



2012 HORIZON MEDICAL SCHEME
MEMBER GUIDE

Contact Details

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Horizon Member Zone website	www.medscheme.co.za
CareCross Call Centre	Members: 0860 103 491 Providers: 0860 101 159 Chronic: 0860 102 182 Email: horizon@carecross.co.za Website: www.carecross.co.za
Your choice of Plan, Membership and PSA contributions Administration (Member Registrations)	Tel: 0860 101 103 Fax: 0860 111 785 Email: horizon@medscheme.co.za
Hospital Benefit Management (pre-authorisation)	Tel: 0860 100 081 Fax: 0860 21 22 23 Email: authorisations.cpt@medscheme.co.za
Chronic Medicine Management	Tel: 0860 100 081/608 Fax: 0800 223 670/680 E-Mail: cmm@medscheme.co.za
Clicks Direct Medicines	Tel: 0861 444 405 Fax: 0861 444 414 Postal address: P O Box 751902, Gardenview, 2047
Oncology Case Manager (for patients diagnosed with cancer)	Tel: 0860 100 572 Fax: 021 466 2303 Email: cancerinfo@medscheme.co.za
HIV and AIDS Management Programme with Aid for AIDS	Tel: 0860 100 646 Fax: 0800 600 773 Email: afa@afadm.co.za
ER24 (24-hour emergency transport approvals)	Tel: 084 124
Whistle Blowers - Fraud Hotline	Tel: 0800 11 28 11 Email: fraud@medscheme.co.za

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The notes in this guide are a summary of the Rules of the Scheme and are given for easy reference for day-to-day enquiries. The Registered Rules of the Scheme override any information contained in these notes. Should you require further details, please contact the Horizon Medical Scheme Call Centre on 0860 101 103.

1. Welcome

In this section

- [Why have a medical scheme?](#)
- [How can this Member Guide help me?](#)
- [What are my responsibilities as a member?](#)

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 options 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 option you choose. It also contains information on the various options, to help you choose the one that suits you best, plus information on claims processes, chronic medication 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?

- Understand how the Scheme and specific options 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.

2. How to choose your option for 2012

➔ In this section

- [What are the main changes for 2012?](#)
- [Can I have a quick overview of the options?](#)
- [How should I decide which option is best for me?](#)

The benefit structure for the 2012 benefit year will continue to offer a choice of three options, catering to our various members' needs.

Before the new benefit year starts on 1 January 2012, 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.

This section offers a quick and easy comparison of the three options to help you determine which option will work best for you. When making this important decision, you will basically have to weigh up the benefits and contributions of the various options 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.

What are the main changes for 2012?

Quite a number of enhancements have been made to the benefits available under the various Plans for 2012. In short, these are as follows.

HOSPITAL AND SAVINGS PLAN

New name - It was agreed that this reflected a better description for what used to be known as the Hospital Plan, as members on this option are not only entitled to a wide range of hospital benefits, but also have access to their own savings account to cover everyday services expenses.

Up-front credit - A significant change to this option that members will surely appreciate, is that the amount available at the start of the benefit year will equal 12 x their monthly savings. No more having to wait until you build up enough money in the Plan before claiming for day-to-day medical services!

ENHANCED MANAGED HEALTHCARE PROGRAMMES

Your medical scheme offers various Managed Healthcare Programmes to help those who suffer from certain serious conditions. These programmes have been enhanced even further for the coming year.

HIV and AIDS Management Programme

The HIV and AIDS Management Programme is managed by Aid for AIDS (AfA) to ensure member confidentiality. The purpose of the Programme is to support HIV-positive members and their families through counselling and education, to coordinate their treatment via their provider, to manage

their benefits optimally and to optimise the medical costs resulting from the treatment. By joining this programme, HIV-positive members and their dependants will qualify for unlimited benefits per beneficiary, subject to the HIV/AIDS treatment guidelines.

Oncology Benefit Management Programme (for cancer patients)

If you or one of your dependants are diagnosed with cancer, the Oncology Benefit Management Programme will not only help you manage the high costs associated with treatment, but you will also receive guidance, support and education on your condition from the Oncology Case Manager.

CO-PAYMENTS FOR LAPAROSCOPIC PROCEDURES

To allow members the option of having laparoscopic procedures as a less invasive, but more expensive alternative to conventional open surgery, the Scheme is implementing the following co-payments that members would be responsible for, should they prefer to have a laparoscopic procedure done:

Procedure	Co-payment
Laparoscopic appendectomy	R8 000
Laparoscopic hernia repair	R4 000
Laparoscopic assisted vaginal hysterectomy	R8 000
Laparoscopic radical prostatectomy	R16 000

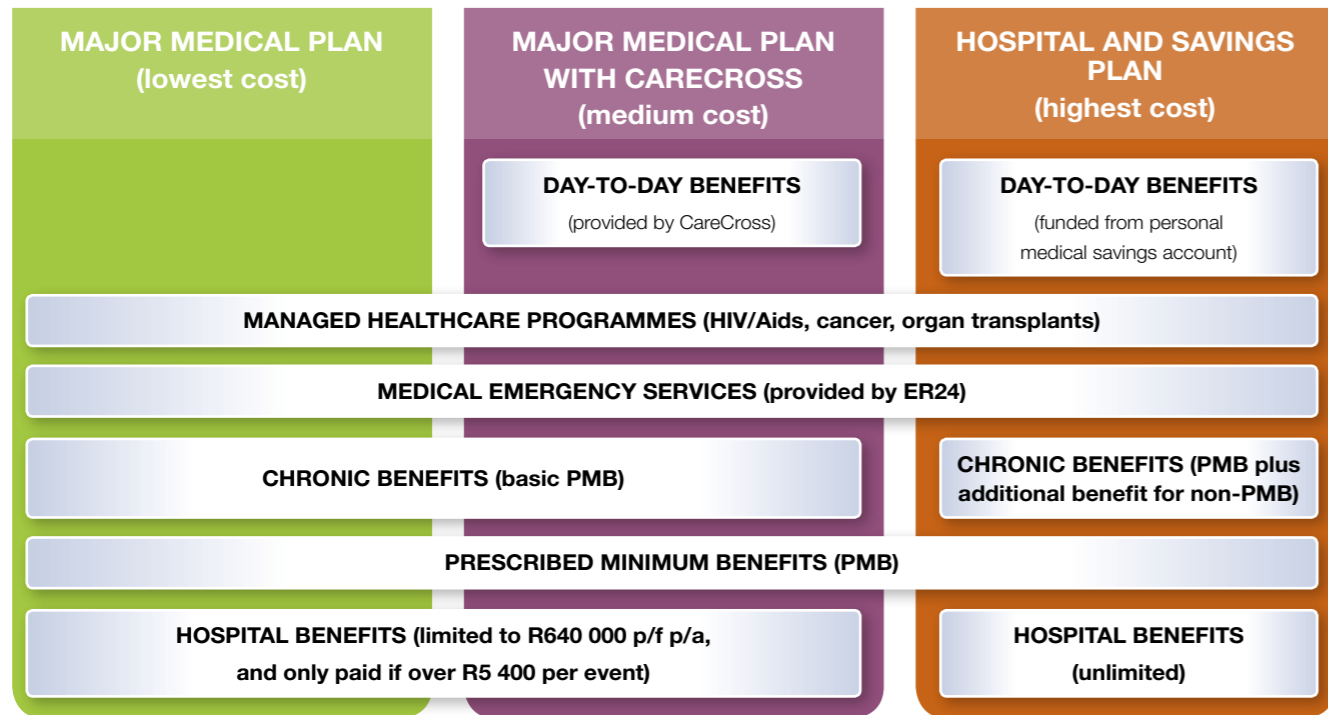
Procedure	Co-payment
Laparoscopic nephrectomy	R16 000
Laparoscopic pyeloplasty	R13 000
Knee arthroscopy	R5 000
Hip arthroscopy for femoroacetabular impingement (FAI) reconstruction, where it forms part of other diagnostic or therapeutic hip arthroscopy procedures	R10 000
Upper GI endoscopy / colonoscopy	R1 600
Balloon Sinuplasty	R5 000
Transvaginal mesh procedures for pelvic prolapsed repair e.g. Prolift	R5 000

NEW MAJOR MEDICAL BENEFITS

- Benefits for cardiac resynchronisation therapy and corneal grafts have been added to the major medical benefits that are available under all options.

