horizon medicalscheme

Member Guide

2021

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ER24 (24-hour emergency transport approvals)	**Tel: 084 124**
Whistle Blowers - Fraud Hotline	Tel: 0800 112 811 | Email: fraud@medscheme.co.za
Medscheme 3rd Party Recoveries Unit	Tel: 0800 117 222 | Email : recoveries@medscheme.co.za

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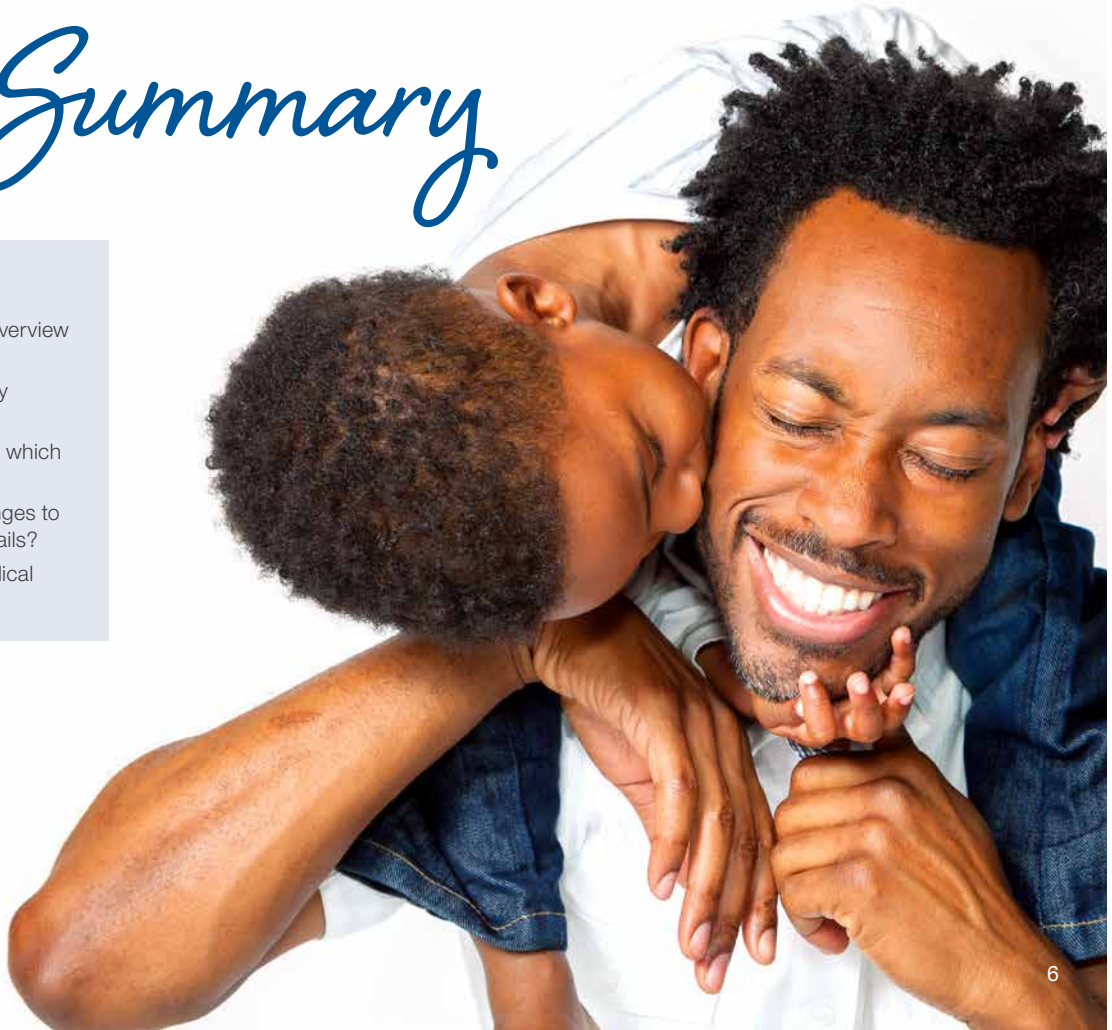
1 In Summary

IN THIS SECTION

- Can I have a quick overview of the Plans?
- What are the monthly contribution rates?
- How should I decide which Plan is best for me?
- How do I make changes to my membership details?
- How can I keep medical costs low?



The benefit structure for the 2021 benefit year will continue to offer a choice of three Plans, catering to our various members' needs.

Before the new benefit year starts on 1 January 2021, you will need to decide whether your current Plan (if you are already a member) still meets your medical needs or whether you should consider switching to a more suitable Plan.

Please note that option changes can only be processed once a year, at the beginning of each benefit year.

This section offers a quick and easy comparison of the three Plans to help you determine which Plan will work best for you. When making this important decision, you will basically have to weigh up the benefits and contributions of the various Plans with your needs – so please read this member guide carefully to get all the information you need before making your decision.

If you have any questions after reading this guide, or need help in making your choice, please contact your HR Consultant, or Medscheme on 0860 101 103 if you are a pensioner.

Can I have a quick overview of the Plans?

HOSPITAL CORE PLAN

This is a "basic" hospital benefit option providing comprehensive cover for major medical events at scheme rates. It is targeted at those looking for major medical cover, but willing to cover the cost of any shortfall between fees charged and the medical scheme rate. Chronic cover is limited to the Prescribed Minimum Benefits (PMBs).

HOSPITAL PLUS NETWORK PLAN

This plan provides essential hospital, chronic and routine cover at a low cost by requiring members to use Designated Service Providers for the full spectrum of cover to access care. Chronic cover is limited to the Prescribed Minimum Benefits (PMBs).

HOSPITAL PLUS SAVINGS PLAN

This is the most comprehensive plan on Horizon, offering unlimited hospital cover and additional chronic medicine cover for non-PMB conditions. Routine cover is offered via a medical savings account, allowing members choice in how to use their benefits. This Plan also enjoys enhanced maternity benefits.

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Specialist Benefits
Wellness Benefits
Chronic Medicine Benefits
Hospital Benefits
Maternity Benefits
Medical Emergency Benefits
Managed Healthcare Programmes
Prescribed Minimum Benefits
How to claim
All about membership
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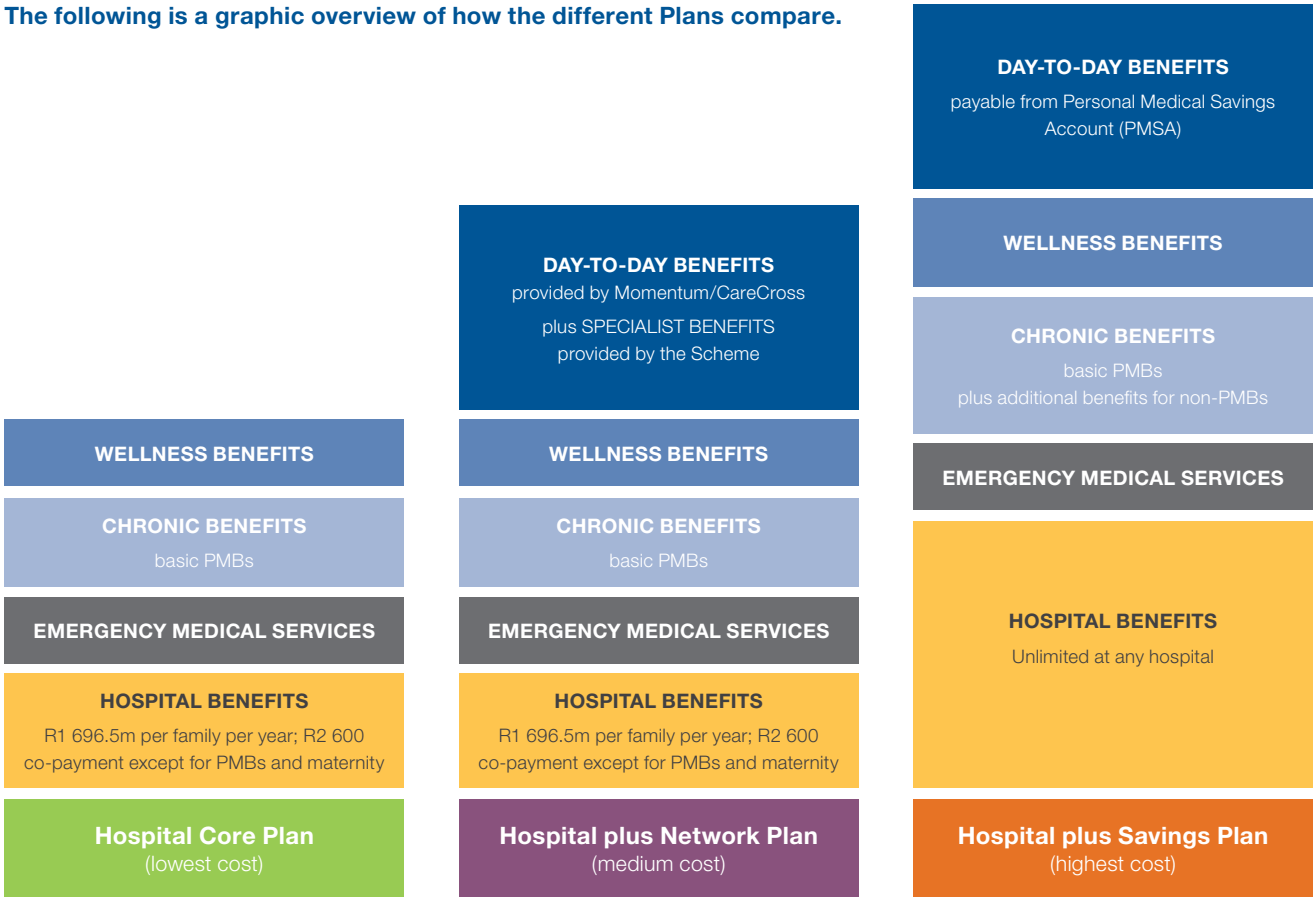
The following is a graphic overview of how the different Plans compare.



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Summary of benefits and contributions

	Hospital Core Plan	Hospital plus Network Plan	Hospital plus Savings Plan
DAY-TO-DAY BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 16-20 FOR MORE INFORMATION.)*			
General	No benefit	Services obtainable from the Momentum/ CareCross Network of Primary care providers	Paid from available savings in Personal Medical Savings Account In addition, a contraceptive benefit for female beneficiaries aged 15-45 years, limited to **R2 050** per beneficiary per year.
Dentistry		Basic dentistry at a Network Dentist subject to Network protocols	
Optical		One eye test every two years and one pair of standard or bifocal lenses, as well as standard frames to the value of R200 every two years at a Network Optometrist, OR contact lenses to the value of R525 per beneficiary	
Acute Medicine		Momentum/CareCross provider, formulary applies In addition, the Scheme offers a contraceptive benefit for female beneficiaries aged 15-45 years, limited to **R2 050** per beneficiary per year.	
GP benefit		Unlimited medically necessary consultations at a Momentum/CareCross General Practitioner GP. 3 emergency out-of-network visits to a max of **R1 000** per family per year	
Radiology		Black and white X-rays as requested by a Momentum/CareCross GP only (not specialist), subject to Network protocols and according to an approved list	
Pathology		Basic pathology tests as requested by a Momentum/CareCross GP only, subject to Network protocols and according to an approved list	

	Hospital Core Plan	Hospital plus Network Plan	Hospital plus Savings Plan
External medical appliances including artificial limbs and long leg calipers			Limited to **R13 900** per beneficiary per year
SPECIALIST BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 21-22 FOR MORE INFORMATION.)*			
Specialist benefit		**R1 360** per family per year; any specialist. Managed by the Scheme.	
MATERNITY BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 44-51 FOR MORE INFORMATION.)*			
A range of maternity benefits covering (depending on your Plan) elements such as antenatal classes, consultations with GPs or specialists, ultrasound scans, pathology tests, hiring of water baths and more.			
WELLNESS BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 23-27 FOR MORE INFORMATION.)*			
	R1 270 per family per year	**R1 270** per family per year	**R3 284** per family per year
	This total benefit limit can be applied to the following tests and vaccines: **Pharmacy based tests:** Blood glucose, Lipogram (finger-prick test) **Pharmacy based vaccines:** Flu vaccine, HPV vaccine, Pneumococcal vaccine; Child immunisations (as per Department of Health protocols) **Non-pharmacy based tests:** Papsmear, Prostate Specific Antigen, Mammogram		Members on the Hospital plus Savings Plan can also use their Wellness Benefit limit to claim for the following: • Dietician consultation • Biokineticist consultation • Occupational therapist consultation • Speech therapist consultation • GoSmokeFree Programme at Clicks Pharmacies

	Hospital Core Plan	Hospital plus Network Plan	Hospital plus Savings Plan
CHRONIC BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 28-33 FOR MORE INFORMATION.)*			
Medicine	Prescribed Minimum Benefit (PMB) conditions at 100% of cost from Clicks pharmacies. Restrictive formulary applies. 30% co-payment applies from other pharmacies.	Prescribed Minimum Benefit (PMB) conditions at 100% of cost from Network. Formulary applies.	Prescribed Minimum Benefit (PMB) conditions + a number of additional conditions at 100% of cost from Clicks pharmacies. Comprehensive formulary applies. 30% co-payment applies from other pharmacies. Cover for additional conditions limited to **R13 020** per beneficiary per year
MEDICAL EMERGENCY BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 52-53 FOR MORE INFORMATION.)*			
ER24	100% of tariff as agreed to with the contracted provider, subject to the use of the Scheme's preferred provider's services	100% of tariff as agreed to with the contracted provider, subject to the use of the Scheme's preferred provider's services	100% of tariff as agreed to with the contracted provider, subject to the use of the Scheme's preferred provider's services. If the preferred provider is not used, cost will be covered from the available medical savings account balance.
HOSPITAL BENEFITS *(THE FOLLOWING IS A SUMMARY ONLY – PLEASE SEE PAGES 34-43 FOR MORE INFORMATION.)*			
Hospital Cover	Subject to overall annual limit of **R1 696 500** per family per year; any hospital. **R2 600** co-payment for non-PMB admissions	Subject to overall annual limit of **R1 696 500** per family per year; any hospital. **R2 600** co-payment for non-PMB admissions	Unlimited cover at any hospital
Rates	100% of Medical Scheme Rate (MSR)	100% of Medical Scheme Rate (MSR)	100% of Medical Scheme Rate (MSR)

What are the monthly contribution rates?

