OLDMUTUAL

# MEMBER GUIDE
## 2019/20

OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND

Effective 1 July 2019

# CONTACT DETAILS

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

**Fax:** 0862 957 355

**Email:** authorisations@omsmaf.co.za

### Pre-authorisation: Chronic Medicine Management

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

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

**Email:** chronic@omsmaf.co.za

**Fax:** 0864 613 913

### Pre-authorisation: Oncology Case Manager (patients diagnosed with cancer)

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

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

**Fax:** 0864 613 917

**Email:** oncology@omsmaf.co.za

### Independent Clinical Oncology Network (ICON)

**Website:** cancernet.co.za

**Email:** oncology@omsmaf.co.za

### Out-of-hospital PMB Care Plans

**Fax:** 0864 647 808

**Email:** pmb@omsmaf.co.za

### Healthcare Professionals Contact Centre

**Tel:** 0860 100 076

**Fax:** 0864 647 808

### HIV and AIDS Management Programme

Universal Healthcare HIV/AIDS Management Programme

**Tel:** 0860 378 800

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

**Fax:** 0864 613 921

**Email:** hivprogramme@omsmaf.co.za

**Website:** omsmaf.co.za

### Mental Health Programme

Universal Healthcare Mental Health Programme

**Tel:** 0860 100 076

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

**Email:** mentalhealth@omsmaf.co.za

### Active Disease Risk Management Programme

Universal Healthcare Disease Management Programme

**Tel:** 0860 100 076

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

**Fax:** 0864 613 918

**Email:** diseasemanagement@omsmaf.co.za

| Back and Neck Programme |
| --- |
| **Tel:** 0860 100 076 or +27 11 208 1021<br>**Hours:** 8:00 to 17:00 Monday – Friday only<br>**Fax:** 0862 957 355<br>**Email:** backandneck@omsmaf.co.za |
| **Mother and Baby Programme** |
| **Tel:** 0860 100 076 or +27 11 208 1021<br>**Hours:** 8:00 to 17:00 Monday – Friday only<br>**Fax:** 0862 957 355<br>**Email:** maternity@omsmaf.co.za |
| **PAED-IQ's Babyline** |
| **Tel:** 0860 666 110 |
| **Universal Healthcare Network Providers** |
| **Email:** network.accounts@omsmaf.co.za |
| **Escalations (for members)** |
| **Email:** escalations@omsmaf.co.za |

| PO Office escalations |
| --- |
| **Email:** principalofficer@omsmaf.co.za |
| **Whistle Blowers – Fraud Hotline** |
| **Tel:** 080 111 4447 (Toll free number)<br>**Fax:** 086 672 1681<br>**Email:** fraud@omsmaf.co.za<br>**Website:** thehotline.co.za<br>**WebApp:** thehotlineapp.co.za<br>**Callback:** (Please call me) ) 072 595 9139 |
| **GAP Insurance cover** |
| **Email:** reservesavings @omsmaf.co.za |
| **Council for Medical Schemes** (if you cannot resolve a query with the Fund) |
| **Tel:** 0861 123 267 or +27 12 431 0500<br>**Email:** complaints@medicalschemes.com |

**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 send an email to OMSMAF_Office@oldmutual.com.

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- What must I consider before making a choice?
- Who are the Fund's contracted providers, and what co-payments could I incur?

## Can I have a quick overview of the Plans?

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

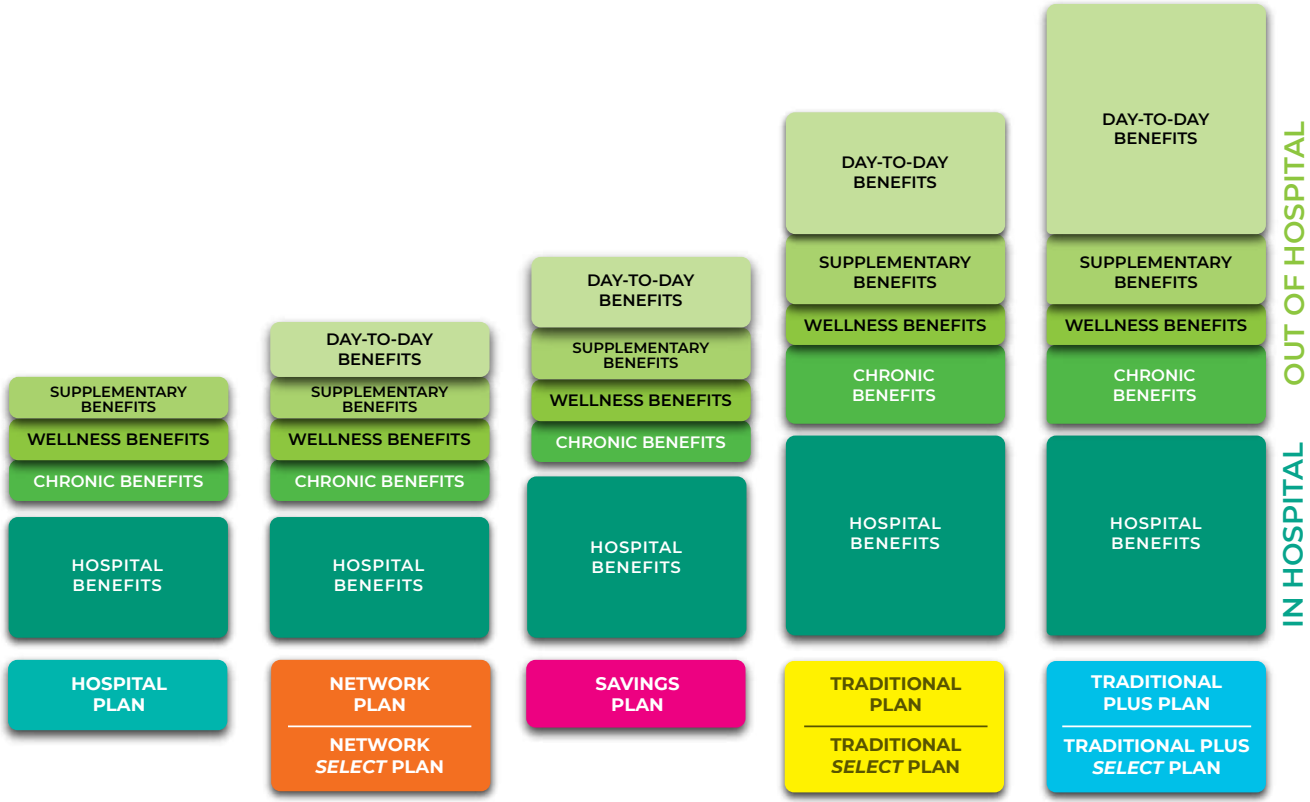
The Plans range from lower cost options that offer lower cover, to higher cost options that offer more comprehensive cover.

**In addition, members can also choose one of the *SELECT* Plans, which offer a reduced contribution rate in return for access to selected hospitals only. See page 22 for important information on these Plans.**

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

The Fund's benefit year runs from 1 July to 30 June of the following year. You will be entitled to full benefits if your membership is active at the beginning of the benefit year. If you join the Fund during a benefit year, you will only be entitled to pro-rata benefits. If there is movement in membership, for example, the addition or removal of a dependant, benefits will be adjusted accordingly.

# A GRAPHIC OVERVIEW OF **THE PLANS**



| | Hospital Plan | Network Plan<br>Network *SELECT* Plan* | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan* | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan* |
|---|---|---|---|---|---|
| **DAY-TO-DAY BENEFITS** | ✓ Limited Primary Care Benefits for specified procedures only<br>✓ No Personal Medical Savings Account | ✓ Primary healthcare benefits via Universal Healthcare Network GP<br>✓ No Personal Medical Savings Account<br>✓ **NEW!** Annual Flexi Benefit (AFB) for pathology, radiology, optometry and auxiliary services<br>✓ **NEW!** Specialist consultations | ✓ Limited to Personal Medical Savings Account only; no PCB limits | ✓ Comprehensive; from Personal Medical Savings Account at cost; then from PCB at 1 x MSR | ✓ Very comprehensive; from Personal Medical Savings Account at cost; then from PCB at 3 x MSR |
| **SUPPLEMENTARY BENEFITS** | ✓ Limited, paid at 1 x MSR | ✓ Limited, paid at 1 x MSR | ✓ Limited, paid at 1 x MSR | ✓ Comprehensive, paid at 1 x MSR | ✓ Comprehensive, paid at 1 x MSR |
| **WELLNESS BENEFITS** | ✓ Standard | ✓ Standard | ✓ Standard | ✓ Standard | ✓ Standard |
| **CHRONIC BENEFITS** | ✓ Limited | ✓ Via Universal Healthcare Network GPs | ✓ Limited | ✓ Comprehensive | ✓ Comprehensive |

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan* | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan* | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan* |
|---|---|---|---|---|---|
| **HOSPITAL BENEFITS** | ✓ **NEW!** Overall Annual Limit (OAL): **R500 000** per beneficiary per benefit year; **R1 000 000** per family 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. Refer to detailed table under Hospital Benefits. | ✓ **NEW!** Overall Annual Limit (OAL): **R500 000** per beneficiary per benefit year; **R1 000 000** per family per benefit year (subject to certain sub-limits). Certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. See page 89 for more information. | ✓ **NEW!** Overall Annual Limit (OAL): **R750 000** per beneficiary per benefit year; **R1 500 000** per family per benefit year (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) |
| | ✓ **NEW!** Sub-limits apply:<br>- Basic pathology: **R18 000** per family per benefit year<br>- Basic radiology: **R24 250** per family per benefit year<br>- Physiotherapy: **R5 300** per family per benefit year | | | ✓ Subject to the Overall Annual Limit and Managed Care protocols | |
| | ✓ Oncology covered within ICON Essential Protocols | ✓ Oncology covered within ICON Essential Protocols<br>*Please note that under the ***SELECT*** Plan, members' choice of hospitals is restricted – see page 22 for more information. | ✓ Oncology covered within ICON Enhanced Protocols | ✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit)<br>*Please note that under the ***SELECT*** Plan, members' choice of hospitals is restricted – see page 22 for more information. | ✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit) |

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

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

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 40-62 FOR MORE INFORMATION

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Rate payable** | Paid at 1 x Medical Scheme Rates (MSR) | | | | Paid up to 3 x MSR |
| **Personal Medical Savings Account** (PMSA) - see page 115.. | No | No | Yes | Yes | Yes |
| **Annual Flexi Benefit** (AFB) | No | **NEW!** Annual Flexi Benefit (AFB), subject to **R5 100** per beneficiary per benefit year and **R8 500** per family per benefit year. | No | No | No |
| **Primary Care Benefit (PCB) Limit** | **R1 960** per family for specified procedures in doctors' rooms only. | At Universal Healthcare Network Provider. | No PCB benefit; benefits are payable from available PMSA or, thereafter, accumulated savings. | Depends on income band and family size – see page 52. | Depends on income band and family size – see page 55. |

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **GPs and Specialists** | No benefit. | Medically necessary visits to Universal Healthcare Network GPs, subject to Universal Healthcare Network benefits.<br>**NEW!** Specialist consultations subject to referral from a Universal Healthcare Network GP, limited to two consultations per beneficiary per benefit year; four consultations per family per benefit year. | At 100% of cost from PMSA and then from accumulated savings, subject to available funds. | At 100% of cost from PMSA, then at 1 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. | At 100% of cost from PMSA, then at 3 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. |
| **Specified procedures in doctors' rooms** | Subject to PCB limit. | Covers minor trauma treatment and small procedures in Universal Healthcare Network GPs' rooms. | | | |
| **Dentistry** | No benefit. | Covers fillings, primary extractions, scaling, polishing and **one pair of plastic dentures (NEW!)** per beneficiary per three-year period at a Universal Healthcare Network provider (dentists only). | At 100% of cost from PMSA and then from accumulated savings, subject to available funds. | At 100% of cost from PMSA, then at 1 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. | At 100% of cost from PMSA, then at 3 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. |

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Radiology** | No benefit. | Basic X-rays as requested by Universal Healthcare Network GP and subject to Universal Healthcare protocols and limited to available AFB. | At 100% of cost from PMSA and then from accumulated savings, subject to available funds. | At 100% of cost from PMSA, then at 1 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. | At 100% of cost from PMSA, then at 3 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. |
| **Pathology** | No benefit. | Basic blood tests as requested by Universal Healthcare Network GP and subject to Universal Healthcare protocols and limited to available AFB. | | | |
| **Psychology** | | **NEW!** Limited to AFB, subject to sub-limits:<br>**R1 700** per beneficiary per benefit year;<br>**R2 850** 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 100% of MMAP or medicine price, whichever is the lesser, from PMSA and then from accumulated savings, subject to available funds. | At 100% of MMAP or medicine price, whichever is the lesser, from PMSA. Once PMSA is depleted, from PCB at 100% of MMAP or medicine price, whichever is the lesser.<br>Thereafter, accumulated savings can be used. | At 100% of MMAP or medicine price, whichever is the lesser, from PMSA. Once PMSA is depleted, from PCB at 100% of MMAP or medicine price, whichever is the lesser.<br>Thereafter, accumulated savings can be used. |

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Pharmacy-Advised Therapy (PAT)** | No benefit. | No benefit. | At 100% of MMAP or medicine price, whichever is the lesser, from PMSA and then from accumulated savings, subject to available funds.<br>(Medicine exclusion list may apply.) | At 100% of MMAP or medicine price, whichever is the lesser, from PMSA. Once PMSA is depleted, from PCB at 100% of MMAP or medicine price, whichever is the lesser.<br>Thereafter, accumulated savings can be used.<br>(Medicine exclusion list may apply.) | At 100% of MMAP or medicine price, whichever is the lesser, from PMSA. Once PMSA is depleted, from PCB at 100% of MMAP or medicine price, whichever is the lesser.<br>Thereafter, accumulated savings can be used.<br>(Medicine exclusion list may apply.) |
| **Auxiliary Services**<br>**Physiotherapy** | No benefit. | **NEW!** Auxiliary services limited to available AFB, subject to sub-limits:<br>**R1 700** per beneficiary per benefit year;<br>**R2 850** per family per benefit year | At 100% of cost from PMSA and then from accumulated savings, subject to available funds. | At 100% of cost from PMSA, then at 1 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. | At 100% of cost from PMSA, then at 3 x MSR from PCB, up to overall Day-to-Day limit.<br>Thereafter, accumulated savings can be used. |
| **Optical benefits**<br>▸ Eye tests<br>▸ Spectacles, Frames, Contact Lenses and Readers (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.<br>See page 44 for more information. | | | |

## OUT-OF-HOSPITAL: Supplementary Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 58-62 FOR MORE INFORMATION.

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Maternity benefits** (dependent on registration on the Mother and Baby Care Programme)<br>**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.** | | | | | |
| Antenatal classes | No benefit. | No benefit. | **R1 280** per family per benefit year. | **R2 010** per family per benefit year. | **R2 010** per family per benefit year. |
| Antenatal visits | | Please refer to Network/ Network ***SELECT*** Plan section for services rendered by Universal Healthcare. | **R3 020** per pregnancy. | **R5 030** per pregnancy. | **R5 030** per pregnancy. |
| Ultrasound scans (pregnancy) | | Two 2D scans per pregnancy at Universal Healthcare Network GP, or referral by Universal Healthcare Network GP to a radiologist. | Two 2D scans per beneficiary. | Two 2D scans per beneficiary. | Two 2D scans per beneficiary. |
| Out-of-hospital pathology tests | | Please refer to Network/ Network ***SELECT*** Plan section for services rendered by Universal Healthcare. | **R2 490** per family per benefit year. | **R3 110** per family per benefit year. | **R3 110** per family per benefit year. |

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| Antenatal vitamins | No benefit. | No benefit. | 100% of MMAP or Medicine Price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit. | 100% of MMAP or Medicine Price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit. | 100% of MMAP or Medicine Price, whichever is the lesser, subject to prescription from an approved list and included in the Hospital Benefit. |
| **Ultrasound scans in and out of hospital** (other than for pregnancy) – combined benefit limit | **R4 790** per family per benefit year. | **R4 790** per family per benefit year. | **R4 790** per family per benefit year. | **R7 140** per family per benefit year. | **R7 140** per family per benefit year. |
| **Specialised Radiology in and out of hospital** (including MRI, CT and Radio-isotope Scans and Nuclear Medicine) - combined benefit limit | **R14 100** per family per benefit year, with a co-payment of **R1 500** per authorisation. | **R14 100** per family per benefit year, with a co-payment of **R1 500** per authorisation. | **R14 100** per family per benefit year, with a co-payment of **R1 500** per authorisation. | **R17 400** per family per benefit year, with a co-payment of **R1 500** per authorisation. | **R17 400** per family per benefit year, with a co-payment of **R1 500** per authorisation. |
| **Dental implants** | No benefit, except for Prescribed Minimum Benefits. | No benefit, except for Prescribed Minimum Benefits. | At 100% of cost from PMSA and then from accumulated savings, subject to available funds. | **R14 500** per family per benefit year. | **R14 500** per family per benefit year. |
| **Medical Appliances** | | | | **R9 660** per family per benefit year, subject to approval. | **R9 660** per family per benefit year, subject to approval. |
| **Foot Orthotics** | | | | **R4 360** per family and included in the appliance limit of **R9 660** per family above. | **R4 360** per family and included in the appliance limit of **R9 660** per family above. |

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Hearing Aids** (including repairs – see page 62) | No benefit, except for Prescribed Minimum Benefits. | No benefit, except for Prescribed Minimum Benefits. | At 100% of cost from PMSA and then from accumulated savings, subject to available funds. | **R17 200** per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for beneficiaries under age 7, and every 5 years for beneficiaries older than 7 years.<br>The benefit excludes consultations and associated tests. | **R17 200** per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for beneficiaries under age 7, and every 5 years for beneficiaries older than 7 years.<br>The benefit excludes consultations and associated tests. |
| **Refractive procedures** | | | | 1 x MSR or cost, whichever is the lesser, up to a sub-limit of **R15 300** per beneficiary per benefit year. See page 62 for more information. | 1 x MSR or cost, whichever is the lesser, up to a sub-limit of **R15 300** per beneficiary per benefit year. See page 62 for more information. |
| **Back and Neck Rehabilitation Programme** | Please see page 96 for more information. | | | | |
| **Mental Health Programme** | **R10 500** per beneficiary per benefit year. Please see page 102 for more information. | | | | |

# OUT-OF-HOSPITAL: Wellness Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 63-65 FOR MORE INFORMATION.

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Wellness Benefit**<br>(1 per beneficiary per benefit year) | ▸ **Pharmacy-based health-screening tests:** Blood pressure, blood glucose, cholesterol, HIV/AIDS, BMI. One of each screening test per beneficiary per benefit year.<br>▸ **Pharmacy-based vaccines:** One flu vaccine per beneficiary per benefit year, one pneumococcal vaccine per lifetime (available from Clicks, Dis-Chem and Pick n Pay Pharmacy clinics).<br>▸ **Contraceptive benefit: R2 990** per beneficiary per benefit year. **R1 880** sub-limit per beneficiary for oral contraceptives.<br>▸ Non-pharmacy based benefits consist of one pap smear and mammogram per female beneficiary per benefit year and one prostate test per male beneficiary, as well as colorectal screening, limited to one test per beneficiary per benefit year including the consultation at the GP or gynaecologist (for female beneficiaries) or urologist (for male beneficiaries), paid up to the Medical Scheme Rates for a visit to a GP, gynaecologist or urologist, plus one health risk assessment per beneficiary per benefit year for services rendered by a registered healthcare practitioner (such as a General Practitioner). **It is very important that your service provider uses the correct ICD-10 code to claim for these benefits - see the green note on page 65 for more information.**<br>▸ **Hearing screening** for newborns up to six weeks.<br>▸ **PAED-IQ's Babyline** -A 24/7, paediatric telephone service, whereby parents or caregivers of children from birth to three years of age registered on the Fund can phone in and get up-to-date child healthcare advice and reassurance. | | | | |

# OUT-OF-HOSPITAL: Chronic Benefits

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 66-74 FOR MORE INFORMATION.

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|---|
| **Non-PMB conditions** | A limit of **R5 030** per family (for Chronic Hepatitis, Depression, Macular Degeneration and Oedema, Anxiety and Post-Traumatic Stress Disorder only), subject to Maximum Medical Aid Price (MMAP) or the Medicine Price, whichever is the lesser. | Subject to the Universal Healthcare Network Formulary and approval. In addition, a benefit for Chronic Hepatitis, Macular Degeneration and Oedema, Anxiety and Post Traumatic Stress Disorder. Preauthorised by Universal Healthcare Chronic Medicine Management. | A limit of **R5 030** per family (for Chronic Hepatitis, Depression, Macular Degeneration and Oedema, Anxiety and Post-Traumatic Stress Disorder only), subject to Maximum Medical Aid Price (MMAP) or the Medicine Price, whichever is the lesser. For other conditions, subject to available PMSA or, thereafter, accumulated savings. | A limit of **R12 200** per family per benefit year, subject to chronic medicine benefit, Chronic Disease Lists and approval. | A limit of **R14 600** per family per benefit year, subject to chronic medicine benefit, Chronic Disease Lists and approval. |
| **PMB Conditions** | Unlimited, subject to the **Universal Healthcare restrictive formulary** and approval. | Unlimited subject to **Universal Healthcare Network Formulary** and approval. Preauthorised by Universal Healthcare Chronic Medicine Management. | Unlimited, subject to the **Universal Healthcare restrictive formulary** and approval. | Unlimited, subject to the **Universal Healthcare comprehensive formulary** and approval. | Unlimited, subject to the **Universal Healthcare comprehensive formulary** and approval. |

# IN-HOSPITAL: Hospital Benefits (HB)

THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 75-95 FOR MORE INFORMATION.

| Hospital Plan | Network Plan<br>Network *SELECT* Plan | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan | Traditional Plus Plan<br>Traditional Plus *SELECT* Plan |
|---|---|---|---|---|
| **NEW!** Annual limit of **R500 000** per beneficiary per benefit year, and **R1 000 000** per family per benefit year, subject to certain sub-limits.<br>**Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP). | **NEW!** Annual limit of **R500 000** per beneficiary per benefit year, and **R1 000 000** per family per benefit year for Hospital Benefits (HB), subject to certain sub-limits.<br>**Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP). | **NEW!** Annual limit of **R750 000** per beneficiary per benefit year, and **R1 500 000** per family per benefit year for Hospital benefits (HB), subject to certain sub-limits.<br>**Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP). | Unlimited cover for Hospital Benefits (HB), subject to certain sub-limits.<br>**Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP). | Unlimited cover for Hospital Benefits (HB), subject to certain sub-limits.<br>**Unlimited** Prescribed Minimum Benefits (PMB) if obtained from a Designated Service Provider (DSP). |

**NOTE:** Under the **Hospital**, **Network** and **Network *SELECT*** Plans, certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. See page 89 for more information.

## Terms used in the table:

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

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

### Why have the *SELECT* Plans been introduced?

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

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

The ***SELECT*** Plans are based on offering the same benefits as those on the standard Plans, but at a reduced contribution – in return for members then using the ***SELECT*** list of hospitals (see page 151).

**For example:**

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

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

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

### How were the hospitals for *SELECT* Plans chosen?

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

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

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

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

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

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

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

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

### What if there is an emergency?

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

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

## What are the monthly contributions for 2019/20?

The total monthly contribution to the Fund is based on the Plan you have chosen, the number of your dependants and your income (see following tables). You can find a definition of income on page 148.

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

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

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

Late Joiner Penalties will be imposed in accordance with the Rules of the Fund (please see page 127 for more information).

### Pensioners

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

Please see page 148 for the definition of income.

## Hospital Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | RISK | R850 | R663 | R185 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R850** | **R663** | **R185** |
| R5 041 - R7 560 | RISK | R918 | R716 | R191 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R918** | **R716** | **R191** |
| R7 561 - R10 090 | RISK | R1 087 | R854 | R214 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 087** | **R854** | **R214** |
| R10 091 - R13 470 | RISK | R1 464 | R1 178 | R378 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 464** | **R1 178** | **R378** |
| R13 471 - R19 970 | RISK | R1 631 | R1 311 | R422 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 631** | **R1 311** | **R422** |
| R19 971 - R33 300 | RISK | R1 715 | R1 377 | R443 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 715** | **R1 377** | **R443** |
| R33 301+ | RISK | R1 731 | R1 389 | R446 |
| | | R0 | R0 | R0 |
| | **TOTAL** | **R1 731** | **R1 389** | **R446** |

Please see page 148 for the definition of income.

## Network Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | RISK | R1 479 | R1 229 | R465 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 479** | **R1 229** | **R465** |
| R5 041 - R7 560 | RISK | R1 935 | R1 240 | R492 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 935** | **R1 240** | **R492** |
| R7 561 - R10 090 | RISK | R2 005 | R1 282 | R510 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R2 005** | **R1 282** | **R510** |
| R10 091 - R13 470 | RISK | R2 192 | R1 842 | R765 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R2 192** | **R1 842** | **R765** |
| R13 471 - R19 970 | RISK | R2 268 | R1 905 | R791 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R2 268** | **R1 905** | **R791** |
| R19 971 - R33 300 | RISK | R2 292 | R1 927 | R801 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R2 292** | **R1 927** | **R801** |
| R33 301+ | RISK | R2 312 | R1 946 | R809 |
| | | R0 | R0 | R0 |
| | **TOTAL** | **R2 312** | **R1 946** | **R809** |

## Network *SELECT* Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | RISK | R1 333 | R1 108 | R420 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 333** | **R1 108** | **R420** |
| R5 041 - R7 560 | RISK | R1 744 | R1 117 | R444 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 744** | **R1 117** | **R444** |
| R7 561 - R10 090 | RISK | R1 808 | R1 157 | R459 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 808** | **R1 157** | **R459** |
| R10 091 - R13 470 | RISK | R1 977 | R1 661 | R689 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R1 977** | **R1 661** | **R689** |
| R13 471 - R19 970 | RISK | R2 045 | R1 719 | R715 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R2 045** | **R1 719** | **R715** |
| R19 971 - R33 300 | RISK | R2 066 | R1 737 | R722 |
| | PMSA | R0 | R0 | R0 |
| | **TOTAL** | **R2 066** | **R1 737** | **R722** |
| R33 301+ | RISK | R2 085 | R1 754 | R730 |
| | | R0 | R0 | R0 |
| | **TOTAL** | **R2 085** | **R1 754** | **R730** |

See page 22 for important information on this option.

Please see page 148 for the definition of income.