Can I have a quick overview of the options?

The following is a graphic overview of how the different options compare. The details of your options are set out in *The three options in more detail* section of this guide, starting on [page 18](#).



Note: Members have the right to change options once per year. This right can be exercised on 1 January of each year. MEMBERS CANNOT CHANGE OPTIONS DURING THE YEAR.

How should I decide which option is best for me?

- Review the benefits offered by each of the three options to make sure that you choose the option most suited to your medical needs.
- Review your past medical claims history (in other words, what your medical expenses were during the 2011 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 medication and treatment.
- Consider whether you have an existing chronic ailment that may require chronic medication and treatment.
- Verify the monthly contribution rates of each option to make sure that you can afford the option you select. At the same time, there is no point in choosing a cheaper option if that option doesn't provide you with enough benefits and requires you to make regular co-payments.



3. General information around benefits

➔ In this section

- [What should we do in an emergency?](#)
- [How does hospitalisation pre-authorization work?](#)
- [How does the Managed Care programme for HIV/AIDS work?](#)
- [How does the Oncology Benefit Management Programme work?](#)
- [How does the Major Medical Plan with CareCross option work?](#)
- [How does the Personal Medical Savings Account \(PMSA\) work?](#)
- [What services and procedures are *not* covered by the Scheme?](#)

Members and their beneficiaries are entitled to benefits from the first day of joining Horizon Medical Scheme (except where waiting periods are applicable). 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.

What should we do in an emergency?

Horizon Medical Scheme offers members ER24, a countrywide 24-hour medical emergency service 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 Control Centre is supervised by registered medical doctors and staffed by Intensive Care Unit (ICU) nurses and paramedics. ER24's highly trained staff will advise you in an emergency on what steps to take immediately and, if necessary, activate their extensive ground and 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:

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

ER24 provides full cover to members and their beneficiaries on the Scheme. In an emergency call 084 124 (also for 24- hour emergency

advice). ER24 strongly urges you to attach the car sticker to the rear-window in your motor vehicle. This will alert any emergency service on the scene of an accident that you are a member of ER24.

**Remember, in an emergency,
dial 084 124.**

How does hospital pre-authorization 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:
 - the name and practice number of the doctor who wishes to admit you to hospital;
 - your medical scheme number, as well as the patient's name and date of birth;
 - the proposed treatment or procedure;
 - ICD10 and tariff codes as available from your treating doctor;
 - the planned date of admission to hospital; and
 - the name of the 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.

Please note: If you do not obtain pre-authorization as set out above, the Scheme will NOT PAY ANY OF THE COSTS ARISING FROM THE ADMISSION.

Contact Details:

Office Hours are from 08:00 till 16:30 from Monday to Friday, excluding public holidays. For your convenience, an **automated voice system** is available afterhours, 7 days a week. An agent will return your call the next working day to complete the authorisation.

Call Centre Number: 0860 100 081

Facsimile Number: 0860 21 22 23

E-Mail Address: authorisations.cpt@medscheme.co.za

How does the Managed Care programme for HIV/Aids work?

A special programme is available to assist members with HIV and Aids. Experienced professionals will assist members and their families in dealing with the realities of this disease in a caring and secure environment. They will be counselled to take their medication regularly, as the correct usage of prescribed medication is very important. Progress and treatment will be carefully monitored while the member is registered on this programme. *All information is treated with the highest confidentiality.*

For further information, please contact Aid for AIDS on:

Tel: 0860 100 646

Fax: 0800 600 773

E-mail: afa@afadm.co.za

How does the Oncology Benefit Management Programme work?

If you (or one of your dependants) is diagnosed with cancer, the Oncology Benefit Management Programme will not only help you manage the high costs associated with treatment, but you will also receive guidance, support and education on your condition from the Oncology Case Manager.

How does the Major Medical Plan with CareCross option work?

Horizon offers members on the **Major Medical Plan with CareCross** option access to primary care day-to-day benefits via the CareCross network of General Practitioners. This benefit includes General Practitioner



(GP) consultations, radiology and pathology requested by the CareCross GP according to an approved tariff list, acute medicine according to the CareCross Acute Chronic Medicine formulary, and as scripted or dispensed by your CareCross GP, chronic medicines according to the CareCross chronic medicine formulary on approval, basic dental benefits and optical benefits.

By selecting the Major Medical plus CareCross Option, you will need to select a CareCross GP who will manage your primary care day-to-day benefits. This benefit will be paid directly by CareCross 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 to stay healthy.

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

To obtain access to this range of benefits (please refer to the table of designated service providers on [page 41](#)), you need to select the Major Medical plus CareCross Option, and you need to select a single CareCross General Practitioner from the list of CareCross General Practitioners to manage your health.

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

www.carecross.co.za. Once you have chosen your doctor, please enter this information on your option choice form (or application form in the case of new members).

You must then always visit this doctor for medical care and may only change your choice of CareCross doctor once a year on 1 January. Should the provider you have chosen leave the CareCross Network, you will be contacted to choose an alternative provider on the Network to manage your healthcare needs.

How does the Personal Medical Savings Account (PMSA) work?

Members who choose the **Hospital and Savings Plan** will automatically contribute to a savings account at a rate of 15% of their total contribution. The member's contribution shall be credited to an account kept by the Scheme in respect of each Member, called a Personal Medical Savings Account (PMSA).

The funds in the PMSA shall be for the exclusive use of the member 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, or for any other shortfall which may occur, or the funds may be used to pay for any hospital levy or excess and to pay costs up to any threshold. 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 shall either be paid to his estate or, in the case of his beneficiaries becoming Continuation Members, this amount shall be paid into their PMSA. Such payment shall be made after the expiry of 5 complete months after the death of the member.

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

On transfer to another option 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 which does not provide for a PMSA, the balance due to the member must 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 must be transferred to such scheme within 5 months after termination of membership.

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 PMB, the following are excluded from the benefits:

- a. Any non-emergency hospital incidents that have not been authorised.
- b. For the Major Medical with CareCross option, any non- CareCross generated claim apart from those covered under 'Out of Area'.
- c. Travel expenses.
- d. Cosmetic treatment, operations, procedures and applicators, toilet preparations, etc.
- e. Reports, examinations and tests for insurance policies, legal reasons.
- f. Injuries arising from or appliances for professional sport, bungee or parachute jumps.
- g. Accommodation in an old age home, general care institutions, spas, health or holiday resorts.
- h. Treatment for obesity.
- i. Treatment and operations of choice and non-essential medical items.
- j. Acupuncture, biokinetics, chiropractors, herbalists, naturopaths and homeopaths.
- k. Ptosis

Exclusions (continued)

- l. Injuries sustained during participation in strikes, illegal picketing, riots or physical struggle.
- m. Nutritional supplements, tonics, stimulants, vitamins, minerals.
- n. Contraceptives and devices to prevent pregnancy.
- o. Stimulant laxatives.
- p. Treatments for sexual dysfunction.
- q. Treatment of an experimental nature:
A medical or surgical procedure, treatment, cause of treatment, equipment, drug or medicine will be regarded as experimental if it is not widely accepted and known to be safe, effective and appropriate for the treatment of an illness or injury. Furthermore if the treatment is under study or investigation in a test period or part of or in a clinical research, it will also be regarded as experimental.
- r. Services that are regarded as not medically necessary.