	Hospital Core Plan	Hospital plus Network Plan	Hospital plus Savings Plan*
MONTHLY CONTRIBUTIONS			
Principal member	R905	R1 517	R2 490
Additional adult/Spouse/Life partner	R724	R1 213	R1 991
Child	R318	R530	R871

***The total contributions for the Hospital plus Savings Plan are made up as follows:**

	Principal member	Additional adult dependant/ spouse/ life partner	Child dependant
Risk	R2 179	R1 742	R762
Allocation to PMSA	R311	R249	R109
Total	**R2 490**	**R1 991**	**R871**

How should I decide which Plan is best for me?

- Review the benefits offered by each of the three Plans to make sure that you choose the Plan most suited to your medical needs.
- Review your past medical claims history (in other words, what your medical expenses were during the previous benefit year).
- Estimate your anticipated medical expenses during the coming year.
- Consider any medical procedures that are planned for the next benefit year.
- Think about the number of dependants you have and whether they may require chronic medicine and treatment.
- Consider whether you have an existing chronic ailment that may require chronic medicine and treatment.
- Verify the monthly contribution rates of each Plan to make sure that you can afford the Plan you select. At the same time, there is no point in choosing a cheaper Plan if that Plan doesn't provide you with enough benefits and requires you to make regular co-payments.

How do I make changes to my membership details?

All changes must be done via your HR department, with supporting documentation (where relevant) accompanying your form. Refer to the Membership chapter for more information on supporting documentation required in various circumstances.

How to *save* money
and make the most of your benefits

This is how you can save the Scheme and yourself money:

Use the Scheme's pharmacy network to avoid unnecessary co-payments.

If you are on the Hospital Plus Network Plan, use a Momentum/CareCross General Practitioner (GP) to avoid unnecessary co-payments.

Consider paying in cash and then claiming back to get discounts (unless you are registered on the Chronic Medicine Management programme).

Get a quote from the doctor before undergoing any procedure and check with the Contact Centre how much will be paid. Negotiate with your doctor to charge (at least closer to) the amount covered by the Scheme.

Ask for generic medicine whenever possible.

Think twice about undergoing elective surgery procedures.

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, arrange for hospital admission after 12pm.

Maintain a healthy lifestyle, as prevention is always the better option.

Make healthier choices to avoid or better manage lifestyle-related chronic conditions.

Use the screening tests and vaccines offered as part of your Wellness Benefits to identify potential lifestyle diseases early.

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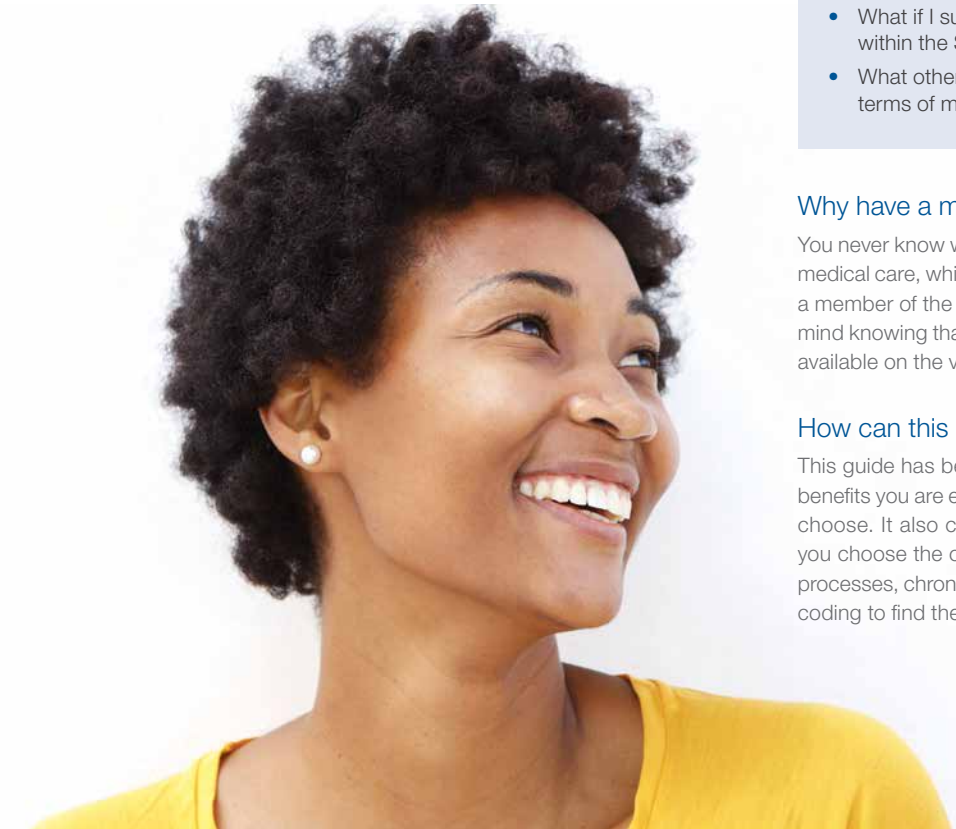
2 Welcome



IN THIS SECTION

- Why have a medical scheme?
- How can this Member Guide help me?
- What are my responsibilities as a member?
- What if I suspect fraudulent activity, waste or even abuse within the Scheme?
- What other general information should I keep in mind in terms of my benefits?

Why have a medical scheme?

You never know when you or one of your family members may need medical care, which could cost a substantial amount. Fortunately, as a member of the Horizon Medical Scheme, you can enjoy peace of mind knowing that you and your family are protected by the benefits available on the various Plans offered by your medical scheme.

How can this Member Guide help me?

This guide has been written to give you all the information on what benefits you are entitled to as a member, irrespective of the Plan you choose. It also contains information on the various Plans, to help you choose the one that suits you best, plus information on claims processes, chronic medicine and more. Use the side tabs and colour coding to find the information you need, when you need it.

What are my responsibilities as a member?

- Use your benefits responsibly.
- Understand how the Scheme and specific Plans work by reading this Member Guide.
- Keep the Scheme up to date on any changes to your membership details.
- Check all accounts from service providers as well as your statements and claims advices from the Scheme to make sure that all your details are correct and that your claims have been processed correctly.
- Inform the Scheme before you are admitted to hospital.
- File all your documentation regarding the Scheme 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.
- Contact HR or your Payroll department if you want to make any changes to your dependants or other details on record with the Scheme.

What if I suspect fraudulent activity, waste or even abuse within the Scheme?

Unnecessary and fraudulent expenses are funded by you, the member, through increased contributions. You can contribute towards the fight against fraud by carefully and regularly checking your claims transactions and making sure that you have not been involved in a fraud scam without your knowledge.

Examples of fraud scams discovered by the Scheme have been:

- 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 Scheme 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 your Scheme, please call 0800 11 28 11, SMS 33490, or email information@whistleblowing.co.za. This service is managed by an independent company, Tip-Offs Anonymous, and you can choose to remain anonymous. You can also email fraud@medscheme.co.za to report your suspicions.

What other general information should I keep in mind in terms of my benefits?

- Major Medical Benefits include all services at public and private hospitals.
- Formulary and supplier networks are subject to change from time to time. The latest information is available on request from Medscheme or the Momentum/CareCross Network.
- The chronic medicine benefits on the Hospital plus Savings Plan are covered according to the Medscheme Chronic Medicine Management formulary.
- The Medical Scheme Rate (MSR) in respect of medicine is the SEP (Single Exit Price) and the dispensing fee as per the Medicine and Related Substances regulations.
- All benefits are subject to PMB legislation where applicable.

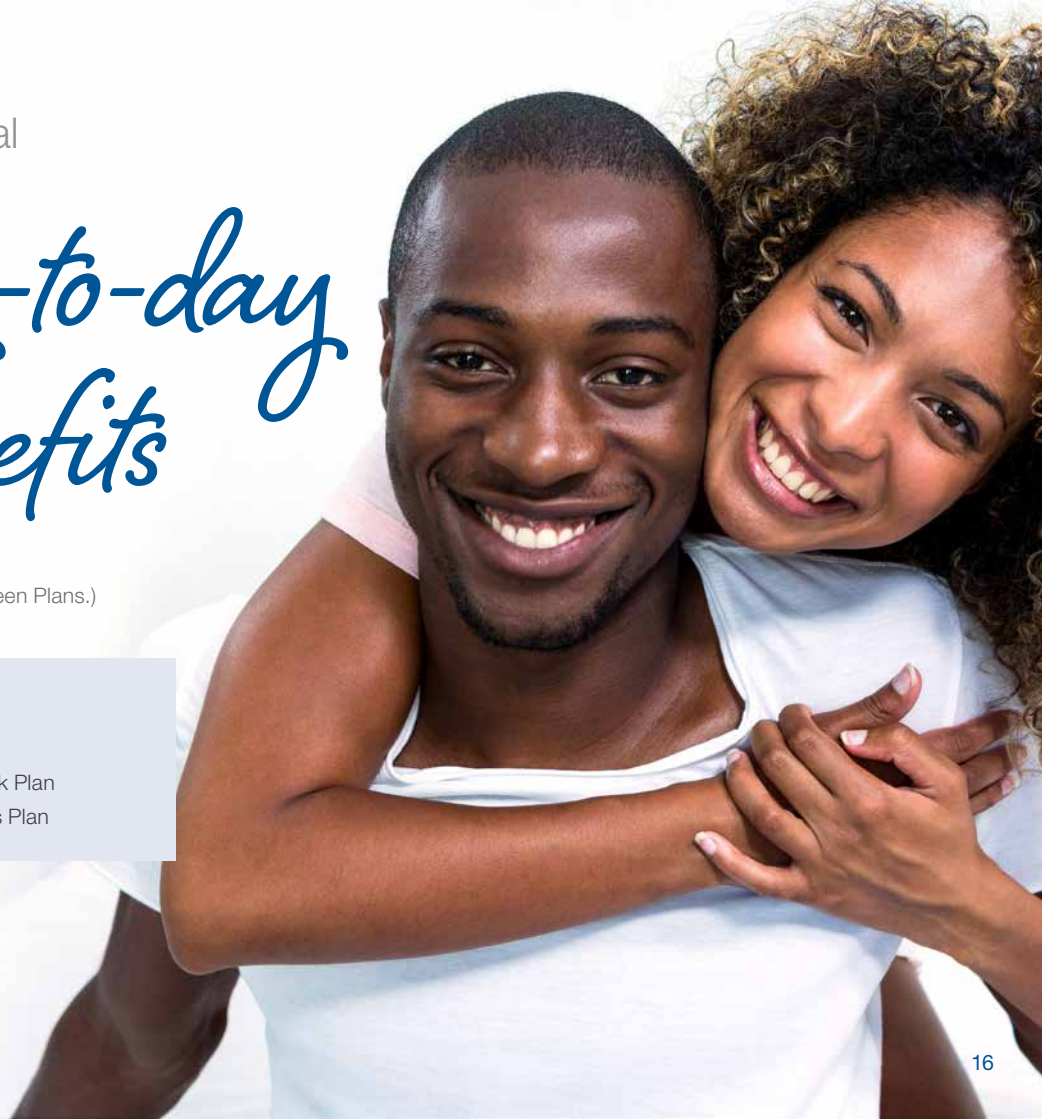
3 Out-of-Hospital

Day-to-day Benefits

(These benefits differ between Plans.)

IN THIS SECTION

- Hospital Core Plan
- Hospital plus Network Plan
- Hospital plus Savings Plan



HOSPITAL CORE PLAN

Because this is a low-cost plan that is focused more on offering you and your family hospital coverage, day-to-day benefits are limited only to PMB (or related) conditions:

Day-to-day benefits	
Primary services obtained from preferred provider	No benefit
Primary services not obtained from preferred provider	No benefit
Specialists (including radiology & pathology, excluding MRI & CAT scans)	No benefit
Specialised dentistry	No benefit
MRI & CAT scans	No benefit
Chronic medicine	100% of cost for PMB related conditions
Surgical and medical appliances	No benefit
Pathology	No benefit
Medical auxiliaries / other	No benefit

HOSPITAL PLUS NETWORK PLAN

Horizon offers members on the Hospital plus Network Plan access to primary care day-to-day benefits via the Momentum/CareCross network of General Practitioners, Dentists and Optometrists. This benefit includes General Practitioner (GP) consultations, radiology and pathology requested by the Momentum/CareCross GP according to an approved tariff list, acute medicine according to the Network Acute Medicine formulary, and as scripted or dispensed by your Momentum/CareCross GP, chronic medicines according to the Network chronic medicine formulary on approval, basic dental benefits from a Network Dentist and optical benefits from a Network Optometrist.