## Savings Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | RISK | R1 331 | R1 118 | R224 |
| | PMSA | R276 | R232 | R46 |
| | **TOTAL** | **R1 607** | **R1 350** | **R270** |
| R5 041 - R7 560 | RISK | R1 713 | R1 138 | R280 |
| | PMSA | R357 | R235 | R58 |
| | **TOTAL** | **R2 070** | **R1 373** | **R338** |
| R7 561 - R10 090 | RISK | R1 779 | R1 178 | R289 |
| | PMSA | R369 | R245 | R60 |
| | **TOTAL** | **R2 148** | **R1 423** | **R349** |
| R10 091 - R13 470 | RISK | R1 924 | R1 633 | R509 |
| | PMSA | R400 | R340 | R105 |
| | **TOTAL** | **R2 324** | **R1 973** | **R614** |
| R13 471+ | RISK | R2 017 | R1 712 | R533 |
| | | R419 | R356 | R111 |
| | **TOTAL** | **R2 436** | **R2 068** | **R644** |

Please see page 148 for the definition of income.

## Traditional Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | RISK | R2 280 | R1 733 | R554 |
| | PMSA | R294 | R223 | R71 |
| | **TOTAL** | **R2 574** | **R1 956** | **R625** |
| R5 041 - R7 560 | RISK | R2 748 | R1 823 | R619 |
| | PMSA | R355 | R235 | R81 |
| | **TOTAL** | **R3 103** | **R2 058** | **R700** |
| R7 561 - R10 090 | RISK | R2 893 | R1 921 | R653 |
| | PMSA | R372 | R248 | R84 |
| | **TOTAL** | **R3 265** | **R2 169** | **R737** |
| R10 091+ | RISK | R3 361 | R2 771 | R1 045 |
| | | R435 | R358 | R135 |
| | **TOTAL** | **R3 796** | **R3 129** | **R1 180** |

## Traditional *SELECT* Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | RISK | R2 057 | R1 563 | R499 |
| | PMSA | R265 | R201 | R64 |
| | **TOTAL** | **R2 322** | **R1 764** | **R563** |
| R5 041 - R7 560 | RISK | R2 477 | R1 644 | R558 |
| | PMSA | R320 | R212 | R73 |
| | **TOTAL** | **R2 797** | **R1 856** | **R631** |
| R7 561 - R10 090 | RISK | R2 610 | R1 732 | R590 |
| | PMSA | R335 | R224 | R75 |
| | **TOTAL** | **R2 945** | **R1 956** | **R665** |
| R10 091+ | RISK | R3 031 | R2 499 | R942 |
| | | R392 | R323 | R122 |
| | **TOTAL** | **R3 423** | **R2 822** | **R1 064** |

See page 22 for important information on this option.

## Traditional Plus Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R7 560 | RISK | R4 849 | R3 973 | R1 507 |
| | PMSA | R558 | R458 | R174 |
| | **TOTAL** | **R5 407** | **R4 431** | **R1 681** |
| R7 561+ | RISK | R5 603 | R4 592 | R1 742 |
| | | R646 | R530 | R201 |
| | **TOTAL** | **R6 249** | **R5 122** | **R1 943** |

## Traditional Plus *SELECT* Plan

| Income band | Contribution | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R7 560 | RISK | R4 293 | R3 519 | R1 335 |
| | PMSA | R495 | R406 | R154 |
| | **TOTAL** | **R4 788** | **R3 925** | **R1 489** |
| R7 561+ | RISK | R4 962 | R4 069 | R1 542 |
| | | R573 | R469 | R178 |
| | **TOTAL** | **R5 535** | **R4 538** | **R1 720** |

See page 22 for important information on this option.

Please see page 148 for the definition of income.

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

### Hospital Plan

Maximum annual PCB limit of R1 960 per family for specified procedures.

### Network Plan

Subject to Universal Healthcare Network benefits.

### Savings Plan

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | Annual PMSA | R3 312 | R2 784 | R552 |
| R5 041 - R7 560 | | R4 284 | R2 820 | R696 |
| R7 561 - R10 090 | | R4 428 | R2 940 | R720 |
| R10 091 - R13 470 | | R4 800 | R4 080 | R1 260 |
| R13 471+ | | R5 028 | R4 272 | R1 332 |

Please see page 148 for the definition of income.



## Traditional Plan

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | Annual PMSA | R3 528 | R2 676 | R852 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R7 778** | **R6 286** | **R2 132** |
| R5 041 - R7 560 | Annual PMSA | R4 260 | R2 820 | R972 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 510** | **R6 430** | **R2 252** |
| R7 561 - R10 090 | Annual PMSA | R4 464 | R2 976 | R1 008 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 714** | **R6 586** | **R2 288** |
| R10 091+ | Annual PMSA | R5 220 | R4 296 | R1 620 |
| | | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R9 470** | **R7 906** | **R2 900** |

## Traditional *SELECT* Plan

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | Annual PMSA | R3 180 | R2 412 | R768 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R7 430** | **R6 022** | **R2 048** |
| R5 041 - R7 560 | Annual PMSA | R3 840 | R2 544 | R876 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 090** | **R6 154** | **R2 156** |
| R7 561 - R10 090 | Annual PMSA | R4 020 | R2 688 | R900 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 270** | **R6 298** | **R2 180** |
| R10 091+ | Annual PMSA | R4 704 | R3 876 | R1 464 |
| | | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 954** | **R7 486** | **R2 744** |

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

**Traditional Plus Plan**

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R7 560 | Annual PMSA | R6 696 | R5 496 | R2 088 |
| | Annual PCB limit | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R15 196** | **R12 296** | **R4 228** |
| R7 561+ | Annual PMSA | R7 752 | R6 360 | R2 412 |
| | | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R16 252** | **R13 160** | **R4 552** |

**Traditional Plus *SELECT* Plan**

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R7 560 | Annual PMSA | R5 940 | R4 872 | R1 848 |
| | Annual PCB limit | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R14 440** | **R11 672** | **R3 988** |
| R7 561+ | Annual PMSA | R6 876 | R5 628 | R2 136 |
| | | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R15 376** | **R12 428** | **R4 276** |

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

*Unless you retire or you (or a beneficiary) are newly registered on the Oncology Programme.

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

## What must I consider before making a choice?

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

- The monthly contributions of each Plan to ensure that you can afford the Plan you select.
- Whether the Plan you are considering offers adequate benefits most suited to your medical needs.
- Your health history or what your medical expenses were during the previous benefit year.
- Your anticipated healthcare needs during the coming year.
- The number of dependants you have and whether this may change in the next benefit year.
- If you have a chronic condition, whether the Plan you choose covers your condition, and whether you are comfortable with the formulary that is applicable to your Plan (more information on pages 66-74 of this guide).

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

A ***SELECT*** Plan should be considered:

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

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

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

### If you are thinking of joining the Hospital Plan:

- If you have a savings credit balance after 5 months, your savings balance will be paid out to you.

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

### Why does the Fund make use of contracted providers?

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

### Why does the Fund make use of co-payments?

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

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

### GENERAL – MEDICAL SCHEME RATES (MSR) VS ACTUAL COSTS

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

| If you ... | ... you will have to pay |
|---|---|
| claim for Hospital or Supplementary Benefits, (unless it is is in accordance with Prescribed Minimum Benefits), your claim will be covered at 1 x MSR and... | the difference between what you are charged by the medical service provider and 1 x MSR. |
| are on the **Traditional** or **Traditional *SELECT*** Plan and claim for Day-to-Day Benefits after exhausting your Personal Medical Savings Account (PMSA) portion, your claim will be covered at 1 x Medical Scheme Rates (MSR) and ... | the difference between what you are charged by the medical service provider and 1 x MSR. (Medical practitioners are under no obligation to charge MSR and often charge substantially more.) |
| are on the **Traditional Plus** or **Traditional Plus *SELECT*** Plan and claim for Day-to-Day Benefits after exhausting your Personal Medical Savings Account portion, your claim will be covered at up to 3 x Medical Scheme Rates (MSR) and ... | the difference between what you are charged by the medical service provider and 3 x MSR. (Medical practitioners are under no obligation to charge MSR and often charge substantially more.) |

### APPLIANCES, TESTS, CONSULTATIONS

| If you claim for ... | ... you will have a co-payment of | Is there a contracted provider you can use to avoid the co-payment on the left? |
|---|---|---|
| a consultation with a non-ICON oncologist | 20% of the consultation claim | YES. The Fund has appointed the Independent Clinical Oncology Network (ICON) as the DSP for Oncology treatment. ICON is a dedicated network of oncologists committed to the comprehensive management of members with cancer. |
| a hearing aid | 10% of the cost of such hearing aid. | NO |
| specialised radiology in or out of hospital | R1 500 per authorisation | NO |

## CHRONIC MEDICINES

| If you claim for a medicine that is ... | ... you will have a co-payment of | Is there a contracted provider you can use to avoid the co-payment on the left? |
|---|---|---|
| not in your Plan Formulary | 25% of the cost of such medicine. | NO. If you do not want to incur the co-payment, use medicine in your Plan Formulary. |
| not within the Maximum Medical Aid Price (MMAP) | the difference between the cost of the medicine and MMAP. See page 68. | NO. If you do not want to incur the co-payment, use medicine within MMAP. |

*See page 66 for more information.*

## PHARMACY CLAIMS

| If you claim for ... | ... then | Is there a contracted provider you can use to avoid this? |
|---|---|---|
| chronic medicine from a pharmacy that is not part of the Preferred Provider network of the Fund | you may have a co-payment of the difference between the Fund's agreed Preferred Provider dispensing rate and what the non-Preferred Provider pharmacy charges you. | YES. There is a Universal Healthcare pharmacy network. To find a provider, call 0860 100 076 or by logging into omsmaf.co.za (effective 1 July 2019). |
| pharmacy-based Wellness Benefits such as screening tests or flu vaccines from a pharmacy that is not a Designated Service Provider of the Fund | your benefit will be covered from your available Day-to-Day Benefits, instead of from your Wellness Benefits, unnecessarily depleting your Day-to-Day Benefits. | YES. Clicks Pharmacies, Dis-Chem Pharmacies and Pick n Pay Pharmacies are the Fund's Designated Service Providers for pharmacy-based Wellness Benefits. |

## HOSPITALISATION

| If you ... | ... you will have a co-payment of | Is there a contracted provider you can use to avoid the co-payment on the left? |
|---|---|---|
| are a member of the **Network *SELECT***, **Traditional *SELECT*** or **Traditional Plus *SELECT*** Plan and use a hospital that is not on the ***SELECT*** list of hospitals* | 20% of the total hospital bill* | YES. The ***SELECT*** list of hospitals, which have been chosen for both their efficiency and value for money (see page 151). |

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

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

## PROCEDURES IN HOSPITAL

| If you have any of the following procedures*... | | ... you will have a co-payment of | Is there a contracted provider you can use to avoid the co-payment on the left? |
|---|---|---|---|
| **ALL Plans** | Non-PMB dental procedures in hospital | R1 500 | NO |
| | Gastroscopy / colonoscopy / arthroscopy in hospital; cystoscopy, facet joint injections, flexible sigmoidoscopy, functional nasal surgery, hysteroscopy (not endometrial ablation), myringotomy, tonsillectomy and adenoidectomy, varicose vein surgery | R1 500 | |
| | Specialised radiology | R1 500 per authorisation | |
| | Spinal surgery, if you decline participation in the Back and Neck Rehabilitation Programme before surgery | R5 000 | YES. Document Based Care (DBC) and physiotherapists following the South African Society of Physiotherapy defined care pathways are the Fund's DSPs for the Back and Neck Rehabilitation Programme. |
| | Laparoscopic appendectomy, laparoscopic hernia repair (for inguinal or femoral hernias: funding only if the hernia is bilateral or recurrent), laparoscopic hysterectomy, laparoscopic radical prostatectomy, balloon sinuplasty, diagnostic laparoscopy , percutaneous radiofrequency ablations (percutaneous rhizotomies), laparoscopic pyeloplasty, Nissen Fundoplication (reflux surgery) | R3 500 | NO. The alternative, if you do not want to incur the co-payment, would be to undergo open surgery. |
| **Savings**, **Traditional**, **Traditional *SELECT***, **Traditional Plus** and **Traditional Plus *SELECT*** Plans | Hip or knee replacements not undertaken by the Fund's Designated Service Providers | R5 000 | YES. ICPS and Jointcare, two groups of orthopaedic surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways, are the Fund's DSPs. |

**These co-payments will not apply if the procedure is in accordance with Prescribed Minimum Benefits. Please see page 110, Prescribed Minimum Benefits, for more information.*

1

# **WELCOME** TO YOUR MEMBER GUIDE

## IN THIS SECTION



## Why have a medical aid fund?

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 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.

## 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.
- 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 s ure 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.
- If you are an active employee, ensure that your current location and/or home address as well as email address, or any relevant changes, are captured on the Human Capital management system, and if you are 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 and email address.
- If you are a pensioner, ensure that you notify the Fund of your valid postal address and 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 (1 x MSR) - the rate at which the Fund will pay for relevant health services. This is adjusted from time to time, following consultation with suppliers in the industry. |
| **PCB** | Primary Care Benefit |
| **PET** | Positron Emission Tomography |
| **PMB** | Prescribed Minimum Benefits |
| **PMSA** | Personal Medical Savings Account |
| **SEP** | Single Exit Price (for medicines) |
| **TTO** | To-take-out (medicine to take home from hospital event) |

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# OVERVIEW OF OUT-OF-HOSPITAL BENEFITS

## IN THIS SECTION

- What benefits form my Out-of-Hospital Benefits?
- How do these benefits compare across Plans?

## What benefits form my Out-of-Hospital Benefits?

To make the Fund's benefits easier to understand, the out-of-hospital benefits are now all grouped together in the following chapters. Depending on the Plan you belong to, your Out-of-Hospital benefits will consist of the following benefits:

- Day-to-Day Benefits (see page 40)
- Supplementary Benefits (see page 58)
- Wellness Benefits (see page 63)
- Chronic Benefits (see page 66)

## How do these benefits compare across Plans?

| | Hospital Plan | Network Plan<br>Network *SELECT* Plan* | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan* | Traditional Plus Plan<br>Traditional Plus SELECT Plan* |
|---|---|---|---|---|---|
| **Day-to-Day Benefits** | ✓ Limited Primary Care Benefits for specified procedures only<br>✓ No Personal Medical Savings Account | ✓ Primary healthcare benefits via Universal Healthcare Network GP<br>✓ **NEW!** Limited Annual Flexi Benefit (AFB) per family, per benefit year, paid at 1 x Medical Scheme Rates<br>✓ No Personal Medical Savings Account | ✓ Limited to Personal Medical Savings Account only; no PCB limits | ✓ Comprehensive; from Personal Medical Savings Account at cost; then from PCB at 1 x Medical Scheme Rates | ✓ Very comprehensive; from Personal Medical Savings Account at cost; then from PCB at 3 x Medical Scheme Rates |
| **Supplementary Benefits** | ✓ Limited, paid at 1 x Medical Scheme Rates | ✓ Limited, paid at 1 x Medical Scheme Rates | ✓ Limited, paid at 1 x Medical Scheme Rates | ✓ Comprehensive, paid at 1 x Medical Scheme Rates | ✓ Comprehensive, paid at 1 x Medical Scheme Rates |
| **Wellness Benefits** | ✓ Standard | ✓ Standard | ✓ Standard | ✓ Standard | ✓ Standard |
| **Chronic Benefits** | ✓ Limited | ✓ Limited | ✓ Limited | ✓ Comprehensive | ✓ Comprehensive |

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# DAY-TO-DAY BENEFITS

(Cover depends on Plan selected.)

## IN THIS SECTION



## What are my Day-to-Day benefits under each Plan?

The level of Day-to-Day Benefits you receive will depend on the Plan you select. These benefits are explained in more detail below.

### Hospital Plan

Your Day-to-Day Benefits consist of a Primary Care Benefit, which covers specified procedures in doctors' rooms only, subject to a sub-limit. Services are covered at 1 x MSR or cost, whichever is the lesser.

Any other day-to-day services on the **Hospital** Plan will be for your account. No PMSA contributions can be made on this Plan.

### You and your family are covered for the following:

| Primary Care Benefit | |
|---|---|
| **Service paid at 1 x MSR or cost, whichever is the lesser** | Limit per family per benefit year |
| **Maximum annual PCB limit for specified procedures (plus the related consultation) in general practitioners' and specialists' rooms** | **R1 960** |

**Specified procedures in general practitioners' and specialists' rooms**

| Service/treatment | Tariff code |
|---|---|
| Stitching of wound | 0300 |
| Stitching of soft-tissue, additional wounds | 0301 |
| Nebulisation in rooms | 1136 |
| Peak Expiratory Flow (PEF) | 1192 |
| ECG without effort | 1232 |
| ECG with effort | 1233 |
| ECG with bike ergometer | 1234 |
| Tonometry | 3014 |

The procedures listed above are some of the common procedures covered by the Primary Care Benefit, but not limited to the above procedures only.

## Network and Network *SELECT* Plans

The **Network** and **Network *SELECT*** Plans are value-for-money options that aims to curb escalating medical costs, while still offering you the basic primary healthcare cover that you need.

Your Day-to-Day Benefits consist of unlimited access to medically necessary basic primary healthcare through the Universal Healthcare General Practitioner network. In addition you will have access to basic dentistry and optical services via network providers, as well as radiology and pathology, subject to protocols and an approved tariff list. See below for more information.

**NEW!** Out-of hospital Annual Flexi Benefit (AFB), subject to **R5 100** per beneficiary per benefit year and **R8 500** per family per benefit year, covering the following benefits:

- Basic pathology
- Basic radiology
- Optometry
- Auxiliary services, subject to the following sub-limits: R1 700 per beneficiary per benefit year and R2 850 per family per benefit year.

Any other services not forming part of the Universal Healthcare benefits that are deemed medically necessary will be for your own account, except for those relating to PMB.

### How can I access benefits?

The first and most important step is to select a Universal Healthcare Network GP from whom you will obtain primary care medical services.

Contact the Universal Healthcare Call Centre on 0860 100 076 for more information on a Universal Healthcare Network provider closest to you.

Please remember that consulting hours for individual Universal Healthcare Network General Practitioners may vary. Doctors

are generally open during office hours, between 9am – 5pm on weekdays and until 12pm on Saturdays.

Universal Healthcare Network service providers are mainly based in Southern Africa; therefore the **Network** and **Network *SELECT*** Plans may not be appropriate for members who live in Namibia or other outlying countries.

### Can I choose which doctor I wish to consult?

Yes, as long as the doctor you choose is on the list of Universal Healthcare Network General Practitioners. When choosing this Plan, you must therefore make sure that there is a Universal Healthcare Network practice within easy reach of your home or work. Universal Healthcare has contracted with private GPs across the country who are part of their network of doctors - you might find that your GP is linked to this network. Each member of the family is able to select a Universal GP that suits them. This means that where family members live apart, each dependant is still able to visit a Universal Healthcare Network doctor near him/her.

### Will I have to wait in a queue for treatment?

Like any GP visit, you will need to make an appointment beforehand to see the doctor.

### Do I pay each time I visit a Universal Healthcare Network practice?

No. There are no limitations on the number of medically necessary visits you make to the Universal Healthcare Network GP. The Universal Healthcare Network GPs have committed to ensuring that primary benefits remain affordable and will treat you professionally, without compromising on the quality of care.

### What happens in the case of an emergency and if my chosen doctor is not available?

You and your beneficiaries each have two additional out-of-network visits at any other general practitioner practice in the country in the event of an emergency or where your chosen provider is not available.

You will be required to pay for all treatment received at the point of service. The costs of these services (including medicines, pathology and radiology) and excluding facility fees may be claimed back by submitting your claim/s to Universal Healthcare. The reimbursement will be subject to Universal Healthcare protocols and limited to two visits per beneficiary per benefit year, subject to R1 110 per visit. Members are also allowed emergency room visits, subject to the out-of-network benefit, limited to two visits per beneficiary per benefit year.

### What if I need to consult a doctor after hours or if on holiday?

The consultation will be treated as an emergency and will be counted as one of your two out-of-network visits. You will be required to pay for the treatment at the point of service and may submit the account and receipt to Universal Healthcare for reimbursement. The reimbursement will be subject to Universal Healthcare protocols and limited to two visits per beneficiary per benefit year, subject to R1 110 per visit. Members are also

allowed emergency room visits, subject to the out-of-network benefit, limited to two visits per beneficiary per benefit year.

## Which services are covered by Universal Healthcare?

There are no limitations on the **Network** and **Network *SELECT*** Plans on the number of medically necessary visits you make to the Universal Healthcare Network General Practitioner.

You and your family are covered for the following:

- Medically necessary consultations with GPs (at a Universal Healthcare Network practice)
- NEW! Out-of-hospital specialist consultations, subject to referral from a Universal Healthcare Network GP, limited to two consultations per beneficiary and four consultations per family per benefit year
- Minor procedures in doctors' rooms
- Basic dentistry (fillings, extractions, scale and polish and one pair of plastic dentures per beneficiary per three-year period only; no benefit for specialised and advanced dentistry), available from a contracted Universal Healthcare Network dentist only
- Specified radiology and pathology (specified black and white X-rays and basic blood tests according to an approved tariff list), subject to the AFB.
- NEW! Auxiliary services, including Psychology (out-of-hospital) and Physiotherapy (out-of-hospital), subject to AFB and sub-limits of R1 700 per beneficiary and R2 850 per family per benefit year
- Acute prescribed medicines as per the Universal Healthcare Network Medicine Benefit Formulary and as requested by the Universal Healthcare Network GP
- Specified optical services, subject to the AFB
- Flu vaccines (if administered in the Universal Healthcare Network GP rooms, or if the member goes directly to the DSP pharmacy – in which case it will be covered from Wellness Benefits.)

## Which services are NOT covered?

The following services will not be covered and will be for your own account:

- Advanced dentistry, orthodontic treatment and services not received from a dentist.
- Services/medicine not covered on the Universal Healthcare approved tariff lists or formularies
- Any non-emergency hospital incidents not authorised
- Any claims from non-Universal Healthcare Network service providers, apart from those covered under your two additional consultations
- Over-the-counter medicine and Pharmacy-Advised Therapy (PAT)
- Facility fees
- Travel expenses
- Cosmetic treatment, operations, procedure and applicators, toiletries, etc.
- Reports, examinations and tests for insurance policies or legal reasons

- Injuries arising from professional sport, bungee or parachute jumps
- Accommodation in an old age home, general care institutions, spa, health or holiday resorts
- Obesity, alcohol or drug abuse (admission for alcohol or drug abuse is covered under Hospital Benefits)
- Treatment and operations of choice and non-essential medical items
- Chronic psychiatric conditions and mental disorders (admission into an institution is covered under Hospital Benefits)
- Pathology and Radiology tests not included on the approved tariff list
- Ptosis
- Stimulation laxatives
- Infertility and sexual dysfunction (those procedures and interventions not covered under PMB)
- Funding of beds, mattresses (including pressure relieving mattress), pillows and overlays, back rests, chair seats, kneeler chairs and massage cushions.

Even though these costs are not covered by Universal Healthcare, you can still submit claims for these to Universal Healthcare, so that it can be processed for tax purposes.

## What are my dental benefits?

- Dental benefits are available from a contracted Universal Healthcare Network dentist only.
- The Universal Healthcare dental benefit covers basic dentistry only, and is subject to clinical protocols.
- Benefits are limited to primary extractions, fillings, scaling and polishing, as well as emergency pain relief.
- NEW! One pair of plastic dentures per beneficiary per three-year period.
- Root canal treatment, crowns and other advanced dentistry are not covered.

Please contact Universal Healthcare to confirm your dental benefits or find a dentist in your area.
**Telephone:** 0860 100 076
**Email:** network.accounts@omsmaf.co.za

## What cover do I have for optometry?

- Universal Healthcare will only provide cover at a network contracted optometrist and is subject to Universal Healthcare protocols. Qualifying norms for near and distance visions apply.
- The benefit covers one optical test per beneficiary, one pair of clear plastic, single or bi-focal lenses, in a standard frame, or contact lenses to the value of **R477**, not both. Subject to available benefits in the AFB.
- Universal Healthcare has ensured that you receive affordable access to optometry services within the Universal Healthcare provider network arrangement, without compromising on quality. This is to ensure that you do not experience any out-of-pocket expenses. However, should you wish to choose a

frame outside of the Universal standard range, you will have to pay the balance of the frame directly to the optometrist.

- Any additional services (such as tinting) are not covered under this benefit. You will have to pay for these services yourself.
- The optical benefit is available per beneficiary, every 24 months.
- Universal Healthcare does not require a clinical motivation for spectacles or contact lenses for young children.
- No benefit if a non-network provider is used.

Please contact Universal Healthcare to confirm your optometry benefits or find an optometrist in your area.
**Telephone:** 0860 100 076
**Email:** network.accounts@omsmaf.co.za

## What medicines can I get through Universal Healthcare?

Universal Healthcare has a Universal Healthcare Network Formulary, which contains a wide range of cost-effective medicine (mostly generics) that covers most ailments, both acute and chronic. This list excludes certain non-generic branded medicines. If you insist on these non-generic medicines, you will be responsible for the cost of such medicines.

To apply for chronic medicine benefits, members may call 0860 100 076 or complete a Universal Healthcare Chronic Medicine Application Form together with your Universal Healthcare Network doctor. If the medicine is approved by the Universal Healthcare Chronic Medicine Programme you will be contacted. As soon as the authorisation is completed, you will be informed via SMS. A Chronic Authorisation letter will also be mailed to you. The authorisation letter lists the chronic medicines that will be funded as chronic.

You may collect your medicine from a pharmacy on the Universal Healthcare Pharmacy Network or have it delivered to you by a courier pharmacy. Please ensure that your doctor provides you with a valid repeatable prescription for your chronic medicines. **If you move from any other benefit option to the Network** or **Network *SELECT* Plans, you will need to reapply for Chronic Medicine approval.**

## Where do I obtain my acute medication?

- Acute medication is medicines prescribed by GPs to treat common, acute illnesses such as influenza (flu). Acute medication is provided subject to the Universal Healthcare Network Formulary.
- Should you require acute medication, there are two ways in which you may receive the medication:
  - A Universal Healthcare Network dispensing GP will provide you with the medication from his consulting rooms, or
  - A non-dispensing Universal Healthcare Network GP will give you a prescription, which can be filled at any pharmacy on the Universal Healthcare Pharmacy Network.

- Ask your Universal Healthcare Network GP if he/she has scripted medicine according to the Universal Healthcare Network Formulary.
- You will be required to pay for medicines that are not on the acute formulary.