4. More about Prescribed Minimum Benefits and Chronic Benefits

➔ In this section

- [What are PMB?](#)
- [Why do we have PMB?](#)
- [Which PMB conditions are covered by the Scheme?](#)
- [What are chronic medicines?](#)
- [How do I apply for the chronic medication?](#)
- [How do I obtain an additional month's supply of chronic medication?](#)
- [How do I make changes to my chronic medication prescription?](#)
- [Who are the Scheme's designated service providers \(DSP\) for chronic medication?](#)
- [Which basic chronic diseases are covered by all options, under PMB?](#)
- [Which additional chronic benefits are covered under the Hospital and Savings Plan?](#)

What are PMB?

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 (PMB) 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.

PMB 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
- 26 chronic conditions (defined in the Chronic Disease List on [page 16 and 17](#) 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).

Prescribed Minimum Benefits						
270 Diagnostic Treatment Pairs (DTP)				26 Chronic Diseases List (CDL) conditions		
Acute Conditions		Chronic Conditions		Hospitalisation	Medical management of the condition	Medicine for the condition
Medical management of the condition	Medicine management of the condition	Medical management of the condition	Medicine for the condition			

Why do we have PMB?

There are two reasons why PMB 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 PMB, the medical scheme has to approve treatment. Schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

Diagnostic Treatment Pairs (270 medical conditions)

The Regulations to the Medical Schemes Act provide a long list of conditions identified as PMB. 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 100 080 to clarify this. The agent will require the ICD-10 code to determine whether the condition is an acute PMB condition.

Once the condition has been identified as an acute PMB condition, the agent will request that you submit your claim/s, together with the ICD-10 code, relevant tariff codes, doctor's practice number and any test results (including pathology and radiology) that support the diagnosis.

To avoid PMB claims being rejected

- Check that your doctor/service provider has put the correct ICD-10 code on your account.
- ICD-10 codes provide accurate information on your diagnosis and this assists in determining which benefits you are entitled to and how these benefits could be paid.
- Your PMB condition will be identified by the ICD code, so if the

incorrect code is used, your PMB-related condition will be paid from the wrong benefit.

- ICD-10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers.

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 option.* (Acute medicine is medicine that is prescribed by your doctor to treat a temporary illness.)

How do I apply for chronic medication?

Please note that the process differs for members on the Major Medical Plan with CareCross option and the other two options.

Major Medical Plan with CareCross

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

You will only have cover for the cost of the medications listed on the CareCross Chronic Medicine Lists according to the CareCross formulary and only if the medicine has been prescribed by your CareCross GP. This is subject to approval by CareCross.

Step 1	Step 2	Step 3	Step 4
Visit your CareCross doctor for confirmation of your diagnosis. The doctor will complete the chronic medication application on your behalf.	After you signed the form, the doctor will fax the form to the CareCross clinical division for verification.	The clinical department will evaluate the appropriateness of the request according to the chronic drugs list and CareCross formulary.	On completion of the process, your doctor will be informed if your application has been successful. The approved medication will be delivered to a CareCross preferred pharmacy provider, your doctor's rooms or the nearest Post Office.

Major Medical Plan and Hospital and Savings Plan

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

To apply for chronic authorisation, the member, prescribing doctor or pharmacist can contact the Medscheme Chronic Medicine Management Call Centre on 0860 100 608 with the relevant details.

Alternatively, the member, prescribing doctor or pharmacist may complete the chronic application on-line via the Medscheme website.

The following information will be required for new chronic applications.

- Membership number;
- The patient's consent to register them onto the Chronic Medicine Benefit;
- Weight, Height, Blood pressure readings, ICD-10 codes of diagnosis; and
- Test results where appropriate e.g. lipogram results, Hba1c, lung function tests.

Once the application details have been received, the chronic request is then reviewed by a member of the clinical team who, if necessary, may contact the prescribing doctor (telephonically or in writing) in order to select more appropriate and/or cost-effective treatment alternatives.

How do I obtain an additional month's supply of chronic medication?

Should you require more than one month's supply of medication, for example if you are going away on holiday, you will need to provide a motivation to cmm@medscheme.co.za , at least one month before you need the additional medication.

How do I make changes to my chronic medication prescription?

In order for payment to be made from the Chronic Medicine Benefit, changes or additions to your medicine access card may be done in one of

the following ways (diagnoses and supportive test results may be required):

- your prescribing doctor or dispensing pharmacist can phone our **Call Centre on 0860 100 608**
OR
- your prescribing doctor or dispensing pharmacist can update the chronic medication online by logging onto www.medscheme.co.za.

Medscheme Chronic Medicine Management department contact details:

Call Centre Number: 0860 100 608
E-Mail address: cmm@medscheme.co.za
Website: www.medscheme.co.za

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

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

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

1. Clicks Group Pharmacy Network
2. Clicks Direct Medicine

If you currently obtain your chronic medication 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:
General Enquiries: 0861 444 405
General Fax line: 0861 444 414

The latest prescription will be required for your chronic medication to be dispensed from the DSP. The chronic authorisation can be verified via the Member Zone at www.medscheme.co.za.

Which basic chronic diseases are covered by all options, under PMB?

Members will receive benefits for the 26 ailments specified by the Minister of Health as PMB, subject to the CareCross formulary or the Medscheme Comprehensive formulary. Medicines will be approved if the relevant Clinical Entry Criteria are met.

The 26 PMB conditions are:

Addison's disease	Epilepsy
Asthma	Glaucoma
Bipolar mood disorder	HIV and AIDS
Bronchiectasis	Hyperlipidaemia
Cardiac failure	Hypertension

Cardiomyopathy	Hypothyroidism
Chronic obstructive Haemophilia	Multiple Sclerosis
Chronic renal disease	Parkinson's disease
Coronary artery disease	Pulmonary 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 and Savings Plan?

If you select the Hospital and Savings Plan, you will also qualify for treatment of the following conditions.

Acne	Osteoporosis
Allergic Rhinitis	Paget's Disease
Alzheimer's Disease	Panic Disorder
Ankylosing Spondylitis	Paraplegia
Anxiety Disorder	Paroxysmal Tachycardia
Aplastic Aneamia	Pemphigus
Attention Deficit Hyperactivity Disorder	Peripheral Vascular Disease
Barrets Disease	Phlebitis and Thrombophlebitis
Benign Prostatic Hypertrophy	Pituitary Disease

Cerebral Palsy	Pituitary Microadenomas
Cystic Fibrosis	Polycystic Ovarian Syndrome
Depression	Post Traumatic Stress Syndrome
Dermatomyositis	Pregnancy
Eczema	Prolactinoma
Endocarditis	Psoriasis
Endometriosis	Psychotic Disorders
Gord	Pulmonary Embolism
Gout	Pulmonary Interstitial Fibrosis
Hyperthyroidism	Quadriplegia
Hypoparathyroidism	Sarcoidosis
Incontinence	Scleroderma
Menopause	Stroke
Migraine	Systemic Sclerosis
Motor Neuron Disease	Thromboangiitis Obliterans
Muscular Dystrophy	Thrombocytopenic Purpura
Myasthenia Gravis	Tourette's Syndrome
Narcolepsy	Unipolar Disorder
Obsessive Compulsive Disorder	Valvular Heart Disease
Osteo-Arthritis	Vertigo
Osteopenia	Wilson's Disease

