claims electronically on behalf of members. However, it remains the member's responsibility to ensure that the claim reaches the Scheme within four months from the date of treatment. It is also your responsibility to check remittance advices for accuracy and to ensure the validity of the supplier's claim.

Paper claims

Claims must be submitted within four months from date of service and may be sent to the Scheme using the following contact details:

Fax: **011 208 1028**
Email: **tiger@universal.co.za or claims@universal.co.za**
Post: **Tiger Brands Medical Scheme, Private Bag X131, Rivonia, 2128**

Before submitting a claim, please ensure that the following details appear on the account:

- Your membership number
- Principal member's details (name, address, etc.)
- Supplier's details (name, address, practice number)
- Treatment date
- Patient's details
- Details of the treatment including diagnosis, tariffs and ICD10 codes, amount charged, etc.)

18. Not withstanding the provisions of this Rule, the Board of Trustees shall be entitled, but at no stage obliged, in its role and absolute discretion, to pay the whole or part of any account, which may otherwise be excluded in terms of the Rules.

19. Omnibus rule - "Unless otherwise decided by the Board of Trustees, no claim shall be payable by the Scheme if, in the opinion of the Medical Advisor, the healthcare service in respect for which such claim is made, is not appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition at an acceptable and reasonable level of care". The maximum benefits to which a beneficiary shall be entitled in any financial year shall be limited as set out in Annexure "B".

21. In cases where a specialist, except an eye specialist or gynaecologist, is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at the discretion of the Board of Trustees, be limited to the amount that would have been paid to a general practitioner for the same service.

22. Charges for appointments that a beneficiary fails to keep.

23. Costs for services rendered by:
    - Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
    - Any institution, nursing home or similar institution not registered in terms of any law except a state or provincial hospital.

24. Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in Annexure B of the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

25. Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof.

26. Organ Transplants -Donor costs outside of South Africa i.e. DonorSearch.

27. In-hospital procedures on the Base option only (unless it is a PMB):
    - Dentistry
    - Cochlear implants
    - Auditory brain implants and internal nerve stimulators
    - Nissen fundoplication (reflux surgery)
    - Treatment for obesity
    - Skin disorders
    - Functional nasal problems
    - Elective caesarean section
    - Refractive eye surgery

For a copy of Annexure B. benefit rules, please contact the Administrator.

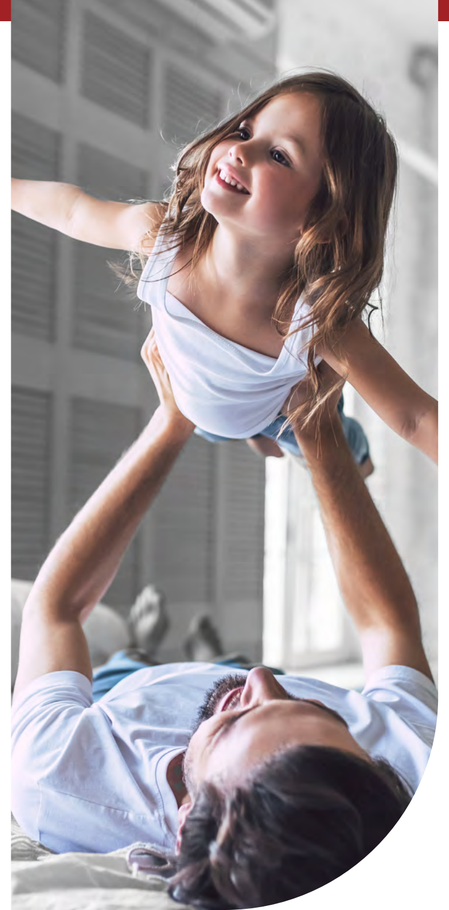
Keep in control of your medical scheme with the Tiger Brands Medical Scheme App

Simple, seamless and super convenient, the App makes it quick and easy for you to check anything from claims to benefits, and where your closest doctor is. Download the Mobi App on your smart device using the Google Play Store (Android users) or the Apple App Store (iOS users).

	Claims Submit new claims and view your claims history.
	Hospital pre-authorisation Submit new pre-auth requests and view your hospital pre-auth history.
	Query Submit queries and view important contact details.
	Membership Card See a digital version of your Membership Card so you're never caught without it again! You can even send it on as and when needed.
	Benefits View all your benefits, annual limits and your available balances.
	And Much More Request your Tax or Member Certificates. See all your registered Chronic Conditions, register new conditions, update your scripts and apply for an extended supply. Access your personal details, your dependant details and your Scheme details. You can also search for Network Specialists in your area.