This claim will be paid directly to the contracted provider if the tests are on the approved tariff list or formulary. This means that there is no need for you to get involved with claim submissions.

The service provided ensures that your doctor is able to control and prescribe treatments that are medically necessary in order for you to stay healthy.

The services also extend to basic conservative dentistry, optometry, medicines dispensed or prescribed by the Momentum/CareCross General Practitioner, according to the Acute or Chronic Medicine formulary and specified radiology and pathology tests according to an approved tariff list.

To obtain access to this range of benefits, you need to select the Hospital plus Network Plan.

You can obtain a list of Momentum/CareCross General Practitioners by calling 0860 103 491 or emailing horizon@carecross.co.za. The list of Momentum/CareCross General Practitioners can also be found on the CareCross website at www.carecross.co.za.

Should the provider you have chosen leave the Network, you will be contacted so that you may choose an alternative Network provider in your area to manage your healthcare needs.

Primary services obtained from preferred provider	As per the Network schedule: • Unlimited medically necessary consultations at a Momentum/CareCross GP. • Basic Primary Care services. • Minor Trauma Treatment: – Stitching of wounds, – Limb casts, – Removal of foreign body, – Clamp Circumcision, – Excision and repair, and – Drainage of subcutaneous abscess and avulsion of nail. • Pre- and Postnatal Care: – Supervision of uncomplicated pregnancy up to Week 20. – Including one 2D sonar scan in the first trimester.
Acute medicines	As dispensed or scripted by the chosen Momentum/CareCross GP subject to the Network Acute Formulary. Medicines obtainable from a Momentum/CareCross (dispensing) or a Mediscor enabled pharmacy (scripting). In addition, on all Plans except Hospital Core Plan, the Scheme offers a contraceptive benefit for female beneficiaries aged 15-45 years, limited to **R2 050** per beneficiary per year.
Primary care dentistry	Subject to Network protocols, use of a Network dentist and according to a list of approved dental codes: • Consultations, primary extractions, fillings, scaling and polishing. • Emergency/unplanned treatment of pain. No benefit for root canal treatment, crowns, dentures and other advanced dentistry.

Specialised dentistry	No benefit.
Radiology	Covers a list of black and white X-rays. Only on request from a Momentum/CareCross General Practitioner. If requested by a Medical Specialist, the claim will be rejected as this is not covered by the Scheme.
Pathology	Covers a list of basic blood tests. Only on request from a Momentum/CareCross General Practitioner. If requested by a Medical Specialist, the claim will be rejected as this is not covered by the Scheme.
Optometry	One eye exam every two years and one set of standard or bifocal lenses every two years at a Network Optometrist only, OR contact lenses to the value of R505.
MRI & CAT scans	No benefit except for PMBs. Managed by Scheme.
Chronic medicine	• 100% of Cost for 26 PMB and other PMB related conditions. Network providers only and formulary applies. • Subject to the Network Chronic Formulary (CDL conditions plus other Scheme-approved chronic conditions). • On registration and approval from the Network's clinical division. • Medicine to be supplied by Network providers as arranged with the beneficiary or provider.
Surgical and medical appliances	No benefit except for PMBs. Managed by Scheme.
Medical auxiliaries / other	No benefit.
Out of network / emergency visits	Limited to 3 genuine after-hour emergency General Practitioner consultations per family per year. The member will be required to pay for these services and submit the claim to Momentum/CareCross for reimbursement to a maximum of **R1 000** per family per year.

HOSPITAL PLUS SAVINGS PLAN

Members who choose the Hospital plus Savings Plan will automatically contribute to a savings account at a rate of 12.5% of their total contribution. The member's contribution will be credited to an account kept by the Scheme in respect of each Member, called a Personal Medical Savings Account (PMSA). Day-to-day claims for non-PMBs for members on the Hospital plus Savings Plan will be paid from the Personal Medical Savings Account at 100% of cost, subject to the available balance.

Hospital plus Savings Plan - Annual Savings

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.

Principal member	Additional adult dependant/ spouse/ life partner	Child dependant
R3 732	R2 988	R1 308

More about the PMSA

The funds in the PMSA will be for the exclusive use of the member and his/her beneficiaries while he/she is a member of the Scheme. Members may draw on any accumulated balance in the PMSA to settle the difference between the amount charged and the benefit paid. On the member's request, the PMSA can also be used to cover any other shortfall which may occur, or to pay for any hospital levy or excess. The PMSA will be credited with interest at the rate determined by the Board. The limit for benefits from the PMSA will be the credit balance, if any, in the PMSA for a member at the time of receipt of a claim.

In the event of a member passing away, the amount (if any) standing to his credit in his PMSA will either be paid to his estate or, in the case of his beneficiaries becoming continuation members, this amount will be paid into their PMSA. Such payment will be made five complete months after the death of the member.

Members retiring as employees of the Employer, but remaining as continuation members of the Scheme, will not be entitled to withdraw any credit remaining in their PMSA.

On transfer to another Plan of the Scheme that does not provide for such an account, any balance in the PMSA will be refunded to the member, 5 months after such transfer and subject to applicable laws.

Should a member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme that does not provide for a PMSA, the balance due to the member will be refunded to the member 5 months after termination of membership, and subject to applicable laws. Should a member be admitted to membership of another medical scheme that provides for a PMSA, the balance due to the member will be transferred to such scheme within 5 months after termination of membership.

It is the responsibility of the member to communicate the banking details of the new scheme, or changes to their own banking details, to the Scheme.

4

Out-of-Hospital

Specialist Benefits

(These benefits differ between Plans.)

IN THIS SECTION

- What is a specialist?
- Does the Scheme have a specific network of specialists that I should use?
- What cover is available for consultations with specialists?

What is a specialist?

A medical specialist is a doctor who has completed advanced education and clinical training in a specific area of medicine (their specialty area), such as cardiology, neurology, and so on.

Providers of auxiliary health services, such as audiologists, physiotherapists, dietitians and chiropractors are NOT specialists and such claims will not qualify under this benefit.

Does the Scheme have a specific network of specialists that I should use?

The Scheme does not have a specific network of specialists - a claim from any specialist will be covered if you have available benefit.

What cover is available for consultations with specialists?

Members who belong to the **Hospital plus Network Plan** have cover for consultations with specialists, up to a limit of **R1 360** per family per benefit year at MSR only.

You do not have to be referred by your treating CareCross GP for the claim to be considered for payment (subject to your available benefit limit), but it is generally advisable to have a reference letter from your treating doctor so that the specialist will have appropriate information for your further treatment.

Please remember that the specialist might charge higher rates. It is therefore in your interest to confirm the rates and the benefit that is available to be paid.

Members on the **Hospital plus Savings Plan** will have cover for specialist consultations to the extent that they have funds available in their Personal Medical Savings Account.

Members on the **Hospital Core Plan** do not have cover available for specialist consultations.

5 Out-of-Hospital

Wellness Benefits

(These benefits differ between Plans.)

IN THIS SECTION

- Why should I go for screening tests?
- How can the Wellness Benefits help me?
- How much is available under the different Plans in respect of Wellness Benefits?
- What is available under the pharmacy Wellness Benefit?
- What is available under the non-pharmacy Wellness Benefit?

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, specialist or radiologist (depending on the test).

These benefits are separate from your other day-to-day benefits and are not paid from these limits, but they are subject to the use of the correct diagnostic and tariff codes as well as the correct Designated Service Provider (Clicks or, in the case of members on the Hospital plus Network Plan, a Network provider must be used).

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.

How much is available under the different Plans in respect of Wellness Benefits?

The total amount that can be claimed for Wellness Benefits is shown in the table below. This amount excludes consultation fees and related procedural costs.

Hospital Core Plan	Hospital plus Network Plan	Hospital plus Savings Plan
R1 270 per family per year	**R1 270** per family per year	**R3 284** per family per year

What is available under the pharmacy Wellness Benefit?

The Pharmacy Wellness Benefit gives you access to Clicks 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 these benefits are only covered from your Wellness Benefits limit if obtained from a Clicks pharmacy clinic (or Network provider, in the case of members on the Hospital plus Network Plan).**

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

VACCINES

- **Flu vaccine** – Limited to 1 vaccination per beneficiary per benefit year, covered at cost or MSR, whichever is the lesser.
- **HPV vaccine** - Limited to one course per female beneficiary between the ages of 9 and 26 years.
- **Pneumococcal vaccine** – Limited to 1 vaccination per beneficiary per year, covered at cost or MSR, whichever is the lesser.
- **Child immunisations** (as per Department of Health protocols) – Limited to children up to the age of 12, and applies to the cost of the relevant drops and vaccinations only (excludes facility fee and/or nursing consultations).

SCREENINGS:

- **Blood glucose** – Covered at cost or MSR, whichever is the lesser. Please note that this is a finger-prick test and can only be done at a clinic within a Clicks pharmacy.
- **Lipogram (finger-prick) test** – Covered at cost or MSR, whichever is the lesser. Please note that this finger-prick test can only be done at a clinic within a Clicks pharmacy.

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 pharmacy clinic or Network provider to make an appointment.

What is available under the non-pharmacy Wellness Benefit?

Other wellness benefits available outside a pharmacy are the following:

Papsmear – limited to one test per female beneficiary per benefit year, covered at cost or MSR, whichever is the lesser. This benefit is also available to members on the Hospital plus Network Plan, at Network providers.

Prostate Specific Antigen – limited to one test per male beneficiary per benefit year, covered at cost or MSR, whichever is the lesser. This benefit is also available to members on the Hospital plus Network Plan, at Network providers.

Mammogram – limited to one test every two years per beneficiary.

Members on the Hospital plus Savings Plan can also use their Wellness Benefit limit to claim for the following:

CONSULTATIONS

- Dietician consultation
- Biokineticist consultation
- Occupational therapist consultation
- Speech therapist consultation

Limited to one consultation per beneficiary per year, covered at 100% of cost or MSR, whichever is lesser, and subject to the overall Wellness Benefit limit.

PROGRAMMES

- GoSmokeFree Programme

100% of cost or MSR, whichever is lesser, and subject to the overall Wellness Benefit limit and using Clicks Pharmacies as DSP.

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MORE ABOUT THE GOSMOKEFREE PROGRAMME

The GoSmokeFree programme is aimed at helping members who smoke to kick the habit!

Studies show that 70% of smokers would like to give up smoking and 30% go on to attempt to stop each year… yet fewer than 3% successfully quit cold turkey! The GoSmokeFree programme begins with a pre-quit assessment where a smoker's readiness and motivations to stop smoking is determined and a quit date is set, followed by six once-a-week, one-on-one sessions with a Nursing Sister who is trained as a GoSmokeFree advisor. The follow up sessions are designed to provide support and guidance along the GoSmokeFree journey to triple your chances of success.

HOW DOES IT BENEFIT YOU?

Stopping smoking is the single most important decision you can make for your health. The benefits of stopping smoking are almost immediate, but stopping smoking is not easy, as nicotine is highly addictive and smoking is associated with social activities such as drinking or eating and psychological factors such as work pressure, anxiety and body weight concerns.

The GoSmokeFree Stop Smoking Programme is available at certain Clicks pharmacies throughout South Africa. Simply visit www.gosmokefree.co.za, and leave your contact details including your location. You will then be contacted with a list of the closest accredited Clicks Pharmacies.

6 Out-of-Hospital

Chronic Medicine Benefits

(These benefits differ between Plans.)

IN THIS SECTION

- What are chronic medicines?
- How do I apply for chronic medicine?
- How do I obtain an additional month's supply of chronic medicine?
- Who are the Scheme's designated service providers for chronic medicine?
- Which basic chronic diseases are covered by all Plans, under PMBs?
- What additional chronic benefits are covered under the Hospital plus Savings Plan?

What are chronic medicines?

This is medicine that you need to treat a long-term illness, and that you will need to take regularly (usually daily). This is an additional benefit over and above any day-to-day benefits allowed for by your Plan. (Acute medicine is medicine that is prescribed by your doctor to treat a temporary illness.) Chronic medicine authorisations are subject to clinical criteria and protocols.

How do I apply for chronic medicine?

Please note that the process differs depending on your Plan, particularly for members on the ***Hospital plus Network Plan.***

Hospital plus Network Plan

If you have selected this Plan, the following process will apply:

You will only have cover for the cost of the medicines listed on the Network Chronic Medicine Lists according to the Network formulary and only if the medicine has been prescribed by your Momentum/ CareCross GP. This is subject to approval by the Network's clinical division.

If you move from any other benefit option to the **Hospital plus Network Plan,** you will need to reapply for Chronic Medicine approval.

Step 1

Visit your Momentum/CareCross doctor for confirmation of your diagnosis. The doctor will complete the chronic medicine application on your behalf.

Step 2

After you signed the form, the doctor will fax the form to the Network's clinical division for verification.

Step 3

The clinical department will evaluate the appropriateness of the request according to the chronic drugs list and Network formulary.

Step 4

On completion of the process, your doctor will be informed if your application has been successful. The approved medicine may be collected at your nearest network pharmacy, including the Clicks group of pharmacies.

You may collect your chronic medicine from any Network pharmacy, including the Clicks group of pharmacies. Log on to the CareCross web site www.carecross.co.za to find your nearest pharmacy.

Hospital Core Plan and Hospital plus Savings Plan

If you have selected one of these Plans, the following process will apply:

How your medicine is approved:

Disease authorisations: Your Scheme has introduced a new way of approving chronic medicine to make management of changes easier for you, your pharmacist and your doctor. When you apply for chronic medicine, you are approved for treatment of your chronic condition and will have access to a list of pre-approved medicine, referred to as a formulary. This means that when you need to change

or add a new medicine for your condition, you can do this quickly and easily at your pharmacy with your new prescription.