## What if I have a chronic condition?

- Please consult your Universal Healthcare Network GP to confirm your diagnosis.
- Once confirmed, your Universal Healthcare Network GP will complete a chronic medicine application form to register you for chronic benefits.
- This form will be forwarded to the Universal Healthcare Chronic Medicine Programme by your GP, for an evaluation.
- You will be notified via SMS as soon as the chronic application has been processed.
- Chronic benefits are subject to the **Network** and **Network *SELECT*** Plans' list of chronic conditions and the Universal Healthcare Network Formulary. All chronic medicines must be pre-authorised by the Universal Healthcare Chronic Medicine Programme.
- If you have any queries in this regard, please contact the Universal Healthcare Call Centre on 0860 100 076 or +27 11 208 1021, and follow the voice prompts for chronic medicines.

## What if I need chronic medication?

- Approved chronic medicines are obtainable from pharmacies on the Universal Healthcare Pharmacy Network.
- Most chronic medicines may only be collected once per month.
- It may also be necessary for you to visit your Universal Healthcare Network GP to renew your chronic prescription at least every 6 months.

## What about blood tests (pathology)?

- Basic blood tests are only covered if requested by your Universal Healthcare Network GP and if the required test is on the Universal Healthcare-approved tariff list.
- Your Universal Healthcare Network GP will have a list of these tests and will be able to advise you whether or not the required tests are covered by Universal Healthcare.
- Your Universal Healthcare Network GP may draw the specimen himself or he/she may complete the Universal Healthcare Network Pathology request form and send you to the closest pathology laboratory to have the tests done.
- Pathology tests are subject to your AFB.

## What if I need X-rays (radiology)?

- The Universal Healthcare Network benefits cover a list of X-rays that may be performed by a radiologist.
- Your Universal Healthcare Network GP will advise you whether or not the required X-ray is covered.

- Radiology tests are subject to your AFB.
- Your Universal Healthcare Network GP will complete the Universal Healthcare Network radiology request form for the radiologist, indicating the type of X-ray to be performed.
- Your GP will direct you to the closest Radiology practice to have the X-ray performed.

## Am I covered for pregnancy on the Network and Network SELECT Plans?

- Universal Healthcare benefits allow for visits to a Universal Healthcare Network GP for your pregnancy. The benefit also allows for two 2D scans per pregnancy.
- For more information on the Mother and Baby Care Programme please refer to page 104.

## What if I need to consult a specialist?

The **Network** and **Network *SELECT*** Plans allow out-of-hospital specialist consultations, subject to referral from a Universal Healthcare Network GP, limited to two consultations per beneficiary per benefit year and four consultations per family per benefit year.

## What if I require specialist services for any of the PMB conditions?

You should send an email to Universal Healthcare at pmb@omsmaf.co.za to find out what information is required to authorise specialist services for these conditions.

## What are clinical protocols and formularies?

Protocols are a set of clinical guidelines, while formularies refer to lists of medicines and/or tests that apply to certain benefits on the **Network** and **Network *SELECT*** Plans. Unless otherwise specified, benefits under the **Network** and **Network *SELECT*** Plans are generally unlimited, as long as they are medically necessary and within Universal Healthcare protocols and formularies and requested by your Universal Healthcare Network GP.

**Please note:** You should not receive any accounts for treatment and services received at a Universal Healthcare Network practice as these accounts are submitted directly to Universal Healthcare for payment. Should you receive any Universal Healthcare Network provider related accounts, please forward these to Universal Healthcare, PO Box 1411, Rivonia, 2128 or email claims@omsmaf.co.za.

## What should I know about Hospital Benefits that are not available under the Network and Network SELECT Plans?

No benefit is available under the **Network** and **Network *SELECT*** Plan for the following Hospital Benefits. See pages 75-95 for more information on hospital benefits that are and are not covered.

- Basic dentistry (in hospital)
- Advanced dentistry
- Removal of impacted wisdom teeth
- Orthognathic surgery
- Osseo-integrated implants
- Oral surgery not applicable to dental PMB
- Bariatric (obesity) surgery (including all related costs)
- Diagnostic Polysomnograms (whether in or out of hospital)
- Elective procedures such as hip, knee, shoulder and elbow replacements are not covered, other than in accordance with Prescribed Minimum Benefits. See page 110 for more information.

## You and your family are covered for the following day-to-day benefits:

| Primary Care Benefits | |
|---|---|
| **General Practitioners' Consultations** | ▸ Medically necessary consultations<br>▸ Basic Primary Care<br>▸ Pre- and Postnatal Care<br>▸ Supervision of uncomplicated pregnancy (see page 59 for more information)<br>▸ Specified Minor Trauma treatment |
| **Acute Medication** | As dispensed by a Universal Healthcare Network dispensing General Practitioner or a pharmacy on the Universal Healthcare Pharmacy Network according to the Universal Healthcare Network Formulary |
| **Chronic Medication** | Subject to registration and approval from the Universal Chronic Medicine Programme and according to the Universal Healthcare Network Formulary. Medication to be supplied by a pharmacy on the Universal Healthcare Pharmacy Network as arranged with the beneficiary or Supplier. |

| | |
|---|---|
| **Basic Dentistry** | Subject to Universal Healthcare Dentistry protocols, consultations, primary extractions, fillings, scaling and polishing and one pair of plastic dentures per beneficiary per three-year period. Dental network applies.<br>Dental benefits are available from a contracted Universal Healthcare Network dentist only.. |
| **Optical** | Subject to Universal Healthcare Optometry protocols and to be obtained from Universal Healthcare Network Optometry providers. Subject to the AFB limit.<br>▸ One optical test per beneficiary.<br>▸ One pair of clear plastic, single or bi-focal lenses, in a standard frame, or contact lenses to the value of R477, not both.<br>▸ The optical benefit is available per beneficiary per 24 months.<br>▸ Qualifying norms for near and distance visions apply.<br>No benefit if a non-network provider is used. |
| **Pathology** | Basic blood tests as requested by Universal Healthcare Network General Practitioner and subject to Universal Healthcare Network protocols and the AFB limit. |
| **Radiology** | Basic X-rays as requested by Universal Healthcare Network General Practitioner and subject to Universal Healthcare Network protocols, and to the AFB limit. |
| **Out of Network / Emergency Visits** | The reimbursement will be subject to Universal Healthcare protocols and limited to two visits per beneficiary per benefit year, subject to R1 110 per visit. Members are also allowed emergency room visits, subject to the out-of-network benefit, limited to two visits per beneficiary per benefit year. |

Out-of hospital **Annual Flexi Benefit (AFB)**, subject to **R5 100** per beneficiary per benefit year and **R8 500** per family per benefit year, covering the following benefits:

- Basic pathology
- Basic radiology
- Optometry
- Auxiliary services, subject to the following sub-limits: **R1 700** per beneficiary per benefit year and **R2 850** per family per benefit year.

## Savings Plan

Your Day-to-Day Benefits are funded from your PMSA, to which you contribute a fixed percentage of your total monthly contributions. It can be used to cover day-to-day expenses as well as any co-payments or shortfalls, except for those relating to PMB.

### The following services are covered at cost from your PMSA or accumulated savings, subject to available funds:

- GP and specialist consultations
- Pathology
- Radiology
- Acute medicine, paid at 100% of cost or Medicine Price, whichever is the lesser (refer to page 56 for more information).
- Dentistry – including inlays, crowns, bridges, mounted study models, metal base to partial dentures, treatment of periodontitis, prosthodontists and dental technicians
- Optometry – including eye test, spectacles, contact lenses, fitting consultations and solutions for contact lenses
- Psychology and psychiatry
- Physiotherapy
- Auxiliary services (refer to the Explanation of Terms for a list of services)
- Specified procedures in doctors' rooms (If you have depleted your PMSA limit, these can be covered by your Hospital Benefits limit, subject to pre-authorisation and approval. Please see page 79 for more information.)

### Annual amount available in PMSA up to a maximum of three child dependants

| Income band | Member | Adult | Child (max 3) |
|---|---|---|---|
| R0 - R5 040 | R3 312 | R2 784 | R552 |
| R5 041 - R7 560 | R4 284 | R2 820 | R696 |
| R7 561 - R10 090 | R4 428 | R2 940 | R720 |
| R10 091 - R13 470 | R4 800 | R4 080 | R1 260 |
| R13 471+ | R5 028 | R4 272 | R1 332 |

## Traditional and Traditional *SELECT* Plans

### Your Day-to-Day Benefits consist of:

Your Personal Medical Savings Account (PMSA), to which you contribute a fixed percentage (see page 115) of your total monthly contributions. **Your day-to-day expenses are first paid from your PMSA**, up to the actual cost. Once your PMSA has been depleted, the benefits listed below are payable from your Primary Care Benefit. Accumulated savings can also be used to cover exclusions, co-payments or shortfalls, except for those relating to PMB.

**PLUS**

The **Primary Care Benefit**, which covers comprehensive primary care after your PMSA has been depleted, up to an annual sub-limit. Services are covered at 1 x MSR or cost, whichever is the lesser.

### What is covered under Day-to-Day Benefits?

There is an overall annual limit for day-to-day services. The following standard tests and services are covered under Day-to-Day Benefits:

- GP and specialist consultations
- Specified procedures in general practitioners' and specialists' rooms
- Pathology
- Radiology

- Acute medicine paid at 100% of MMAP or medicine price, whichever is the lesser. (refer to page 56 for more information).
- Pharmacy-Advised Therapy (PAT)
- Basic and advanced dentistry – including inlays, crowns, bridges, mounted study models, metal base to partial dentures, treatment of periodontitis, prosthodontists' and dental technicians' fees, including dental implants if not approved. Orthodontic treatment for beneficiaries up to the age of 21 will be covered.

- Psychology
- Physiotherapy
- Auxiliary services (please refer to the Explanation of Terms for a list of services)
- Optometry (including eye test, spectacles, frames, contact lenses, readers, fitting consultations for contact lenses and solutions).

## You and your family have the following healthcare spend available:

The overall annual amounts available depend on your family size. To calculate the overall amounts available for you and your family for the benefit year, simply select the appropriate income band and add the limits in the relevant columns, e.g. member + adult + child + child.

**Traditional Plan**

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | Annual PMSA | R3 528 | R2 676 | R852 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R7 778** | **R6 286** | **R2 132** |
| R5 041 - R7 560 | Annual PMSA | R4 260 | R2 820 | R972 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 510** | **R6 430** | **R2 252** |
| R7 561 - R10 090 | Annual PMSA | R4 464 | R2 976 | R1 008 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 714** | **R6 586** | **R2 288** |
| R10 091+ | Annual PMSA | R5 220 | R4 296 | R1 620 |
| | | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R9 470** | **R7 906** | **R2 900** |

**Traditional *SELECT* Plan**

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R5 040 | Annual PMSA | R3 180 | R2 412 | R768 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R7 430** | **R6 022** | **R2 048** |
| R5 041 - R7 560 | Annual PMSA | R3 840 | R2 544 | R876 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 090** | **R6 154** | **R2 156** |
| R7 561 - R10 090 | Annual PMSA | R4 020 | R2 688 | R900 |
| | Annual PCB limit | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 270** | **R6 298** | **R2 180** |
| R10 091+ | Annual PMSA | R4 704 | R3 876 | R1 464 |
| | | R4 250 | R3 610 | R1 280 |
| | **Overall Day-to-Day limit** | **R8 954** | **R7 486** | **R2 744** |

## You and your family are covered as shown below.

**Please note that all claims will first be paid from your Personal Medical Savings Account (PMSA), then from PCB.**

| Day-to-day medical expense | How the PMSA covers the expense | How the PCB then covers the expense | After the PCB limit has been reached |
|---|---|---|---|
| **General practitioners' and specialists' visits and consultations out of hospital** | At 100% of cost, subject to available funds in your PMSA, until your annual PMSA allocation is reached. | At 1 x MSR, up to the overall PCB limit. | Amounts above the PCB limit can be paid from accumulated savings, if there are any available (in other words, if any savings rolled over from the prior benefit year/s). |
| **Specified procedures in general practitioners' and specialists' rooms** | | | |
| **Dentistry** | | | |
| **Pathology** | | | |
| **Radiology** | At 100% of cost, subject to available funds in your PMSA, until your annual PMSA allocation is reached. | At 1 x MSR, up to the overall PCB limit. | Amounts above the PCB limit can be paid from accumulated savings, if there are any available (in other words, if any savings rolled over from the prior benefit year/s).<br><br>Lenses tinted in excess of 35% will only be covered from accumulated savings. |
| **Psychology** | | | |
| **Auxiliary services** (Please refer to the Explanation of Terms on page 146 for a full list of these services.) | | | |
| **Physiotherapy** | | | |
| **Optical Benefits:** Eye tests, spectacles, frames, contact lenses and readers (including fitting consultation for contact lenses and solutions) | | | |
| **Prescribed (acute) medicines** (see page 56) | At 100% of MMAP or medicine price, whichever is the lesser, subject to available funds in your PMSA, until your annual PMSA allocation is reached.<br>Medicine exclusion list may apply. | 100% of MMAP or medicine price, whichever is the lesser, up to the overall PCB limit.<br>Medicine exclusion list may apply. | Amounts above these limits can be paid from accumulated savings, if there are any available. |
| **Pharmacy-Advised Therapy (PAT)** (medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist, for the treatment of minor ailments) | | | |

## Traditional Plus and Traditional Plus *SELECT* Plans

### Your Day-to-Day Benefits consist of:

Your Personal Medical Savings Account (PMSA), to which you contribute a fixed percentage (see page 115) of your total monthly contributions. **Your day-to-day expenses are first paid from your PMSA**, up to the actual cost. Once your PMSA has been depleted, the benefits listed below are payable from your Primary Care Benefit. Accumulated savings can also be used to cover exclusions, co-payments or shortfalls, except for those relating to PMB.

**PLUS**

**The Primary Care Benefit**, which covers comprehensive primary care after your PMSA has been depleted, up to an annual sub-limit. Services are covered at 3 x MSR or cost, whichever is the lesser.

### What is covered under Day-to-Day Benefits?

There is an overall annual limit for day-to-day services. The following standard tests and services are covered under Day-to-Day Benefits:

- GP and specialist consultations
- Specified procedures in general practitioners' and specialists' rooms
- Pathology
- Radiology
- Acute medicine paid at medicine price (refer to page 56 for more information).
- Pharmacy-Advised Therapy (PAT)
- Dentistry – including inlays, crowns, bridges, mounted study models, metal base to partial dentures, treatment of periodontitis, prosthodontists' and dental technicians' fees, including dental implants if not approved. Orthodontic treatment for beneficiaries up to the age of 21 will be covered.
- Psychology
- Physiotherapy
- Auxiliary services (please refer to the Explanation of Terms for a list of services)
- Optometry (including eye test, spectacles, frames, contact lenses, readers, fitting consultations for contact lenses and solutions).

### You and your family have the following healthcare spend available:

The overall annual amounts available depend on your family size. To calculate the overall amounts available for you and your family for the benefit year, simply select the appropriate income band and add the limits in the relevant columns, e.g. member + adult + child + child.

**Traditional Plus Plan**

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R7 560 | Annual PMSA | R6 696 | R5 496 | R2 088 |
| | Annual PCB limit | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R15 196** | **R12 296** | **R4 228** |
| R7 561+ | Annual PMSA | R7 752 | R6 360 | R2 412 |
| | | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R16 252** | **R13 160** | **R4 552** |

**Traditional Plus *SELECT* Plan**

| Income band | | Member | Adult | Child (max 3) |
|---|---|---|---|---|
| R0 - R7 560 | Annual PMSA | R5 940 | R4 872 | R1 848 |
| | Annual PCB limit | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R14 440** | **R11 672** | **R3 988** |
| R7 561+ | Annual PMSA | R6 876 | R5 628 | R2 136 |
| | | R8 500 | R6 800 | R2 140 |
| | **Overall Day-to-Day limit** | **R15 376** | **R12 428** | **R4 276** |

## You and your family are covered as shown below.

**Please note that all claims will first be paid from your Personal Medical Savings Account (PMSA), then from PCB.**

| Day-to-day medical expense | How the PMSA covers the expense | How the PCB then covers the expense | After the PCB limit has been reached |
|---|---|---|---|
| **General practitioners' and specialists' visits and consultations out of hospital** | At 100% of cost, subject to available funds in your PMSA, until your annual PMSA allocation is reached. | At 3 x MSR, up to the overall PCB limit. | Amounts above the PCB limit can be paid from accumulated savings, if there are any available (in other words, if any savings rolled over from the prior benefit year/s). |
| **Specified procedures in general practitioners' and specialists' rooms** | | | |
| **Dentistry** | | | |
| **Pathology** | | | |
| **Radiology** | | | |

| | | | |
|---|---|---|---|
| **Psychology** | At 100% of cost, subject to available funds in your PMSA, until your annual PMSA allocation is reached. | At 3 x MSR, up to the overall PCB limit. | Amounts above the PCB limit can be paid from accumulated savings, if there are any available (in other words, if any savings rolled over from the prior benefit year/s).<br><br>Lenses tinted in excess of 35% will only be covered from accumulated savings. |
| **Auxiliary services** (Please refer to the Explanation of Terms on page 146 for a full list of these services.) | | | |
| **Physiotherapy** | | | |
| **Optical Benefits:** Eye tests, spectacles, frames, contact lenses and readers (including fitting consultation for contact lenses and solutions) | | | |
| **Prescribed (acute) medicines** (see page 56) | At 100% of MMAP or medicine price, whichever is the lesser, subject to available funds, until your annual PMSA allocation is reached.<br>Medicine exclusion list may apply. | 100% of MMAP or medicine price, whichever is the lesser, up to the overall PCB limit.<br>Medicine exclusion list may apply. | Amounts above these limits can be paid from accumulated savings, if there are any available. |
| **Pharmacy-Advised Therapy (PAT)** (medicines supplied by a registered pharmacist without a prescription from a medical practitioner or dentist, for the treatment of minor ailments) | | | |

## What should I know about acute medicine?

### Restricted prescriptions

This information relates to prescribed (acute) medicines, including Pharmacy-Advised Therapy (excluding the administration fee). The funding of compound analgesics e.g. Stilpane® and Syndol® will be restricted to a limited supply of 150 tablets or capsules per beneficiary per benefit year. Ibuprofen combination products e.g. Myprodol® will be restricted to 200 tablets or capsules per beneficiary per benefit year. Prescriptions for compound analgesics, anxiolytics and sleeping tablets are limited to 4 prescriptions per beneficiary per benefit year.

If your condition requires medicine (as listed above) in excess of this limit, you can call the OMSMAF Contact Centre on 0860 100 076. Verbal motivation from medical professionals will be considered.

## Oncology medicine

If you are diagnosed with cancer, please see additional information on acute medicine under the Oncology Benefit Management Programme on page 97.

## Medicine Exclusion List (MEL)

The Fund makes use of a Medicine Exclusion List (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.

## Maximum Medical Aid Price (MMAP)

The Maximum Medical Aid Price (MMAP) is a reference pricing system that benchmarks the price of a type or group of similar products. This benchmark price limits the amount that will be paid by the Fund for this type or group of medicine. It often applies to a medicine that has one or more generic equivalents that can be considered in its place.

MMAP is used, together with formularies and authorisation, to manage medicine costs, encourage you to be aware of the costs, to make use of generics and to make sure you get the maximum use out of your acute and chronic medicine benefit limits. The reference pricing system does not restrict your choice of medicines as there are always alternatives available that will not cost you more.

It is important to note that Fund rules, such as formularies, are still applicable to medicine listed in an MMAP group. For example, if you currently have an out-of-formulary co-payment on your medicine, you may still have an out-of-formulary co-payment and the MMAP co-payment. If you change to the alternative, you may continue to have an out-of-formulary co-payment but will not have an MMAP co-payment (see the diagram on page 68 for more information).

To avoid unnecessary co-payments, ask your doctor and pharmacist to prescribe and dispense medicines that are fully reimbursed within the MMAP.

For more information on MMAP or MEL please visit omsmaf.co.za.

4

# SUPPLEMENTARY BENEFITS

(These benefits differ across Plans.)

## IN THIS SECTION



## What are Supplementary Benefits?

On most commercial 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 all the following 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 1 x 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 **Network** (including ***SELECT***) or **Hospital** Plan, you will not have additional benefits, but you will receive educational support and relevant contact information. (See page 104 for more information.)<br>**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** |
| Antenatal classes | **Educational and support services and antenatal classes by a registered midwife, subject to the following limits per Plan:**<br>**Network** (including ***SELECT***) and **Hospital** **P**lans: No benefit.<br>**Savings** Plan: **R1 280** per family per benefit year.<br>**Traditional** and **Traditional Plus** (including S***ELECT***) Plans: **R2 010** per family per benefit year. |
| Antenatal visits | **Hospital** Plan: No benefit.<br>**Network** (including ***SELECT***) Plan: May visit a Universal Healthcare Network GP for the management of their pregnancy. The Universal Healthcare Network GP may refer the patient to an Obstetrician for further management in the event of a high risk pregnancy and this will be subject to pre-authorisation. PMBs only. Telephone: 0860 100 076<br>**Savings** Plan: **R3 020** per pregnancy.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R5 030** per pregnancy. |
| Ultrasound scans (pregnancy) | **Hospital** Plan: No benefit.<br>**Network** (including ***SELECT***) Plan: Two 2D scans per pregnancy, if done, or referred by a Universal Healthcare Network GP.<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: Two 2D scans per beneficiary. |

| | |
|---|---|
| Out-of-hospital pathology tests (pregnancy) | **Hospital** Plan: No benefit.<br>**Network** (including ***SELECT***) Plan: Basic blood tests, if requested by Universal Healthcare Network GP and on the approved tariff list.<br>**Savings** Plan: **R2 490** per family per benefit year.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R3 110** per family per benefit year.<br>This benefit is dependent on the patient registering on the Mother and Baby Care Programme.<br>Beneficiaries who register on the programme will receive a list of pathology tests that are covered under this benefit.<br>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.<br>You can assist the Fund by doing the following when blood tests are required:<br>▸ 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.<br>▸ Ask your doctor about the cost of the tests you are due to have done.<br>▸ Ask your doctor if he/she can recommend a supplier who charges reduced rates.<br>▸ Ensure that the doctor uses the correct ICD-10 code so that the claim comes off the correct benefit. |
| Antenatal vitamins | **Network** (including ***SELECT***) and **Hospital** Plans: No benefit.<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: 100% of MAPP or Medicine Price, whichever is the lesser, subject to prescription and Formulary.<br>Beneficiaries who register on the programme will receive a list of antenatal vitamins that are covered under this benefit. |
| **Ultrasound scans**<br>In and out of hospital – combined benefit limit | **(All scans other than for pregnancy.)**<br>**1 x MSR or cost, whichever is the lesser,** subject to the following sub-limits per Plan per benefit year:<br>**Network** (including ***SELECT***), **Hospital** and **Savings** Plans: **R4 790** per family per benefit year.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R7 140** per family per benefit year. |

| | |
|---|---|
| **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. | **1 x 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 86, 'Specialised Radiology in hospital'.<br>**Network** (including ***SELECT***), **Hospital** and **Savings** Plans: **R14 100** per family per benefit year, with a co-payment of **R1 500** per authorisation.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R17 400** per family per benefit year, with a co-payment of **R1 500** per authorisation.<br>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.<br>**Network** (including ***SELECT***) and **Hospital** Plans: No benefit.<br>**Savings** Plan: PMSA, subject to available funds.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R14 500** per family per benefit year.<br>All other associated costs, i.e. anaesthetic fees and hospitalisation, will not accumulate to this limit, and are subject to the Hospital Benefit at 1 x MSR.<br>A **R1 500** co-payment will apply for all non-PMB dental admissions to hospital.<br>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. |
| **Medical Appliances** (External)* (e.g. wheelchair, crutches, baumanometer, as well as CPAP machines subject to managed care protocols)<br><br>plus<br><br>Foot Orthotics | **1 x 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.<br>**Limits per Plan per benefit year:**<br>**Network** (including ***SELECT***) and **Hospital** Plans: No benefit, unless a PMB.<br>**Savings**: PMSA, subject to available funds.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: Sub-limit of **R9 660** per family per benefit year.<br>Repairs are subject to approval and service rendered by an accredited supplier. If not approved, the benefit will be paid from available PMSA.<br>Foot orthotics: **R4 360** per family per benefit year on **Traditional** and **Traditional Plus** (including ***SELECT***) Plans, subject to the overall Medical Appliances benefit. |

| | |
|---|---|
| **Hearing Aids*** | 1 x MSR or cost, whichever is the lesser.<br>**Sub-limits per Plan per benefit year:**<br>**Network** (including ***SELECT***) and **Hospital** Plans: No benefit.<br>**Savings** Plan: PMSA, subject to available funds.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R17 200** per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for beneficiaries under age 7, and every 5 years for beneficiaries older than 7 years.<br>This benefit excludes consultations and associated tests.<br>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.<br>Repairs are subject to approval and service rendered by an accredited supplier. |
| **Refractive Procedures*** (including all related costs) | Subject to pre-authorisation.<br>**Network** (including ***SELECT***) and **Hospital** Plans: PMB only.<br>**Savings** Plan: Subject to PMSA<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: 1 x MSR or cost, whichever is the lesser, up to a sub-limit of **R15 300** per beneficiary per benefit year. 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 approve benefit. |
| **Mental Health Programme*** | Limited to **R10 500** per beneficiary, subject to pre-authorisation and relevant managed healthcare protocols. Please see page 102 for more information. |
| **Back and Neck Rehabilitation Programme*** | Please see page 96 for more information on this programme. |

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

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# WELLNESS BENEFITS

(These benefits are essentially the same across all 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 Wellness Benefits help me?

These preventative benefits are available on all Plans and consists of two types of Wellness Benefits: a Pharmacy Wellness 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 as well as the correct Designated Service Provider.

The aim of this benefit is to encourage members 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 Wellness Benefit?

