TIGER BRANDS

Medical Scheme

2018

Tiger Brands Medical Scheme

Mzansi benefit and member guide

Tiger Brands
Medical Scheme

The Mzansi Network option is an affordable healthcare plan that offers primary cover within the Universal Healthcare Provider Network.

Here's why the Mzansi Network option offers exceptional value and benefits

We cover all your clinically necessary, essential, day-to-day primary healthcare benefits, e.g:

- Unlimited GP visits,
- Unlimited acute and chronic medication,
- Unlimited basic radiology and basic pathology, within the private healthcare environment,
- Basic dentistry and optometry benefits,
- Cover for 27 chronic conditions,
- Wellness benefit, including preventative screening for blood pressure, glucose, cholesterol and body mass index paid from risk,
- You pay only for the first three child dependants - the rest are free!
- Hospitalisation at any private hospital.

Abbreviations

PMB	Prescribed minimum benefit
AFB	Annual Flexi Benefit
MRP	Medicine Reference Price
MMAP	Maximum Medical Aid Price
CDL	Chronic Disease List
***Scheme Rate**	Scheme rate **2017** + **5.7%** or **Agreed Tariff
SAOA	South African Opthalmology Association
Auxiliary services	Associated Medical Services e.g. speech therapy
TBMS	Tiger Brands Medical Scheme

* ***Scheme Rate:*** *The rules of the scheme make provision for benefits to be paid at a specific tariff, or rate, known as 'the Scheme Rate'. This Scheme Rate is in line with the industry benchmark tariff.*

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

Annual Flexi Benefit

Day-to-day services are subject to the utilisation of the Universal Provider Network. Services rendered will be paid at an agreed tariff up to specified limits. Some benefits are subject to the Annual Flexi Benefit (AFB). The AFB will be pro-rated if you join during the year.

AFB Limits:
R 2 500 per beneficiary; subject to a maximum of R 3 700 per family

Day-to-day services paid from the AFB

BENEFITS	LIMITS
Specialists	100% of Agreed Tariff, paid from the AFB. Two visits per beneficiary, subject to a maximum of three per family, per year. Two additional antenatal visits per pregnancy. Specialist visits are subject to referral by a **Universal Network GP.** Pre-authorisation required for each specialist visit.
Basic dentistry	100% of Agreed Tariff, paid from the AFB. One consultation per beneficiary, per year. Preventative care, infection control, fillings, extractions and dental x-rays, subject to protocols, list of applicable dental codes and use of a **Universal Network Dentist**. No benefit for out-of-network dental visits/ procedures except for PMB emergencies.
Specialised Dentistry	PMB only
Optometry	100% of Agreed Tariff, paid from the AFB. Test – One per beneficiary, every second year. Lenses, frames - clear plastic single vision OR bifocal lenses every second year. Basic range of frames. No benefit for contact lenses. **Subject to use of a Universal Network Optometrist.**
Hospital emergency room/ casualty emergency visits (not requiring admissions, excluding facility fees)	No benefit, unless a bona-fide emergency that results in a hospital admission.

Day-to-day services not subject to the AFB

BENEFITS	LIMITS
GP Consultations	100% of Agreed Tariff, unlimited, subject to clinical necessity. Each beneficiary must select a contracted **Universal Network GP** for day-to-day care. Two out-of-area visits per beneficiary, per year. Member required to pay the out-of-area provider in cash and claim back. Limited to R950 per event including the GP consultation and all related costs.
Acute Medication	100% of Agreed Tariff, unlimited if prescribed by a **Universal Network GP**, or by a specialist provided member referred by a **Universal Network GP**. Subject to formulary. No cover for non-formulary medicines, unless otherwise pre-authorised. No cover in cases of voluntary use of **non-Universal Network Provider**, or voluntary use of a specialist without referral by a **Universal Network GP**.
Specialised Radiology including MRI, CT and PET Scans	PMBs only, subject to pre-authorisation and case management by the Scheme's designated agent. Please contact **0860 102 312**
Basic Radiology	100% of Agreed Tariff, unlimited when clinically appropriate within the **Universal Network** and subject to referral by a **Universal Network GP**. Limited to list of codes. Subject to case management. No benefit if not referred by a **Universal Network Provider**, or by a specialist following referral by a **Universal Network GP** (except when involuntary).
Basic Pathology	100% of Agreed Tariff, unlimited when clinically appropriate within the **Universal Network** and subject to referral by a **Universal Network GP**. Limited to list of codes. Subject to case management. No benefit if not referred by a **Universal Network Provider**, or by a specialist following referral by a **Universal Network GP** (except when involuntary).
Auxiliary Services	PMB rules apply, subject to protocols.
Clinical Psychologist	PMB rules apply, subject to protocols.
Psychiatry	PMB rules apply, subject to protocols.
Surgical and Medical Appliances	PMB rules apply, subject to protocols. No benefit for hearing aids.