5. The three options in more detail

➔ In this section

- [What general information should I keep in mind in terms of my benefits?](#)
- Under the **Major Medical Plan** option -
 - [what are the benefits for 2012?](#)
 - [who are the designated services providers for PMB?](#)
 - [what are the contribution rates?](#)
- Under the **Major Medical Plan with CareCross** option -
 - [what are the benefits for 2012?](#)
 - [who are the designated services providers for PMB?](#)
 - [what are the contribution rates?](#)
- Under the **Hospital and Savings Plan** option -
 - [what are the benefits for 2012?](#)
 - [who are the designated services providers for PMB?](#)
 - [what are the contribution rates?](#)

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

1. Definitions:
 - PMB = Prescribed minimum benefits.
 - SPNP = Society of Private Nursing Practitioners of South Africa.
 - MSR = 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.
 - Beneficiary = per person registered on the scheme.
 - Member Family = the benefit is allocated to the principal member and his family and is the equivalent of one benefit limit per family.
2. Major Medical Benefits include all services at public and private hospitals.
3. Where a member selects the Major Medical and CareCross Option as his provider and he shall also nominate a GP to provide services in respect of him/herself and the same or another GP in respect of each beneficiary of the member. This selection may only be changed on 1 January of each ensuing year.
4. Formulary and supplier networks are subject to change from time to time. The latest information is available on request from Medscheme or CareCross.

5. The chronic medication benefits on the Hospital and Savings Plan option are covered according to the Medscheme Chronic Medicine Management formulary.
6. The Scheme Rate in respect of medication is the SEP (Single Exit Price) and the dispensing fee as per the Medicine and Related Substances regulations.
7. All benefits are subject to PMB legislation where applicable.

MAJOR MEDICAL PLAN

This is a low-cost plan that offers you and your family limited hospital coverage for procedures and treatments that require hospitalisation that costs more than R5 400.

What are the benefits for 2012?

BENEFITS FOR 2011

Overall Annual Limit	R640 000 per family per year.
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MAJOR MEDICAL BENEFITS

Prescribed Minimum Benefits (PMB)

Prescribed Minimum Benefits – preferred provider: State facilities and as per DSP schedule	All specified benefits - 100% of cost.
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HOSPITALISATION	
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.
Emergencies, trauma (external violent events) and confinements	ANY hospital.
Routine and scheduled hospitalisation events	ANY hospital.
Specified high risk procedures	ANY hospital.
Threshold per event	R5 400 per event for hospital costs only. No threshold will apply to admissions for Confinements or treatment for PMB conditions.
Ward and theatre fees	100% of cost or MSR, whichever is the lesser.
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.
Medicine Medicine on discharge from Hospital (TTO)	100% of Medicine Price. R350 per beneficiary per admission. This excludes anti-coagulants listed under the Drug Policy.
GP's & Specialists (except radiology and pathology)	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.

HOSPITALISATION	
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.
Maxillofacial Surgery (excluding specialised dentistry)	100% of cost or MSR, whichever is the lesser, limited to R26 000 per member family per year.
Basic Dentistry performed by a dental practitioner and/or a dental therapist including minor oral surgery as defined in section J of SADA guide.	Subject to relevant Hospital Managed Care Protocols and authorisation. General anaesthesia, conscious sedation and hospitalisation will only be granted for beneficiaries: <ul style="list-style-type: none"> • Under the age of 8; • Or with bony impaction of third molars.
Medical Auxiliaries/Other In hospital	100% of the cost or MSR, whichever is the lesser.
Ambulance Services	100% of tariff agreed with the Scheme's preferred provider, subject to the limit of R4 250 per member family per year.
Blood and Blood products	100% of cost or MSR, whichever is the lesser.
General Radiology	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Specialised radiology, MRI & CAT Scans	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Pathology	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.

HOSPITALISATION

<p>Hearing aid benefit</p> <p>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.</p>	<p>Beneficiaries up to the age of 6 years: 2 Hearing Aids up to R25 200 per member family once every 2 benefit years.</p> <p>Beneficiaries 7 years and older: 1 Hearing Aid up to R12 600 per member family once every 2 benefit years.</p>
<p>Physiotherapy</p>	<p>100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.</p>
<p>Organ Transplants</p>	<p>100% of cost, limited to R140 000 per beneficiary for transport of organs, hospital accommodation, surgically related services and procedures. No benefits shall be allowed in respect of any services related to the organ donor.</p> <p>100% of cost of anti-rejection drugs, provided that the drugs are obtained from a preferred provider, subject to PMB protocols.</p>
<p>Renal dialysis</p>	<p>100% of cost or MSR, whichever is the lesser in respect of all materials, related costs and approved medication. Subject to PMB protocols.</p> <p>R170 000 per beneficiary per year.</p> <p>Subject to the relevant Hospital Managed Care Protocol and authorisation.</p> <p>This benefit includes related pathology, scans and consultations.</p> <p>For all services, medicine and materials associated with the cost of renal dialysis.</p>

HOSPITALISATION

<p>Oncology</p>	<p>R281 000 per member family per year.</p> <p>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), medication for terminal illness, radiotherapy, mammograms and the oncologist's consultations.</p>
<p>PET Scans</p>	<p>R23 500 per beneficiary per year for treatment of non-PMB conditions.</p>
<p>Specialised drugs for Oncology</p>	<p>R140 000 per member family. Subject to Oncology limit, Hospital Managed Care Protocols and authorisation.</p> <ul style="list-style-type: none"> • Biological drugs applicable to monoclonal antibodies and interleukins. • Tyrosine Kinase Inhibitors. • Proteasome Inhibitors, e.g., Bortezomib. • Azacitidine
<p>Brachytherapy materials</p>	<p>R34 600 per member family per year.</p> <p>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.</p> <p>Includes seeds, disposables and equipment. Subject to Hospital Managed Care Protocols and authorisation.</p>

HOSPITALISATION	
<p>Specialised drugs for non-oncology</p> <ul style="list-style-type: none"> Biological drugs applicable to monoclonal antibodies and interleukins Human immunoglobulin for chronic use Palivizumab (Synagis®) for prevention of RSV infection. 	<p>R130 000 per member family. Subject to Oncology limit, Hospital Managed Care Protocols and authorisation.</p> <p>Includes treatment for:</p> <ul style="list-style-type: none"> Multiple Sclerosis (as per the Prescribed Minimum benefits Algorithm); Inflammatory Arthritides; Inflammatory Bowel disease; Chronic Hepatitis; and Iron chelating agents for chronic overload with drugs such as Deferasirox.
<p>Drugs for treatment of Macular degeneration</p>	<p>R43 300 per member family, subject to Hospital Managed Care Protocols and authorisation.</p>
<p>Acute rehabilitation</p>	<p>R53 750 per member family per year.</p> <p>100% of cost provided that treatment is at an approved facility.</p> <p>Subject to pre-authorisation and the submission of a motivation by the treating medical practitioner to the Case Manager. Progressive neurological conditions are excluded.</p> <p>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.</p>
<p>Private Nursing in the place of Hospitalisation</p>	<p>100% of cost or MSR, whichever is the lesser, subject to the limit of R14 000 per family per year.</p> <p>Nursing and hospice services must be pre-authorised by the Case Manager.</p> <p>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 case only, in the place of hospitalisation. Only necessary medical services will be covered.</p>