It is important to note that not all conditions are managed this way and you may need to still call in to update us if you require medicine that is not in your condition's formulary or if you are diagnosed with a new condition. The quantity of each medicine in the formulary is limited to the most commonly prescribed monthly dose. If you require higher quantities than those in the formulary, you will have to contact us for authorisation.

You do not need to update us with your new medicine if:

- your medicine is in the formulary; or
- you change to another medicine in the formulary; or
- you need a quantity or dosage of a medicine that is listed in the formulary.

Pre-approved medicine in the formulary will still be subject to MPL and formulary co-payments.

You can check for co-payments with your pharmacist or view the formularies, formularies and MPL lists on the logged-in Member Zone, which you can access via horizon.medscheme.com.

How to apply on the telephone and online:

If you need to register for, or update, your chronic medicine, you can do this on the telephone or online through the Chronic Medicine Management Department (CMM). The advantages of using these systems are that we can give you a quicker response and the online applications are available after hours as well. You, your doctor, or pharmacist or even your broker can complete the application. Below we provide you with a little more information on how.

When you contact us, it is important to have a copy of your current prescription with you during this phone call, although there is no need to send it in to us. Have the following information on hand:

- your membership number
- the date of birth of the person applying
- the ICD 10 code
- doctor's practice number

To authorise certain medicine you may also need to supply:

- medicine details
- 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

Telephonically:

- Call CMM between 8:30am and 5pm by calling 0860 101 103 and select option 2 for members and then press 3 for chronic medicine.
- Follow the prompts; once you select the appropriate option your call will be routed through to a consultant who will guide you through the process.
- You will be informed of any co-payments.

By Email

- You can also email horizoncmm@medscheme.co.za.

Online:

- On the top right hand side of the web page, click LOGIN and enter your username and password. If you are a first time user you will need to register.
- Go to “My Authorisations” and click on “My Chronic Application”.
- Follow the prompts on the system and once all information has been captured, a summary can be viewed. You can print this screen for your records. Proceed to “Step 3” for a questionnaire.
- Click on “Save Application” and a reference number will be provided for follow up on the progress of the application.

The registration process is then completed and for both processes you may receive an immediate response. Where more clinical information is required, members of the clinical team will review the information supplied and correspond with you and your doctor either telephonically or in writing, on the status of the medicine requested. You can follow up on the progress of your application at any time by contacting CMM.

Things to be aware of:

- Approved medicine will be paid from the chronic medicine benefit.
- You will still need to take your original prescription to the pharmacy for the dispensing of your chronic medicine.

What if my medicine changes?

In most cases where your medicine is changed by your treating doctor, you will be able to go straight to your pharmacist with a new script. If you have a Disease Authorisation you will have access to a formulary of pre-approved medicines for your condition.

You only need to update us with your new medicine, either telephonically or online as described above, if:

- your medicine is not in the formulary; or
- you are diagnosed with a new chronic condition; or
- you need a quantity or dosage of a medicine that is more than the quantity listed in the formulary.

MPL and out of formulary co-payments will still apply to medicine that is pre-approved in formularies. Check the formulary for your condition as well as the MPL information on the logged-in Member Zone, which you can access via horizon.medscheme.com.

How do I obtain an additional month’s supply of chronic medicine?

Should you require more than one month’s supply of medicine, for example if you are going away on holiday, you will need to provide a motivation to the Scheme through the call centre or via horizon@medscheme.co.za, at least one month before you need the additional medicine. You will be required to provide a travel itinerary.

Please note that there will be a 30% co-payment if you use any pharmacy other than Clicks to obtain your chronic medicine.

For enquiries about chronic medicine claims, please contact the Horizon Medical Scheme Call Centre.

Who are the Scheme's designated service providers for chronic medicine?

You may obtain your authorised chronic medicine for Prescribed Minimum Benefits (PMBs) and other chronic conditions (Hospital plus Savings Plan) from the Scheme's Designated Service providers (DSPs). The Scheme's DSPs are as follows:

- Clicks Group Pharmacy Network
- Clicks Direct Medicine

If you currently obtain your chronic medicine from Clicks Direct Medicine or if you are a new chronic medicine user and prefer to use a courier pharmacy, or do not live within a reasonable distance of a Clicks Pharmacy, you may use Clicks Direct Medicine as your DSP.

The contact details for Clicks Direct Medicine are as follows

Postal address: P O Box 751902, Gardenview, 2047
Telephone: 0861 444 405 (General Enquiries)
Fax: 0861 444 414

The latest prescription will be required for your chronic medicine to be dispensed from the DSP. The chronic authorisation can be verified via the Member Zone which you can access via horizon.medscheme.com.

Which basic chronic diseases are covered by all Plans, under PMBs?

Members will receive benefits for ailments specified by the Minister of Health as PMBs, subject to the Network formulary or the Medscheme Comprehensive formulary. Medicines will be approved if the relevant Clinical Entry Criteria are met.

The PMB conditions are:

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

Which additional chronic benefits are covered under the **Hospital plus Savings Plan**?

If you select the **Hospital plus Savings Plan**, you will also qualify for treatment of the following conditions, to a limit of **R13 020** per beneficiary per year.

Acne	Hyperthyroidism
Allergic Rhinitis	Hyperparathyroidism
Alzheimer's Disease	Hypoparathyroidism
Anxiety Disorder	Macular degeneration and oedema
Attention Deficit Hyperactivity Disorder (6-18 years, unless clinically appropriate)	Menopause
	Myasthenia Gravis
Benign Prostatic Hypertrophy	Osteo-Arthritis
Cerebral Palsy	Osteoporosis
Depression	Psoriasis
GORD	Psychotic Disorders
Gout	Pulmonary Embolism

7 In-Hospital

Hospital Benefits

(These benefits are mostly the same across Plans, unless otherwise stated.)

IN THIS SECTION

- What are Hospital Benefits?
- What cover is available for Hospital Benefits?
- How does hospital pre-authorisation work?
- What co-payments are payable on laparoscopic surgery?
- What services and procedures are covered during hospitalisation?

What are Hospital Benefits?

Major Medical Benefits generally cover major medical expenses that you would incur when undergoing surgery or while admitted in hospital, as well as specified procedures performed in the doctors' rooms.

A visit to a hospital's Emergency Rooms (ER) 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 on all Plans are covered for Major Medical Benefits, but the overall annual limit and some of the specific benefit limits differ between Plans.

How does hospital pre-authorisation work?

To facilitate your hospital admission, you should always adhere to the procedures described below:

- Before you (or any of your beneficiaries) are admitted to hospital to undergo a medical procedure, please inform Medscheme's Hospital Benefit Management of your forthcoming hospital admission and provide them with the following information:
  - membership number
  - beneficiary details
  - patient's date of birth
  - planned date of admission to hospital or treatment
  - name and practice number of the hospital/facility
  - name and practice number of the doctor who is treating the patient in hospital
  - relevant codes
  - if treatment will be in or out of hospital
- It will be in your interest if you contact the Call Centre for ALL Hospital Procedures.
- In an emergency situation, where you, or any of your beneficiaries, are admitted directly to hospital, a member of your family or the hospital concerned must contact the Hospital Benefit Management Department on the first working day after admission.
- Phone the Authorisation Centre for general admissions, scans and radio-isotope studies.
- If you/your dependants are scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you/them after 12:00. In this way the Scheme can avoid incurring unnecessary hospital costs.

Contact Details:

Office Hours are from 08:30 till 16:30 from Monday to Friday, excluding public holidays. For your convenience, an **automated voice system** is available after hours, 7 days a week. An agent will return your call the next working day to complete the authorisation.

Email Address: horizon.authorisations@medscheme.co.za
Call Centre Number: 0860 101 103
Facsimile Number: 0860 21 22 23

What co-payments are payable on laparoscopic surgery?

- Laparoscopic procedures are more expensive, and the procedure may in general be performed as an open procedure. The Scheme has therefore decided, like many other medical schemes, to fund these procedures with a co-payment, rather than only cover open procedures.
- Members who undergo the following procedures will therefore be liable for the co-payments shown below (excluding PMB level of care):

Procedure	Co-payment
Laparoscopic hernia repair	R1 200
Laparoscopic hysterectomy	R3 060
Laparoscopic radical prostatectomy	R9 620
Laparoscopic pyeloplasty	R9 620
Knee arthroscopy	R1 200
Upper GI endoscopy / colonoscopy	R1 200
Balloon Sinuplasty	R3 060

What services and procedures are covered during hospitalisation?

The table below outlines services and procedures you and your registered dependants are covered for, subject to the relevant managed healthcare programme and to prior authorisation. Benefits are the same across Plans, unless otherwise stated.

1. Overall annual limit	**Hospital Core Plan** and **Hospital plus Network Plan: R1 696 500** per family per year. **Hospital plus Savings Plan:** Unlimited
2. Co-payment per event	**Hospital Core Plan** and **Hospital plus Network Plan: R2 600** co-payment is payable on admission. **Hospital plus Savings Plan:** None
3. Pre-authorisation	All scheduled hospital admissions are subject to pre-authorisation, which must be obtained 3 working days prior to admission. Authorisation for unscheduled admissions or emergencies must be obtained within 24 hours of admission or on the first working day thereafter. Authorisation will only be granted for medically necessary treatment and procedures. If authorisation is not obtained, the member may be liable for a penalty.

4. **Emergencies, trauma** (external violent events) **and confinements**	ANY hospital.
5. **Routine and scheduled hospitalisation events**	ANY hospital.
6. **Specified high risk procedures**	ANY hospital.
7. **Ward and theatre fees**	100% of cost or MSR, whichever is the lesser.
8. **Medicine – Ward and theatre drugs** (excluding drugs to take out of hospital)	100% of the medicine price. Includes medicines and materials for injections or vaccinations, prescribed while accommodated in a hospital, nursing home or clinic.
9. **Medicine – Medicine on discharge from hospital** (TTO)	100% of Medicine Price. **R640** per beneficiary per admission. This excludes anti-coagulants listed under the Drug Policy.
10. **GP's & specialists** (except radiology and pathology)	100% of cost or MSR, whichever is the lesser, subject to Managed Care Protocols.
11. **Procedures performed in doctors' rooms** Subject to pre-authorisation.	100% of cost or MSR, whichever is the lesser, subject to pre-authorisation. This covers Major Medical Procedures (normally performed in hospital) that are performed in doctors' rooms.
12. **Maxillofacial surgery** (in and out of hospital, excluding specialised dentistry)	100% of cost or MSR, whichever is the lesser, limited to **R50 400** per member family per year, subject to prior authorisation.
13. **Basic dentistry performed by a dental practitioner and/or a dental therapist including minor oral surgery as defined in section J of the SADA guide.**	100% of cost or MSR, whichever is the lesser, subject to relevant Managed Care Protocols and authorisation. General anaesthesia, conscious sedation and hospitalisation will only be granted for beneficiaries: • Under the age of 8; • Or with bony impaction of third molars.

14. Medical auxiliaries/other in hospital	100% of the cost or MSR, whichever is the lesser.
15. Ambulance services	**Hospital Core Plan** and **Hospital plus Network Plan:** 100% of tariff as agreed to with the contracted provider, subject to the use of the Scheme's preferred provider's services. **Hospital plus Savings Plan:** 100% of tariff as agreed to with the contracted provider, subject to the use of the Scheme's preferred provider's services. Contracted services only, otherwise subject to balance in PMSA.
16. Blood and blood products	100% of cost or MSR, whichever is the lesser.
17. General radiology	100% of cost or MSR, whichever is the lesser, subject to Managed Care Protocols. Bone densitometry scans performed in a specialist practice limited to one per family per year (in or out of hospital).
18. Specialised radiology, MRI & CAT scans	100% of cost or MSR, whichever is the lesser, subject to Managed Care Protocols and prior authorisation. A R2 000 co-payment per event will apply to non-PMB specialised radiology.
19. Pathology	100% of cost, subject to using the DSPs for pathology services (Ampath, Lancet, Pathcare or Vermaak) at negotiated rates. MSR for services rendered by a non-DSP provider.
20. Hearing aid benefit Benefit is subject to the submission of a motivation by the treating doctor to the Scheme and approval prior to the acquisition or hire of the device.	Beneficiaries up to the age of 6 years: 2 Hearing Aids up to **R43 600** per member family once every 3 benefit years, as from 1 January 2019. Beneficiaries 7 years and older: 1 Hearing Aid up to **R21 800** per member family once every 3 benefit years, as from 1 January 2019.
21. Physiotherapy	100% of cost or MSR, whichever is the lesser, subject to Managed Care Protocols.
22. Organ Transplants	100% of cost per beneficiary per year for transport of organs, hospital accommodation, surgically related services and procedures, subject to PMBs. 100% of cost of anti-rejection drugs, provided that the drugs are obtained from a preferred provider, subject to PMB protocols.