Other Benefits

BENEFITS	LIMITS
Emergency Assistance and Ambulance Transportation	Subject to approval from the referred Preferred Provider - ER 24
Wellness, Lifestyle and Preventative Care	Blood pressure, blood sugar and cholesterol test, limited to R130 per beneficiary and **Universal Network Pharmacy**

In-hospital benefits

BENEFITS	LIMITS
Overall Annual Limit (OAL)	Unlimited
Private Hospitals and Nursing Homes	100% of Agreed Tariff, subject to pre-authorisation
Take home medication (TTO)	Limited to seven days' supply, subject to OAL
GP and Specialist Cost	100% of Agreed Tariff, subject to OAL
Surgical Prosthesis and Electronic Nuclear Devices	PMB benefits Subject to pre-authorisation, protocols and OAL
Radiology and Pathology	100% of Agreed Tariff, subject to OAL
MRI, CT Scans/PET Scans	100% of Agreed Tariff, subject to OAL, pre-authorisation required
Physiotherapy in hospital	100% of Agreed Tariff, subject to OAL
Organ Transplants, Renal Dialysis (includes transportation of the organ, surgically related procedures, professional fees and services, as well as immunosuppressant drugs)	100% of Agreed Tariff, PMB's only, subject to OAL, pre-authorisation and protocols
Emergency Room/Casualty	100% of Agreed Tariff, subject to OAL, for emergency medical conditions and injuries resulting from accidents or trauma on application

Alternatives to Hospitalisation

The Mzansi Network option offers cover for step down nursing facilities, Hospice and rehabilitation. Cover is subject to pre-authorisation, protocols, case management and OAL.

Exclusions

The following in-hospital procedures are not covered on the Mzansi Network option, unless it is a PMB:

Dentistry, back and neck surgery, hip and knee replacement, cochlear implants, auditory brain implants and internal nerve stimulators, Nissen fundoplication (reflux surgery), treatment for obesity, skin disorders, functional nasal problems, elective caesarean section, refractive eye surgery, brachytherapy for prostate cancer and fibroadenoma.

Contribution Table

Salary (Rand)	Principal	Adult	Child
R 0 - R 4 200	R 612	R 612	R 192
R 4 201 - R 5 400	R 708	R 708	R 210
R 5 401 - R 7 200	R 894	R 894	R 270
R 7 201 - R 8 400	R 972	R 972	R 288
R 8 401 - R 9 800	R 1 062	R 1 062	R 318
R 9 801 - R 11 400	R 1 152	R 1 152	R 342
R 11 401 - R 12 600	R 1 302	R 1 302	R 348
R 12 601 - R 16 200	R 1 548	R 1 548	R 348
R 16 201 - R 19 400	R 1 848	R 1 848	R 354
R 19 401 - R 23 600	R 2 286	R 2 286	R 366
R 23 601- R 26 600	R 2 718	R 2 718	R 372
R 26 601 +	R 2 910	R 2 910	R 384

Please confirm with your HR department to find out whether you qualify for a subsidy.
Dependants over the age of 21 pay adult rates.