The Pharmacy Wellness Benefit gives you access to Clicks, Dis-Chem and Pick n Pay pharmacy clinics, where a qualified nurse will assess your current state of health and give you advice as well as tools on how to improve your health. Please note that you will be covered for one visit per beneficiary per benefit

## Pharmacy-based

**VACCINES**
Pneumococcal Vaccine
*(1 per lifetime)*
Flu Vaccine

**CONTRACEPTIVES**
*Limited amount*

**BODY MASS INDEX**

**BLOOD PRESSURE**

**BLOOD TESTS**
Cholesterol
Blood glucose
HIV

## Non-pharmacy-based

**BABYLINE**
Paediatric telephone service

**HEARING SCREENING**
*<6 weeks*

**HEALTH RISK ASSESSMENT**
*by registered healthcare practitioner*

**CANCER SCREENING:**

**MAMMOGRAM**

**PAP SMEAR**

**COLORECTAL SCREENING**

**PROSTATE SPECIFIC ANTIGEN**

year and that **these benefits are only redeemable from your Wellness Benefits if obtained from one of the listed pharmacy clinics.**

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

- **Blood pressure** - Limited to 1 test per beneficiary per benefit year.
- **Blood glucose** – Limited to 1 test per beneficiary per benefit year.
- **Cholesterol** – Limited to 1 test per beneficiary per benefit year.
- **HIV/ Aids Test** – Limited to 1 test per beneficiary per benefit year.
- **Body Mass Index** (BMI) - Limited to 1 test per beneficiary per benefit year.
- **Flu vaccine** – Limited to 1 vaccination per beneficiary per benefit year. (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.)
- **Contraceptives – R2 990** per beneficiary per benefit year. **R1 880** sub-limit for oral contraceptives. (Products must be prescribed 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, Gynaecologist or Urologist (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.

**TIP:** Discuss your contraceptive options with your healthcare provider when you have your papsmear.

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 Clicks, Dis-Chem or Pick n Pay Pharmacy clinic to make an appointment. Members may request a list of pharmacy clinics by emailing network.accounts@omsmaf.co.za.

If you wish to visit a Clicks pharmacy clinic to make use of this benefit, always present your OMSMAF membership card, which enables the Fund to obtain your results efficiently and pay for your visit.

## What is available under the non-pharmacy Wellness Benefit?

Other wellness benefits available outside a pharmacy are the following:

- **Pap smear** – limited to 1 test per female beneficiary per benefit year, 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 per benefit year, 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 Wellness benefit.)
- **Prostate Specific Antigen** – limited to 1 test per male beneficiary per benefit year, including consultation with General Practitioner or Urologist.
- **Colorectal screening** – limited to 1 test per beneficiary per benefit year.
- **Health Risk assessment** – limited to 1 test per beneficiary per benefit year. Only for services rendered by a registered healthcare practitioner (for example, a General Practitioner).
- **Audiology screening** – Limited to one 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.

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

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# CHRONIC BENEFITS

(These benefits may differ across Plans.)

## IN THIS SECTION



## What is a chronic condition?

A chronic condition is a condition that requires on-going 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 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 non-PMB chronic conditions, depending on the Plan you have selected. Please see page 69-70 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 Maximum Medical Aid Price (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 that provide cover for the listed chronic conditions.
- **The Universal Healthcare Comprehensive Formulary**, applicable to the **Traditional** and **Traditional Plus** (including ***SELECT***) Plans, provides access to a wider range of medicines than the Universal Healthcare Restrictive Formulary.

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. Any products that are removed from the Formulary will be communicated to you during the 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 100% of the actual medicine price or the Maximum Medical Aid Price (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. You will be made aware of changes to the MMAP groups a month before it takes effect to give you an opportunity to change to an alternative medicine that does not attract an MMAP co-payment.

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.

## MMAP co-payments

An 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 Maximum Medical Aid Price instead of choosing an alternative from the list, e.g. an appropriate generic equivalent.

### Out-of-formulary co-payments

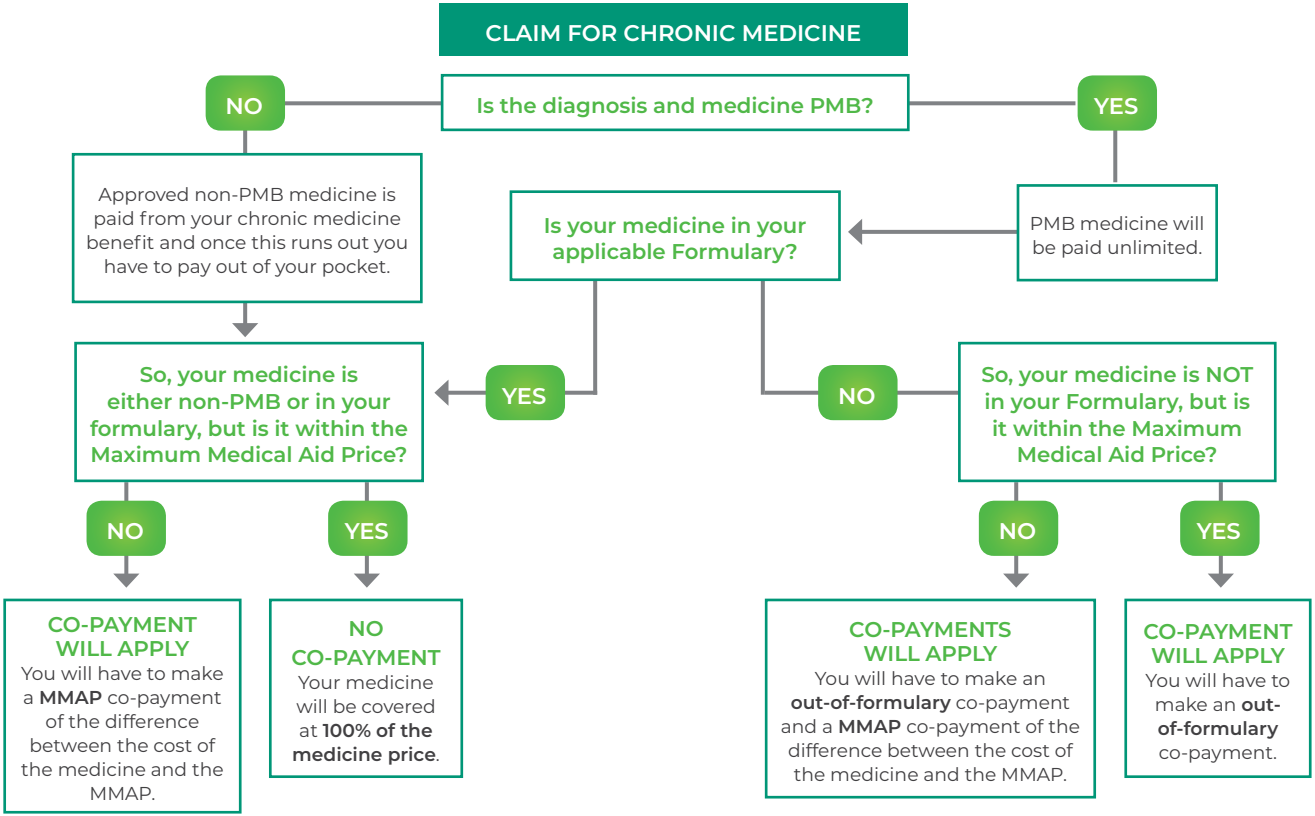
These co-payments will be payable whenever you claim for chronic medicine that is not in your Plan Formulary.

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 – see page 74.

## 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 or 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 |
| --- |
| 100% of MMAP or the Medicine Price, whichever is the lesser, for medicine prescribed in respect of Prescribed Minimum Benefit 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** and **Traditional Plus** (including ***SELECT***) 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 Chronic Diseases

In addition to the chronic diseases covered as Prescribed Minimum Benefits, the Fund offers cover for certain additional conditions and up to different limit amounts, depending on the Plan you are on.

| Hospital Plan | Network Plan<br>Network *SELECT* Plan* | Savings Plan | Traditional Plan<br>Traditional *SELECT* Plan* | Traditional Plus Plan<br>Traditional Plus SELECT Plan* |
|---|---|---|---|---|
| **R5 030 per family per benefit year** | | **R5 030 per family per benefit year** | **R12 200 per family per benefit year** | **R14 600 per family per benefit year** |
| ▸ Chronic Hepatitis<br>▸ Depression<br>▸ Macular Degeneration and Oedema<br>▸ Anxiety<br>▸ Post-Traumatic Stress Disorder | **The following non-PMB chronic conditions are covered by Universal Healthcare. Registration and approval required and medicine subject to the Universal Healthcare Network Formulary:**<br>▸ Acne<br>▸ Allergic rhinitis<br>▸ Cardiac Arrhythmia<br>▸ Depression<br>▸ Gout<br>▸ Female Hormone Replacement Therapy<br>▸ Migraine<br>▸ Osteoarthritis<br>**In addition, the Fund offers cover for:**<br>▸ Chronic Hepatitis<br>▸ Macular Degeneration and Oedema<br>▸ Anxiety<br>▸ Post-Traumatic Stress Disorder | ▸ Chronic Hepatitis<br>▸ Depression<br>▸ Macular Degeneration and Oedema<br>▸ Anxiety<br>▸ Post-Traumatic Stress Disorder | **The following conditions are subject to the non-PMB Chronic Medicine Benefit limit:**<br>**SUBJECT TO LIMIT ONLY**<br>▸ Acne (cystic nodular)<br>▸ Allergic rhinitis (if beneficiary has asthma or is under 12 years)<br>▸ Alzheimer's disease<br>▸ Anxiety<br>▸ Attention deficit hyperactivity disorder (ADHD)<br>▸ Chronic Hepatitis<br>▸ Depression<br>▸ GORD (if linked to one of the following PMB conditions: asthma, Crohn's Disease, rheumatoid arthritis or ulcerative colitis)<br>**UNLIMITED ONCE NON-PMB CHRONIC MEDICINE LIMIT EXCEEDED**<br>▸ Cushing's disease<br>▸ Cystic fibrosis<br>▸ Deep vein thrombosis<br>▸ Hormone replacement therapy | ▸ Gout<br>▸ Hyperfunction of pituitary gland<br>▸ Hyperthyroidism (thyrotoxicosis)<br>▸ Hypofunction of pituitary gland<br>▸ Hypoparathyroidism<br>▸ Macular degeneration and oedema<br>▸ Migraine (prophylactics therapy)<br>▸ Myasthenia gravis and myoneural disorders<br>▸ Osteoarthritis<br>▸ Osteoporosis<br>▸ Post-Traumatic Stress Disorder<br>▸ Psoriasis |

| | |
|---|---|
| **Specialised drugs for non-Oncology**<br>(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 arthtritis, 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 omsmaf.co.za (effective 1 July 2019). | **Network** (including ***SELECT***) and **Hospital** Plans: PMB only (only Multiple Sclerosis is covered)<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **100% of MMAP or Medicine Price, whichever is the lesser, limited to R194 000** per beneficiary per benefit year, included in the overall annual limit.<br>**Subject to the relevant managed healthcare programme and to pre-authorisation.** |
| **Drugs for the treatment of MDR and XDR-TB** | **100% of MMAP or Medicine Price, whichever is the lesser**, subject to the relevant managed healthcare programme and pre-authorisation. |
| **Drugs applicable for treatment of Macular degeneration and oedema** | **Network** (including ***SELECT***) and **Hospital** Plans: PMB only<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **100% of MMAP or Medicine Price, whichever is the lesser, limited to R61 900** per beneficiary per benefit year and included in the specialised drugs for non-oncology benefit.<br>Subject to approval and pre-authorisation by the managed healthcare programme. |

## How do I apply for the Chronic Medicine Benefit?

If your doctor has diagnosed you with a chronic condition, your doctor should apply for chronic benefits for you.

The doctor will complete a Chronic medicine application form with you.

The completed application form and/or a copy of your recent prescription may be faxed or emailed to the Chronic Medicine Programme. Alternatively your doctor may call the Chronic Medicine Programme directly to register your chronic condition.

The request for chronic medicine will be reviewed by the Chronic Medicine Programme.

Clinical Entry Criteria will be applied as your application must meet certain clinical criteria before benefits will be authorised.

Your doctor will also provide information on clinical examination information and test results e.g. blood pressure readings, lipogram test results, or glucose results etc.

Cover will be provided for medicines on the chronic formulary, where the entry criteria have been met. Chronic medicines will be approved from the date that your application is received, provided it is fully completed and includes all supporting documentation.

If necessary, the Chronic Medicine Programme will contact your doctor for information regarding your application and/or request your doctor to prescribe formulary medication.

The outcome of your application will be communicated to you. If approved you will be mailed an Authorisation letter that lists the medicines that will be funded as chronic. You will also be sent an SMS to notify you when your chronic medicine application has been finalised.

When the authorisation has been finalised, you may obtain your chronic medicines from a pharmacy on the Universal Healthcare Pharmacy Network or have it delivered to you by a Courier pharmacy. Please ensure your doctor provides you with a valid repeatable prescription for your chronic medicine. **If you move from any other benefit option to another Plan, you will need to reapply for Chronic Medicine approval.**

## What if I need non-PMB chronic medicine?

If you are on the **Traditional** and **Traditional Plus** (including ***SELECT***) Plans, you have chronic medicine benefit cover for all the chronic diseases listed on page 70 subject to the annual sub-limit. You can apply to use this benefit as indicated on the following pages.

On the **Hospital** and **Savings** Plans there is a limit applicable for Chronic Hepatitis, Depression, Macular degeneration and oedema, Anxiety and Post-Traumatic Stress Disorder only. Once this limit is exceeded medication for these diseases will be funded from available funds in you PMSA, if relevant. Both these Plans also provide cover for the PMB Chronic Disease list (CDL) listed on page 69.

If you are on the **Network** or **Network *SELECT*** Plan, you will have cover for non-PMB chronic medicines benefit for the conditions listed on page 70. Benefit is subject to registration and approval as for the other chronic conditions.

## After I am diagnosed with a chronic condition, what do I do?

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 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 omsmaf.co.za.

## How do I update my chronic treatment 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 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 your Preferred Provider. An 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 Medical Management Care 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 non-PMB 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.

You must still make use of your Preferred Provider, as stipulated by the Fund, to avoid co-payments. If you are forced to use the services of a non-Preferred Provider, your doctor must submit a written motivation giving reasons why a Preferred Provider, could not be accessed. This motivation will be reviewed and if approved, you will be reimbursed according to the Fund Rules.

## 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 can be obtained by contacting the Universal Healthcare contact centre on 0860 100 076.

### Contact details for Chronic Medicine Management

| | |
|---|---|
| Telephone: | 0860 100 076 (Members)<br>0860 100 076 (Doctors & pharmacists) |
| Fax: | 0864 613 913 (Members)<br>0864 647 808 (Doctors & pharmacists) |
| Email: | chronic@omsmaf.co.za |
| Business hours: | Monday - Friday, 08:00 – 17:00 |

7

# 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.

## What cover is available for Hospital Benefits?

All members are covered for Hospital Benefits, no matter which Plan they belong to, except for those services that are specifically excluded (see pages 135-138).

There is no overall annual limit on the Hospital Benefits cover you receive for the **Traditional** and **Traditional Plus** (including ***SELECT***) Plans.

The following Overall Annual Limits (OAL) apply:

- **Savings Plan:** R750 000 per beneficiary per benefit year and R1 500 000 per family per benefit year
- **Hospital Plan:** R500 000 per beneficiary per benefit year and R1 000 000 per family per benefit year
- **Network and Network *SELECT* Plans:** R500 000 per beneficiary per benefit year and R1 000 000 per family per benefit year

There are sub-limits for certain services and it is important to understand the level of benefits under each sub-limit, as claims will be paid up to the available sub-limits only. (Refer to pages 82-95 for more information.)

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 if I want to fund my hospitalisation costs from my Gap insurance, etc.?

All hospital-related claims are covered at Medical Scheme Rates. If there is a short payment (difference) on your hospital-related claims and you are on the **Savings**, **Traditional**, **Traditional *SELECT***, **Traditional Plus** or **Traditional Plus *SELECT*** Plan, the difference will automatically be funded from your available funds in your Personal Medical Savings Account (PMSA).

However, some members take out private medical insurance, also known as Gap cover, to supplement their existing medical aid benefits. Gap cover usually helps to cover out-of-pocket expenses such as co-payments. If you fall in this category and wish to make use of this cover instead, rather than your PMSA, please email your claim details to reservesavings@omsmaf.co.za.

## 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 (see back of this guide). See page 22 for more information.

## 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 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.

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.

**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.

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 fax 0862 957 355, 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.

**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.

## 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.

In the case of a major hospitalisation event, a Case Manager from Hospital Benefit Management will monitor the patient's progress, including 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.**

**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 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.

### What about procedures in general practitioners' and specialists' rooms?

If you have obtained a pre-authorisation number, certain procedures that are undertaken in doctors' rooms will be funded from your Hospital Benefits at 100% of MSR or cost, whichever is the lesser, subject to Managed Care protocols. These include, but are not limited to, the following:

**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.

- 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 GI endoscopy
- Vasectomy
- 0307 Excision and repair
- 0255 Drainage of subcutaneous abscess & avulsion of nail
- 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 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.
- 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 preauthorisation, do a laparoscopic appendectomy and laparoscopic ovarian cystectomy. These procedures, as well as the full theatre

**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.

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 do I need to know about pathology?

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.
- Ask your doctor if he/she can recommend a supplier who charges reduced rates.
- Ensure that the doctor uses the correct ICD-10 code so that the claim comes off the correct benefit.

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

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

The DSPs are ICPS (Improved Clinical Pathway Services) and Jointcare, two groups 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

**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.

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 admin staff at the practice. This will ensure payment in full, with no co-payment for the procedure.

To alleviate the admin 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 services and procedures are covered during hospitalisation?

The following services and procedures are covered at 1 x 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.

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.

**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 100% of MSR or cost, whichever is the lesser.** | |
| **OVERALL ANNUAL LIMIT:** | **Network** and **Hospital** Plans: **R500 000** per beneficiary per benefit year and **R1 000 000** per family per benefit year.<br>**Savings** Plan: **R750 000** per beneficiary per benefit year and **R1 500 000** per family per benefit year.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: Unlimited. |
| **Prescribed Minimum Benefits (PMBs)*** | **100% of cost** for services received in accordance with State hospital level of care. Refer to pages 110-114 for more information on PMBs. |
| **1. Hospital Services***<br><br>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, 1 x MSR** in respect of the following:<br>▸ Wards - unless otherwise specified, general ward on all options*<br>▸ Intensive and high care units*<br>▸ Surgical and theatre fees*<br>▸ Labour and recovery wards*<br>▸ Hospital procedures*<br>Private wards are paid at general ward rates unless pre-authorised and subject to clinical protocols.<br>**Co-payments may apply to certain procedures – please refer to page 35 for details about co-payments payable.**<br>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. |

**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 |
|---|---|
| **2. Maternity Benefits*** | All pregnant beneficiaries have to register on the Mother and Baby Care Programme. |
| Confinement **in hospital**<br>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. | **1 x MSR or cost, whichever is the lesser,** in respect of the following, subject to the overall annual limit:<br>▸ Medical practitioner services whilst hospitalised.<br>▸ Theatre and recovery rooms.<br>▸ Normal delivery limited based on protocols.<br>▸ Caesarean delivery limited based on protocols.<br>▸ Material used in hospital.<br>▸ 100% of the Medicine Price for medicines.<br>▸ Medicine taken on discharge from hospital, limited to **R540**. |
| Confinement in **a registered birthing unit** | **100% of the Society for Private Nurse Practitioners of South Africa (SPNP) rate (for midwife or home delivery).**<br>**Midwife must be registered with the BHF and the Nursing Council.**<br>**Limited to and including the following Maternity Benefits:**<br>▸ Delivery by a midwife;<br>▸ Hire of water bath included in Maternity Benefit;<br>▸ 4 Post-natal midwife consultations per event if a gynaecologist is not used. |
| Confinement **out of hospital** | **100% of negotiated fee, 100% of 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.**<br>**Limited to and included in the Maternity Benefit:**<br>▸ Hire of water bath and oxygen cylinder included in the Maternity Benefit.<br>▸ 4 Post-natal midwife consultations per event if a gynaecologist is not used. |

**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 |
|---|---|
| **3. Medical Services** | **1 x MSR or cost, whichever is the lesser**, in respect of the following:<br>▸ Surgery and medical procedures that require hospitalisation.<br>▸ Anaesthetics.<br>▸ Perfusion services.<br>▸ Pathology during hospitalisation.<br>▸ Radiology during hospitalisation.<br>▸ Physiotherapy during hospitalisation.<br>▸ Clinical technology during hospitalisation.<br>▸ Visits and consultations by a GP or specialist during hospitalisation.<br>▸ Speech therapy during hospitalisation.<br>▸ Occupational therapy during hospitalisation.<br>▸ Dietetic services during hospitalisation.<br>▸ Social worker services during hospitalisation.<br>▸ Other services performed by registered medical practitioners.<br>▸ 100% of the cost of blood.<br>▸ Certain services related to the initial pre-authorised hospitalisation may be covered by Hospital Benefits, subject to approval.<br>**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.**<br>**NEW!** The following in-hospital sub-limits apply to the **Savings**, **Network** (including ***SELECT***) and **Hospital** Plans:<br>▸ Basic pathology: R18 000 per family per benefit year<br>▸ Basic radiology: R24 250 per family per benefit year<br>▸ Physiotherapy: R5 300 per family per benefit year |
| **4. Ultrasound scans - in hospital** | (All scans other than for pregnancy.) **100% of MSR or cost, whichever is the lesser.**<br>Limited to the overall combined benefit amount for ultrasound scans - please see page 60. |

**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 |
|---|---|
| **5. Basic Dentistry - in hospital*** (performed by a dental practitioner, including minor oral surgery) | **Network** (including ***SELECT***) and **Hospital** Plans: No benefit<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **1 x MSR or cost, whichever is the lesser.** Subject to the relevant managed healthcare programme and pre-authorisation.<br>General anaesthetic, conscious sedation, theatre fees and hospitalisation for dental work will only be granted for:<br>▸ 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.<br>▸ 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.<br>▸ 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.<br>All dental-related cases requiring surgery need to be motivated by the attending dental practitioner and are subject to approval. This includes simple extractions.<br>**A R1 500 co-payment will apply for non-PMB 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.<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **1 x MSR or cost, whichever is the lesser,** subject to the relevant managed healthcare programme and pre-authorisation.<br>This benefit excludes the following for the **Network** (including ***SELECT***) and **Hospital** Plans:<br>▸ Orthognathic surgery<br>▸ Osseo-integrated implants<br>▸ Advanced dentistry<br>▸ Oral surgery not applicable to dental PMB<br>▸ Removal of impacted wisdom teeth<br>**A R1 500 co-payment will apply for non-PMB dental admissions to hospitals.** |

**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 |
|---|---|
| 7. **Physiotherapy – after hospitalisation*** | **1 x MSR or cost, whichever is the lesser,** provided that physiotherapy is related to the relevant hospital admission and is administered within 30 days of discharge.<br>Limited to 10 appointments per beneficiary per hospital admission. |
| 8. **Procedures in Doctors' Rooms*** | **1 x MSR or cost, whichever is the lesser,** subject to pre-authorisation.<br>Major Medical Procedures (normally performed in hospital) performed in doctors' rooms. |
| 9. **Drugs and medicine (other than chronic)** | **100% of the cost** for the following:<br>▸ Material used during hospitalisation.<br>▸ Theatre drugs.<br>▸ 100% of the Medicine Price for medicines supplied during hospitalisation, subject to Hospital Benefits. |
| 10. **Medicines dispensed on discharge from hospital** [to-take-out medicine (TTO)] | **100% of the Medicine Price limited to R540 per beneficiary per admission.**<br>Subject to the overall annual limit, **excluding anti-coagulants after surgery,** which are subject to the managed healthcare programme protocols and, if approved, subject to Hospital Benefits.<br>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**<br>**1 x MSR or cost, whichever is the lesser,** limited to the overall combined benefit amount for specialised radiology (please see page 61). A **R1 500** co-payment per authorisation for non-PMB Specialised Radiology services rendered in and out of hospital.<br>This benefit excludes Oncology and Organ transplant-related MRI, CAT, PET and radio-isotope scans. |

**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 79 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.

| Service category | Benefit |
|---|---|
| **12. Intra-ocular Lenses*** | Subject to a sub-limit of **R3 450** per lens per beneficiary per benefit year. |
| **13. Psychiatric Treatment & Psychotherapy*** | Subject to pre-authorisation.<br>**1 x MSR or cost, whichever is the lesser,** up to a maximum of 21 days per beneficiary per benefit year or outpatient psychotherapy, up to 15 (fifteen) contacts.<br>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.<br>Maximum of three days' hospitalisation for beneficiaries admitted by a general practitioner or specialist.<br>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.<br>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.<br>**Remember that**, as an active employee member, you and your household dependants have access to short-term counselling and support on Old Mutual's 'Caring For You' Wellbeing Programme. Call the Helpline on 0800 006 068.<br>(You also have access to the Fund's Mental Health Programme, as part of the Fund's Managed Care Programmes. See page 102 for more information.) |
| **14. Drug and Alcohol Abuse Rehabilitation*** | Subject to pre-authorisation.<br>**100% of MSR or cost, whichever is the lesser,** up to a maximum of 21 days per beneficiary per benefit year.<br>(You also have access to the Fund's Mental Health Programme, as part of the Fund's Managed Care Programmes. See page 102 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.

| Service category | Benefit |
|---|---|
| **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.<br>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.<br>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.<br>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.<br>On application and approval, 100% of cost subject to the following sub-limits (which include bone cement and antibiotic cement, where applicable):<br>**INTERNAL PROSTHESES COVERED THE SAME ON ALL PLANS:**<br>▸ **Aortic stents: R152 000** per stent (including the delivery system) per beneficiary per benefit year, limited to one stent per beneficiary per benefit year.<br>▸ **Carotid stents: R21 900** per stent per beneficiary per benefit year.<br>▸ **Detachable platinum coils: R54 400** per beneficiary per benefit year.<br>▸ **Embolic protection devices: R54 200** per beneficiary per benefit year.<br>▸ **Peripheral arterial stent grafts: R44 900** per beneficiary per benefit year.<br>▸ **Cardiac Stents: R31 700** per stent per beneficiary per benefit year. Limited to three stents per beneficiary per benefit year.<br>▸ **Cardiac Pacemakers** [including Implantable Cardioverter Defibrillators (ICDs)]: R74 400 per beneficiary per benefit year.<br>▸ **Cardiac Valves: R43 900** per valve per beneficiary per benefit year. Limited to two valves per beneficiary per benefit year. Included in this benefit are percutaneous valve replacements, including transcatheter aortic valve implantation (TAVI).<br>▸ **Neuro-stimulation/ ablation devices for Parkinson's: R49 500** per beneficiary per benefit year.<br>▸ **Vagal stimulator** (for intractable epilepsy): **R41 900** per beneficiary per benefit year.<br>▸ **Bone lengthening devices: R48 800** per beneficiary per benefit year.<br>▸ **Any other prosthesis**, including total ankle replacement: **R57 500** per beneficiary.. |

**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 |
|---|---|
| **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.<br><br>For members on the **Savings**, **Traditional** and **Traditional Plus** (including *SELECT*) Plans, ICPS and Jointcare will be the Designated Service Providers (DSPs) for non-PMB hip and knee replacements.<br><br>**A R5 000 co-payment will apply if the DSP is not used.**<br><br>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 see page 80 for more information. | **INTERNAL PROSTHESES NOT COVERED ON THE NETWORK (INCLUDING *SELECT*) AND HOSPITAL PLANS (EXCEPT FOR PMB), BUT ON THE OTHER PLANS:**<br>▸ Hip replacement subject to the following limits per benefit year:<br>– **Network** (including ***SELECT***) and **Hospital** Plans: PMB only (see note to the left).<br>– **Savings** Plan: **R53 700** per hip per beneficiary.<br>– **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: R57 900 per hip per beneficiary.<br>▸ Knee replacement subject to the following limits per benefit year:<br>– **Network** (including ***SELECT***) and **Hospital** Plans: PMB only (see note to the left).<br>– **Savings** Plan: **R53 700** per knee per beneficiary.<br>– **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: R57 900 per knee per beneficiary.<br>▸ Shoulder replacement subject to the following limits per benefit year:<br>– **Network** (including ***SELECT***) and **Hospital** Plans: PMB only (see note to the left).<br>– **Savings** Plan: **R53 700** per shoulder per beneficiary.<br>– **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: R57 900 per shoulder per beneficiary.<br>▸ Elbow replacement subject to the following limits per benefit year:<br>– **Network** (including ***SELECT***) and **Hospital** Plans: PMB only (see note to the left).<br>– **Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: R48 000 per elbow per beneficiary. |
| **NOTE:** An initial assessment is compulsory for non-PMB cases. Please see page 96 for more information on the Back and Neck Rehabilitation Programme. | **SPINAL DEVICES COVERED ON ALL PLANS**<br>▸ **Spinal plates and screws: R39 800** per beneficiary.<br>▸ **Other approved spinal implantable devices and intervertebral discs: R54 400** per beneficiary.<br>**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.** |

**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 |
|---|---|
| 16. **Artificial limbs & artificial eyes*** | **100% of the cost subject to the following sub-limits:**<br>▸ **Artificial leg: R78 900** per leg per beneficiary per benefit year.<br>▸ **Artificial arm: R78 900** per arm per beneficiary per benefit year.<br>▸ **Artificial eye: R27 300** per eye per beneficiary per benefit year.<br>Benefit is available every 2-5 years.<br>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.) | **1 x MSR or cost, whichever is the lesser.** Sub-limit of **R20 600** per beneficiary per benefit year.<br>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) | **1 x MSR or cost, whichever is the lesser,** subject to pre-authorisation and clinical guidelines and protocols.<br>**Network** (including ***SELECT***) and **Hospital** Plans: No benefit<br>**Savings** Plan: PMSA, subject to available funds.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R110 000** per beneficiary per benefit year. |
| 19. **Paramedical and auxiliary services in hospital*** (See Explanation of Terms on page 146 for a full list of services) | **1 x 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.