23. Renal dialysis	100% of cost or MSR, whichever is the lesser in respect of all materials, related costs and approved medicine. Subject to the relevant Managed Care Protocol and authorisation. This benefit includes related pathology, scans and consultations. For all services, medicine and materials associated with the cost of renal dialysis.
24. Oncology	**R544 000** per member family per year. 100% of cost or MSR, whichever is the lesser, subject to enrolment on the Oncology Benefit Management Programme and submission of a treatment plan. Subject to PMB protocols. This limit will apply to the following cancer-related disciplines: Pathology, X-rays, MRI and CAT Scans, chemotherapy, drugs associated with chemotherapy (e.g. anti-nausea), medicine for terminal illness, radiotherapy, mammograms and the oncologist's consultations.
25. PET Scans	**R38 900** per beneficiary per year for treatment of non-PMB conditions, subject to the Oncology limit of **R544 000**.
26. Oncology specialised drugs 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.	**R251 000** per member family. Subject to Oncology limit, Managed Care Protocols and authorisation. Subject to published list. Subject to the re-imbursement limit, in other words, Maximum Generic Price or Medicine Price List.
27. Brachytherapy materials	**R62 100** per member family per year, subject to the Oncology limit of **R544 000.** 100% of the negotiated fee, or in the absence of such fee, 100% of the cost or MSR or Uniform Patient Fee schedule for public hospitals for radiation oncologists. Includes seeds, disposables and equipment. Subject to Managed Care Protocols and authorisation.

28. Specialised drugs for non-oncology The non-oncology specialised drug list is a continuously evolving list of high-cost drugs, used for the treatment of chronic conditions. This list includes but is not limited to biological drugs (biological therapy for inflammatory arthritides, inflammatory bowel disease, chronic demyelinating 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.	**R233 000** per member family. Subject to Managed Care Protocols and authorisation. Subject to published list.
29. Drugs for treatment of macular degeneration and oedema	**R77 800** per member family, subject to the non-oncology specialised drugs limit, Managed Care Protocols and authorisation.
30. Acute rehabilitation	**R96 300** per member family per year. 100% of the negotiated fee, or, in the absence of such fee, 100% of cost or MSR, whichever is the lesser. Subject to pre-authorisation and the submission of a motivation by the treating medical practitioner to the Case Manager. Progressive neurological conditions are excluded. 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.
31. Private nursing in the place of hospitalisation	100% of cost or MSR, whichever is the lesser, subject to the limit of **R25 100** per family per year. Nursing services must be pre-authorised by the Case Manager. This benefit covers home services by a registered nurse, pre- and post-confinement treatment by a registered midwife and is for short-term episodes of acute cases only, in the place of hospitalisation. Only medically necessary services will be covered.

32. Home oxygen therapy Home oxygen, cylinders, concentrators and ventilation expenses.	100% of cost provided the service is pre-authorised. **R24 500** per member family per year. This benefit is subject to pre-authorisation and includes the cost of an appliance obtained from a preferred provider.
33. Mental health (in and out of hospital – Consultations and visits, assessments, therapy, treatment, procedures and/or counselling)	100% of the negotiated tariff up to a maximum of 21 days per beneficiary per benefit year or outpatient psychotherapy, up to 15 contact sessions. This benefit covers all related costs. Subject to application, approval and authorisation by the Scheme. This benefit includes consultations with a psychiatrist on an outpatient basis.
34. Internal surgical appliances and surgical prosthesis	Any other prosthesis not listed below will be subject to a limit of **R71 800** per beneficiary per year. Subject to managed healthcare programme and its prior authorisation.
35. Cardiac system	Cardiac stents: **R39 700** per stent, 3 stents per beneficiary per year. Cardiac pacemakers: **R96 000** per beneficiary per year. Cardiac valves: **R56 500** per valve, 2 valves per beneficiary per year. Cardiac resynchronisation therapy: **R66 100** per beneficiary per year.
36. Endovascular devices	Aortic Stents: **R165 000** per stent, 1 stent per beneficiary per year, includes the delivery system. Carotid stents: **R27 300** per beneficiary per year. Detachable platinum coils: **R67 900** per beneficiary per year. Embolic protection devices: **R67 800** per beneficiary per year. Peripheral arterial stent grafts: **R56 300** per beneficiary per year.

37. Orthopaedic prostheses and devices	Total hip replacement: **R77 800** per hip per beneficiary per year, includes the cost of cement and antibiotics. Total knee replacement: **R74 100** per knee per beneficiary per year, includes the cost of cement and antibiotics. Total shoulder replacement: **R64 400** per shoulder per beneficiary per year, includes the cost of cement and antibiotics. Total elbow replacement: **R59 700** per elbow per beneficiary per year, includes the cost of cement and antibiotics. Bone lengthening devices: **R61 100** per beneficiary per year. Spinal plates and screws: **R49 300** per beneficiary per year. Other approved spinal implantable devices and intervertebral discs: **R67 900** per beneficiary per year.

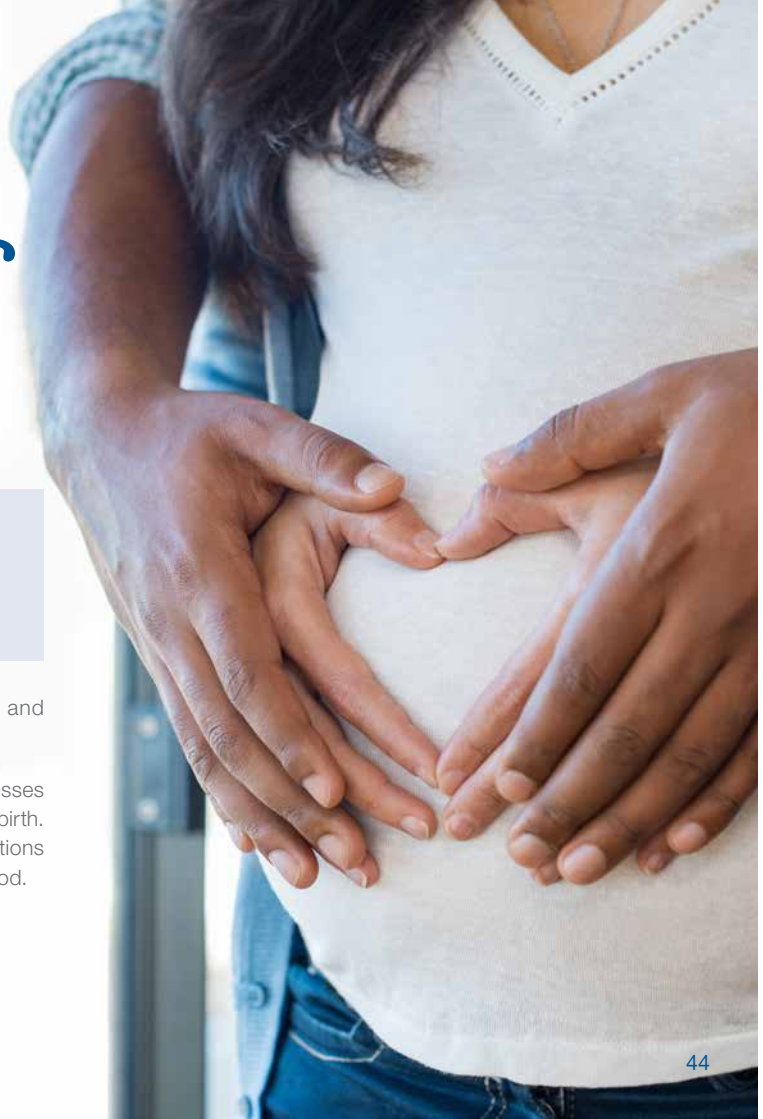
38. Central nervous system	Neuro-stimulation/ablation devices for Parkinsons: **R61 800** per beneficiary per year. Vagal stimulator for intractable epilepsy: **R52 300** per beneficiary per year.
39. Ophthalmic system	Intraocular lenses: **R4 250** per lens, 2 per beneficiary per year. Corneal grafts: **R36 300** per beneficiary per year, subject to overall annual limit.
40. HIV HIV Positivity Pathology HIV counselling and testing Prophylactic medicine for prevention of HIV virus transmission in the case of needle-prick, rape or infection of mother (mother–to-child prevention)	100% of cost, subject to registration on the HIV Management Programme. Polymerase chain reaction (3974) to be paid from the Major Medical benefits for dependants up to 18 months old, where the diagnosis refers to HIV testing. Pre-test counselling Testing and post-test counselling 100% of Medicine Price.
41. External medical appliances/prosthesis	**Hospital plus Savings Plan:** 100% of cost or MSR, whichever is the lesser, subject to **R13 900** per beneficiary per year. Permanent or temporary devices that are not surgically implanted and are seen to improve the function of a diseased organ. Benefit is subject to the submission of a motivation by the treating doctor to the Scheme and approval of the purchase or hire of the device prior to the acquisition or hire of the device. No benefit shall be available for APS machines unless approved by the Scheme. **Hospital Core Plan** and **Hospital plus Network Plan:** No benefit
42. Maternity Benefits – See our new chapter on Maternity Benefits.	

PLEASE NOTE:

The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with or pilot with or credential specific provider groups (networks) or centres of excellence as determined by the Scheme in order to ensure cost-effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMBs and other benefits (as set out in Annexure D of the Scheme's Rules). The Scheme reserves the right not to fund, partially fund or may impose a co-payment for services acquired outside of these networks, provided reasonable steps are taken by the Scheme to ensure access to the network. The application of these rules will be subject to Prescribed Minimum Benefits.

8

Maternity Benefits



IN THIS SECTION

- What maternity benefits are offered by the Scheme?
- Frequently asked questions around maternity

Pregnancy is an exciting time, but also one of change and uncertainty.

This chapter guidelines around your benefits and the processes that should be followed before, during and after your baby's birth. It also offers some questions to the frequently asked questions that parents-to-be often have during this life-changing period.

All the best with your and your baby's journey ahead!

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What maternity benefits are offered by the Scheme?

	WHY YOU NEED IT	HOW THE SCHEME CAN HELP
1. ANTENATAL CONSULTATIONS	To make sure your pregnancy is progressing well, you would need to consult your GP, a gynaecologist or a midwife from time to time. **Members' questions:** Q *Would I need to pay upfront then claim back? Or will the GP, gynaecologist or midwife send in my claim?* A *This will depend on your service provider - ask them how they usually do things when you make your appointment.* Q *Can I see a gynaecologist of my choice?* A *Yes*	The Scheme covers consultations that form part of your pregnancy as follows (see Member Guide). **BENEFIT AMOUNT:** • If you are on the **Hospital Core** or **Hospital plus Network** Plan: **R2 300*** per pregnancy. • If you are on the **Hospital plus Savings** Plan: **R3 160*** per pregnancy. **100% of cost or MSR, whichever is the lesser, subject to PMB protocols* **IN ADDITION:** Hospital plus Network Plan members also qualify for consultations with a Momentum/CareCross GP to supervise an uncomplicated pregnancy up to week 20. (In the case of a complicated pregnancy, the GP should refer the patient to a gynaecologist for the remainder of the pregnancy. The consultations for the gynaecologist would be funded from the member's available specialist benefit limit, whereafter it would be for the member's own account.)
2. ANTENATAL CLASSES	Childbirth education, often referred to as antenatal classes, is an opportunity for expectant parents to learn about the physical and emotional aspects of pregnancy, childbirth and early parenting. **Members' question:** Q *Would I need to pay upfront then claim back? Or will they send in my claim?* A *This will depend on your service provider - ask them how they usually do things before you start with your classes.*	The Scheme covers antenatal classes offered by a registered midwife. **BENEFIT AMOUNT ON ALL PLANS:** **R1 800*** per family per benefit year. **100% of the SPNP rate or in the absence of such a fee, 100% of the cost or MSR, whichever is the lesser.*

	WHY YOU NEED IT	HOW THE SCHEME CAN HELP
3. ULTRASOUND SCANS DURING PREGNANCY	The main purpose of the first scan (usually between 10 and 14 weeks) is to estimate your delivery date, check how many babies you're carrying, and whether they're developing normally. **Members' question:** Q *What is the importance of the scan? Is there a scan for Down Syndrome or birth defects?* A *Between week 11-13 a scan together with blood tests can be used to check for Down's syndrome and early abnormalities. Around week 22 a detailed foetal anomaly scan is done to monitor the development of all the organ systems and the physical structure of your baby.*	The Scheme covers two 2D scans per beneficiary per pregnancy on the **Hospital Core** and **Hospital plus Network** Plans, and four 2D scans per beneficiary per pregnancy on the **Hospital plus Savings** Plan. **IN ADDITION:** Hospital plus Network Plan members also qualify for one 2D scan in the first trimester of their pregnancy.
4. OUT-OF-HOSPITAL PATHOLOGY TESTS	Some tests are standard in a pregnancy, while others may become necessary if your healthcare provider picks up a potential problem.	The Scheme covers certain applicable blood tests, urine stick tests and other pathology tests you may need, subject to it being clinically indicated. **BENEFIT AMOUNT ON ALL PLANS:** **R2 910*** per family per year **100% of cost, subject to a list of pathology tests and using the DSPs for pathology services (Ampath, Lancet, Pathcare and Vermaak) at negotiated rates. MSR for services rendered by a non-DSP provider.*

	WHY YOU NEED IT	HOW THE SCHEME CAN HELP
5. PRIVATE HOSPITAL / BIRTHING UNIT	When giving birth, it is comforting to have access to quality medical equipment and support staff. The Scheme offers great in-hospital maternity benefits - you just need to make some decisions around the birth of your baby beforehand, to ensure you can make the necessary pre-bookings and pre-authorise the facility you will be using. *See page 35 on how to pre-authorise your admission.*	**HOSPITALISATION AT A PRIVATE HOSPITAL*** • Cover for general wards (generally 2 days for normal delivery and 3 days for Caesarean section, if there are no complications) • Theatre and recovery room fees • Doctor's/gynaecologist's/midwife's' visits whilst in hospital, • at Medical Scheme Rate (TIP: Find out beforehand what they will charge and call the Contact Centre to help you compare that with the Medical Scheme Rate, to get an idea of your potential out-of-pocket costs.) • Medication on discharge from hospital (limited to **R640**). **The cover is at Medical Scheme Rate or cost, whichever is the lesser, and subject to pre-authorisations and managed care protocols.* **REGISTERED BIRTHING UNIT** • Delivery by a registered midwife. • Hire of a water bath, which is included in the confinement benefit. • Four post-natal midwife consultations per event if a gynaecologist is not used.
6. ER24 / ASK THE NURSE HELPLINE	Whether you are experiencing an emergency, or simply need some advice to decide whether you need to see someone about a health-related problem you are experiencing, ER24 can help. Their 24-hour helpline covers emergencies as well as offers access to professional nursing sisters to advise you.	As a member/dependant of the Scheme, you have access to ER24's helpline - simply call **084 124**. Have your Horizon membership number handy, if possible.