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Prescribed minimum benefits (PMBs)

- Subject to Scheme Protocols
- Hospitalisation - 100% AT, unlimited and subject to use of a Universal Network Provider
- Medication - CDL conditions are unlimited, subject to a formulary and dispensing by a **Universal Network Provider**
- Medical management in and out of hospital - 100% AT, subject to protocols and treatment by a Universal Network Provider
- An HIV/AIDS Disease Management Programme is available to all HIV-positive members. The programme aims to support and assist HIV patients in the management of their condition

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

Cover for chronic conditions

The Mzansi Network Option offers extensive cover for 27 PMB CDL conditions.

If you suffer from one of the chronic conditions on the list, you need to register on the Universal Chronic Management Programme.

Chronic medication is subject to a formulary and reference pricing. Chronic medication is unlimited, only if prescribed by a **Universal Network Provider**. Any voluntary use of chronic medicine prescribed by an out-of-network provider and any non-formulary medicines are for the member's own account, unless pre-authorised by the Medical Advisor. PMB rules apply.

Managed care initiatives and pre-authorisation

At TBMS, taking good care of our members is what matters most. It is for this reason that we have implemented managed care initiatives designed to ensure that members receive the right type of quality care at an affordable cost, whilst ensuring the long-term sustainability of the Scheme.

Hospital utilisation management

One such initiative is the full hospital management service that we provide to our members. It involves the implementation of specific systems to ensure that our members experience the highest possible levels of hospital services and that their needs are met effectively and satisfactorily.

Hospital authorisation

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

- What information should you have ready when you apply for an authorisation?
- TBMS membership number;
- The name and date of birth of the patient;
- Date of admission and procedure;
- Name and practice number of the treating healthcare provider;
- Name and practice number of the hospital;
- Reason for the admission, treatment and diagnosis; and
- Tariff and ICD 10 codes for the procedure.

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

Please note:

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

HIV/AIDS Management Programme

As with any chronic condition, a holistic healthcare management approach can help to ensure that an HIV positive person enjoys a healthy and fulfilled life. It is therefore important to know your status. Only when you know you are HIV positive can you take the necessary steps to protect your partner and family, and to manage your own health and wellness for the future. The Scheme has the utmost respect for patient confidentiality and will not disclose any information about your status to anyone but you. If your tests show that you are HIV positive, you or your treating doctor should contact us to register you on the TBMS HIV Management Programme. This programme is operated by highly skilled, dedicated nurses who provide continuous telephonic support and counselling to HIV positive persons. 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. The sooner you are registered, the quicker the appropriate treatment can commence. Please contact us on **0860 111 900** for any further information or assistance.

Disease management

All members with a chronic disease condition such as asthma, cardiac failure, Chronic Obstructive Pulmonary Disease (COPD) and diabetes mellitus will be contacted by Universal Healthcare to enrol on the Disease Management Programme. This programme provides telephonic support and personalised health and wellness information to assist members in managing their chronic conditions. If you have been diagnosed with one of these chronic conditions, you or your doctor may enrol you or the Scheme will identify you through claims, chronic medicine registrations and hospital admissions. Members are also invited to contact the Disease Management Call Centre should they wish to speak to a nurse counsellor. Please contact us on **0860 111 900** for any further information or assistance. Please remember to register your chronic medication with Mediscor.

Oncology Management

We understand that battling cancer is a difficult and emotional experience. Our Oncology Management Programme offers members with cancer the support they need to manage this condition. With the incredible advancements that have been made and the current treatments available, cancer can be beaten. However, treatment is often draining and the last thing on a patient's mind should be: "Will my treatment will be paid by my Scheme?" It is important that your treating doctor contacts the Scheme as soon as you are diagnosed with cancer and that he/she registers you on the Oncology Management Programme. Your doctor will devise a proposed treatment plan to treat your condition, which should be sent to The Scheme as soon as possible. A medical professional will review the treatment plan according to accepted treatment guidelines and protocols. If necessary, your doctor will be contacted to discuss more appropriate treatments. Once the treatment plan has been approved, your treatment may commence. You will not have to obtain a separate medicine authorisation, as this will form part of your approved oncology treatment plan. Most oncology treatment takes place on an out-patient basis. Please remember to get a separate authorisation if you require hospitalisation during your oncology treatment period. You may contact us on **0860 111 900** for any further information or assistance.