## 20. ER24 Ambulance & Travelling expenses

**1 x 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 **R 9 580** per family per benefit year.

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 conveyance.

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.

### 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) | **1 x 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 **R18 200** per beneficiary per benefit year. Benefits are subject to prior application and approval.<br>**Network** (including ***SELECT***) Plan: Benefits are subject to obtaining submission of a Universal Healthcare Network provider's report.<br>This benefit includes private nursing (not for general or chronic care). |
| **22. Hospice*** (excluding long-term care or chronic care) | **1 x 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 **R34 900** per beneficiary per benefit year for non-PMBs. PMBs are unlimited. Benefits are subject to prior application and approval.<br>**Network** (including ***SELECT***) Plan: Benefits are subject to obtaining submission of a Universal Healthcare Network provider's report. |
| **23. Oncology**<br>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* | **100% of cost at DSP, or 100% of 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.**<br>**Limits per Plan:**<br>**Network** (including ***SELECT***) and **Hospital** Plans: PMB or **R486 000** per beneficiary per benefit year within ICON Essential Protocols<br>**Savings Plan**: **R486 000** per beneficiary per benefit year within ICON Enhanced Protocols.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R619 000** per beneficiary per benefit year within ICON Enhanced Protocols.<br>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. |

**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 |
|---|---|
| General Oncology*(continued) | Subject to pre-authorisation, 100% of 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.<br>**A 20% co-payment for consultation will apply if service is obtained from a non-ICON Oncologist.**<br>Vitamins, antibiotics, alternative medicine, sleeping tablets, anti-anxiety medicine and medicines for depression are subject to applicable and available Day-to-Day Benefits.<br>Approved related medicine and nutritional supplements subject to the above limits per Plan. |
| Specialised drugs for Oncology* | **Network** (including ***SELECT***) and **Hospital** Plans: PMB benefits only<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **100% of MMAP or Medicine Price, whichever is the lesser, limited to R194 000** per beneficiary per benefit year, included in the Oncology benefit.<br>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 omsmaf.co.za. |
| PET Scans* | **Subject to the Oncology limit, PET Scans are covered up to the following sub-limits per Plan:**<br>**Network** (including ***SELECT***), **Hospital** and **Savings** Plans: **R31 700** per beneficiary per benefit year.<br>**Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R32 400** per beneficiary per benefit year.<br>This benefit is subject to the submission of a motivation by the treating Oncologist and approval by the Case Manager. |
| Brachytherapy materials* (including seeds and disposables) and equipment | **100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the MSR or cost or the Uniform Patient Fee Schedule for public hospitals for consultations, visits, treatment and materials used in radiotherapy and chemotherapy by Oncologists, haematologists and credentialed medical practitioners.**<br>Limited to **R49 400** per beneficiary per benefit year, and subject to the Oncology benefit limit. |

**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 |
|---|---|
| Social worker benefit for cancer patients | **1 x MSR or cost, whichever is lesser,** for consultations with a social worker, up to a sub-limit of **R3 450** per family per benefit year, and on referral from ICON and subject to Managed Care Protocols. |
| **24. Renal dialysis*** | **1 x MSR or cost, whichever is the lesser.**<br>Automated Peritoneal Dialysis will only be approved subject to the Fund's criteria.<br>Subject to pre-authorisation, **100% of 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.<br>**1 x MSR or cost, whichever is the lesser,** up to a sub-limit of **R83 200** per beneficiary per benefit year provided that treatment is at a registered facility.<br>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.<br>Progressive neurological conditions are excluded. |
| **26. Organ Transplants*** | **1 x 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.<br>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. |
| Anti–rejection drugs* | **100% of MMAP or Medicine Price** of anti-rejection drugs provided that drugs from an approved provider are used. Subject to pre-authorisation. |
| Organ donor* | **1 x 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.<br>**1 x MSR or cost, whichever is the lesser,** up to a sub-limit of **R33 200** per eye per beneficiary per benefit year. |

**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 |
|---|---|
| **28. Hyperbaric Oxygen Therapy*** | **100% of 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. |
| **29. HIV/AIDS*** | Subject to pre-authorisation and clinical guidelines and protocols.<br>**100% of MMAP or Medicine Price** for HIV-related chronic medicine.<br>**1 x MSR or cost, whichever is the lesser,** for the medical management and related pathology tests and doctors' visits as required.<br>**Tariff code 4766** (HIV drug-resistance testing) excluded unless pre-authorised on the relevant HIV Disease Management Programme.<br>**Tariff code 3974** - Polymerase chain reaction to be paid from Hospital Benefits for babies < 18 months where the diagnosis refers to HIV testing.<br>For members on the **Network** (including ***SELECT***) Plan only cover for Prescribed Minimum Benefits is applicable at 100% of cost or MSR, whichever is the lesser, for the medical management and the related pathology tests required. 100% of Medicine Price for HIV related chronic medicine for PMB only. |
| **30. Stoma Care Products** | **100% of cost.** |
| **31. Cochlear Implants*** | **R316 000** per beneficiary per benefit year. Subject to managed healthcare protocols and pre-authorisation. |
| **32. Sleep Studies:**<br>CPAP titration in hospital* | **100% of cost or MSR,** whichever is the lesser, subject to pre-authorisation and clinical guidelines and protocols.<br>**Network** (including ***SELECT***) Plan: PMB only |
| Diagnostic Polysomnograms (whether in or out of hospital) | **Network** (including ***SELECT***) and **Hospital** Plans: No benefit<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: PMSA, subject to available funds. |

**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.

8

# MANAGED CARE PROGRAMMES

(These benefits may differ across Plans.)

## IN THIS SECTION

- Back and Neck Rehabilitation Programme
- Oncology Benefit Management Programme
- HIV and AIDS Management Programme
- Mental Health Programme
- Active Disease Risk Management Programme
- Mother and Baby Care Programme

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
- Identification through predictive modelling
- 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 a fax to 0864 613 917 or 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
- 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 or R486 000 per beneficiary per benefit year within ICON Essential Protocols
- Savings Plan: R486 000 per beneficiary per benefit year within ICON Enhanced Protocols.
- Traditional and Traditional Plus (including SELECT) Plans: R619 000 per beneficiary per benefit year within 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 Managemen by visiting 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, the following guidelines are important:**

- The application to upgrade must reach the Fund within 60 days after the first diagnosis;
- Upgrading is only allowed to the **Savings**, **Traditional** or Traditional Plus (including ***SELECT***) 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;
- 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.

**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.

## 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 Universal Healthcare HIV/AIDS Management 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 per year.

**Contact details for the HIV/AIDS Programme**

Tel: 0860 378 800; follow prompts for HIV/AIDS programme

### 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 and ask for an application form.

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 active employee member, you and your household dependants have access to short-term counselling and support on Old Mutual's 'Caring For You' 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.

### 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 'Caring For You' Wellbeing Programme (with your consent)
- Universal Healthcare identification through predictive modelling

You will be contacted to enrol on the programme for the last two options by the Fund's administrator.

### What does the benefit consist of?

When you enrol on the mental health programme we will set up a care template that provides benefits that will allow your team of healthcare professionals to optimally manage your condition. This will be individualised based on your unique requirements, making this a tailored benefit structured specifically for you, ensuring the best possible outcome.

## Active Disease Risk Management Programme

The Active Disease Risk Management Programme a co-ordinated system of health care interventions aimed at supporting members with chronic diseases 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
- Mental Health: Depression, General Anxiety, Bipolar Mood Disorder, Post-Traumatic Stress Disorder (PTSD) and Substance Abuse.

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. With your prior consent, we work together with your GP, to monitor your condition and treatment.

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 regular 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 **Network** (including ***SELECT***) or **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 58). You will, however, still receive educational support and relevant contact information.

Your confidentiality is assured.

### 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 100% of MMAP or the Medicine Price, whichever is the lesser.

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

## What services are covered?

The following services are covered:

- 100% of the 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.

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

- Antenatal visits subject to the sub-limits per pregnancy.
- 100% of the 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 1 x 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:**<br>▸ **Hospital** Plan: No benefit, but education and support is available via the Mother and Baby Care Programme and website (www.omsmaf.co.za).<br>▸ **Network** (including ***SELECT***) Plan: No benefit, but education and support is available via the Mother and Baby Programme and website (www.omsmaf.co.za).<br>▸ **Savings** Plan: R1 280 per family per benefit year.<br>▸ **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R2 010** per family per benefit year. |
| Antenatal visits | Supplementary benefits | **1 x MSR or cost, whichever is the lesser.**<br>Limits per Plan per benefit year:<br>▸ **Hospital** Plan: No benefit.<br>▸ **Network** (including ***SELECT***) Plan: May visit a Universal Healthcare Network GP for the management of their pregnancy. The Universal Healthcare Network GP may refer the patient to an Obstetrician for further management in the event of a high risk pregnancy and this will be subject to pre-authorisation. PMBs only.<br>▸ **Savings** Plan: R3 020 per pregnancy.<br>▸ **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R5 030** per pregnancy. |
| Ultrasound scans (pregnancy) | Supplementary benefits | **Limits per Plan per benefit year:**<br>▸ **Hospital** Plan: No benefit.<br>▸ **Network** (including ***SELECT***) Plan: Two 2D scans per pregnancy, if done, or referred by Universal Healthcare Network GP.<br>▸ **Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: Two 2D scans per beneficiary. |

| Maternity Benefits | Paid from | All pregnant beneficiaries have to register on the Mother and Baby Care Programme. |
|---|---|---|
| Out-of-hospital pathology tests<br>(pregnancy) | Supplementary benefits | ▸ **Hospital** Plan: No benefit.<br>▸ **Network** (including ***SELECT***) Plan: Basic blood tests, if requested by Universal Healthcare Network GP and on the approved tariff list.<br>▸ **Savings** Plan: **R2 490** per family per benefit year.<br>▸ **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: **R3 110** per family per benefit year.<br>This benefit is dependent on the patient registering on the maternity programme (not available to members on **Hospital** and **Network** (including ***SELECT***) Plans).<br>Beneficiaries who register on the programme will receive a list of pathology tests that are covered under this benefit.<br>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.<br>You can assist the Fund by doing the following when blood tests are required:<br>▸ 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.<br>▸ Ask your doctor about the cost of the tests you are due to have done.<br>▸ Ask your doctor if he/she can recommend a supplier who charges reduced rates.<br>▸ Ensure that the doctor uses the correct ICD-10 code so that the claim comes off the correct benefit. |
| Antenatal vitamins | Supplementary benefits | **Network** (including ***SELECT***) and **Hospital** Plans: No benefit.<br>**Savings**, **Traditional** and **Traditional Plus** (including ***SELECT***) Plans: 100% of MMAP or medicine price, subject to prescription from an approved list and Formulary and included in the overall annual limit. |

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 | **1 x MSR or cost, whichever is the lesser,** in respect of the following, subject to the overall annual limit:<br>▸ Medical practitioner services whilst hospitalised.<br>▸ Theatre and recovery rooms.<br>▸ Normal delivery limited based on protocols.<br>▸ Caesarean delivery limited based on protocols.<br>▸ Material used in hospital.<br>▸ 100% of the Medicine Price for medicines.<br>▸ Medicine taken on discharge from hospital, limited to **R540**. |
| Confinement in a registered birthing unit | Hospital benefits | **100% of the 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:**<br>▸ Delivery by a midwife;<br>▸ Hire of water bath included in confinement benefits;<br>▸ 4 Post-natal midwife consultations per event if a gynaecologist is not used. |
| Confinement out of hospital | Hospital benefits | **100% of negotiated fee, 100% of 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.**<br>▸ Limited to and included in the Maternity Benefit:<br>▸ Hire of water bath and oxygen cylinder included in the Maternity Benefit.<br>▸ 4 Post-natal midwife consultations per event if a gynaecologist is not used. |

**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** and **Network** (including ***SELECT***) Plans 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 preauthorise:**
**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 pages 151-163.**

## 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. When you register on the Programme, you will receive a registration form for easy registration of your baby. 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. General and/or condition-specific waiting periods will apply if the baby is not registered within 30 days of birth. Refer to page 128 for the procedure to register a dependant and page 125 to find out which dependants are covered.

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# **PRESCRIBED** MINIMUM BENEFITS (PMB)

(These benefits are the same across all Plans.)

## IN THIS SECTION

- Why do we have PMB?
- Which PMB conditions are covered by the Fund?
- How are PMB claims covered?

## Why do we have PMB?

The PMB legislation was created to ensure that all medical scheme members have access to continuous healthcare for specific conditions even if a member's annual limits have run out and regardless of the benefit option they have selected. Members are entitled to at least the minimum specified treatment to manage their PMB condition.

PMB legislation requires the Fund to provide benefits for the diagnosis, treatment and care of:

- any Emergency Medical Condition and
- a list of 270 groups of conditions known as Diagnostic Treatment Pairs (DTP) which includes
- 26 common chronic conditions grouped on the Chronic Disease List (CDL).

The costs related to the diagnosis, treatment and care of PMB conditions are fully covered by medical schemes, provided a member follows the guidelines.

When deciding whether a condition is a PMB, the doctor should only look at the symptoms and not at any other factors, such as how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis has been made, the appropriate treatment and care is decided upon as well as where the patient should receive the treatment (at a hospital, as an outpatient or at a doctor's rooms).

To manage the treatment, medical schemes apply PMB formularies and protocols, which are largely based on the

government's guidelines to manage these conditions. This is referred to as PMB level of care.

## Which PMB conditions are covered by the Fund?

### Emergency Medical Conditions

An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and /or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

In an emergency it is not always possible to diagnose the condition before admitting the patient for treatment. However, if doctors suspect that the patient is suffering from a condition covered by PMB, the medical scheme has to approve treatment. Schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

### Diagnostic Treatment Pairs (270 medical conditions)

The Regulations to the Medical Schemes Act provide a long list of conditions identified as PMB conditions. The list is in the form of Diagnosis and Treatment Pairs (DTPs). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximate 270 PMB conditions should be treated.

Here is an example of a DTP as it appears in the Medical Schemes Act:

| Code | Diagnosis | Treatment |
|---|---|---|
| 109A | Vertebral dislocations/ fractures, open or closed with injury to spinal cord | Repairs/reconstruction; medical management; inpatient rehabilitation up to two months |

The 270 conditions that qualify for PMB cover are diagnosis-specific and include a range of ailments that can be divided into 15 broad categories:

| PMB Category | Example |
|---|---|
| **Brain and nervous system** | Stroke |
| **Eye** | Glaucoma |
| **Ear, nose, mouth and throat** | Cancer of oral cavity, pharynx, nose, ear, and larynx |
| **Respiratory system** | Pneumonia |
| **Heart and vasculature (blood vessels)** | Heart attacks |
| **Gastro-intestinal system** | Appendicitis |
| **Liver, pancreas and spleen** | Gallstones with cholecystitis |
| **Musculoskeletal system (muscles and bones); Trauma NOS** | Fracture of the hip |
| **Skin and breast** | Treatable breast cancer |
| **Endocrine, metabolic and nutritional** | Disorder of the parathyroid gland |

| PMB Category | Example |
|---|---|
| **Urinary and male genital system** | End-stage kidney disease |
| **Female reproductive system** | Cancer of the cervix, ovaries and uterus |
| **Pregnancy and childbirth** | Antenatal and obstetric care requiring hospitalisation, including delivery |
| **Haematological, infectious and miscellaneous systemic conditions** | HIV and AIDS and TB |
| **Mental illness** | Schizophrenia |
| **Chronic conditions** | Asthma, diabetes, epilepsy, hypothyroidism, schizophrenia, glaucoma, hypertension |

If your PMB condition is not an emergency or a chronic condition, but is diagnosed by your doctor as a once-off acute out-of-hospital PMB condition, you will be covered (subject to Fund Rules and the PMB limits). If you are unsure whether the acute condition diagnosed by your doctor will be covered as a PMB, call 0860 100 076 or email enquiries@omsmaf.co.za to clarify. The agent will require the ICD-10 code to determine whether the condition is an acute PMB condition.

If the condition has been identified as an acute out-of-hospital PMB condition, the agent will request that you submit any claim/s (together with the ICD-10 code, relevant tariff codes, doctor's practice number and any test results, including pathology and radiology) that support the diagnosis. If these items have already been submitted, the agent will pass these on to the PMB department. Once the relevant information has been received, qualifying claims will be paid first from your Primary Care Benefit, available AFB or Hospital Benefit, and then from the PMB benefit. No PMB claims may be paid from your PMSA.

## How are PMB claims covered?

PMB claims are paid at cost in accordance with Fund Rules, provided that PMB criteria are met. (If PMB criteria are not met, claims will be considered for payment as set out in the Fund Rules.)

### Can the Fund refuse to cover my medication if I need, or want, a brand other than that which the Fund says it will pay for?

The Fund may refuse to cover your medicine if you want to use a brand-name medicine that is not on the Fund's formulary for your specific PMB condition.

The Fund uses what is known as a formulary – a list of safe and effective medicines that can be prescribed to treat certain conditions. The Fund states in its rules that it will only cover your medication in full if your doctor prescribes a drug on that formulary.

Often the medicines on the list will be generics – copies of the original brand-name drug – that are less expensive but equally effective. If you want to use a brand-name medicine that is not on the list, your medical Fund may foot only part of the bill and you will have to pay either the difference between the price of the medication you use and the one on the formulary, or a percentage co-payment as registered in the scheme rules.

If you suffer from specific side-effects from drugs on the formulary, or if substituting a drug on the formulary with one you are currently taking affects your health detrimentally, you can put your case to the Fund and ask the Fund to pay for your medicine. You can also appeal to the Fund if the formulary drug is ineffective and does not have the desired effect. If your treating doctor can provide the necessary proof and the Fund agrees that you suffer from side-effects, or that the drug is ineffective, then the Fund must give you an alternative and pay for it in full.

## Why can I not pay for PMB from my Personal Medical Savings Account?

Regulation 10.6 of the Medical Schemes Act stipulates that members may not use the Personal Medical Savings Account to pay for PMB, in part or full. You must therefore settle any co-payment directly with the service provider (whether it is for medicines or doctors'/specialists' fees). The Council for Medical Schemes regards this as a contravention of the law and will penalise the Fund if regulations are not followed.

## Why are the ICD-10 codes on PMB claims so important?

Check that your doctor (or any other medical service provider) has placed the correct ICD-10 code on your account. ICD-10 codes provide accurate information on your diagnosis; these codes help the Fund to determine what benefits you are entitled to and how these benefits could be paid.

This becomes very important if you have a PMB condition, as these can only be identified by the correct ICD-10 codes. Therefore, if the incorrect ICD-10 codes are provided, your PMB-related services might be paid from the wrong benefit (such as from your Personal Medical Savings Account), or it might not

be paid at all if your Day-to-Day or Hospital Benefits have been exhausted.

ICD-10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers (e.g. pathologists and radiologists) who are not all able to make a diagnosis. Therefore, they require the diagnosis information from your referring doctor so that their claim to your medical Fund can also be paid out of the correct pool of money.

It is important to note that not all tariff codes qualify for PMB funding. For example, if a tariff is not prevailing practice in a government facility, the claims will only be paid at MSR for the tariff in question.

## Who can I call if my PMB claim is rejected?

You can contact 0860 100 076 to query the rejection. As mentioned, it is important to check that your medical practitioner has placed the correct codes on your invoice.

Once diagnosed, please keep all your supporting documents on file as the operator will ask for this information when reviewing your claim/s.

## The 26 chronic diseases

The Chronic Disease List (CDL) specifies medicine and treatment for the 26 chronic conditions (listed on page 69 of this Member Guide). To manage risk and ensure appropriate standards of healthcare, so-called treatment algorithms were developed for the CDL conditions. The algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment the Fund must provide for may not be inferior to the algorithms.

If you have one of the 26 listed chronic diseases, your medical Fund not only has to cover medicine, but also doctors' consultations and tests related to your condition. The Fund may make use of protocols, formularies (list of specified medicines) and Preferred Providers to manage this benefit.

## Can the Fund set a chronic medicine limit?

Yes, the Fund can set a limit for your chronic medicine benefit. Any authorised non-PMB chronic medicine that you claim will first be offset against your chronic medicine limit. Only claims for medicines authorised for the PMB Chronic Disease List (CDL) conditions will be funded as PMB unlimited. Refer to the list of qualifying PMB chronic conditions on page 69.

## Do any exclusions apply?

The Fund has a list of conditions – such as cosmetic surgery – for which they will not pay, or circumstances – such as travel costs and examinations for insurance purposes – under which a member has no cover. These are called exclusions. Exclusions, however, do not apply to PMB. If you contract septicaemia after cosmetic surgery, for example, the Fund will provide healthcare cover for the septicaemia part because septicaemia is a PMB. (Cosmetic surgery remains an exclusion.) PMB relates to the diagnosis; it does not matter how you developed the condition.

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# PERSONAL MEDICAL **SAVINGS ACCOUNT** (PMSA)

(Available on all Plans except the Hospital and Network / Network *SELECT* Plans.)

## IN THIS SECTION

- What is a PMSA?
- What can the money in my PMSA be used for?
- What are accumulated savings?
- What can the money in my accumulated savings be used for?
- Will the money in my PMSA and accumulated savings earn interest?
- Can I withdraw money from my PMSA?
- What happens if I do not have enough money left in my PMSA to settle my claims?
- Is there a credit facility?
- How will I know what the balance in my PMSA or accumulated savings account is?
- What will happen to the balance in my PMSA should I decide to change to the Hospital, Network or Network *SELECT* Plan, none of which has a PMSA allocation?
- What happens to the money in my PMSA if I am no longer a member of the Fund?

## What is a PMSA?

The Personal Medical Savings Account is a savings account held by the Fund 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 Fund 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. For the 2019/20 benefit year, the PMSA allocation, as a percentage of total contributions, is as follows:

**Savings** Plan: 17.2%
**Traditional** (including ***SELECT***) Plan: 11.5%
**Traditional Plus** (including ***SELECT***) Plan: 10.4%

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.

Please remember that the **Hospital** and **Network** (including ***SELECT***) Plans have no PMSA contributions and therefore no PMSA balance. Also remember that if you move to the **Hospital** or **Network** (including ***SELECT***) Plan, your PMSA balance will be paid out to you after 5 months.

## What can the money in my PMSA be used for?

### You can use the money in your PMSA to pay for:

- Day-to-day services, if applicable on the Plan you selected.
- Any services that are deemed medically necessary, but are not covered under the Wellness Benefit and Day-to-Day Benefit.
- The difference between the actual cost of a service and MSR, other than PMB.
- Any co-payments for Hospital Benefits, other than for PMB.
- Co-payments if you do not pre-authorise.

## What are accumulated savings?

If a member does not use all the money in the PMSA in any given year, the accumulated savings are recorded separately.

## What can the money in my accumulated savings be used for?

### You can use the accumulated savings for:

- Services that are generally or specifically excluded according to the Rules of the Fund. These services should be obtained from a registered practitioner, and you must advise the Fund in writing to ensure that these services are paid from your accumulated savings.
- Claims during a waiting period.

- Any claims that come in after the PMSA and PCB have been depleted on the **Traditional** and **Traditional Plus** (including ***SELECT***) Plans, or after the PMSA has been depleted on the **Savings** Plan.

### You cannot use the money in your PMSA and accumulated savings to pay for:

- PMB conditions
- Costs that are higher than the medicine price (e.g. the administration fee).