	WHY YOU NEED IT	HOW THE SCHEME CAN HELP
7. HEARING TEST FOR NEW-BORN BABY	Hearing tests for newborns focus on identifying hearing loss early, as identifying any hearing problem sooner rather than later can make a big difference in your child's development. It is normally performed in hospital before the mother and baby are discharged, and it is a painless test that only takes a few minutes.	You have access to a hearing screening for your newborn baby,– just remember to have the test done before your baby is 8 weeks old. This test will be paid at 100% of cost or MSR, whichever is less.
8. CHILD IMMUNISATIONS	Immunisation helps your baby to create immunity to certain diseases. It protects your baby against debilitating and often life-threatening diseases such as polio, TB, tetanus, measles and more. **Members' question:** Q *Where can I get these immunisations?* A *You can get free child immunisations at Primary Care State clinics as per the Department of Health's guidelines. Private Mother and Baby clinics, some pharmacy clinics (e.g Clicks pharmacies) and some private hospitals have their own private clinics e.g. Netcare Stork's Nest.*	You have access to child immunisations as per the Department of Health's protocols for your baby (and up to the age of 12 years). This benefit applies to the cost of the relevant drops and vaccinations and does not cover facility fees and/or nursing consultations fees (although these may be covered from your other available benefit limits – call the Contact Centre to check).
9. PHOTOTHERAPY	Newborn babies sometimes develop jaundice (visible in their skin and the whites of their eyes turning yellow) because their livers are not mature enough to remove bilirubin from the blood. Too much bilirubin is harmful to your baby, which is why such jaundice must be treated.	Sometimes it is enough for a baby to receive a bit of natural sunlight. In more severe cases your healthcare provider may recommend phototherapy. In such a case you do not need the treatment to be performed at the hospital for it to be funded from your Hospital Benefits. As long as the treatment is authorised by the Scheme, it can be performed at your home by a registered nurse and will still be funded from your Hospital Benefit, subject to clinical criteria.

Frequently Asked Questions about Maternity

How do I decide between natural birth and a C-section?

Emergency Caesarean sections have saved the lives of countless mothers and babies who would have died, had they not received this lifesaving intervention.

It's become so prevalent in fact, that in South Africa, C-section rates in the private sector stand at over 70%, according to 2014 information by the South African Council for Medical Schemes. This is worrying as the World Health Organisation recommends an ideal 10-15% Caesarean section rate worldwide. The C-section rate exceeding the WHO recommendation is a worldwide trend.

WHY ARE SO MANY WOMEN CHOOSING C-SECTION?

A prospective mother's anxiety is often a motivating factor when choosing C-section. The media and society in general feeds this fear of something that used to be normal: natural childbirth. In contrast, we have casual attitudes towards surgery and have lost our fear of medical procedures, even though surgery is also risky. We simply do not have enough education on the positives of natural childbirth.

In an environment where patients are increasingly suing their healthcare providers for malpractice, doctors may also err on the side of safety by encouraging a mother-to-be to choose a C-section.

WHAT ARE THE BENEFITS OF NATURAL BIRTH?

There are many benefits to choosing natural birth over C-section (if the mother's and baby's health permits this).

GOOD FOR BABY

Babies born via natural delivery have physiological advantages, say the experts. For example, babies' digestive systems are colonised by their mother's flora as they pass through the birth canal; they receive stimulation from being squeezed and having their lungs compressed, and emerge more enlivened, with fewer admissions for wet lungs, fewer respiratory problems, and a lower incidence of asthma.

GOOD FOR MOM

For the mother, recovery time is quicker and bonding is easier, and she can experience birth as empowering.

GOOD FOR THE BUDGET

A natural delivery's costs are around half of that of a C-section. This means that you have smaller out-of-pocket expenses with a natural childbirth. Your medical scheme also has lower delivery claims, which ultimately has a positive effect on your contributions and benefits.

What should I consider when planning my baby's birth?

Birth partners

Whether you choose a gynaecologist, a general practitioner, or a registered midwife to help you with your birth will depend on a number of factors, including what kind of experience you want, where you plan to give birth, whether your pregnancy is normal or high risk, and what your medical aid will pay for.

Many women prefer the peace of mind of a gynaecologist, especially if they expect higher risk pregnancies and deliveries.

For others, the personal touch of a midwife is more what they are looking for.

Some combine these options, by opting for a midwife, but with a gynaecologist as a back-up.

Birth setting

Likewise, if you want your birth setting clinical and with all the emergency equipment at hand, a gynaecologist would be your obvious choice. If you want to deliver at home or in a more relaxed setting, a midwife could arrange that for you. Once again, you can combine these by using a midwife but 'renting' a birth unit from a hospital. Some of these even offer water therapy in the unit.

Birth plan

You may want to look at writing a birth plan well before you are ready to give birth. A birth plan is a way for you to communicate your wishes to the midwives and doctors who care for you in labour when you may be unable to do so yourself. Of course, you may change your plan over time, but at least it gives you, and those around you, some direction in a challenging situation.

When and how should I register my baby with the Scheme?

Your newborn baby should be registered **within 30 days from his/her date of birth** to ensure that relevant claims related to your baby will be paid.

If you only register your baby after 30 days from birth, the baby will be loaded from the 1st of the following month and not from date of birth, which means that you will have unnecessary out-of-pocket costs.

Register your baby by submitting the required forms to the Scheme via your relevant HR Department. They will require the full name, surname and date of birth of your baby.

What other resources can I use to prepare for my baby?

There are some excellent resources for parents-to-be on the internet, so be sure to search for something that suits your needs. The following websites could give you a headstart:

www.bellybelly.com.au

www.childmag.co.za

www.thebump.com

9 In-Hospital

Medical Emergency Benefits

(These benefits are the same on all Plans.)

IN THIS SECTION

- What are the emergency benefits?
- What is an emergency?
- What must I do in an emergency?

What are the emergency benefits?

Horizon Medical Scheme is contracted with ER24, a countrywide 24-hour medical emergency service provider that renders assistance ranging from immediate telephonic advice to active intervention, using a specialised medical fleet, qualified medical professionals, and portable, high-level equipment.

The ER24 Contact Centre is supervised by medical doctors experienced in emergency medicine and staffed by qualified and experienced nurses and paramedics. ER24's highly trained staff will advise you on what steps to take in an emergency situation

and, if necessary, activate their extensive ground or air resources to assist you. ER24's database of medical services and facilities throughout South Africa ensures that every call receives the best possible attention.

This emergency service is available countrywide, 24 hours a day, 365 days a year:

- Emergency medical response by road or air, whichever is the most appropriate, to the scene of a medical emergency.
- Transfer by ambulance or air to the closest, most appropriate medical facility.
- Inter-hospital transfers (only when medically justified as motivated by a medical practitioner), subject to authorisation by ER24.

ER24 provides full cover to Horizon members and their beneficiaries. In an emergency call 084 124 (also for 24-hour emergency advice). ER24 strongly advises you to attach your car sticker to the rear-window of your motor vehicle. This will alert any emergency service on the scene of an accident that you are a member of ER24.

What is an emergency?

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.

What must I do in an emergency?

- Call **084 124** (ER24's number) in an emergency.
- ER24's staff can advise you what immediate steps to take.
- If necessary, ER24 will activate their ground and air resources to help you.
- If you have to go to the hospital, remember to take along your membership card (if possible).

Remember to authorise hospitalisation to minimise costs!

If you or any of your beneficiaries are admitted directly to hospital in an emergency, a member of your family or the hospital concerned must contact the Hospital Benefit Management Department on the first working day after admission.

Call Centre number: **0860 101 103**

Please note: 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.

10

Managed Healthcare Programmes

(These benefits are the same on all Plans.)

IN THIS SECTION

- How does the Managed Care programme for HIV work?
- How does the Oncology Benefit Management Programme work?

How does the Managed Care programme for HIV work?

Members and dependants of the Horizon Medical Scheme have access to benefits for the treatment of HIV. These benefits can be accessed by registering on the ***HIV management programme***.

HIV

HIV is a manageable chronic disease. Treatment is available that allows people living with HIV to lead healthy and productive lives. Research has demonstrated that people living with HIV can live a near normal lifespan if they are compliant to treatment.

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 are available to attack the virus, while good nutrition and exercise can play a critical role in keeping your body strong and healthy. Starting treatment early ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infections or other complications. Our ***HIV management programme*** can help you access benefits to assist you with the best way of managing HIV.

We can help you to manage your condition

Our ***HIV management programme*** is specifically for HIV-related medicine. This programme is used to pay for medicine to attack the virus, medicine to prevent opportunistic infections and regular pathology monitoring tests. You will also receive support from the adherence coordinators who will assist you with relevant information to assist you in managing your disease.

Your condition will stay confidential

HIV is a sensitive matter and every effort is made to keep your condition confidential. The staff members have all signed confidentiality agreements and are employed in a separate company from the Scheme or the administrator. Staff at the ***HIV management programme*** will not reveal your HIV status to anyone, without your permission. The ***HIV management programme*** uses separate telephone, fax and private mailbag facilities from the Scheme or the administrator. Patients need to use these facilities to maintain confidentiality.

You must register on our *HIV management programme*

If your test shows you are HIV-positive you must register on the ***HIV management programme*** as soon as possible to make use of this benefit. Telephone in confidence and ask for an application form and the counsellor will also assist you with registering on the ***HIV management programme***. Your doctor can also contact us on your behalf.

After you have registered

After you receive the application form, you and your doctor must complete it and return it to the ***HIV management programme*** by using the confidential, toll-free fax line number or email address on the form. A highly qualified medical team will examine your details and if necessary, discuss an appropriate treatment with your doctor.

Once treatment has been agreed upon, you and your doctor will be sent a detailed treatment plan, which explains the approved

medicine as well as the regular tests that need to be done to ensure that the medicines are working correctly.

What the HIV management programme offers you

The Scheme's HIV management programme is a complete HIV disease management programme that offers both members and beneficiaries:

- Medicine to treat HIV (including drugs to prevent mother-to-child transmission and infection after sexual assault or needle stick injury) at the most appropriate time.
- Treatment to prevent opportunistic infections like certain serious pneumonias and TB.
- Regular monitoring of disease progression and response to therapy.
- Regular monitoring tests to pick up possible side-effects of treatment.
- Ongoing patient support via an HIV Care Co-ordination Line.
- Clinical guidelines and telephonic support for doctors.
- Help in finding a registered counsellor for emotional support.

Contact Aid for AIDS (AfA).

Tel: 0860 100 646
Fax: 0800 600 773
Email address: afa@afadm.co.za
Website: www.aidforaids.co.za
Mobi-site: www.aidforaids.mobi
SMS (call me): 083 410 9078

How does the Oncology Benefit Management Programme work?

If you are diagnosed with cancer, it will be to your advantage to contact the Oncology Case Manager before starting any treatment. The Oncology Benefit Management Programme will not only help you to manage the high costs associated with treatment, but you will also receive help, support and education on your condition from the Oncology Case Manager.

Why is it necessary for me to register on the Oncology Benefit Management Programme?

By enrolling on the programme, you will qualify for the annual oncology family benefit limit. It will also ensure that health services related to oncology, such as your doctor's consultations, general and specialised radiology and pathology during follow-up visits to the doctor, will be covered from your oncology benefit. By obtaining authorisation you are also ensuring that your treatment is effectively managed within your available benefits.

This benefit forms part of your Hospital Benefits. It is envisaged that in most cases this limit will be sufficient to cover well-managed costs.

If your care plan is not approved, you will not have access to the oncology benefit limit, and all your cancer-related accounts will be paid from your day-to-day benefit (if applicable) and, once depleted, from what is available in your Personal Medical Savings Account.

The Oncology Case Manager will address any concerns with the treating oncologist.

- Please submit your care plan to Medscheme via email to: cancerinfo@medscheme.co.za.
- If you have any queries regarding the Oncology Benefit Management Programme or your condition, please contact the Oncology Case Manager on 0860 100 572.

How to obtain authorisation for associated treatment

1. Surgery/procedures/hospital admissions:

If you need to be admitted to hospital for chemotherapy or radiotherapy, please contact the ***Oncology Management Department*** directly.

Surgery or related procedures are covered from the hospital benefits and not the oncology benefit, so you will need to obtain a pre-authorisation from the ***Hospital Pre-authorisation Department.***

2. Specialised radiology (including PET scans):

If you require specialised radiology, such as CT, MRI or PET scans, you will need an additional authorisation from the ***Oncology Management Department*** for it to be covered from your oncology benefit.

When applying for a specialised radiology authorisation, the following information is required:

- membership number,
- dependant number,
- requesting doctor practice number,
- radiology practice number,
- codes to be charged and estimated cost, and
- reason for the scan.