HOSPITALISATION	
<p>Home Oxygen therapy</p> <p>Home Oxygen, cylinders, concentrators and ventilation expenses CPAP machines are excluded.</p>	<p>100% of cost provided the service is pre-authorised.</p> <p>R13 600 per member family per year.</p> <p>This benefit is subject to pre-authorisation and includes the cost of an appliance obtained from a preferred provider.</p>
<p>Psychiatric treatment</p>	<p>All related costs at 100% of the negotiated tariff, up to a maximum of 21 days in an approved facility or outpatient psychotherapy treatment, up to 15 contact sessions, per beneficiary per year.</p> <p>Subject to application, approval and authorisation by the Scheme. This benefit includes consultations with a psychiatrist on an outpatient basis.</p>
<p>Internal surgical appliances and surgical prosthesis</p>	<p>Any other prosthesis not listed below will be subject to a limit of R43 450 per beneficiary per year.</p>
<p>Cardiac system</p>	<p>Cardiac stents: R24 100 per stent, 3 stents per beneficiary per year.</p> <p>Cardiac pacemakers: R58 000 per beneficiary per year.</p> <p>Cardiac valves: R34 100 per valve, 2 valves per beneficiary per year.</p> <p>NEW: Cardiac resynchronisation therapy: R40 000 per beneficiary per year.</p>
<p>Endovascular devices</p>	<p>Aortic Stents: R99 200 per stent, 1 stent per beneficiary per year, includes the delivery system.</p> <p>Carotid stents: R16 450 per beneficiary per year.</p> <p>Detachable platinum coils: R41 100 per beneficiary per year.</p> <p>Embolic protection devices: R41 000 per beneficiary per year.</p> <p>Peripheral arterial stent grafts: R34 000 per beneficiary per year.</p>

HOSPITALISATION

Orthopaedic prostheses and devices

Total hip replacement: **R47 000** per hip per beneficiary per year, includes the cost of cement and antibiotics.

Total knee replacement: **R44 850** per knee per beneficiary per year, includes the cost of cement and antibiotics.

Total shoulder replacement: **R38 950** per shoulder per beneficiary per year, includes the cost of cement and antibiotics.

Total elbow replacement: **R36 200** per elbow per beneficiary per year, includes the cost of cement and antibiotics.

Bone lengthening devices: **R36 900** per beneficiary per year.

Spinal plates and screws: **R29 650** per beneficiary per year, limited to 2 levels.

Other approved spinal implantable devices and intervertebral discs: **R41 100** per beneficiary per year.

Central Nervous System

Neuro-stimulation/ablation devices for Parkinsons: **R37 400** per beneficiary per year.

Vagal stimulator for intractable epilepsy: **R31 600** per beneficiary per year.

Ophthalmic system

Intraocular lenses: **R2 375** per lens.

NEW: Corneal grafts: **R20 000** per beneficiary per year.

AIDS and HIV Positivity

100% of cost, subject to registration on the HIV and AIDS Management Programme.

If not registered, the limit is **R28 100** per beneficiary per year for HIV-related chronic medicine, related doctors consultations and blood tests. Subject to PMB protocols.

Pathology

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.

HOSPITALISATION

HCT testing (HIV, Counselling, Testing)

Pre-test counselling

- Testing and post-test counselling
- Limited to 2 tests per beneficiary per year

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 Medicine Price.

Maternity Benefit

Midwife services

Confinement in registered birthing unit (general practitioner and midwife)

100% of the negotiated (SPNP) fee or in the absence of such fee, 100% of cost or MSR, whichever is the lesser. Uniform Patient Fee Schedule will apply for public hospitals.

Hire of water bath and Oxygen included.

Subject to the relevant Hospital Managed Care Protocols and authorisation.

Post-natal midwife consultations limited to 4 per pregnancy.

Confinement out of hospital

Pre- and post-confinement treatment by a registered midwife for episodes of acute care must be pre-authorised by the Case Manager. Limited to **R14 000** per member family per year. Post-natal midwife consultations limited to 4 per pregnancy.

Antenatal classes

R920 per member family per year. 100% of the SPNP rate or in the absence of such a fee, 100% of the cost or MSR, whichever is the lesser.

Confinement Specialist Benefit: Consultations prior to and post hospitalisation

100% of cost or MSR, whichever is the lesser.

3 specialist consultations per confinement and 1 ultrasonic scan. Subject to PMB.

HOSPITALISATION

Hospital limitations	Subject to PMB protocols. Admission for normal deliveries, maximum of 3 days. Caesarean Section limited to a maximum of 4 days.
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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 Medication	100% of cost for 26 PMB and other PMB related conditions.
Surgical and Medical Appliances	No Benefit
Pathology	No Benefit
Medical Auxiliaries / Other	No Benefit

Who are the designated service providers for Prescribed Minimum Benefits?

DESIGNATED SERVICE PROVIDERS FOR PMB - MAJOR MEDICAL PLAN

General Practitioners	CareCross doctor network
Chronic Medicine	Clicks Group network of pharmacies
Other Primary Care Services	CareCross doctor network
Other out-of- hospital services	CareCross network of providers

What is the monthly contribution rate?

Income Band	Principal Member	Additional Adult Dependant	Spouse/ Life Partner	Child Dependant
All income categories	559	559	224	84

MAJOR MEDICAL PLAN WITH CARECROSS

This is a plan that offers you and your family limited hospital coverage for procedures and treatments that require hospitalisation that costs over R5 400, with the addition of a network-based Day-to-Day benefit through CareCross (see [page 8](#) for more information).

What are the benefits for 2012?

BENEFITS FOR 2011	
Overall Annual Limit	R640 000 per family per year.
MAJOR MEDICAL BENEFITS	
Prescribed Minimum Benefits (PMB)	
Prescribed Minimum Benefits – preferred provider: State facilities and as per DSP schedule	All specified benefits - 100% of cost.
HOSPITALISATION	
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.
Emergencies, trauma (external violent events) and confinements	ANY hospital.

HOSPITALISATION	
Routine and scheduled hospitalisation events	ANY hospital.
Specified high risk procedures	ANY hospital.
Threshold per event	R5 400 per event for hospital costs only. No threshold will apply to admissions for Confinements or treatment for PMB conditions.
Ward and theatre fees	100% of cost or MSR, whichever is the lesser.
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.
Medicine Medicine on discharge from Hospital (TTO)	100% of Medicine Price. R350 per beneficiary per admission. This excludes anti-coagulants listed under the Drug Policy.
GP's & Specialists (except radiology and pathology)	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
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.
Maxillofacial Surgery (excluding specialised dentistry)	100% of cost or MSR, whichever is the lesser, limited to R26 000 per member family per year.

HOSPITALISATION	
Basic Dentistry performed by a dental practitioner and/or a dental therapist including minor oral surgery as defined in section J of SADA guide.	<p>Subject to relevant Hospital Managed Care Protocols and authorisation.</p> <p>General anaesthesia, conscious sedation and hospitalisation will only be granted for beneficiaries:</p> <ul style="list-style-type: none"> • Under the age of 8; • Or with bony impaction of third molars.
Medical Auxiliaries/Other In hospital	100% of the cost or MSR, whichever is the lesser.
Ambulance Services	100% of tariff agreed with the Scheme's preferred provider, subject to the limit of R4 250 per member family per year. Contracted rescue services only, accept for PMB's.
Blood and Blood products	100% of cost or MSR, whichever is the lesser.
General Radiology	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Specialised radiology, MRI & CAT Scans	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Pathology	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Hearing aid benefit	<p>Beneficiaries up to the age of 6 years: 2 Hearing Aids up to R25 200 per member family once every 2 benefit years.</p> <p>Beneficiaries 7 years and older: 1 Hearing Aid up to R12 600 per member family once every 2 benefit years.</p>
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.	
Physiotherapy	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.