## Will the money in my PMSA and accumulated savings earn interest?

Any money in your PMSA or accumulated savings will earn interest at a rate of 100% of the actual average interest rate earned by the Fund.

## Can I withdraw money from my PMSA?

No, the Fund Administrator will manage your PMSA. When claims have to be settled they will automatically deduct the money from your PMSA.

## What happens if I do not have enough money left in my PMSA to settle my claims?

The Fund will pay these claims up to the available PMSA balance and then from accumulated savings, whereafter you will be liable to settle the difference directly with your supplier.

## Is there a credit facility?

The PMSA offers a credit facility, which means that you can use the credit balance in your PMSA to settle claims, even if you have not made all the monthly contributions to your PMSA.

## How will I know what the balance in my PMSA or accumulated savings account is?

For the most up-to-date information on your balances, you can contact 0860 100 076, or you can view detailed statements of all your transactions, available benefits, and the balance in your PMSA/accumulated savings on omsmaf.co.za. You will also receive monthly member statements.

## What will happen to the balance in my PMSA should I decide to change to the **Hospital**, **Network** or ***Network SELECT*** Plan, none of which has a PMSA allocation?

Your PMSA balance will be paid out to you after five (5) months, to allow the Fund to settle any claims that may be submitted in the period after you terminate your membership. PMSA is subject to tax implications.

## What happens to the money in my PMSA if I am no longer a member of the Fund?

If your membership of the Fund ends, e.g. you resign, are retrenched, pass away or transfer to your spouse's or partner's employer-preferred medical scheme, the following will happen:

- Any amounts that have been paid by the Fund, but which exceed the benefits to which you are entitled, will be recovered from you or your estate.
- The money in your PMSA will be used by the Fund to pay any non-PMB outstanding claims.
- If there is no money in your PMSA, only the benefit amount will be paid to the service provider. You (or your estate) will be responsible for settling the balance with the service provider.
- The onus is on you, as the member, to notify the Fund of your new medical scheme, banking and/or your contact details.

If you have used your up-front PMSA and resigned before the end of the benefit year, the overspent amount must be paid back to the Fund within 30 days of the termination date. Recoveries will also be made via Payroll.

Five months after your membership has ended and once the Fund has received a completed selling form from you, the balance in your PMSA will be calculated and paid out into the banking account recorded by the Fund as follows:

- If you do not join another medical aid
- If you join another medical aid on a Plan that does not have a savings account
- If you join another medical aid as a dependant
- If you move to the **Hospital** or **Network** (including ***SELECT***) Plan

All members will be paid out their remaining PMSA balances in full and are responsible for the tax implications thereof.

If you pass away, the balance in your PMSA will be kept by the Fund to be used by your dependants who become continuation members of the Fund, if applicable, or be paid to your estate after five months.

## If I leave the Fund for another scheme with a PMSA, can I transfer my PMSA /accumulated savings balance to my new scheme?

If you are joining another medical scheme with a PMSA, we request that you provide us with your new medical aid details by emailing these to membership@omsmaf.co.za. Upon receipt of this information, the Fund will arrange to transfer the balance of your PMSA to your new medical scheme after the 5th month following your termination date. This option will allow you to not incur any tax on the balance.

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# TRAVEL BENEFITS

## IN THIS SECTION



## What should I keep in mind if I plan to travel outside South Africa?

**IMPORTANT: Medical care abroad can be very expensive (depending on the country you will be travelling to) and, given our exchange rate, it may be wise to take out additional medical cover. Your travel agent will be able to assist you with this.**

You will be glad to know, however, that you can claim from the Fund for medical expenses incurred while travelling outside South Africa. However, you need to be aware of the following:

- You will be responsible for settling the account upfront. You can then claim the cost back from the Fund when you return.
- If your account is in a foreign language, it must be fully translated and detailed before you submit it to the Fund.
- Complete the claim form for foreign claims, which you can request from the Contact Centre. The more detailed your claim, the quicker the Fund can process it. You need to clearly indicate the following details:
  - The name of the country in which you were treated
  - Treatment dates
  - Whether there was anaesthesia involved and if so, how long it was for
  - The medicine, materials, treatment, procedures and operations involved. These must all be clearly specified and charged individually.
  - The patient's name
  - The currency in which the claim was paid

- Submit your original claim to: foreignclaims@omsmaf.co.za.
- Your claim will be subject to the Fund's Rules as if the treatment was rendered in South Africa. In other words, the same exclusions, benefits and limits will apply.
- Your claims will be paid according to the equivalent tariff and will be refunded to you in Rands, at the exchange rate that applied on the treatment date.

If you or one of your accompanying dependants use chronic medicine, you must also remember to arrange for advance supplies. Do so at least seven working days before you leave.

## What if we have a medical emergency 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-hospital transfers

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# CLAIMING MADE EASY

## IN THIS SECTION

- What must I do if I have a claim?
- Where do I submit my claim?
- How much time do I have to submit my claim?
- How do electronic claims work?
- How is member debt created and recovered?
- Whom should I contact if I have queries?

## What must I do if I have a claim?

Simply sign all original accounts, invoices and prescriptions and submit them directly to the Old Mutual Staff Medical Aid Fund (Claims). Remember to keep a copy for your records. Please note that claims that are faxed or submitted as scanned documents will only be processed if legible and received within the four-month claiming period. The payment run is every Thursday and it includes all claims to members and providers that were processed the previous week up and until Friday 12h00.

Members on the **Network** (including ***SELECT***) Plans do not need to submit accounts for any service received at a Universal Healthcare Network practice as the practice will submit its accounts directly to Universal Healthcare. However, you can submit a claim for any medical costs not submitted by the practice, to Universal Healthcare, so that the claim can be processed for tax purposes.

Before submitting your claim, check that the following information appears on the account:

- The name of the Fund and Plan, e.g. **Traditional** or **Savings** Plan
- Your membership number
- Surname and initials of member
- The patient's first name(s) and date of birth as it appears on your membership card
- ICD-10 code
- The date of service

- Valid provider practice number
- Valid attending provider practice number
- Tariff code(s)
- Quantities

In the case of accounts from a service provider such as a doctor or pharmacy, the name and practice number, as well as the chargeable code, should appear on the account.

If any of the above information does not appear on the account, this will lead to a delay in the processing of your account.

1. Check that the account details are correct and that you have been charged the correct amount.
2. If you have already paid the account, write "Account Paid" clearly on the account and attach the receipt.
3. Sign the original account and keep a copy for your records.
4. Submit your claim to OMSMAF via internal mail, post or email (see below).

Old Mutual Staff Medical Aid Fund (Claims) undertakes to settle the account within 30 days of receipt, and any money owing to you will be paid directly into your bank account recorded by the Fund via Electronic Fund Transfer.

## Where do I submit my claim?

### Via email:

claims@omsmaf.co.za

### Via internal mail:

Old Mutual Staff Medical Aid Fund (Claims) Mutualpark

### Via the post office:

Old Mutual Claims, P O Box 1411 Rivonia, 2128

### All claims for services rendered outside the borders of RSA:

foreignclaims@omsmaf.co.za

## How much time do I have to submit my claim?

Members on all OMSMAF Plans must submit their claims as soon as possible after receiving the service. If your claim is received later than four months after the date of service, your claim will be stale and your account will not be paid by the Fund. For example, if you visit the dentist on 20 April, you must submit your claim for that service before 1 September. If the Fund changes any of the benefits offered, claims submitted after these changes will be paid according to the Rules that existed at the date of the service and not the Rules that exist at the date when the claims are submitted or received.

## How do electronic claims work?

The majority of service providers submit claims electronically. They are then paid directly, which means that you do not have to submit the account.

If your service provider uses this facility, ask them for a copy of the claim for your records and check that the services and

amounts charged are correct. You do not have to submit a copy to the Old Mutual Staff Medical Aid Fund (Claims), unless you notice on your member statement that the claim has not been processed three months after the date of service. Remember, it is your responsibility to ensure that your claims have been submitted within the regulated time, by either checking your member statements or visiting the website regularly.

## How is member debt created and recovered?

Member debt may be created if a claim is reversed or reworked. If you have a member debt, you will be required to pay the outstanding amount directly to the Fund.

If you use you full upfront savings credit and you terminate your membership during the benefit year, a member debt will be created that will need to be paid back to the Fund within 30 days of the termination date. Recoveries will also be made via Payroll.

### Pensioners

Your member portion will be reflected on your monthly statement. Pensioners must pay member portions directly to the Fund.

## Whom should I contact if I have any queries?

If you have any queries regarding claims, you should call the Contact Centre at 0860 100 076.

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# ALL ABOUT **MEMBERSHIP**

## IN THIS SECTION

- Who qualifies to be a member?
- Who qualifies to be a dependant?
- Do waiting periods apply to new members and dependants?
- What is a Late Joiner Penalty (LJP)?
- How do I add a dependant?
- How do I remove a dependant?
- How will changes affect my contributions?
- What happens if I terminate my membership?
- What happens if the principal member passes away?

It is a condition of employment that all employees belong to the Fund, unless they wish to remain a dependant on their spouse's/partner's employer-preferred medical aid. Old Mutual's contract of employment requires all permanent employees to belong to the Fund, unless they provide proof of their membership on their spouse's or partner's employer-preferred medical scheme. **You and your dependants have 90 days from your date of employment to join the Fund, without underwriting.**

The Fund offers medical scheme benefits to qualifying employees and their dependants.

## Who qualifies to be a member?

### Employees

All permanent employees must belong to the Fund, unless they belong to their spouse's or partner's employer-preferred medical scheme. The Employer may conduct annual audits to monitor membership compliance. If you and your spouse/partner are employed by Old Mutual, either one of you may be the member while the other will be registered as a dependant. Alternatively, both spouses and partners could be members in their own rights and would then pay the contribution rates of a principal member.

### Retirees/pensioners

Active members who retire from Old Mutual may continue to belong to the Fund as continuation members.

### Widow/widower and dependants of a deceased member

If a member of the Fund passes away, his/her dependants may choose to remain with the Fund as continuation members. See the last section of this chapter (page 131) for more information on what happens if the principal member passes away.

## Who qualifies to be a dependant?

The following dependent members of your immediate family may qualify to receive benefits from the Fund. Note that in most cases you will need to provide some proof of their dependence when you submit your application.

### Spouse

Your spouse to whom you are legally married and who is not a member of another medical scheme. Such a dependant will pay the adult rate, regardless of age.

### Spouse(s) in polygamous and traditional marriages

Your spouse(s) to whom you are married in terms of any law or custom and who is not a member of another medical scheme. Such a dependant will pay the adult rate, regardless of age.

### Life Partner

A person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of a shared and common household, irrespective of the gender of either party. Such a dependant will pay the adult rate, regardless of age.

**NOTE:** For a dependant to be regarded as financially dependent on the member, such a dependant should comply with the definition of financial dependency, as stipulated in the Fund's Rules. Please contact 0860 100 076 if you wish to verify financial dependency.

### Children up to the age of 21

Your or your spouse's/life partner's financially-dependent child, including a step-child, legally adopted child, or a child in the care and custody of a member/spouse/partner by virtue of court order, or a child in the process of being legally adopted or being placed in foster care, or a child for whom the member has a duty to support. Child rates are payable.

### Children over the age of 21

Your or your spouse's/life partner's child over the age of 21 who is financially dependent on you or your spouse/partner, including all categories of children as set out in the section above for children up to the age of 21. The contribution rate for adults will apply from age 21.

### Children from the age of 22 to 29

The onus is on the member to advise the Fund if the dependant is no longer financially dependent on the member.

### Children from age 30 onwards

You will have to provide annual proof of financial dependency for these dependants. Income confirmation letters will be sent to you annually.

### Grandchild(ren)/Great-grandchild(ren)

The grandchild(ren) or great grandchild(ren) of a member, spouse or partner, who lives on a permanent basis with the member, and is maintained by the member.

### Dependent parent(s)/grand-parents

A parent or grand-parent of a member, spouse or partner and for whom the member is liable for family care and support. An annual review will be sent to members with dependent parents/grand-parents. The onus is on the member to advise the Fund if the dependant is no longer financially dependent on the member. If the dependant is still financially dependent on the member, there is no need to respond. Refer to the definition of financial dependency on page 125.

## Do waiting periods apply to new members and dependants?

Yes, waiting periods apply to new members and dependants individually.

- No waiting period will apply for new employees who apply to join the Fund within 90 days of first becoming an employee of Old Mutual or within 90 days of their return to employment after a period of unpaid leave or secondment.

**WHAT IS A WAITING PERIOD?**

This is 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.

**General waiting period:** A period during which a beneficiary is not entitled to claim any benefits. This may also apply to PMB.

- No waiting period will apply to a dependant whose application is submitted within 30 days after they became eligible to join the Fund as a dependant.
- No waiting period will apply to a newly born or adopted child, as long as such a child is registered within 30 days of the birth or adoption.
- No waiting period will apply to an employee who undergoes a life-changing event and applies to join the Fund within 90 days from the life-changing event taking place. A life-changing event is defined as retirement, divorce, marriage, retrenchment, a spouse's or partner's change of employment, or death. Proof of such an event needs to be provided within 90 days from the life-changing event.

- If you join the Fund by means of the Employer's default process and you wish to add dependants, no waiting period will apply to such dependants if you add them within 30 days of your join date.

### Waiting periods will apply as follows:

- If you have never been a member or dependant of a medical scheme or were not covered for a period of more than 90 days immediately before applying to the Fund, the Fund may impose the general waiting period and the condition-specific waiting period (if the beneficiary suffers from a pre-existing condition). In this case the waiting periods will also apply to Prescribed Minimum Benefits.
- If you have been a member or dependant of a medical scheme for less than 24 months and you apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), a condition-specific waiting period will apply. If the beneficiary suffers from a pre-existing condition, the Fund may also impose any unexpired balances imposed by the previous scheme. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits. For example, if the beneficiary is pregnant, the Fund will cover the childbirth under Prescribed Minimum Benefits, but not the day-to-day antenatal visits, scans, and so on.
- If you have been a beneficiary of a medical scheme for more than 24 months and apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), the general waiting period will apply. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.

## What is a Late Joiner Penalty (LJP)?

LJPs will be imposed on any beneficiary except the main member.

An LJP will be applied to any dependant over the age of 35 who has not been on a medical scheme before.

Any LJP is only adjusted from the 1st of the next month after proof of previous membership is received and there will be no refunds or backdating.

- If the dependants join at the same time as the main member (within 90 days from date of employment) but they don't have previous medical aid cover and are over the age of 35, we will impose LJPs and no waiting periods will apply.
- If the dependant joins after the main member and is over the age of 35, we will impose LJPs and waiting periods.
- Dependants' LJPs are, for example, calculated as follows: A dependant is 65 years and has had 5 years' previous medical aid cover, but was not covered for the last 90 days. Then we take 65 (age) – 35 = 30 (without medical aid cover) – 5 (previous cover) = 25 years without medical aid cover, therefore the LJP will be 75%.

- Premium penalties may be applied in respect of any beneficiary who is over the age of 35 years and who was without creditable coverage for the period indicated below after the age of 30 years, excluding a person who was a beneficiary of a medical scheme prior to 1 April 2001 and who did not have a break in membership exceeding three consecutive months since 1 April 2001. Such penalties will be applied only to that portion of the contribution relative to the late joiner and shall not exceed the following bands:

| Years without medical cover | Late joiner penalty (LJP) payable |
|---|---|
| 1 - 4 years | 5% of contribution |
| 5 - 14 years | 25% of contribution |
| 15 - 24 years | 50% of contribution |
| 25 and more | 75% of contribution |

- On receipt of the member's application form, the administrator will impose LJPs and waiting periods as per the approved Fund Rules.
- It is important to provide all supporting documents, such as membership certificates of previous medical schemes (indicating the membership end date) to the Fund as soon as possible, to ensure that LJPs, if applicable, are not calculated incorrectly. An affidavit will also be accepted in respect of proof of previous medical aid cover.
- Condition of employment: If a member and his dependants join within 90 days, no waiting periods will apply to the member and his dependants, but LJPs could apply to dependants over the age of 35.
- Please take note that LJPs are implemented for life and do not expire.

## How do I add a dependant?

You should apply to register a new dependant (e.g. child or adopted child) within 30 days after they become eligible to join the Fund as a dependant. If you do not notify the Fund within 30 days, general and/or condition-specific waiting periods and/or LJPs will apply.

You will need to complete an Add/Remove dependant form, which you can obtain by contacting 0860 100 076 or emailing enquiries@omsmaf.co.za.

To add a dependant, you will also need to provide the following documentation:

### Marriage in terms of any law or custom

A copy of your marriage certificate or signed affidavit if the spouse's surname differs from that of the member.

### Child in your custody

Birth certificate and court order. If the child's surname differs from yours, we require an affidavit.

### Child

In order for your child to be registered from date of birth the Fund requires the birth notification (with the child's ID number) or birth certificate within 30 days of birth. If such notification is received after 30 days the child will be registered with effect from the 1st of the following month. If you do not register your child within this period, any medical expenses incurred from the date of birth of your baby will not be covered. General and/or condition-specific waiting periods will apply if the child is not registered within 30 days of date of birth. Your child can also be registered telephonically by calling 0860 100 076. We will require the full name, surname and date of birth of the child. Once you have your child's birth certificate, please inform the Fund of his/her ID number.

### Grandchild(ren)/Great-grandchild(ren)

An affidavit. The member will need to apply annually.

### Partners

A signed affidavit.

### Indigent parents/grand-parents

A signed affidavit. You will have to submit proof of your liability for support. You will also need to prove that the person is financially dependent on you. The onus is on you, the member, to inform the Fund when circumstances change, such as if the dependant passes away.

### Over-age dependent children (over age 21)

Please notify the Fund immediately in the case of death or as soon as dependants must be removed because they became financially independent. Should the Fund not receive notification within 30 days of the event, the dependant will only be cancelled on the date of notification and no contributions will be refunded.

## How do I remove a dependant?

Please inform the Fund 30 days before the date on which you want a dependant to be deregistered, or the date on which a dependant will become financially independent.

Please notify the Fund immediately in the case of death. Should the Fund not receive notification within 30 days of the event, the dependant will only be cancelled on the date of notification and no contributions will be refunded.

## How will changes affect my contributions?

All contributions in respect of new members will be due the first day of the month during which employment commences or from the date of registration, except when the date is the 15th or later of a month, in which case the contribution will be due from the first day of the following month. Benefits will be available, subject to the Fund Rules, from the date on which employment or membership commences, whichever is the later.

### Resignation

If you cancel your membership on the 15th or later of a month, contribution for the full month will be due and you will be covered until the end of that month. In cases where your membership cancellation takes place up to and including the 14th of the month, no contribution is due for that month, provided that the employer advises the Fund of the date of such termination immediately when it takes place. You will be covered until the date of termination of employment.

### Death

The member will be terminated as at date of death and no contributions will be refunded more than 3 years.

### Dual membership

If the Fund has evidence of dual membership of any member or beneficiary, the Fund will terminate the membership of the member or beneficiary at the end of the month in which it receives notification and no contributions will be refunded.

### New-born or newly-adopted child

If you register a new-born or newly-adopted child, there will not be any pro-ration of benefits or any waiting periods provided that you register the new-born or newly-adopted child within 30 days of birth or adoption. Your increased contribution will be due from the first day of the month in which the baby was born, except if the baby was born on or after the 15th of the month, in which case the contribution will be due from the first day of the following month.

### What if my details change?

You must notify the Fund immediately of:

- A change in banking details
- A change in marital status
- The birth of an infant or adoption of a child
- Death
- Your dependant becoming independent/self-supporting/married
- A dependant becoming a member of another medical scheme
- Change of address, or location, where applicable. If you are a working member and are still using your physical location at work as a delivery address, please email the applicable team within the HR Service Centre to update your location.
- Change of income

## What happens if I terminate my membership?

### You will no longer be a member of the Fund if:

- You resign or are retrenched* from Old Mutual
- You pass away (your dependants may continue as members of the Fund)
- You join your spouse's or partner's employer-preferred medical scheme as a dependant.

When a member's employment terminates on the 15th, or later, of a month, contribution for the full month will be due and the member will be covered until the end of that month. In cases where termination takes place up to and including the 14th of the month, no monthly contribution is due that month, provided that the Employer advised the Fund of the date of the termination when it takes place. The member will be covered up to the date of termination of employment. If you leave the employment of Old Mutual, it is your responsibility to inform the Fund in writing of any change of address and/or email address.

* On request of a member who has been involuntarily retrenched, continued membership of the Fund will be granted for three months from the date of retrenchment. Contributions will be payable via debit order.

## What happens if the principal member passes away?

If the main member passes away, membership of dependants will continue until the end of the month. If the principal member passes away and has no dependants, membership will end on the date of death.

If the principal member passes away, dependants have the choice to become continuation members. In such a case, the Fund needs to receive the following documents within three months of the member's date of death to ensure continuation membership for the dependants:

A. Copy of the death certificate of the principal member.

B. Copy of the ID of the surviving spouse/ beneficiary.

C. Copy of bank statement to upload bank details for debit order/refund purposes.

D. Proof of income of the continuation member who will become the new main member - SARS assessment (ITA34) or Fund affidavit.



# MORE ABOUT YOUR FUND

## IN THIS SECTION

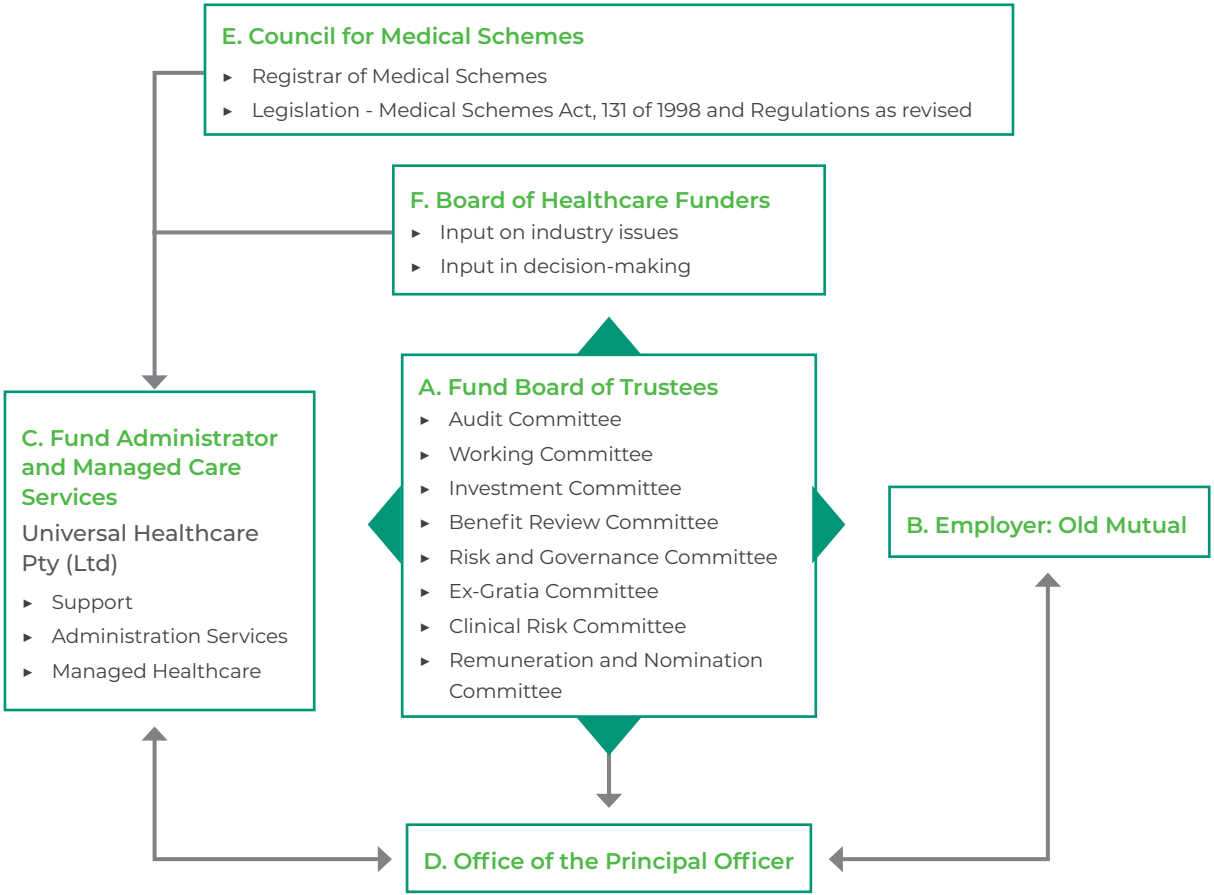
- Who manages the Fund?
- When does the benefit year start?
- What benefits are excluded by the Fund?

## Who manages the Fund?

The Fund is managed by a Board of Trustees consisting of five members appointed by the Employer and five member-elected Trustees. Elected members serve a three-year term and may be re-elected to office. The Trustees are responsible for the proper and sound management of the Fund in terms of the Medical Schemes Act and Regulations, other legislation and the Rules of the Fund.

The Board of Trustees has the following sub-Committees:

- The Audit Committee consists of representatives from the Board of Trustees and independent members. The primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Fund's accounting policies, internal control systems and financial reporting practices. The external auditors formally report to the Committee on critical findings arising from audit activities.
- The Working Committee assists the Board of Trustees with operational and industry-related issues.
- The Benefit Review Committee's primary responsibility is to act in an advisory capacity for the benefit and contribution reviews, make recommendations to the Board regarding the choice and appointment of new and existing third party agreements, and approve provider tariffs on behalf of the Board within the guidelines set by the Board.
- The Investment Committee's primary responsibility is to assist the Board of Trustees in carrying out its duties relating



to the investment policy of the Fund. These include meeting benefit and operating expense commitments; managing financial risk; satisfying regulatory requirements that apply to medical scheme investments; and maximising investment returns.

- The Risk and Governance Committee assists the Board of Trustees in carrying out its duties relating to risk and governance assessments, evaluation and management processes. Risks are reviewed and identified annually and appropriate strategies are implemented.
- The Ex-Gratia Committee has the responsibility of assisting the Board of Trustees in the receiving of all member applications for payments for which there is no obligation on the Fund, and making decisions on them for the Fund.
- The Clinical Risk Committee is responsible for the oversight and governance of the Fund's managed care activities. This includes ensuring, within budgetary constraints and legislative requirements, that cost-effective, good quality treatment is funded for members of the Fund.
- The Remuneration and Nomination Committee assists the Board in establishing a formal and transparent procedure for developing and implementing a remuneration and nomination policy and makes recommendations on succession planning.