If you need an authorisation for a PET scan, your doctor must complete the PET scan form, which is available at all PET scan units.

3. Hospice, private nursing and medical admissions:

If you need services such as home nursing or hospice, you need to contact the ***Hospital Preauthorisation Department.*** You can also contact this department if you have complications such as dehydration or excessive vomiting, or need to be hospitalised for pain control.

Please note: *That the account claims process and claims queries are not handled by the Oncology Case Manager. These queries should be directed to the General Enquiries call centre.*

11 Prescribed Minimum Benefits

(These benefits are the same on all Plans.)

IN THIS SECTION

- What are PMBs?
- Why do we have PMBs?
- Which PMB conditions are covered by the Scheme?

What are PMBs?

The regulations published in terms of the Medical Schemes Act 131 of 1998 stipulate the scope and level of the minimum benefits to which members of the Scheme are entitled. Prescribed Minimum Benefits (PMBs) are a set of defined benefits that ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit Plan they have selected.

PMBs are fully covered by your medical scheme, provided you follow the guidelines. The cover is related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of 270 Diagnostic Treatment Pairs (DTP) defined in the DTP list on the Council for Medical Schemes website; and
- other Scheme-approved chronic conditions (defined in the Chronic Disease List on page 33 of this member guide).

When deciding whether a condition is a PMB, the doctor should look only at the symptoms and not 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).

270 Diagnostic Treatment Pairs (DTP)					Other Scheme-approved Chronic Diseases List (CDL) conditions	
Acute Conditions		Chronic Conditions		Hospitalisation		
Medical management of the condition	Medicine management of the condition	Medical management of the condition	Medicine for the condition		Medical management of the condition	Medicine for the condition

Why do we have PMBs?

There are two reasons why PMBs are in place:

- To ensure that medical scheme beneficiaries have continuous healthcare. This means that even if a member's benefits for the year run out, the Scheme will continue to pay for the treatment of PMB conditions. These benefits are subject to the medical management treatment protocols.
- To ensure that healthcare is paid for by the correct parties. Medical Scheme members with PMB conditions are treated according to the specified treatments and these have to be covered by their medical scheme, even if the patients were treated at a State Hospital.

Which PMB conditions are covered by the Scheme?

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 PMBs, 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 PMBs. The list is in the form of Diagnosis and Treatment Pairs (DTP). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 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 dislocation/ fracture, open or closed with injury to spinal cord	Repair/reconstruction; medical management; in-patient rehabilitation up to two months

If your PMB condition is not an emergency or a chronic condition, but is an acute PMB condition as diagnosed by your doctor, you will be covered, subject to Scheme Rules and the PMB limits. If you are unsure of whether your diagnosed acute condition is covered as a PMB you can contact the Scheme on 0860 101 103 to clarify this. The agent will require the ICD-10 code to determine whether the condition is an acute PMB condition.

Designated Service Providers for PMBs - Hospital plus Network Plan	
General Practitioners	Momentum/CareCross Network doctors
Chronic Medicine	Medicines on Network formulary only; other services not covered by Network pharmacies.
Other Primary Care Services	Momentum/CareCross Network doctors
Other out-of-hospital services	Network providers only (radiology and pathology services covered according to approved Network tariff list only)

12 How to Claim

IN THIS SECTION

- How soon after joining can I claim?
- Would I have to make co-payments or pay levies?
- How do I submit a claim?
- Can my doctor claim electronically?
- Whom should I contact if I have any queries about claims?

How soon after joining can I claim?

Members and their beneficiaries are entitled to benefits from the first day of joining Horizon Medical Scheme (except where waiting periods are applicable – see page 66). Members are advised to phone the Horizon Call Centre at 0860 101 103 before proceeding with treatment if there is any doubt whether such treatment qualifies for benefits.

Would I have to make co-payments or pay levies?

Members are generally not required to pay any co-payments for treatment at the point of service. In the event that the provider charges more than the Medical Scheme Rate (MSR) or where no day-to-day cover is available on the Plan, the member is liable for the account.

Please bear in mind that some doctors charge more than others - it will therefore be in everyone's best interest that you negotiate with your service providers to reduce costs.

How do I submit a claim?

Members on the Hospital plus Network Plan need not submit any claims for network providers. In the case of out-of-network claims, members have to submit such claims to CareCross for reimbursement.

Other members must please ensure that all accounts and claims have the following information:

- the name of the Scheme;
- your membership number;
- your surname and initials;
- the patient's first name/s as it appears on your membership card;
- the name and practice number of the service provider (e.g. doctor or pharmacy);
- a receipt, if you have already paid the account (please state clearly on the account that it has been paid);
- a fully specified account; and
- an ICD10 code or tariff code.

All specialists and medical auxiliaries (physiotherapy, etc.) accounts must be submitted to the Administrator.

Claims can be submitted as follows:

Post: Horizon Medical Scheme, P O Box 74, Vereeniging, 1930, South Africa

Email: claims@medscheme.co.za

Note:

Submit your claim as soon as possible after receiving the account. If it is not submitted by the last day of the fourth month following the date of service, it will not be paid.

Claims that are faxed or submitted as scanned documents will only be processed if legible.

Can my doctor claim electronically?

EDI, Electronic Data Interchange, is a system whereby the doctor claims electronically from the Scheme. If your doctor or provider claims by EDI you do not have to submit a claim at all – the Administrator will automatically process the EDI claim.

Whom should I contact if I have any queries about claims?

For claims enquiries please call **0860 101 103** or fax **0860 111 785.**

13 All about

Membership

IN THIS SECTION

- Who can be a member of the Scheme?
- Who is regarded as a dependant of the member?
- What do I need to do if my dependants/ membership details change?
- How are waiting periods applied?
- What is a Late Joiner Penalty (LJP)?
- What will happen when my Scheme membership comes to an end?

Who can be a member of the Scheme?

All employees qualify to become members once permanently employed. Employees who are required, in terms of their conditions of employment, to be a member of the Scheme, are not allowed to terminate their membership while they are still an employee of the participating employer.

To join the medical scheme, the Horizon Medical Scheme application form must be completed and returned to your respective Salaries, Payroll or HR Department within 30 days of your employment date. If a member joins the Scheme before or on the 15th of a month, full contributions will be payable for that month. If a member joins the Scheme after the 15th of a month, contributions will only be payable from the following month onwards.

Active members who resign or are dismissed from the participating employer can no longer belong to the Horizon Medical Scheme.

Active members who retire, or who leave employment due to ill-health or disability, may remain members of the Scheme.

Who is regarded as a dependant of the member?

The Rules of the Scheme allow dependants of principal members (employees or pensioners) to be on the Scheme. The Rules of the Scheme also allow dependants of deceased principal members (employees or pensioners) to remain on the Scheme. This includes the spouse as well as the children.

The following may be registered as beneficiaries if they do not belong to any other medical aid scheme:

- a member's spouse or life partner;
- a member's child who is under the age of 21;
- children over 21 but under 26 who are full-time or part-time students; and
- any other member of the member's immediate family in respect of whom the member is legally liable for family care and support. The Scheme shall require proof of dependency.

Note: *It is not compulsory for the whole family to register as beneficiaries, but a beneficiary cannot join if the principal member (employee) is not a member of the medical scheme. If the principal member decides not to add family members (beneficiaries) when first joining the Scheme, but does so at a later stage, then the general waiting period and twelve-month exclusions on pre-existing conditions will be applied. It is illegal to belong to more than one medical scheme at a time.*

When a member gets married, or a child is born or adopted, the new beneficiary must be registered within 30 days of the occurrence of the event.

Increased contributions shall be payable for the full month in which the new beneficiary is registered and benefits will be available as from the date of registration. For any other dependants registered, contributions will be payable for the full month in which he/she is registered.

The following may NOT be registered as beneficiaries:

- Nieces and nephews
- Parents-in-law
- Married dependants

If you have any questions about the registration of your dependants, please email: horizon@medscheme.co.za, or call 0860 101 103 / +27 011 671 6837.

What do I need to do if my dependants/membership details change?

To register a beneficiary, please advise the respective Payroll, Salaries or HR Department and submit a "Change of Membership Details" form with the necessary documentation. The same process applies to remove a beneficiary. The Scheme requires 30 days' notice of the removal of a beneficiary. When a beneficiary is removed from the Scheme, contributions in respect of that beneficiary will be due for the month in which the beneficiary is removed, irrespective of when the beneficiary's membership is cancelled.

Note: *Beneficiaries who are not registered do not qualify for any benefits.*

How are waiting periods applied?

Each employer group determines which employees are eligible to join the Horizon Medical Scheme. Employees of participating companies that do not require ALL employees to belong to Horizon Medical Scheme will be subject to the following waiting periods, exclusions and/or penalties when joining the Scheme:

Waiting periods will be applied as follows:

Your (or a beneficiary's) circumstances	Will a three-month general waiting period apply?	Will a 12-month condition-specific waiting period apply?	Will Prescribed Minimum Benefits (PMBs) be covered?
If your membership of the Horizon Medical Scheme is compulsory.	No, there will not be a waiting period, provided you apply within 30 days of your employment.	No	Yes
If, for a period of more than 90 days before your application to the Horizon Medical Scheme, you were not a member of a medical scheme.	Yes, a three-month waiting period will apply, including for Prescribed Minimum Benefits (PMBs).	Yes	No
If you have a child.	No, there will not be a waiting period for the child. Remember to register your baby within 30 days of birth for him/her to be covered from date of birth, otherwise the baby will only be covered from the 1st of the following month.	No	Yes
If you experience one of the following life-changing events: - Divorce; - Marriage; - Retrenchment; or - Partner's change of employment, or death.	No, there will not be a waiting period, provided that you apply to join within 30 days of the event taking place.	No	Yes
If you have been a member of a medical scheme for less than 24 months and you apply to the Horizon Medical Scheme within three months terminating your membership of the previous medical scheme.	It depends. Any unexpired waiting period balance on your previous medical scheme will be applied. You will be entitled to Prescribed Minimum Benefits (PMBs).	Yes	Yes

Your (or a beneficiary's) circumstances	Will a three-month general waiting period apply?	Will a 12-month condition-specific waiting period apply?	Will Prescribed Minimum Benefits (PMBs) be covered?
If you (or a beneficiary) have been a beneficiary of a medical scheme for more than 24 months and you apply to the Horizon Medical Scheme within three months terminating your membership of the previous medical scheme.	Yes, a three-month waiting period will apply. You will be entitled to Prescribed Minimum Benefits (PMBs).	No	Yes

What is a Late Joiner Penalty (LJP)?

LJPs can be imposed on the main member and dependants if they join after 30 days of employment and are over the age of 35 with no previous cover.

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

- If the dependant joins at the same time as the main member (within 30 days from date of employment), no underwriting 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%.

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 years 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 Scheme Rules.
- It is important to provide all supporting documents, such as membership certificates of previous medical schemes (indicating the membership end date) to the Scheme as soon as possible, to ensure that LJPs, if applicable, are not calculated incorrectly. 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.

- Condition of employment: If a member and his dependants join within 30 days, no waiting periods will apply to the member and his dependants.
- Please take note that LJPs are implemented for life and do not expire.
- Also note that the participating companies do NOT subsidise this late joiner penalty.

What will happen when my Scheme membership comes to an end?

A member who resigns or is dismissed from the participating employer cannot remain a member of the Scheme. Membership and benefits cease on the last day of employment, but if this is on or before the 15th of the month, the member will not have to pay contributions for that month.

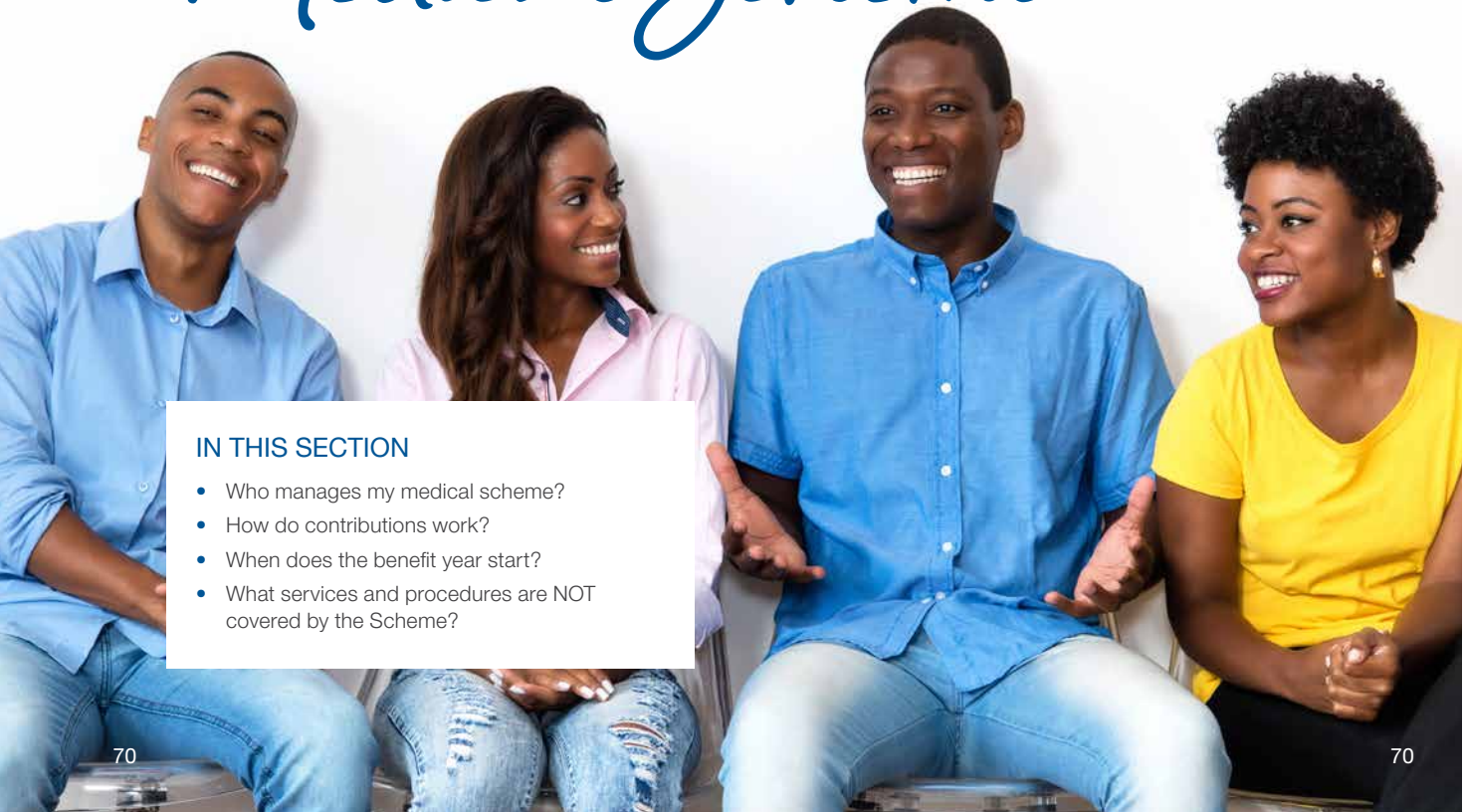
The Salaries, Payroll or HR Department must be advised immediately when an employee resigns. From the date of termination the member and beneficiaries will not be entitled to any further benefits. Any amounts due to the Scheme will be deducted from money owed to the member by the employer.