Authorisation for Specialised Radiology

When a patient requires specialised radiology, such as an MRI scan, PET scan or a CT scan, please contact The Scheme for authorisation. An appropriate motivation must accompany the request for the scan. This is a requirement for both in- and out-of-hospital patients. Please contact us on **0860 111 900** for any further information or assistance.

ER24 offers a 24-hour/7 days a week integrated service to all its clients. The clinical staff are all highly specialised in emergency care and include friendly and helpful professional nurses and paramedics.

Medical Information and Assistance Line – 084 124 ER24 medical personnel, including doctors, paramedics and nurses, will be available 24 hours a day to provide general medical information and advice. This is an advisory and information service, as a telephonic conversation does not permit an accurate diagnosis.

24 hour "Ask the Nurse" Health Line

- Members are encouraged to utilise this 24-hour cost-saving service.
- Our trained medical staff use documented medical algorithms and protocols to advise members on healthcare solutions.
- Members can first seek advice as to:
  - Urgency of attention needed: dispatch ambulance, go to the hospital, go to the doctor.
  - Generic medication advice: go to the pharmacy for over-the-counter medication;
  - Self-medicate from home.

Trauma lines

In addition, the members have access to a 24-hour Crisis Counselling line where trained healthcare professionals will telephonically assist with advice/counselling for:

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

What to do in the case of an emergency

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

Useful tips

- Teach your family members to call **084 124** in case of an emergency.
- In an accident, take note of road names and numbers as this will expedite the emergency services.

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Member guide

1. Rules of the Scheme

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

2. Membership

Membership is restricted to all eligible employees.

2.1 Registration of dependants

A member may apply for the registration of his/her dependants at the time of applying for membership. The following persons can qualify as a dependant:

- A spouse or partner;
- Dependant children under the age of 21;
- Dependant children over the age of 21 but under the age of 25;
- Disabled/mentally challenged children.

2.2 Students and children older than 21

Children over the age of 21 are regarded as dependants if they are financially dependent on the member, i.e. not receiving any income. Children over the age of 21 will pay adult rates.
The membership of a child over the age of 25 will be cancelled at the end of the year in which he/she turns 25 years old.
This does not apply to disabled or mentally challenged dependants.

2.3 Waiting periods

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

2.4 Membership card

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

2.5 change of address

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

2.6 Deceased members

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

3. Contributions payable

The total monthly contributions payable to the Scheme by or in respect of a member are as stipulated in the contribution tables in the Scheme Rules. Contributions increase annually, effective 1 October.

4. Benefits

4.1 Choosing a benefit level

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

4.2 Level changes

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

The change may be made only with effect from 1 January of any financial year; and

- Application to change from one benefit option to another must be in writing and lodged with the Scheme within the period specified by the Scheme.

4.3 Pro-rata Benefits

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

5. How to claim

5.1 Electronic claims

Most suppliers, e.g. hospitals, pharmacies and general practitioners, etc. submit claims electronically and members do not have to submit such claims. However remains the member's responsibility to check remittance advices to ensure that the claim is processed for accurately paid correctly.

5.2 Paper claims

Claims must be submitted within four months from date of service and may be faxed, emailed or posted to the details below:

Fax: 086 505 8038

Email: correspondence@universal.co.za

Post: Tiger Brands Medical Scheme
Private Bag X131
Rivonia 2128

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

- Membership number;
- Principal member's details (name, address,etc.);
- Supplier's details (name, address and practice number);
- Treatment date;
- Patient's details;
- Details of treatment (diagnosis, tariff and ICD10 codes, amount charged, etc.)

The scheme will pay in full for the diagnosis, treatment and care of the prescribed minimum benefits as per regulation 8 of the Act.

Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, based on clinical evidence, the scheme will fund the cost of the appropriate substitution treatment, without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

Exclusions:

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

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

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

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

4. Cosmetic and Treatment for Obesity:
- All costs for operations, medicines, treatment and procedures for cosmetic purposes and obesity, eg Bariatric Surgery, gastric bypass, slimming preparations and appetite suppressants; including tonics, slimming products and drugs as advertised to the public. Consultations and treatments as provided by General Practitioners and Dieticians as part of a conservative lifestyle based protocol will be paid subject to the ARCB.
- Keloid and scar revisions, excluding PMB's which will be paid accordingly.
- Sclerotherapy.

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

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

7. Infertility:
Investigations, operations and/or treatment whether advised for psychiatric or similar reasons in respect of artificial insemination and treatment for infertility. Including but not limited to: Assisted Reproductive Technology, In-vitro fertilization, Gamete Intrafallopian Tube Transfer, vasovasostomy(reversal of vacestomy) and salpingostomy (reversal of tubal ligation), subject to PMB's, which will be covered as per Regulation 8.

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

9. Mental Health:
Sleep therapy and hypnotherapy

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

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

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

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

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

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

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

17. Prosthesis and appliances:
Where not introduced as an integral part of a surgical operation; Transcatheter Aortic Valve Implantation (TAVI); Replacement batteries for hearing aids or other devices;

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

19. Omnibus Rule – "Unless otherwise decided by the Board, no claim shall be payable by the Scheme if, in the opinion of the Medical Advisor, the health care service in respect for which such claim is made, is not appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition at an acceptable and reasonable level of care"

20. The maximum benefits to which a beneficiary shall be entitled in any financial year shall be limited as set out in Annexure "B".

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

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

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

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

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

Complaints and dispute procedure

Members may submit their complaints to the Scheme in writing or telephonically.
The Scheme's contact details are as follows: Dedicated complaints line: 0800 002636 Email address: **admin@universal.co.za** Fax: **086 615 1509**

The Customer Service Department will endeavour to assist the member for as far as possible.

Any queries that have not been resolved to the satisfaction of the member within 30 days of the initial complaint or if the member is not satisfied with the outcome of the query, such query or dispute can be escalated to the Customer Service Manager or the Fund Manager. Email queries may be escalated to **escalations@universal. co.za** or the call centre agent can transfer the member to the appropriate Senior Official. Please note: all escalations will have to be accompanied by supporting evidence of non-delivery. Queries that have not been submitted on call centre level will be referred back to a call centre agent.

Should a member still not be satisfied with the outcome of his enquiry or dispute, a member is entitled to escalate the matter to the Principal Officer. This will only be allowed if the processes above were followed or in cases of extreme emergencies. The Principal Officer will investigate the matter and revert to the member with a final decision in accordance with the rules of the scheme and subject to the provisions of the Medical Schemes Act, 131 of 1998

Any member who is aggrieved by any decision of the Scheme may lodge a complaint with the Office of the Registrar of Medical Schemes, who is the Regulator for all medical schemes established in terms of the Medical Schemes Act, 131 of 1998. The contact details of the Complaints Call Centre of the Office of the Registrar are as follows:

Tel: 086 112 3267
Email: complaints@medicalschemes.com
Fax: (012) 431 0608

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

The Council will give the Scheme an opportunity to respond.
The Council's' ruling will be final.

Contact us

Universal Healthcare Administrators (Administrative)	
Client Services Call Centre	0800 002 636 / 011 208 1010
Fax number	(011) 208 1028
E-mail	correspondence@universal.co.za
Website	www.universal.co.za www.tbms.co.za

Universal Care	
Hospital pre-authorisation	0860 102 312
Prescribed minimum benefit (PMB) management	0860 111 900
HIV/AIDS Disease Management Programme	0860 111 900
Chronic medicine	0860 111 900

Emergency Services	
ER 24	084 124

This brochure is a summary of the benefits of TBMS. A copy of the current rules of the Scheme may be obtained from the Administrator, if required. The rules of the Scheme will always take precedence over this summary.

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

Administered by Universal Healthcare Administrators (Pty) Ltd

Universal
Administrators