Medical scheme benefits are provided by the Employer, via the Fund, to all permanent, full-time employees of Old Mutual.

The Administrator provides an administration service to the Fund and keeps abreast of trends in the healthcare industry. In addition, they liaise with bodies in the industry, such as the Council for Medical Schemes (E) and the Board of Healthcare Funders (F).

Universal Healthcare provides actuarial services to the Fund and provides input on the benefits and contributions of the Fund. Universal Healthcare conducts research on a regular basis to ensure that the medical scheme benefits offered by Old Mutual are in line with those offered by competitors and that the members' needs have been taken into account.

The Principal Officer is the executive officer of the Fund, who must ensure that the decisions and instructions of the Board of Trustees are carried out in line with current legislation. The Principal Officer is also the link between the Fund, the Employer and the Administrator.

## When does the benefit year start?

The Fund's benefit year runs from 1 July to 30 June of the following year. You will be entitled to full benefits if your membership is active at the beginning of the benefit year. If you join the Fund during a benefit year, you will only be entitled to pro-rata benefits. If there is movement in membership, for example, the addition or removal of a dependant, benefits will be adjusted accordingly.

## What benefits are excluded or limited by the Fund?

The following is a summary of the services NOT covered in terms of the Rules of the Fund.

In order to ensure that your specific procedure is not excluded, please find a complete list of exclusions on the Fund website, or call the Contact Centre on 0860 100 076 or +27 11 208 1021.

1. Pre-authorisation will only be considered for Otoplasty (repair of bat ears) performed on beneficiaries who are 12 years or younger. No benefit is available for Otoplasty for any beneficiary who is older than 12 years.
2. The Fund reserves the right not to pay for any new medical technology, gene sequencing, investigational procedures, interventions, drugs or medicine as applied in accepted clinical practice, including new indications for existing medicines or technologies, unless the following clinical data relating to the above have been presented to and accepted by the Medical Advisory Committee of the Fund's contracted managed care organisation and such data successfully demonstrates:
   - therapeutic role in clinical medicine;
   - cost-efficiency and affordability;
   - value relative to existing services or supplies;
   - role in drug therapy as established by the Fund's managed healthcare organisation.
3. The Fund (or contracted managed care company on behalf of the Fund) may from time to time contract with or pilot with credentialed specific provider groups (networks) or centres of excellence as determined by the Fund in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Fund's DSP for PMB benefits and other benefits (as set out in Annexure D Rule 6). The Fund reserves the right not to fund, partially fund or may impose a co-payment for services acquired outside of these networks and that the member is aware of the need to use such a network for the provision of medical care, provided reasonable steps are taken by the Fund to ensure access to the network, and that the member is aware of the need to use such a network for the provision of care. The application of these rules will be subject to Prescribed Minimum Benefits.
4. Investigations, operations or treatments for cosmetic purposes, obesity, artificial insemination, impotence and erectile dysfunction or treatment of an experimental nature except for Prescribed Minimum Benefits.
5. Holidays for recuperative purposes.
6. Purchase of:
   - applicators, toiletries and beauty preparations;
   - bandages, cotton wool and similar aids;
   - contraceptives (condoms and foams only);
   - household and biochemical remedies;
   - sunglasses and prescription sunglasses;

- tinted or coloured Plano lenses and other cosmetic effect contact lenses and contact lens accessories;
- home remedies;
- exercise equipment;
- vitamins (unless prescribed by a registered practitioner during pregnancy or for oncology or HIV.); and
- probiotics (for example, Inteflora, Reuterina, Reuteri)

7. All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules of the Fund.

8. All costs in respect of sickness conditions that were specifically subjected to a waiting period when the member joined the Fund.

9. The purchase of medicines not included in a prescription from a person legally entitled to prescribe.

10. Examinations for insurance, employment, visas, pilot and driving licences or examinations for enrolment to University and College.

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

12. Sleep therapy, art therapy, music therapy, therapeutic massage therapy, aromatherapy and iridology.

13. Treatment or surgery for scars, keloids and excision of a tattoo are deemed to be for cosmetic purposes except in cases of severe burn scars on the face and neck and functional impairment such as contractures. Where necessary the Board will refer cases to a panel of Medical Specialists for a final decision. The decision of the Board following advice from the Specialist panel will be final.

14. Any medical and/or surgical procedure related to the Gamete Intrafallopian Tube Transfer, In-Vitro fertilisation, Zygote Intrafallopian Tube Transfer, Pronuclear Stage Tubal Transfer or any other transfer or egg or sperm collection will not be covered by the Fund. Any other treatment or investigation or service not covered in respect of Code 902M (Diagnosis: Infertility) under the Prescribed Minimum Benefits will not be covered by the Fund.

15. Where diagnostic tests and examinations are performed but do not result in confirmation of a Prescribed Minimum Benefit diagnosis, except for an emergency medical condition as defined in regulation 7 of the Medical Schemes Act, 1998 or a test requested by the Fund's DSP for day-to-day services, such diagnostic tests or examinations are not considered to be a Prescribed Minimum Benefit.

16. Periodontic plastic procedures for cosmetic reasons.

17. Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.

18. Robotic assisted surgery, other than for radical prostatectomy where authorised by the managed healthcare organisation; additional costs relating to use of the robot during such pre-authorised surgery, and including additional fees pertaining to theatre time, disposables, and equipment fees.

19. Long-term implantable ventricular assist devices and total artificial hearts, for example HeartWare and Berlin heart.

20. General anaesthetics, conscious sedation and hospitalisation for dental work, except in the case of patients under the age of 8 years or bony impactions of the third molars.

21. All general anaesthetics and conscious sedation in the practitioner's rooms, unless pre-authorised.

22. The following medicines, unless they form part of the public sector protocol, or qualify in terms of Prescribed Minimum Benefits and are authorised by the relevant managed healthcare programme:

    - any specialised drugs as defined by the managed care company (e.g. biologicals, tyrosine kinase inhibitors) that have not convincingly demonstrated a median overall survival advantage of more than three (3) months in advanced or metastatic malignancies, unless deemed cost-effective for the specific setting compared to standard therapy (excluding specialised drugs) as defined in established and generally accepted treatment protocols, for example Sorafenib for hepatocellular carcinoma, Bevacizumab for colorectal and metastatic breast cancer.
    - Carmustine wafers for the treatment of malignant gliomas.
    - Liposomal amphotericin B for fungal infections.
    - Custom-made hip arthroplasty for inflammatory and degenerative joint disease.

- Services that are regarded as not medically necessary. "Medically necessary" refers to services or supplies that are not rendered or provided because of personal choice or preference of the relevant beneficiary or service provider, while other medically appropriate, more cost-effective alternatives exist. The medical need shall be determined by the Fund taking into account the above requirements. The fact that a Doctor has prescribed, recommended, approved or provided a treatment, service, supply or confinement shall not in itself be regarded as proof that a service is medically necessary. Where necessary the Board will refer cases to a panel of Medical Specialists for a final decision. The decision of the Board following advice from the Specialist panel will be final.

23. Out of hospital maternity benefits that include antenatal classes, specialist antenatal visits and prenatal vitamins on the **Network** and **Network *SELECT*** Plans.
    Out of hospital maternity benefits that include antenatal classes, antenatal visits, prenatal vitamins, maternity related ultra sound scans and pathology on the **Hospital** Plan.
24. Dental surgery on the **Network** (including ***SELECT***) and **Hospital** Plans.
25. Elective (non-PMB) hip, knee, shoulder or elbow replacements on the **Network** (including ***SELECT***) and **Hospital** Plans.

The Fund reserves the right not to pay for procedures performed by non-recognised providers (where applicable).

Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or that requires access to certain infrastructure for quality outcomes. Where such procedures have been identified by the Fund's contracted managed healthcare service provider, recognised providers are those who have been acknowledged by meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed care provider and/or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

The Fund (or contracted managed care company on behalf of the Fund) may from time to time contract with or credential specific provider groups (networks) or centres of excellence as determined by the Fund in order to encourage high-quality, cost effective and appropriate care. The Fund reserves the right not to fund or partially fund services acquired outside of these networks, provided reasonable steps are taken by the Fund to ensure access to the network.

15

# FREQUENTLY ASKED **QUESTIONS**

## IN THIS SECTION

- What is the difference between Medical Scheme Rates and the rates charged by medical practitioners?
- If I visit the Emergency Rooms (ER) at a hospital, will my costs be covered from my Hospital Benefits?
- When will elective procedures be regarded as PMB and therefore be covered under the Hospital and Network (including ***SELECT***) Plans?
- Can I claim for medical expenses incurred outside South Africa?
- What happens in the case of motor vehicle accidents?
- Does the Fund pay for claims in terms of the Compensation for Occupational Injuries and Diseases Act?
- How can I keep my medical costs low?
- What should I do if I suspect fraudulent activity against the Fund?
- When do I get my tax certificate from the Fund?
- Where can I obtain a membership certificate?
- How does my membership card work?
- What can I do if I have an unresolved complaint against my medical aid fund?
- What is the Credit Management Policy and its main objectives?

## What is the difference between Medical Scheme Rates and the rates charged by medical practitioners?

It is really important that you understand the difference between Medical Scheme Rates (MSR) and the rates charged by private providers.

MSR is the tariff determined by the Board of Trustees and is adjusted from time to time, following consultation with suppliers in the industry. On the **Traditional** and **Traditional Plus** (including ***SELECT***) Plans, the Fund covers Day-to-Day Benefits at 100% of cost from PMSA, and then at 1 x MSR from PCB for the **Traditional** (including ***SELECT***) Plan and at 3 x MSR from PCB for the **Traditional Plus** (including ***SELECT***) Plan. Hospital Benefits and Supplementary Benefits are covered at 1 x MSR on all Plans.

However, medical practitioners are under no obligation to charge MSR. Due to the often substantial difference between MSR and the rates charged by medical practitioners, 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.

## If I visit the Emergency Rooms (ER) at a hospital, will my costs be covered from my Hospital Benefits?

A visit to a hospital's Emergency Room does not qualify to be paid from your Hospital Benefit, unless the incident is of such a serious nature that you are admitted to a ward in the hospital itself, for further treatment.

Furthermore, 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.

## When will elective procedures be regarded as PMB and therefore be covered under the Hospital and Network (including *SELECT*) Plans?

Under the **Hospital** and **Network** (including ***SELECT***) Plans, elective procedures will only be covered in accordance with PMB. This means, for example, 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). Alternatively, an emergency admission where loss of limb has to be prevented will also qualify as PMB.

## Can I claim for medical expenses incurred outside South Africa?

If you are injured or become ill while outside South Africa on holiday or business, you will be responsible for settling the account. You can claim the cost back from the Fund when you return.

Claims that are approved will be subject to the Fund's Rules as if the treatment was rendered in South Africa. In other words, the same exclusions, benefits and limits will apply.

Submit your original claim to foreignclaims@omsmaf.co.za.

The benefit will be paid according to the equivalent tariff and will be refunded to the member in Rands, at the exchange rate that applied on the treatment date. If you are intending to travel abroad, it is wise to take out additional medical cover. Your travel agent will be able to assist you with this.

## What happens in the case of motor vehicle accidents?

Motor vehicle accident (MVA) claims have certain procedures, which must be strictly adhered to. The Fund will pay for claims related to such an accident, whether it qualifies as Prescribed Minimum Benefits or not.

To help the Fund recover a portion of the millions of rands spent on claims related to motor vehicle accidents, members have an obligation to co-operate with the recovery process by disclosing all information relating to a possible third-party claim, and to sign all the required legal documents. You will also be required to sign a member undertaking, stating that you will pay the Fund back if you receive a settlement that includes money that the Fund paid on your behalf.

If you are involved in a motor vehicle accident where a third party is liable, inform the Fund as soon as possible at 0860 100 076. Claims will be paid to the service providers (such as the hospitals and doctors concerned) up to the individual member's limits.

Cases that are rejected by the Road Accident Fund will be covered by the Fund up to the individual member's limits. However, a letter will be required from the Road Accident Fund stating that the claim has been rejected. Decisions will be made based on the Rules of the Fund.

If you decide not to institute a claim against a third party (for instance, if your injuries were not serious and did not result in long-term physical impairment or a treatment plan), you will be requested to cede your rights to claim against a third party to the Fund. This will allow the Fund to institute a claim directly, to recover the costs that were paid by the Fund.

## Does the Fund pay for claims in terms of the Compensation for Occupational Injuries and Diseases Act?

**No, such claims are not covered by the Fund.**

Forms in respect of the Compensation for Occupational Injuries and Diseases Act should be completed by the treating hospital or medical practitioner and your Employer, and then submitted

to the Compensation Commissioner. The Fund will not pay any benefits until the Commissioner rules that the injury does not fall under the Compensation for Occupational Injuries and Diseases Act.

## How can I keep my medical costs low?

- Negotiate with your doctor to charge MSR or to give you a discount, if he or she has opted out of charging according to MSR.
- Consider paying in cash and then claiming back, as many service providers offer discounts if they are paid in cash.
- Talk to your doctor about prescribed medicines. An alternative generic medicine may be as effective, and cost you much less. If you are too shy to approach the doctor, the dispensing pharmacist can do this for you.
- Try to avoid all unnecessary treatments. This is wasteful and costly to you and the Fund.
- If your doctor recommends a particular line of treatment and you feel uncertain about whether it is necessary, ask for a second opinion.
- If an operation is scheduled for the afternoon or evening, please arrange for the hospital admission after 12pm. That way the Fund will only pay for the afternoon (i.e. a half-day).
- If you are on the Savings, Traditional or Traditional Plus (including SELECT) Plan and require a non-PMB hip or knee replacement, you have to use the Fund's Designated Service Providers, where available. If you do not use the DSP, you will have a compulsory R5 000 co-payment and may be liable for additional associated costs in excess of the Medical Scheme Rate. See page 80 for more information.
- Use pharmacy Preferred Providers, as these providers offer cost-saving options that will make your medical aid benefits last longer, through low medicine price and generic substitution, as well as not charging additional administration fees. You may obtain medicine from any other Pharmacy; however a co-payment may be applied. If a pharmacy charges more than the Fund's approved rates (which will not occur at any of the contracted pharmacies) you will be liable for the difference.

## What should I do if I suspect fraudulent activity against the Fund?

Unnecessary and fraudulent expenses are funded by you, the member, through increased contributions. 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.

Examples of fraud scams are:

- A service provider putting in a claim for services that were never rendered.
- A service provider performing a procedure or giving treatment that is excluded by the Fund Rules, and then charging for it under a different code.
- A pharmacy providing generic medicine, but charging for the more expensive brand name.

If you suspect that a service provider, colleague or any other person or organisation may be engaged in fraudulent activities against the Fund, please contact the Fraud Hotline on:

**Toll free number:** 080 111 4447

**Fax :** 086 672 1681

**Email:** fraud@omsmaf.co.za

**Website:** thehotline.co.za

**WebApp:** thehotlineapp.co.za

**Callback No (please call me's):** 072 595 9139

You can choose to remain anonymous.

## When do I get my tax certificate from the Fund?

The Fund will mail or e-mail the tax certificate to you by June each year. Please keep this in a safe place for later use. The Fund only stores information relating to tax certificates for a period of 5 years.

## Where can I obtain a membership certificate?

Contact 0860 100 076 to request a certificate. Alternatively, e-mail membership@omsmaf.co.za.

## How does my membership card work?

Your membership card (e-card) is available electronically on your smartphone.

Whereas it is possible for someone to use your plastic membership card fraudulently, your e-card ensures that only you can use it.

The e-card facility will initially run in parallel with printed cards. Printed cards will only be phased out once we are satisfied that the e-card works well.

However, you will still be able to request a plastic membership card from the Fund.

## What can I do if I have an unresolved complaint against the Fund?

Please ensure that you follow the Fund's internal escalation procedure before lodging a complaint with the Council for Medical Schemes (CMS).

- The Registrar of the Council for Medical Schemes is the regulator of the medical scheme industry. Any member or any person who is aggrieved with the conduct of a medical scheme, health professionals, private hospital or nurse, can submit a complaint to the Registrar's Office.
- A complaint form is available on their website (medicalschemes.com).
- Complaints can be submitted through fax, e-mail or in person at the Registrar's office. The Registrar's contact details are as follows:

  **Customer Care Share call telephone number:**
  0861 123 267 or +27 12 431 0500

  **Fax number:** +27 12 431 7544

  **Email address:** complaints@medicalschemes.com

  **Street address:**
  Council for Medical Schemes
  Block A Eco Glades 2 Office Park
  420 Witch-Hazel Street
  Ecopark
  CENTURION

- The Registrar's Office will send a written acknowledgement of a complaint within 3 working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with the complaint.
- In terms of Section 47 of the Medical Schemes Act, a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the Registrar's Office within 30 days.

- The Registrar's Office shall, within 4 days of receiving the complaint from the administrator, analyse the complaint and refer the complaint to the medical scheme for comments.
- Upon receipt of the response from the medical scheme, the Registrar's Office will analyse the response in order to make a decision or ruling. Decisions / rulings will be made within 120 days of the date of referral of a complaint and communicated to the parties.

### The Registrar's Ruling and appeal to Council

- Section 49 of the Act makes provision for any party who is aggrieved with the decision of the Registrar to appeal such a decision. This appeal is at no cost to either of the parties.
- An appeal must be lodged within 30 days of the date of the decision. The operation of the decision shall be suspended pending review of the matter by the Council's Appeals Committee.
- The secretariat of the Appeals Committee will inform all parties involved of the date and time of the hearing. This notice should be provided no less than 14 days before the date of the hearing.
- The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative.
- The Appeals Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision as they seem just.

### The Section 50 Appeals process

- Any party that is aggrieved with the decision of the Appeals Committee may appeal to the Appeal Board.
- The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanation of the grounds of his or her appeal.
- The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing.
- Appeal Board shall be heard in public unless the chairperson decides otherwise.
- The Appeal Board shall have the powers which the High Court has to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.
- The decisions of the Appeal Board are in writing and a copy thereof shall be furnished to parties. A prescribed fee of R2 000 is payable for Section 50 Appeals.

## What is the Credit Management Policy and its main objectives?

The Credit Management Policy is a policy put in place by the Trustees to ensure that debt owed to the Fund is collected timeously.

# 16 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** and **Traditional Plus** (including ***SELECT***) 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:<br>▸ Basic pathology<br>▸ Basic radiology<br>▸ Optometry<br>▸ Auxiliary services, subject to beneficiary and family sub-limits per benefit year. |
| **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.<br>**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 July to 30 June. 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. |

| Term | Explanation |
|---|---|
| **Child dependant** | "CHILD", shall mean a member's or a member's spouse's or partner's:<br>(a) natural child and/or<br>(b) grandchild and/or<br>(c) great grandchild and/or<br>(d) stepchild of the member and/or<br>(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<br>(f) a child for whom the member has a duty of support; and/or<br>(g) a child who is factually being cared for by the member including an orphaned child and/or<br>(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, 20015 (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. |
| **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, Jointcare and DBC, as well as Clicks, Dis-Chem and Pick n Pay pharmacies for pharmacy-based Wellness Benefits. |
| **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. |

| Term | Explanation |
|---|---|
| **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.<br>▸ For employees whose remuneration is pensionable remuneration received from the Employer: Income = Pensionable Remuneration divided by 90%.<br>▸ For employees whose remuneration is deemed commission received from the Employer: Income = deemed commission received from the Employer.<br>▸ For employees who earn a fixed income and commission, the medical aid contribution will be based on the fixed income only.<br>▸ For any members other than retirees: Income = their gross monthly income.<br>▸ 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. |
| **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 aid scheme after the age of 35, or who have never been medical aid 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 aid 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. |

| Term | Explanation |
|---|---|
| **Medicine Price** | Amount payable by the Fund in respect of medicines. This amount is the sum of the SEP 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. |
| **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:<br>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, ICPS and Jointcare. |
| **Universal Healthcare Comprehensive Formulary** | Applicable to the **Traditional** and **Traditional Plus** (including ***SELECT***) 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. |

| Term | Explanation |
|---|---|
| **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 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<br>contributions to the Fund. There are two types of waiting periods:<br>▸ **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.<br>▸ **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. |

# *SELECT* list of hospitals

Please note that this list may change from time to time, and that the Fund cannot guarantee the correctness of the hospital contact details. For up-to-date details of the ***SELECT*** list of hospitals in your area, please call 0860 100 076.