A member must inform the Scheme within 30 days if any of his or her beneficiaries are no longer members, i.e. if deceased or when the beneficiary gets married, etc.

A beneficiary shall be deemed to have ceased to be eligible as a beneficiary if:

- he or she was a dependent child and attained the age of 21 years, unless the member provides satisfactory evidence that this child is still dependent on the member; or
- at the end of the benefit year he or she was a parent, including a parent of an adopted child, brother or sister of a member, unless the member provides satisfactory evidence that the member is still liable for family care and support in respect of this beneficiary.

14 More about your Medical Scheme



IN THIS SECTION

- Who manages my medical scheme?
- How do contributions work?
- When does the benefit year start?
- What services and procedures are NOT covered by the Scheme?

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Who manages my medical scheme?

The Horizon Medical Scheme has been designed to address the needs of as many of its current and future members as is possible. The Scheme is autonomous and managed by a Board of Trustees. Each participating company has two representatives on the Board – one elected by the employees and one nominated by the company – who serve for a period of five years.

To assist the Trustees in fulfilling their duties they are assisted by NMG Actuarial & Specialised Consulting who are the Actuaries and Consultants, and Medscheme, who are the Administrators. Momentum/CareCross manages the day-to-day benefits on the Hospital plus Network Plan.

The Administrators' services include the handling of claims and queries, as well as managing the finances of the Scheme.

How do contributions work?

Funds in the Scheme are contributed by both the members and the company. Apart from all non-healthcare administration costs, the contributions are used entirely for the medical expenses of members. Any excess funds (surpluses) of the Scheme at each year-end (of contributions over expenditure) are retained by the Scheme and forms part of a reserve account. It is a requirement by law that all medical schemes must have a reserve account equal to at least 25% of annual gross contributions to protect members against any unforeseen increases in claims and future price increases.

Because the money in the Scheme is mainly used to pay benefits to members, it is in the interest of all members to be vigilant in the control of expenses and to report any abuse of the Scheme. The better the costs are controlled, the better the benefits that can be offered, and the lower the annual increases in your contributions.

When does the benefit year start?

The benefit year runs from 1 January to 31 December each year. Annual limits are based on the benefit year from January to December and will be apportioned according to the period of membership, in relation to the Medical Scheme benefit year. This means, for example, that if a member joins the Scheme on 1 July, he or she will only get six-twelfths (half) of the annual benefits, since he or she will only be a member for six months of that benefit year.

What services and procedures are NOT covered by the Scheme?

All medical schemes have to make sure that the members' money is used for genuine medical reasons and therefore there are rules pertaining to exclusions and benefits. Below is an extract from our Scheme's Rules, but if you are in any doubt about your own circumstances, you can contact the Horizon Medical Scheme Call Centre at 0860 101 103 for clarification or alternatively email horizon@medscheme.co.za.

Exclusions

In so far as they are not prescribed PMBs, the following are some of the exclusions:

- For the Hospital plus Network Plan, any non-Momentum/CareCross-generated claim apart from those covered under 'Out of Area'.

- Travel expenses.
- Cosmetic treatment, operations, procedures and applicators, toilet preparations, etc.
- Reports, examinations and tests for insurance policies, employment, visas, pilot and driving licenses or legal reasons.
- Injuries arising from or appliances for professional sport, bungee or parachute jumps.
- Accommodation in an old age home, general care institutions, spas, health or holiday resorts.
- Treatment for obesity.
- Treatment and operations of choice and non-essential medical items.
- Acupuncture, biokinetics, chiropractors, herbalists, naturopaths and homeopaths.
- Ptosis
- Injuries sustained during participation in strikes, illegal picketing, riots or physical struggle.
- Nutritional supplements, tonics, stimulants, vitamins, minerals.
- Contraceptives used for skin conditions.
- Stimulant laxatives.
- Treatments for sexual dysfunction.
- A medical or surgical procedure, treatment, cause of treatment, equipment, drug or medicine that is not widely accepted and known to be safe, effective and appropriate for the treatment of an illness or injury by a consensus of professional medical specialists which are recognised as such by the South African medical community.
- If the treatment is under study or investigation in a test period or part of or in a clinical research
- Services that are regarded as not medically necessary.

For a comprehensive list of exclusions, please call the Horizon Contact Centre on 0860 101 103, email horizon@medscheme.co.za, or visit www.medscheme.co.za.

15 Frequently Asked Questions

IN THIS SECTION

- What is the difference between GPs, specialists and auxiliary service providers?
- What rules apply if I have been involved in a motor car accident?
- How can I claim in terms of the Compensation for Occupational Injuries and Diseases Act?
- What can I do if I have a complaint against my medical scheme?
- What can I do if my benefits run out in the case of a serious illness?
- What if I suspect fraudulent activity against the Scheme?
- How confidential will my information be kept?

What is the difference between GPs, specialists and auxiliary service providers?

A general practitioner (GP) is someone who completed the standard training for a medical doctor.

A specialist is someone who has completed advanced education and clinical training in a specific area of medicine (their specialty area), such as cardiology, neurology, and so on.

Auxiliary services providers are generally not doctors, but trained in a specific field. Examples are audiologists, physiotherapists, dietitians and chiropractors.

What rules apply if I have been involved in a motor vehicle accident?

The Scheme will cover treatment of injuries sustained in line with the Scheme's rules and your available benefits.

We would like to remind you that a third party, such as the Road Accident Fund (RAF) or another public party, may often be liable for the payment (or part thereof) of the medical expenses members and/or their Scheme incurred as a result of an accident.

In terms of the Horizon member obligations, as set out in Annexure C of the Scheme Rules, your support and co-operation in assisting the Scheme to recover past medical expenses paid on your behalf is imperative. It is only with the assistance of its members that the Scheme is able to recover medical expenses. Members therefore have an obligation to disclose all information relating to a possible third-party claim and to sign all required legal documents.

If you have been involved in any kind of motor vehicle or other accident in which someone else (other than you or your dependent) may have been responsible, or partly responsible, for the accident in which you were injured, you may have an eligible third-party claim.

To help you understand your obligations and to assist with lodging a third-party claim, the Board of Trustees appointed Medscheme Holdings as the Scheme's provider for the recovery of all eligible past medical expenses paid by the Scheme that may be recoverable from a third party.

Contact the Scheme on 0860 101 103 and ask for assistance with third-party claims so that your call can be transferred to a legal adviser in the Third-Party Claims team. Alternatively, you can contact the team directly on 0800 117 222.

If you appear to have a valid third-party claim, you will be asked to complete an accident questionnaire. This will help to ensure that you receive accurate advice and that the correct forms are completed. You will also be required to sign a mandatory Horizon member undertaking, agreeing that you will include in your claim, and pay the Scheme back if you receive a settlement from a third party such as the Road Accident Fund (RAF) that includes money that the Scheme paid on your behalf.

Please read clause 3.2 of Annexure C of the Horizon Medical Scheme Rules for the detailed member and Scheme obligations in the event of a potential third-party claim.

How can I claim in terms of the Compensation for Occupational Injuries and Diseases Act?

In certain circumstances, you may not be covered by the Scheme for injuries resulting from an accident sustained in the workplace, as these medical expenses can be claimed from a third party. Claims in terms of the Compensation for Occupational Injuries and Diseases Act are not covered by the Scheme.

Forms for the Compensation for Occupational Injuries and Diseases Act should be completed by the treating hospital or medical practitioner and the relevant employer, and then submitted to the Commissioner of Occupational Injuries and Diseases.

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

What can I do if I have a complaint against my medical scheme?

The Registrar of 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. However, the Registrar requires that members FIRST try to resolve any complaints with their medical scheme, before they contact the Registrar.

Once you have tried and failed to resolve a complaint with the Scheme, you may contact the Registrar to make a complaint. Complaints can be submitted through fax, email or in person at the Registrar's office. The Registrar's contact details are as follows:

Council for Medical Schemes

Block A Eco Glades 2 Office Park, 420 Witch-Hazel Street,
Ecopark, CENTURION 0157

Website address: www.medicalschemes.com – (on the landing page click on 'Consumer Assistance' in the menu bar, and then on 'The Complaints Procedure' for further information.)

Customer Care Share call no.: 0861 123 267
Complaints fax no.: 0866 732 466
Email address: complaints@medicalschemes.com

- 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 a 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 of 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 can I do if my benefits run out in the case of a serious illness?

If you find yourself or a beneficiary suffering from a serious illness that results in medical expenses that exceed the annual limits, you may apply in writing to the Board of Trustees for ex-gratia assistance.

Each request will be considered and everything possible will be done to assist you. In order to apply you should:

- obtain the application form from Medscheme
- ask your doctor to assist you in completing the form; and
- submit the completed form to Medscheme

Post or email your form to:
Horizon Medical Scheme
Attention: Ex-gratia Department
PO Box 74, Vereeniging, 1930, South Africa

or horizon@medscheme.co.za

This is your Medical Scheme and the onus is on you to investigate whether you qualify for this additional assistance. However, it should be recognised that existing members will in effect fund additional requests, so only serious cases should be put forward.

What if I suspect fraudulent activity against the Scheme?

Unnecessary and fraudulent expenses are funded by you, the member, through increased contributions. You can contribute towards the fight against fraud by carefully and regularly checking your claims transactions and making sure that you have not been involved in a fraud scam without your knowledge.

Examples of fraud scams discovered by the Scheme have been:

- 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 Scheme 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 your Scheme, please contact the Fraud Hotline on 0800 11 28 11. This hotline is managed by an independent company, Tip-Offs Anonymous, and you can choose to remain anonymous. You can also email fraud@medscheme.co.za to report your suspicions.

How confidential will my information be kept?

The Scheme would like to remind members of our confidentiality policy, which prevents unauthorised persons from obtaining and changing members' information.

Please note that the Scheme will only process changes to member details that have been furnished to the Scheme by the member or his or her representative.

To ensure that your information is secure and that unauthorised callers cannot change your records, we will authenticate the identity of callers, by asking for the following details:

- membership number;
- name of caller;
- identity number or date of birth; and
- address.

If you are disabled, aged or have a personal assistant (PA) who looks after your affairs, you can make special provision to allow that person to access your information. All that is required is a completed Letter of Authority, giving your representative (PA or family member, etc.) the authority to contact us on your behalf. Simply contact us (see contact details at the front of the guide) to send you a Letter of Authority form to complete.

As your protection is our priority, should any of the above details not correspond with what we have on our system, no information will be provided to the caller.

Jargon Guide

Beneficiary	Each person registered on the Scheme.
Benefit year	The period for which benefits and allocations apply, in this case 1 January to 31 December. Should you join the Scheme during a benefit year, you are only entitled to a month appropriate portion of the benefits and limits specified for that year.
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.
DSP (Designated service provider)	Appointed by the Scheme to provide certain specified medical services to members, e.g. a group of service providers or a state facility.
Medicine Exclusion List (MEL)	The list of medicines used by the Scheme, to protect the Acute Medicine Benefits through the exclusion of this list from payment for a number of reasons.
Medicine Price List (MPL)	MPL 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.
Member family	The benefit is allocated to the principal member and his family and is the equivalent of one benefit limit per family.
MSR (Medical Scheme Rate)	The Scheme Tariff/Medical Scheme Rate as approved by the Board of Trustees unless an alternative tariff has been negotiated with specific providers, which will not be less than the fee charged by the State.
Prescribed Minimum Benefits (PMBs)	The unlimited benefits to which all members are entitled for treatment related to the conditions specified in the Medical Schemes Act, provided this treatment is obtained at a DSP and subject to the Scheme's treatment protocols and formularies.
PMSA (Personal Medical Savings Account)	A savings account to accumulate funds for future approved medical needs (**Hospital plus Savings Plan** only)
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.


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