HOSPITALISATION	
Organ Transplants	<p>100% of cost, limited to R140 000 per beneficiary for transport of organs, hospital accommodation, surgically related services and procedures. No benefits shall be allowed in respect of any services related to the organ donor.</p> <p>100% of cost of anti-rejection drugs, provided that the drugs are obtained from a preferred provider, subject to PMB protocols.</p>
Renal dialysis	<p>100% of cost or MSR, whichever is the lesser in respect of all materials, related costs and approved medication. Subject to PMB protocols.</p> <p>R170 000 per beneficiary per year</p> <p>Subject to the relevant Hospital Managed Care Protocol and authorisation.</p> <p>This benefit includes related pathology, scans and consultations.</p> <p>For all services, medicine and materials associated with the cost of renal dialysis.</p>
Oncology	<p>R281 000 per member family per year.</p> <p>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), medication for terminal illness, radiotherapy, mammograms and the oncologist's consultations.</p>
PET Scans	R23 500 per beneficiary per year for treatment of non-PMB conditions.

HOSPITALISATION

<p>Specialised drugs for Oncology</p>	<p>R140 000 per member family. Subject to Oncology limit, Hospital Managed Care Protocols and authorisation.</p> <ul style="list-style-type: none"> • Biological drugs applicable to monoclonal antibodies and interleukins • Tyrosine Kinase Inhibitors • Proteasome Inhibitors, e.g., Bortezomib • Azacitidine
<p>Brachytherapy materials</p>	<p>R34 600 per member family per year.</p> <p>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.</p> <p>Includes seeds, disposables and equipment. Subject to Hospital Managed Care Protocols and authorisation.</p>
<p>Specialised drugs for non-oncology</p> <ul style="list-style-type: none"> • Biological drugs applicable to monoclonal antibodies and interleukins • Human immunoglobulin for chronic use • Palivizumab (Synagis®) for prevention of RSV infection. 	<p>R130 000 per member family. Subject to Oncology limit, Hospital Managed Care Protocols and authorisation.</p> <p>Includes treatment for:</p> <ul style="list-style-type: none"> • Multiple Sclerosis (as per the Prescribed Minimum benefits Algorithm); • Inflammatory Arthritides; • Inflammatory Bowel disease; • Chronic Hepatitis; and • Iron chelating agents for chronic overload with drugs such as Deferasirox.
<p>Drugs for treatment of Macular degeneration</p>	<p>R43 300 per member family, subject to Hospital Managed Care Protocols and authorisation.</p>

HOSPITALISATION

<p>Acute rehabilitation</p>	<p>R53 750 per member family per year.</p> <p>100% of cost provided that treatment is at an approved facility.</p> <p>Subject to pre-authorisation and the submission of a motivation by the treating medical practitioner to the Case Manager. Progressive neurological conditions are excluded.</p> <p>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.</p>
<p>Private Nursing in the place of Hospitalisation</p>	<p>100% of cost or MSR, whichever is the lesser, subject to the limit of R14 000 per family per year.</p> <p>Nursing and hospice services must be pre-authorised by the Case Manager.</p> <p>This benefit covers home services by a registered nurse, pre- and post-confinement treatment by a registered midwife and is for short-tem episodes of acute care only, in the place of hospitalisation. Only necessary medical services will be covered.</p> <p>Services must be delivered by a registered nurse.</p>
<p>Home Oxygen therapy</p> <p>Home Oxygen, cylinders, concentrators and ventilation expenses</p> <p>CPAP machines are excluded.</p>	<p>100% of cost provided the service is pre-authorised.</p> <p>R13 600 per member family per year.</p> <p>This benefit is subject to pre-authorisation and includes the cost of an appliance obtained from a preferred provider.</p>
<p>Psychiatric treatment</p>	<p>All related costs at 100% of the negotiated tariff, up to a maximum of 21 days in an approved facility or outpatient psychotherapy treatment, up to 15 contact sessions, per beneficiary per year.</p> <p>Subject to application, approval and authorisation by the Scheme. This benefit includes consultations with a psychiatrist on an outpatient basis.</p>

HOSPITALISATION	
Internal surgical appliances and surgical prosthesis	Any other prosthesis not listed below will be subject to a limit of R43 450 per beneficiary per year.
Cardiac system	Cardiac stents: R24 100 per stent, 3 stents per beneficiary per year. Cardiac pacemakers: R58 000 per beneficiary per year. Cardiac valves: R34 100 per valve, 2 valves per beneficiary per year. NEW: Cardiac resynchronisation therapy: R40 000 per beneficiary per year.
Endovascular devices	Aortic Stents: R99 200 per stent, 1 stent per beneficiary per year, includes the delivery system. Carotid stents: R16 450 per beneficiary per year. Detachable platinum coils: R41 100 per beneficiary per year. Emboloc protection devices: R41 000 per beneficiary per year. Peripheral arterial stent grafts: R34 000 per beneficiary per year.
Orthopaedic prostheses and devices	Total hip replacement: R47 000 per hip per beneficiary per year, includes the cost of cement and antibiotics. Total knee replacement: R44 850 per knee per beneficiary per year, includes the cost of cement and antibiotics. Total shoulder replacement: R38 950 per shoulder per beneficiary per year, includes the cost of cement and antibiotics. Total elbow replacement: R36 200 per elbow per beneficiary per year, includes the cost of cement and antibiotics. Bone lengthening devices: R36 900 per beneficiary per year. Spinal plates and screws: R29 650 per beneficiary per year, limited to 2 levels. Other approved spinal implantable devices and intervertebral discs: R41 100 per beneficiary per year.

HOSPITALISATION	
Central Nervous System	Neuro-stimulation/ablation devices for Parkinsons: R37 400 per beneficiary per year. Vagal stimulator for intractable epilepsy: R31 600 per beneficiary per year.
Ophthalmic system	Intraocular lenses: R2 375 per lens. NEW: Corneal grafts: R20 000 per beneficiary per year.
AIDS and HIV Positivity	100% of cost, subject to registration on the HIV and AIDS Management Programme. If not registered, the limit is R28 100 per beneficiary per year for HIV-related chronic medicine, related doctors consultations and blood tests. Subject to PMB protocols.
Pathology	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.
HCT testing (HIV, Counselling, Testing)	<ul style="list-style-type: none"> • Pre-test counselling • Testing and post-test counselling Limited to 2 tests per beneficiary per year.
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 Medicine Price.
Maternity Benefit	100% of the negotiated (SPNP) fee or in the absence of such fee, 100% of cost or MSR, whichever is the lesser. Uniform Patient Fee Schedule will apply for public hospitals.
Midwife services	Hire of water bath and Oxygen included. Subject to the relevant Hospital Managed Care Protocols and authorisation. Post-natal midwife consultations limited to 4 per pregnancy.

HOSPITALISATION

Confinement out of hospital	Pre- and post-confinement treatment by a registered midwife for episodes of acute care must be pre-authorized by the Case Manager. Limited to R14 000 per member family per year. Post-natal midwife consultations limited to 4 per pregnancy.
Antenatal classes	R920 per member family per year. 100% of the SPNP rate or in the absence of such a fee, 100% of the cost or MSR, whichever is the lesser.
Confinement Specialist Benefit: Consultations prior to and post hospitalisation	100% of cost or MSR, whichever is the lesser. 3 specialist consultations per confinement and 1 ultrasonic scan. Subject to PMB.
Hospital limitations	Subject to PMB protocols. Admission for normal deliveries, maximum of 3 days. Caesarean Section limited to a maximum of 4 days.