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| **EASTERN CAPE** | | | |
| **ACUTE** | | | |
| East London | LIFE EAST LONDON PRIVATE HOSPITAL | 32 Albany Street, East London | 043 722 3128 |
| East London | LIFE ST DOMINIC'S HOSPITAL | 45 St Marks Road, Southernwood, East London | 043 707 9000 |
| East London | LIFE ST JAMES HOSPITAL | 36 St James Road, Southernwood, East London | 043 722 9685 |
| East London | LIFE BEACON BAY HOSPITAL | 32 Quenera Drive, Beacon Bay | 043 711 5100 |
| East London | EAST LONDON EYE HOSPITAL | 20 St James Road, Southernwood, East London | 043 743 4334 |
| Gelvandale | LIFE MERCANTILE PRIVATE HOSPITAL | Cnr Kempston & Durban Roads, Korsten | 041 404 0400 |
| Humansdorp | LIFE ISIVIVANA PRIVATE HOSPITAL | Du Plessis Street, Humansdorp | 042 200 4250 |
| Matatiele | MATATIELE PRIVATE HOSPITAL | 101 High Street, Matatiele | 039 737 3088 |
| Mthatha | LIFE ST MARY'S PRIVATE HOSPITAL | 30 Durham Road, Mthatha | 047 505 5600 |
| Mthatha | MTHATHA PRIVATE HOSPITAL | Cnr Durham & Victoria Street, Mthatha | 047 532 5005 |
| Port Elizabeth | LIFE ST GEORGES HOSPITAL | 40 Park Drive, Port Elizabeth | 041 392 6111 |
| Queenstown | CARE CURE QUEENSTOWN | King Edward Road, Westbourne | 045 838 4723 |
| Queenstown | LIFE QUEENSTOWN PRIVATE HOSPITAL | Cnr Ebden & Griffith Street, Queenstown | 045 838 4110 |
| **PSYCHIATRIC HOSPITALS** | | | |
| East London | LIFE ST MARK'S CLINIC | 16 St Andrews Road, Southernwood, East London | 043 707 4400 |
| Port Elizabeth | LIFE HUNTERSCRAIG PSYCHIATRIC HOSPITAL | 22 Park Drive, Central, Port Elizabeth | 041 586 2664 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| DAY HOSPITALS | | | |
| East London | EAST LONDON EYE HOSPITAL | 18 Saint James Road, Southernwood | 043 743 4334 |
| Port Elizabeth | MEDICAL FORUM THEATRE | 205 Cape Road, Newton Park, Port Elizabeth | 041 373 0682 |
| **FREE STATE** | | | |
| ACUTE | | | |
| Bloemfontein | BUSAMED BRAM FISCHER | Mazelspoort Rd, Bram Fischer International Airport, Bloemfontein | 051 412 4200 |
| Bloemfontein | LIFE ROSEPARK HOSPITAL | 57 Gustav Crescent, Fichardt Park, Bloemfontein | 051 505 5111 |
| Bloemfontein | HORIZON EYE CARE CENTRE | 54 Pasteur Drive, Hospital Park, Bloemfontein | 051 520 1200 |
| Bloemfontein | CAIRNHALL HOSPITAL | 20 Logeman St, Universitas, Bloemfontein | 051 522 3805 |
| Frankfort | RIEMLAND CLINIC | Cnr Frankfort & Collin St, Frankfort | 058 813 2771 |
| Harrismith | BUSAMED HARRISMITH PRIVATE HOSPITAL | Cnr Alexandra and Vowe Street, Harrismith | 058 624 3000 |
| Welkom | RH MATJHABENG | Stand 7186, 1 Power Road, Welkom | 057 402 0900 |
| Welkom | ST HELENA PRIVATE HOSPITAL | Hamlet Road Extension, St Helena, Welkom | 057 391 4611 |
| PSYCHIATRIC HOSPITALS | | | |
| Bloemfontein | BLOEMCARE PHYCHIATRIC CLINIC | 11 AG Visser St, Bloemfontein | 051 446 3242 |
| Bloemfontein | HILLANDALE HEALTHCARE CENTRE | 6 Woodlands Hills Blvd, Woodlands Hills, Bloemfontein | 051 412 3300 |
| Bloemfontein | M-CARE OPTIMA (BLOEMPSYCH) | 17 Addison St, Hospital Park, Bloemfontein | 051 502 1800 |
| DAY HOSPITALS | | | |
| Bethlehem | BETHLEHEM MEDICAL CENTRE | 4 De Leeuw St, Bethlehem | 058 303 5564 |
| Bloemfontein | CURE DAY HOSPITAL – BLOEMFONTEIN | 29 Poole St, Bloemfontein | 051 072 0018 |
| Bloemfontein | CITYMED DAY CLINIC | Preller Plain Shopping Centre, cnr Louw Wepener & Graaff-Reinet St, Bloemfontein | 051 436 4320 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| Bloemfontein | HORIZON EYE CARE CENTRE (BLOEMFONTEIN EYE) | 54 Pasteur Dr, Hospitaalpark, Bloemfontein | 051 502 1900 |
| Welkom | WELKOM MEDICAL CENTRE | 5 Lategan St, St Helena, Welkom | 057 352 2114 |
| **GAUTENG** | | | |
| **ACUTE** | | | |
| Bedfordview | LIFE BEDFORD GARDENS PRIVATE HOSPITAL | 7 Leicester Road, Bedford Gardens, Bedfordview | 011 677 8500 |
| Benoni | LIFE GLYNNWOOD HOSPITAL | 33 - 35 Harrison Street, Benoni | 011 741 5000 |
| Benoni | SUNSHINE HOSPITAL | 1522 Soma St, Actonville, Benoni | 011 744 8714 |
| Carletonville | THE FOUNTAIN PRIVATE HOSPITAL | Annan Road Ext A (Provincial Road R500), Carletonville | 018 788 1000 |
| Faerie Glen | LIFE FAERIE GLEN HOSPITAL | Cnr Atterbury & Oberon Avenue, Faerie Glen | 012 369 5600 |
| Faerie Glen | LIFE WILGERS HOSPITAL | Denneboom Road, Wilgers Ext. 14, Pretoria | 012 807 8100 |
| Fochville | FOCHVILLE HOSPITAL | 10/12 Third Street, Fochville | 018 771 2021 |
| Germiston | LIFE ROSEACRES CLINIC | Cnr Castor & St Joseph St, Symhurst, Primrose | 011 842 7500 |
| Heidelberg | LIFE SUIKERBOSRAND CLINIC | Cnr H F Verwoerd, Maré & Begeman St, Heidelberg | 016 342 9200 |
| Johannesburg | LIFE BRENTHURST CLINIC | 4 Park Lane, Parktown, Johannesburg | 011 647 9000 |
| Kempton Park | ARWYP MEDICAL CENTRE | 20 Pine Avenue, Kempton Park, Gauteng | 011 922 1000 |
| Lenasia | AHMED KATHRADA PRIVATE HOSPITAL | K43 Highway, Lenasia Ext 8 | 011 213 2019 |
| Lenasia | LENMED DAXINA PRIVATE HOSPITAL | Stand 1682, Impala St, Lenasia South | 011 213 7000 |
| Pretoria | LIFE EUGENE MARAIS HOSPITAL | 696 5th Avenue, Les Marais, Pretoria | 012 334 2777 |
| Pretoria | UROLOCARE HOSPITAL | Grosvenor St & Pretorius St, Hatfield | 012 423 4000 |
| Pretoria | ZUID-AFRIKAANS HOSPITAAL | 255 Bourke St, Muckleneuk | 012 343 0300 |
| Randfontein | LIFE ROBINSON HOSPITAL | Hospital Road, Randfontein | 011 278 8700 |
| Randfontein | LENMED RANDFONTEIN PRIVATE HOSPITAL | Ward Avenue, Randfontein | 011 411 3000 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| Roodepoort | LIFE WILGEHEUWEL PRIVATE HOSPITAL | Amplifier Road, Radiokop Ext 13, Roodepoort | 011 796 6500 |
| Sandton | BUSAMED MODDERFONTEIN PRIVATE HOSPITAL ORTHOPAEDIC & ONCOLOGY CENTRE | 4 Cransley Crescent, Long Lake Ext. 12, Linbro Park, Edenvale | 011 458 2000 |
| Saxonwold | GENESIS MATERNITY CLINIC - SAXONWOLD | 5 Northwold Drive, Cnr Jan Smuts & Northwold, Saxonwold, Johannesburg | 011 544 9800 |
| Soshanguve | BOTSHILU PRIVATE HOSPITAL | Block 212, Buitenkant St, Soshanguve, Pretoria | 012 798 7000 |
| Springs | LIFE SPRINGS PARKLAND CLINIC | West Road, Pollak Park, Springs | 011 812 4000 |
| Tembisa | LENMED ZAMOKUHLE | 128 Flint Mazibuko Dr, Hospital View, Tembisa | 087 087 0643 |
| Vanderbijlpark | CORMED CLINIC | 3 Cormed Clinic, Pasteur Boulevard, Vanderbijlpark | 016 981 8080 |
| Vereeniging | MIDVAAL PRIVATE HOSPITAL | Cnr Square & Nile Drive, Three Rivers, Vereeniging | 016 454 6004 |
| **PSYCHIATRIC HOSPITALS** | | | |
| Alberton | AKESO ALBERTON CLINIC | 15 Clinton Road, New Redruth, Alberton | 087 098 0456 |
| Benoni | LIFE GLYNNVIEW PRIVATE HOSPITAL | 129 – 131 Howard Avenue, Benoni | 011 741 5460 |
| Centurion | VISTA PRIVATE PSYCHIATRIC CLINIC | 135 Gerhard St, Centurion | 012 664 0222 |
| Johannesburg | LIFE RIVERFIELD LODGE | 34 Southernwoods Road, Nietgedacht, Johannesburg | 086 074 8373 |
| Johannesburg | AKESO CRESCENT CLINIC RANDBURG | Cnr President Fouche & Hawken Ave, Bromhof, Randburg | 087 098 0457 |
| Johannesburg | AKESO PARKTOWN CLINIC | 6 Junction Ave, Parktown, Johannesburg | 011 590 9500 |
| Pretoria | AKESO ARCADIA CLINIC | 871 Francis Baard Street, Pretoria | 087 098 0459 |
| Pretoria | DENMAR SPECIALIST PSYCHIATRIC HOSPITAL | 507 Lancelot Road, Garsfontein X16, Pretoria | 012 998 6062 |
| Pretoria | FISHA WELLNESS HOSPITAL | 1 Rebecca Street, Pretoria West | 012 327 5056 |
| Pretoria | ZWAVELSTREAM CLINIC | Plot 122, Achilles Road, Zwavelpoort, Pretoria East | 010 475 0150 |
| Roodepoort | LIFE POORTVIEW HOSPITAL | 18 Malcolm Road, Poortview, Roodepoort | 087 352 2100 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| DAY HOSPITALS | | | |
| Alberton | OPTIMED EYE CARE CENTRE | 1 Danie Theron Street, Alberante, Alberton | 011 896 1717 |
| Alberton | THE EAR AND EYE CLINIC | 3 Dirk Smit Cres, Meyersdal, Alberton | 010 001 9057 |
| Benoni | LAKEFIELD SURGICAL CENTRE | 23 Lakefield Avenue, Lakefield | 011 894 8008 |
| Benoni | THE HEALTHY EYE | 177 Princess Ave, Benoni | 012 427 0105 |
| Boksburg | ADVANCED EAST RAND DAY HOSPITAL | 52 Olivia Road, Eveleigh, Boksburg | 010 534 6321 |
| Bramley | CENTRE OF ADVANCED MEDICINE | 13 Scott Steet, Waverley, Bramley | 011 033 1300 |
| Brooklyn | BROOKLYN SURGICAL CENTRE | Cnr Jan Shoba & Olivier St, 154 Olivier St, Brooklyn | 012 433 0860 |
| Bryanston | SANDHURST EYE CENTRE | 53 Saxon Road, Sandhurst, Bryanston | 011 217 7530 |
| Centurion | CENTURION DAY HOSPITAL | 192 Glover Avenue, Centurion | 012 663 2010 |
| Centurion | CENTURION EYE HOSPITAL | Lifestyle Management Park, 223 Clifton Ave, Lyttleton | 012 644 5000 |
| Crown Mines | FORDSBURG CLINIC | 22 Bonanza Str, Selby Ext 19, Crown Mines | 011 834 4015 |
| Edenvale | EDENVALE DAY CLINIC | 10 Van Riebeeck Ave, Edenvale | 011 453 7628 |
| Emmarentia | VISIOMED EYE LASER CLINIC | 269 Beyers Naude Drive, Northcliff, Emmarentia | 011 476 3119 |
| Florida | FAUCHARD CLINIC | Cnr Jan Smuts Ave & Jan Hofmeyer, Florida Park, Florida | 011 472 2940 |
| Florida | MAYO CLINIC OF SOUTH AFRICA | Cnr Joseph Lister St & William Nicol Road, North Constantia Kloof, Florida | 011 670 3400 |
| Fourways | CURE DAY HOSPITAL - FOURWAYS | 7 Sunset Lane, Magaliesig, Fourways | 010 597 1973 |
| Johannesburg | JOHANNESBURG EYE HOSPITAL | Cnr Beyers Naude & Waugh Ave, Northcliff, Johannesburg | 011 678 1088 |
| Johannesburg | TWENTY TWENTY EYE SURGERY CENTRE | Room 208, Mulbarton Medical Centre, Mulbarton, 25 True North Rd | 011 432 4747 |
| Kempton Park | BIRCHMED SURGICAL CENTRE | 8 Tiger St, Brichleigh, Kempton Park | 011 391 3300 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| Kempton Park | EKURHULENI SURGIKLIN DAY CLINIC | 18 Monument Road, Kempton Park | 087 098 0660 |
| Midrand | CURE DAY HOSPITAL – MIDSTREAM | 1 Madelein St, Retire @ Midstream, Midrand Estate | 012 940 9440 |
| Moreletapark | CURE DAY HOSPITAL - ERASMUSKLOOF | 506 Jochemus str, Erasmuskloof X3, Pretoria | 012 003 2001 |
| Morningside | CENTRE FOR GYNAECOLOGICAL ENDOSCOPY SURGICAL UNIT | Inner Circle Medical Centre, First Floor, 159 Rivonia Road, Morningside | 011 911 4770 |
| Pretoria | ADVANCED GROENKLOOF DAY HOSPITAL | Walker Creek Office Park, Building 2, 90 Florence Ribeiro Avenue, Muckleneuk, Pretoria | 012 346 5020 |
| Pretoria | CURE DAY HOSPITAL – MEDKIN | 374 Schoeman Street, Pretoria | 012 322 1230 |
| Pretoria | KILNERPARK DAY CLINIC | 255 Anna Wilson St, Kilner Park, Pretoria | 012 333 4443 |
| Pretoria | LIFE PRETORIA NORTH SURGICAL CENTRE | 260 Burger St, Pretoria North | 012 546 0322 |
| Pretoria | WATERKLOOF SURGICAL CENTRE | 30 Pinaster Avenue, Hazelwood | 012 001 9800 |
| Roodepoort | LIFE WILGEHEUWEL DAY CLINIC | Amplifier Road, Radiokop Ext 13, Roodepoort | 011 796 6500 |
| Roodepoort | ADVANCED MEDGATE DAY HOSPITAL | Cnr Kingfisher & Pheasant St, Helderkruin, Roodepoort | 011 768 1015 |
| Soweto | ADVANCED SOWETO EYE HOSPITAL | Isixyxabesha Street, Ext. 6 Protea Glen, Soweto | 010 591 7306 |
| Vanderbijlpark | OCUMED EYE AND LASER INSTITUTE | 7 Sylviavale, 9 Vaal Drive, Vanderbijlpark | 016 982 4372 |
| Vereeniging | VISICLIN EYE CLINIC | 128 General Hertzog Road, Vereeniging | 016 454 9809 |
| **KWAZULU-NATAL** | | | |
| **ACUTE** | | | |
| Chatsworth | LIFE CHATSMED GARDEN HOSPITAL | 80 Woodhurst Drive, Woodhurst, Chatsworth | 031 459 8000 |
| Clernaville | LIFE THE CROMPTON HOSPITAL | 102 Crompton St, Pinetown | 031 737 3000 |
| Durban | AHMED AL-KADI PRIVATE HOSPITAL | 490 King Cetshwayo Highway, Mayville, Durban | 031 492 3400 |
| Durban | LIFE WESTVILLE HOSPITAL | 7 Spine Road, Westville | 031 251 6911 |
| Durban | ETHEKWINI HOSPITAL AND HEART CENTRE | 11 Riverhorse Drive, Riverhorse Valley Business Estate, Queen Nandi Drive | 031 581 2400 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| Empangeni | LIFE EMPANGENI GARDEN CLINIC | Cnr Biyela & Ukula St, Empangeni | 035 902 8000 |
| Hillcrest | BUSAMED HILLCREST PRIVATE HOSPITAL | 471 Kassier Rd, Assagay, Outer West Durban | 031 768 8000 |
| Kwadukuza | KWADUKUZA PRIVATE HOSPITAL | Theunissen Road, KwaDukuza | 032 815 3000 |
| Ladysmith | LENMED LA VERNA HOSPITAL | 1 Convent Road, Ladysmith | 036 631 0065 |
| Mayville | LENMED SHIFA PRIVATE HOSPITAL | 482 Randles Road, Sydenham | 031 240 5000 |
| Phoenix | LIFE MOUNT EDGECOMBE HOSPITAL | 163 - 179 Redberry Road, Phoenix | 031 537 4000 |
| Pietermaritzburg | DAYMED PRIVATE HOSPITAL | 595 Greytown Rd, Raisethorpe | 033 387 1100 |
| Pietermaritzburg | MIDLANDS MEDICAL CENTRE PRIVATE HOSPITAL | 162 Masukwana St, Pietermaritzburg | 033 341 5000 |
| Port Shepstone | HIBISCUS HOSPITAL | George St, Port Shepstone | 039 688 9960 |
| Richards Bay | MELOMED RICHARDS BAY | John Ross Eco Junction, Cnr N2 & Mr496, Richards Bay | 035 791 5300 |
| **PSYCHIATRIC HOSPITALS** | | | |
| Hammarsdale | HEALING HILLS HOSPITAL | 2 Inchanga Drive, Inchanga, Hammarsdale | 031 783 4272 |
| Pietermaritzburg | AKESO CLINIC – PIETERMARITZBURG | 216 Woodhouse Rd, Scottsville, Pietermaritzburg | 087 098 0454 |
| Umhlanga | AKESO CLINIC – UMHLANGA | 16 Chestnut Crescent, Prestondale, Umhlanga | 087 098 0451 |
| **DAY HOSPITALS** | | | |
| Durban | LORNE STREET ANAESTHETIC CLINIC | 29 Ismail C Meer St, Durban | 031 309 5202 |
| Howick | HOWICK DAY CLINIC | 102 Main Road, Howick | 033 330 2725 |
| Mayville | WESTRIDGE SURGICAL | 95 King Cetshwayo Highway, West Ridge | 031 832 9700 |
| Pietermaritzburg | PIETERMARITZBURG EYE HOSPITAL | 5a Alan Paton Ave, Scottsville, Pietermaritzburg | 033 812 2020 |
| Overport | DURBAN EYE HOSPITAL | 38 South Road, Overport | 031 492 7000 |
| Shelly Beach | SHELLY BEACH DAY CLINIC | Lot 1253, Flamingo Road, Shelly Beach | 039 315 6430 |
| Umhlanga Rocks | KZN DAY CLINIC | 2nd Floor, Intenuity House no 325 | 031 830 3030 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| **LIMPOPO** | | | |
| **ACUTE** | | | |
| Bela-Bela | ST VINCENTS HOSPITAL | Quagga St, Bela-Bela | 014 736 2216 |
| Lebowakgomo | MEDLEB | Jane Furse Road, Lebowakgomo | 087 087 2884 |
| Louis Trichardt | QUALITY CARE PRIVATE HOSPITAL | 83 Grobler St, Louis Trichardt | 015 516 5439 |
| Louis Trichardt | ZOUTPANSBERG PRIVATE HOSPITAL | 47 Joubert St, Elti Villas | 015 516 0720 |
| **MPUMALANGA** | | | |
| **ACUTE** | | | |
| Barberton | RH PHODICLINIC | Cnr Sheba Road & Havelock Street | 013 712 4279 |
| Emalahleni | EMALAHLENI PRIVATE HOSPITAL | 39 Mandela St, Witbank CBD, Emalahleni | 013 655 3000 |
| Middelburg | LIFE MIDMED HOSPITAL | Cnr OR Tambo & Joubert St, Middelburg | 013 283 8700 |
| Nelspruit | KIAAT PRIVATE HOSPITAL | Kiaat Ridge Boulevard, Nelspruit | 013 590 9150 |
| Nelspruit | LOWVELD HOSPITAL | 10 Rothery St, Sonheuwel | 013 752 7576 |
| Nelspruit | NELSPRUIT SURGICLINIC HOSPITAL | 15 Hendrik Potgieter St, Sonheuwel Central, Nelspruit | 013 753 3364 |
| Piet Retief | LIFE PIET RETIEF HOSPITAL | 6 Mansoor St, Kempville, Piet Retief | 017 826 9200 |
| Witbank | LIFE COSMOS HOSPITAL | Cnr OR Tambo & Beatty Ave, Witbank | 013 653 8000 |
| **PSYCHIATRIC HOSPITALS** | | | |
| Nelspruit | AKESO NELSPRUIT CLINIC | Kiaat Ridge Blvd, R40 Drum Rock, Kiaat Ridge, Nelspruit | 087 098 0460 |
| **DAY HOSPITALS** | | | |
| Emalahleni | ADVANCED DE LA VIE DAY HOSPITAL | Centre De La Vie, 2nd Floor, Betty Avenue, Die Heuwels, Emalahleni | 013 590 0660 |
| Emalahleni | HIGHVELD EYE | 4 Lana St, Emhalahleni | 013 658 4040 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| Emalahleni | ADVANCED EMALAHLENI DAY HOSPITAL | Cosmos Centre, Cnr 37 President Avenue & Northey Street, Emalahleni | 013 655 3062 |
| **NORTH WEST** | | | |
| **ACUTE** | | | |
| Klerksdorp | SUNNINGDALE HOSPITAL | 12 Van Ryneveld St, Wilkoppies, Klerksdorp | 018 462 7536 |
| Klerksdorp | WILMED PARK PRIVATE HOSPITAL | Cnr Ametis & Marmer St, Wilkoppies, Klerksdorp | 018 468 7700 |
| Potchefstroom | MOOIMED PRIVATE HOSPITAL | 1 Chief Albert Luthuli Drive, Potchefstroom | 018 293 0802 |
| Rustenburg | LIFE PEGLERAE PRIVATE HOSPITAL | 173 Beyers Naude Drive, Rustenburg | 014 597 7200 |
| Rustenburg | RUSTENBURG MEDI-CARE CENTRE | 54 Zand St, Rustenburg | 014 523 9300 |
| Vryburg | VRYBURG PRIVATE HOSPITAL | 67 Molopo Road, Vryburg | 053 928 3000 |
| Vryburg | RH VRYBURG | 67 Molopo Rd, Vryburg | 053 928 3000 |
| **PSYCHIATRIC HOSPITALS** | | | |
| Hartbeespoort | BEETHOVEN RECOVERY CENTRE | 28 Beethoven Street, Hartbeespoort | 012 253 9922 |
| Klerksdorp | PARKMED NEURO CLINIC | 94 Desmond Tutu Drive, Klerksdorp | 018 462 3072 |
| Mmabatho | CARE CURE KGATELOPELE WELLNESS CENTRE | Unit 4 Gorona, Erf 2465, Mmabatho | 018 384 2400 |
| **DAY HOSPITALS** | | | |
| Rustenburg | RUSTENBURG PRIVATE EYE CLINIC | 64 Brink St, Rustenburg | 014 592 2284 |
| **NORTHERN CAPE** | | | |
| **ACUTE** | | | |
| Hartswater | JANE KEYSER CLINIC PRIVATE HOSPITAL | 11 Verwoerd St, Hartswater | 053 474 2016 |
| Kathu | LENMED HEALTH KATHU PRIVATE HOSPITAL | Frikkie Meyer St, Kathu | 053 723 3231 |
| Kimberley | ROYAL HOSPITAL AND HEART CENTRE | Cnr Welgevonden Street and Jacobus Smit Avenue, Royaldene, Kimberley | 053 045 0350 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| PSYCHIATRIC HOSPITALS | | | |
| Kimberley | CARELINE CLINIC | Portion 91 of Farm Bultfontein nr. 80, Kimberley | 053 030 0014 |
| DAY HOSPITALS | | | |
| Hartswater | Medi-Harts Day Clinic | 28 Hertzog Street, Hartswater | 053 474 0157 |
| **WESTERN CAPE** | | | |
| ACUTE | | | |
| Athlone | MELOMED GATESVILLE | Clinic Road, Gatesville | 021 637 8100 |
| Bellville | MELOMED BELLVILLE | Cnr Voortrekker & AJ West St, Bellville | 021 948 8131 |
| Bellville | CAPE EYE HOSPITAL | Cnr Oosterzee St & DJ Wood Way, Bellville | 021 948 8884 |
| Cape Town | MELOMED TOKAI | Cnr Main & Keyser Roads, Cape Town | 021 764 7500 |
| Claremont | LIFE KINGSBURY HOSPITAL | Wilderness Road, Claremont | 021 670 4000 |
| Claremont | LIFE PENINSULA EYE HOSPITAL | Life Kingsbury Medical Suites, Wilderness Road, Claremont | 021 670 4316 |
| Knysna | LIFE KNYSNA PRIVATE HOSPITAL | Hunters Estate Drive, Hunters Home, Knysna | 044 384 1083 |
| Mitchells Plain | MELOMED MITCHELLS PLAIN | Symphony Walk, Town Centre, Mitchells Plain | 021 392 3126 |
| Mossel Bay | LIFE BAY VIEW PRIVATE HOSPITAL | Cnr Alhof & Ryk Tulbach Street, Mossel Bay | 044 691 3718 |
| Pinelands | LIFE VINCENT PALLOTTI HOSPITAL | Alexandra Road, Pinelands, Cape Town | 021 506 5111 |
| Rondebosch | RONDEBOSCH MEDICAL CENTRE | 85 Klipfontein Road, Rondebosch | 021 680 5920 |
| Somerset West | BUSAMED PAARDEVLEI PRIVATE HOSPITAL | 4 Gardner Williams Ave, Paardevlei Estate, Somerset West | 021 840 6600 |
| Vredenburg | LIFE WEST COAST PRIVATE HOSPITAL | 22 Voortrekker Road, Vredenburg | 022 719 1030 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| PSYCHIATRIC HOSPITALS | | | |
| Bellville | TIJGER CLINIC | 267 Hendrik Verwoerd Drive, Loevenstein | 021 913 7142 |
| Cape Town | LIFE PATH GROUP - WEST BEACH CLINIC | Westport Square, Sandown Rd West, Blouberg Sands | 021 001 0560 |
| Claremont | MELOMED CLAREMONT PRIVATE CLINIC | 148 Imam Haron Street, Claremont | 021 637 8100 |
| Claremont | CRESCENT CLINIC | 269 Main Road, Claremont, Cape Town | 021 762 7666 |
| Claremont | AKESO KENILWORTH CLINIC | 32 Kenilworth Road, Kenilworth, Cape Town | 021 763 4525 |
| Claremont | MONTROSE MANOR EATING DISORDER TREATMENT CENTRE | 7 Montrose Terrace, Bishopscourt | 021 797 9270 |
| Durbanville | M-CARE DURBANVILLE WELLNESS | 14 Hafele Street, Durbanville | 021 010 0813 |
| Durbanville | TYGER VALLEY CLINIC | Belvedere Office Park, Block A, Pasita Street, Rosenpark, Durbanville | 021 974 7660 |
| Fish Hoek | STEPPING STONES TREATMENT CENTRE | Cnr Kommetjie & Van Imhoff St, Kommetjie, Cape Town | 021 783 4230 |
| Goodwood | CLARO CLINIC | Syfred Douglas Street, N1 City, Goodwood | 021 595 8500 |
| Gordon's Bay | HELDERBERG CLINIC | 2 Fijnbos Close, Strand | 021 841 1000 |
| Hout Bay | HARMONY SUBSTANCE ABUSE CLINIC | 7 Valley Road, Hout Bay | 021 790 7779 |
| Paarl | SERENO CLINIC | Cnr Berlyn & Optenhorst St, Memoleon, Huguenot | 021 872 9760 |
| Milnerton | AKESO MILNERTON CLINIC | Milpark Centre, Cnr Koeberg & Ixia St, Milnerton | 087 098 0101 |
| Milnerton | PALM TREE CLINIC | 19A Pentz Drive, Flamingovlei, Milnerton | 021 556 8080 |
| Rondebosch | SUMMIT CLINIC - RONDEBOSCH MEDICAL CENTRE | 85 Klipfontein Road, Rondebosch | 021 659 1100 |
| Vredekloof Heights | CAPE GATE NEURO CLINIC | 2 Koorsboom Crescent, Vredekloof Heights | 021 982 2726 |
| Worcester | PINES CLINIC | Cnr 24 Church & Fairbairn Street, Worcester | 021 342 3113 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| DAY HOSPITALS | | | |
| Atlantis | WESFLEUR PRIVATE CLINIC | Wesfleur Medical Centre, Wesfleur Circle, Atlantis | 021 572 1846 |
| Bellville | CURE DAY HOSPITAL – BELLVILLE | De Tijger Business Park, 59 Hannes Louw Drive, Parow | 021 000 5050 |
| Bellville | KHANGELLA EYE THEATRE TYGERVALLEY | Eye & Laser Centre, 130 Edward Street, Bellville | 021 910 0300 |
| Cape Town | CAPE DENTAL THEATRES | Suite 123, Broadroad Medical Centre, Broad Rd, Wynberg | 021 762 9941 |
| Constantia | DRIFTWOOD CLINIC | 57 Doordrift Road, Constantia | 021 794 1055 |
| Durbanville | ADVANCED DURBANVILLE SURGICAL CENTRE | 3 Somerset Street, Durbanville | 021 976 2339 |
| Durbanville | THE SURGICAL INSTITUTE | 1 Somerset Crescent, Durbanville | 021 976 2339 |
| Fisherhaven | ADVANCED KNYSNA SURGICAL CENTRE | Cnr. Katonkel and Baraccuda Street, Fisherhaven | 012 346 5020 |
| Gardens | ALCHIMIA CLINIC | 40 Kloof Street , 2nd Floor, Gardens, Western Cape | 021 423 2085 |
| George | GEORGE SURGICAL CENTRE | 44 Langenhoven Road, George | 044 873 2472 |
| Hermanus | HERMANUS DAY HOSPITAL | 44 Church Street, Hermanus | 028 312 2722 |
| Khayelitsha | THEMBANI THEATRES | Shop 6, Thembani Shopping Centre, cnr. Lansdowne & Capital Roads, Khayelitsha | 021 387 1166 |
| Kwanonqaba | VIDAMED PRIVATE HOSPITAL | Alhof Drive, Da Nova, Kwanonqaba | 044 690 3402 |
| Newlands | LIFE SPORT SCIENCE ORTHOPAEDIC SURGICAL DAY CENTRE | Mariendahl Terrace, Off Sports Pienaar Road, Newlands | 021 670 9920 |
| Oudtshoorn | CANGO MEDICENTRE | 131 St John St, Oudtshoorn | 044 272 4676 |
| Paarl | CURE DAY HOSPITAL – PAARL | 10 Skool Street, Northern Paarl | 021 200 2309 |
| Panorama | ADVANCED PANORAMA SURGICAL CENTRE | Panorama Healthcare Centre, 2nd Floor, Cnr Rothschild Blvd & Hennie Winterbach, Panorama | 021 911 3555 |
| Parow | PANORAMA LASER CLINIC | 49 Hennie Winterbach St, Panorama | 021 930 1855 |

| Town | Name | Street Address | Telephone |
|---|---|---|---|
| Somerset West | ADVANCED VERGELEGEN SURGICAL CENTRE | 4 Summer Hill Drive, Somerset West | 087 234 9771 |
| Somerset West | CURE DAY HOSPITAL SOMERSET WEST | 18 Gardner Williams Avenue, Paardevlei | 021 824 1240 |
| Somerset West | SOMERSET AESTHETIC CLINIC | Arun Place, Building 6 Suite D, Sir Lowry's Pass Road, Somerset West | 021 851 3400 |
| Worcester | ADVANCED WORCESTER SURGICAL CENTRE | Cnr. Fairbarn and Russel Streets, Worcester | 023 880 0201 |

OLDMUTUAL