Payment of claims

Tiger Brands Medical Scheme has two payment runs per month to suppliers and to members. Members will receive a monthly statement containing details of all payments made to suppliers.



Claims against the Road Accident Fund (RAF) and other third parties

TBMS will help you by paying for medical and hospital expenses incurred as a result of a motor vehicle accident or other incident where a third party is liable. To do this, TBMS has appointed an attorney that specialises in recovering Road Accident Fund (RAF) claims, to help members with the submission and administration of medical claims. In the unfortunate event that you and/or one of your beneficiaries are involved in an accident, this is what you need to do to make a claim:

Step 1: Let TBMS or the appointed attorney know about the accident as soon as possible.

Step 2: TBMS or the appointed attorney will send you an Accident Report Form. It is very important that you complete the form and return it to the appointed service provider as quickly as possible. This will let the assessors determine whether there are merits to your claim against the RAF. In some cases, you may not be aware that a different party is liable for the payment of your medical costs, and this is where the appointed service provider can be of great help to you.

Step 3: If a third party caused your injuries, our attorney will act on your behalf in order to recover expenses from the RAF. Our attorney will advise you on all aspects of your claim, including items such as loss of income and compensation for pain and suffering, as well as medical expenses.

Step 4: You and your appointed attorney will need to complete a document that says you will reimburse TBMS for any monies which may be recovered from the RAF for past medical and hospital expenses paid by TBMS.

Step 5: As soon as this undertaking is provided, TBMS will pay for all medical costs arising from a third-party claim. Should you have an existing claim where you have already instructed an attorney, you have a legal obligation to inform TBMS and the appointed service provider of the claim. Failure to do so will constitute fraud and TBMS has the discretion to hold the member civilly and criminally liable.

Should you have any enquires or questions in this regard, please do not hesitate to contact our Trauma Department on **011 208 1168** or via email at **trauma@universal.co.za**.

Complaints and Dispute Procedure

Members may submit their complaints to the Scheme in writing or telephonically.

The TBMS contact details are as follows:
Dedicated telephone number: **0800 002 636**
Email: **tiger@universal.co.za**
Fax number: **0866 151 509**
The Customer Service Department will assist you.

Any queries that have not been resolved to the satisfaction of the member within 30 days of the initial complaint, or if the member is not satisfied with the outcome of the query, then this query or dispute can be escalated to the Customer Service Manager or the Fund Manager. Email escalations can be sent to escalations@universal.co.za, or the call centre agent can transfer the member to the appropriate senior official.

Please note: all escalations will have to be accompanied by supporting evidence of non-delivery. Queries that have not been submitted on a call centre level will be referred back to a call centre agent.

Should a member still not be satisfied with the outcome of his/her query or dispute, a member is entitled to escalate the matter to the Principal Officer. This will only be allowed if the processes above have been followed, or in cases of extreme emergency. The Principal Officer will investigate the matter and revert to the member with a final decision.

Any member who is still unhappy with the Scheme's decision may lay a complaint with the Office of the Registrar of Medical Schemes, which is the regulator for all medical schemes established in terms of the Medical Schemes Act, 131 of 1998. The contact details of the Complaints Call Centre of the Office of the Registrar are as follows:

Tel: **0861 123 267**
Email: **complaints@medicalschemes.com**
Fax: **012 431 0608**

Such complaints will be dealt with in terms of Section 47 of the Medical Schemes Act.

Universal Healthcare Administrators

Client Services Call Centre	0800 002 636 | 011 208 1010
Fax number	(011) 208 1028
E-mail	tiger@universal.co.za
Website	www.universal.co.za | www.tbms.co.za

Universal Care

Hospital pre-authorisation	0860 102 312
Prescribed minimum benefit (PMB) management	0860 111 900
HIV/AIDS Disease Management Programme	0860 111 900
Chronic medicine	0860 111 900
Specialist referral authorisation	0800 002 636

Emergency Services

ER 24	084 124

This brochure is a summary of the benefits of TBMS. A copy of the current Rules of the Scheme may be obtained from the Administrator, Universal Healthcare, if required. Please note that the Rules of the Scheme will always take precedence over this summary.

Tiger Brands Medical Scheme
Universal House, 15 Tambach Road, Sunninghill Park, Sandton Private Bag X131, Rivonia, 2128
Tel: 0800 002 636 | Fax: 011 208 1028
Email: tiger@universal.co.za | Website: www.tbms.co.za

Administered by Universal Healthcare Administrators (Pty) Ltd

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