DAY TO DAY BENEFITS - CareCross

Primary services obtained from preferred provider	As per the CareCross schedule: <ol style="list-style-type: none"> Unlimited medically necessary consultations. Basic Primary Care services. Minor Trauma Treatment: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Supervision of uncomplicated pregnancy up to Week 20. Including 2 sonar scans per pregnancy.
Primary services not obtained from preferred provider	No benefit except for PMB.
Acute Medicines	As dispensed or scripted by the chosen CareCross GP subject to the CareCross Acute Formulary GP. Medicines obtainable from CareCross GP (dispensing) or a MediKredit enabled pharmacy (scripting).
Primary Care Dentistry	<ol style="list-style-type: none"> Consultations, primary extractions, fillings, scaling and polishing. Emergency dentistry including emergency pain relief, partial removal of nerve or extractions. No benefit for Root canal treatment, crowns, dentures and other advanced dentistry.
Radiology	Covers a list of black and white X-rays. Only on request from the CareCross General Practitioner.

DAY TO DAY BENEFITS - CareCross

Specialists (including radiology & pathology, excluding MRI & CAT scans)	No benefit.
Pathology	Covers a list of basic blood tests. Only on request from the CareCross General Practitioner.
Specialised Dentistry	No Benefit.
MRI & CAT Scans	No Benefit except for PMB.
Chronic Medication	100% of Cost for 26 PMB and other PMB related conditions. CareCross is DSP and formulary applies. 1. Subject to the CareCross Chronic Formulary (25 CDL conditions plus 8 other chronic conditions). 2. On registration and approval from CareCross. Medication to be supplied by CareCross as arranged with the beneficiary or provider.
Surgical and Medical Appliances	No Benefit except for PMB.
Pathology	Covers a list of basic blood tests. Only on request from the CareCross General Practitioner.
Medical Auxiliaries / Other	No Benefit.
Out of Network / Emergency Visits	1. Limited to 3 genuine after hour emergency consultations per family per year. The member will be required to pay for these services and submit the claim to CareCross for reimbursement to a maximum of R1000 per family per year.

Who are the designated service providers for Prescribed Minimum Benefits?

Designated Service Providers for PMB - Major Medical Plan with CareCross	
General Practitioners	Care Cross doctor network
Chronic Medicine	CareCross - medicines on formulary only; other services not covered by CareCross Scriptnet network of pharmacies.
Other Primary Care Services	CareCross doctor network
Other out-of- hospital services	Care Cross network of providers (Radiology and pathology service covered by CareCross are only as per the approved tariff list, all other services are not covered by CareCross.

What are the monthly contribution rates?

Income Band	Principal Member	Additional Adult Dependant	Spouse/ Life Partner	Child Dependant
All income categories	804	804	346	245

HOSPITAL AND SAVINGS PLAN

This plan offers you and your family comprehensive hospital cover for procedures and treatments performed in hospital. In addition, you also have a savings allocation in a Personal Savings Account (see [page 9](#) for more information) which can be used to fund your Day-to-Day medical costs.

What are the benefits for 2012?

BENEFITS FOR 2011	
Overall Annual Limit	Unlimited
MAJOR MEDICAL BENEFITS	
Prescribed Minimum Benefits (PMB)	
Prescribed Minimum Benefits – preferred provider: State facilities and as per DSP schedule	All specified benefits - 100% of cost.
HOSPITALISATION	
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.
Emergencies, trauma (external violent events) and confinements	ANY hospital.

HOSPITALISATION

Routine and scheduled hospitalisation events	ANY hospital.
Specified high risk procedures	ANY hospital.
Threshold per event	None
Ward and theatre fees	100% of cost or MSR, whichever is the lesser.
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.
Medicine	100% of Medicine Price.
Medicine on discharge from Hospital (TTO)	R350 per beneficiary per admission. This excludes anti-coagulants listed under the Drug Policy.
GP's & Specialists (except radiology and pathology)	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
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.
Maxillofacial Surgery (excluding specialised dentistry)	100% of cost or MSR, whichever is the lesser limited to R26 000 per member family per year.

HOSPITALISATION

Basic Dentistry performed by a dental practitioner and/or a dental therapist including minor oral surgery as defined in section J of SADA guide.	<p>Subject to relevant Hospital Managed Care Protocols and authorisation.</p> <p>General anaesthesia, conscious sedation and hospitalisation will only be granted for beneficiaries:</p> <ul style="list-style-type: none"> • Under the age of 8; • Or with bony impaction of third molars.
Medical Auxiliaries/Other In hospital	100% of the cost or MSR, whichever is the lesser.
Ambulance Services	100% of tariff, subject to the use of the Scheme's preferred provider's services.
Blood and Blood products	100% of cost or MSR, whichever is the lesser.
General Radiology	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Specialised radiology, MRI & CAT Scans	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Pathology	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.
Hearing aid benefit	<p>Beneficiaries up to the age of 6 years: 2 Hearing Aids up to R25 200 per member family once every 2 benefit years.</p> <p>Beneficiaries 7 years and older: 1 Hearing Aid up to R12 600 per member family once every 2 benefit years.</p>
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.	
Physiotherapy	100% of cost or MSR, whichever is the lesser, subject to Hospital Managed Care Protocols.

HOSPITALISATION

Organ Transplants	<p>100% of cost, limited to R140 000 per beneficiary for transport of organs, hospital accommodation, surgically related services and procedures. No benefits shall be allowed in respect of any services related to the organ donor.</p> <p>100% of cost of anti-rejection drugs, provided that the drugs are obtained from a preferred provider, subject to PMB protocols.</p>
Renal dialysis	<p>100% of cost or MSR, whichever is the lesser in respect of all materials, related costs and approved medication. Subject to PMB protocols.</p> <p>R170 000 per beneficiary per year.</p> <p>Subject to the relevant Hospital Managed Care Protocol and authorisation.</p> <p>This benefit includes related pathology, scans and consultations.</p> <p>For all services, medicine and materials associated with the cost of renal dialysis.</p>
Oncology	<p>R281 000 per member family per year.</p> <p>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), medication for terminal illness, radiotherapy, mammograms and the oncologist's consultations.</p>
PET Scans	R23 500 per beneficiary per year for treatment of non-PMB conditions.
Specialised drugs for Oncology	<p>R140 000 per member family. Subject to Oncology limit, Hospital Managed Care Protocols and authorisation.</p> <ul style="list-style-type: none"> • Biological drugs applicable to monoclonal antibodies and interleukins • Tyrosine Kinase Inhibitors • Proteasome Inhibitors, e.g., Bortezomib • Azacitidine

HOSPITALISATION

Brachytherapy materials	<p>R34 600 per member family per year.</p> <p>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.</p> <p>Includes seeds, disposables and equipment. Subject to Hospital Managed Care Protocols and authorisation.</p>
<p>Specialised drugs for non-oncology</p> <ul style="list-style-type: none"> Biological drugs applicable to monoclonal antibodies and interleukins Human immunoglobulin for chronic use Palivizumab (Synagis®) for prevention of RSV infection. 	<p>R130 000 per member family. Subject to Oncology limit, Hospital Managed Care Protocols and authorisation.</p> <ul style="list-style-type: none"> Includes treatment for: <ul style="list-style-type: none"> Multiple Sclerosis (as per the Prescribed Minimum benefits Algorithm); Inflammatory Arthritides; Inflammatory Bowel disease; Chronic Hepatitis; and Iron chelating agents for chronic overload with drugs such as Deferasirox.
Drugs for treatment of Macular degeneration	<p>R43 300 per member family, subject to Hospital Managed Care Protocols and authorisation.</p>
Acute rehabilitation	<p>R53 750 per member family per year.</p> <p>100% of cost provided that treatment is at an approved facility.</p> <p>Subject to pre-authorisation and the submission of a motivation by the treating medical practitioner to the Case Manager. Progressive neurological conditions are excluded.</p> <p>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.</p>

HOSPITALISATION

Private Nursing in the place of Hospitalisation	<p>100% of cost or MSR, whichever is the lesser, subject to the limit of R14 000 per family per year.</p> <p>Nursing and hospice services must be pre-authorised by the Case Manager.</p> <p>This benefit covers home services by a registered nurse, pre- and post-confinement treatment by a registered midwife and is not short-term episodes of acute care only, in the place of hospitalisation. Only necessary medical services will be covered.</p> <p>Services must be delivered by a registered nurse.</p>
<p>Home Oxygen therapy</p> <p>Home Oxygen, cylinders, concentrators and ventilation expenses</p> <p>CPAP machines are excluded.</p>	<p>100% of cost provided the service is pre-authorised.</p> <p>R13 600 per member family per year.</p> <p>This benefit is subject to pre-authorisation and includes the cost of an appliance obtained from a preferred provider.</p>
Psychiatric treatment	<p>All related costs at 100% of the negotiated tariff, up to a maximum of 21 days in an approved facility or outpatient psychotherapy treatment, up to 15 contact sessions, per beneficiary per year.</p> <p>Subject to application, approval and authorisation by the Scheme. This benefit includes consultations with a psychiatrist on an outpatient basis.</p>
Internal surgical appliances and surgical prosthesis	<p>Any other prosthesis not listed below will be subject to a limit of R43 450 per beneficiary per year.</p>
Cardiac system	<p>Cardiac stents: R24 100 per stent, 3 stents per beneficiary per year.</p> <p>Cardiac pacemakers: R58 000 per beneficiary per year.</p> <p>Cardiac valves: R34 100 per valve, 2 valves per beneficiary per year.</p> <p>NEW: Cardiac resynchronisation therapy: R40 000 per beneficiary per year.</p>

HOSPITALISATION

Endovascular devices

Aortic Stents: **R99 200** per stent, 1 stent per beneficiary per year, includes the delivery system.

Carotid stents: **R16 450** per beneficiary per year.

Detachable platinum coils: **R41 100** per beneficiary per year.

Embolic protection devices: **R41 000** per beneficiary per year.

Peripheral arterial stent grafts: **R34 000** per beneficiary per year.

Orthopedic prostheses and devices

Total hip replacement: **R47 000** per hip per beneficiary per year, includes the cost of cement and antibiotics.

Total knee replacement: **R44 850** per knee per beneficiary per year, includes the cost of cement and antibiotics.

Total shoulder replacement: **R38 950** per shoulder per beneficiary per year, includes the cost of cement and antibiotics.

Total elbow replacement: **R36 200** per elbow per beneficiary per year, includes the cost of cement and antibiotics.

Bone lengthening devices: **R36 900** per beneficiary per year.

Spinal plates and screws: **R29 650** per beneficiary per year, limited to 2 levels.

Other approved spinal implantable devices and intervertebral discs: **R41 100** per beneficiary per year.

Central Nervous System

Neuro-stimulation/ablation devices for Parkinsons: **R37 400** per beneficiary per year.

Vagal stimulator for intractable epilepsy: **R31 600** per beneficiary per year.

Ophthalmic system

Intraocular lenses: **R2 375** per lens.

NEW: Corneal grafts: **R20 000** per beneficiary per year.

HOSPITALISATION

AIDS and HIV Positivity

100% of cost, subject to registration on the HIV and AIDS Management Programme.

If not registered, the limit is **R28 100** per beneficiary per year for HIV-related chronic medicine, related doctors consultations and blood tests. Subject to PMB protocols.

Pathology

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.

HCT testing (HIV, Counselling, Testing)

Pre-test counselling.

Testing and post-test counselling.

Limited to 2 tests per beneficiary per year.

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 Medicine Price.

Maternity Benefit

Midwife services

Confinement in registered birthing unit (general practitioner and midwife)

100% of the negotiated (SPNP) fee or in the absence of such fee, 100% of cost or MSR, whichever is the lesser. Uniform Patient Fee Schedule will apply for public hospitals.

Hire of water bath and Oxygen included.

Subject to the relevant Hospital Managed Care Protocols and authorisation.

Post-natal midwife consultations limited to 4 per pregnancy.

Confinement out of hospital

Pre- and post-confinement treatment by a registered midwife for episodes of acute care must be pre-authorized by the Case Manager. Limited to **R14 000** per member family per year. Post-natal midwife consultations limited to 4 per pregnancy.

Antenatal classes

R920 per member family per year. 100% of the SPNP rate or in the absence of such a fee, 100% of the cost or MSR, whichever is the lesser.

HOSPITALISATION

Confinement Specialist Benefit: Consultations prior to and post hospitalisation	100% of cost or MSR, whichever is the lesser. 3 specialist consultations per confinement and 1 ultrasonic scan. Subject to PMB.
Hospital limitations	Subject to PMB protocols. Admission for normal deliveries, maximum of 3 days.
External medical appliances/prosthesis	100% of cost or MSR, whichever is the lesser, subject to R8 550 per beneficiary per year. Permanent or temporary devices that are not surgically implanted and are seen to improve the function of a diseased organ, e.g. wheelchair, crutches, Baumanometer and all orthopaedic braces. 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.

In those instances where "no benefit" or "subject to savings" is indicated, the benefits for out-of-hospital in respect of PMB will be unlimited and paid at 100% of cost at DSP.

2012 Hospital and Savings Plan option - Annual Savings

Income Band	Risk			
	P	A	S	C
R0 to R3000	1704	1704	1056	600
R3001 to R4500	1800	1800	1260	636
R4501 to R6000	1908	1908	1392	672
R6001 to R8000	2076	2076	1584	720
R8001 +	2304	2304	1824	804

Who are the designated service providers for Prescribed Minimum Benefits?

Designated Service Providers for PMB - Hospital and Savings Plan

General Practitioners	CareCross doctor network
Chronic Medicine	Clicks Group network of pharmacies
Other Primary Care Services	CareCross doctor network
Other out-of-hospital services	CareCross network of providers

What are the monthly contribution rates?

These rates include Monthly Savings Allocations.

Income Band	Risk				Savings				Total			
	P	A	S	C	P	A	S	C	P	A	S	C
R0 to R3000	804	804	498	281	142	142	88	50	946	946	586	331
R3001 to R4500	850	850	592	297	150	150	105	53	1000	1000	697	350
R4501 to R6000	899	899	654	314	159	159	116	56	1058	1058	770	370
R6001 to R8000	979	979	746	343	173	173	132	60	1152	1152	878	403
R8001 +	1085	1085	858	380	192	192	152	67	1277	1277	1010	447

P = Principal Member, A = Adult dependant, S = Spouse/life partner, C = Child dependant

Hospital and Savings Plan - Personal Savings Account

Day-to-day claims for non-PMB for members on the Hospital Plan shall be payable from the Personal Medical Savings Account at 100% of cost and subject to the amount in the savings account. (See [page 9](#) for more information on the Personal Medical Savings Account.)

6. More about your medical scheme

➔ In this section

- [Who manages my medical scheme?](#)
- [How do contributions work?](#)
- [When does the benefit year start?](#)

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 two years.

To assist the Trustees in fulfilling their duties they are assisted by Fifth Quadrant who are the Actuaries and Consultants, and Medscheme, who are the Administrators. CareCross manages the day-to-day benefits on the Major Medical with CareCross option.

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.



7. 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 will happen when my Scheme membership comes to an end?](#)

Who can be a member of the Scheme?

All employees qualify to become members on appointment. To join the medical scheme, the Horizon Medical Scheme application form must be completed and returned to your respective Salaries, Payroll or HR Department. 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.

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 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.

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.

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. 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:

- **A general waiting period** of three months for benefits (i.e. the member will pay the contributions but will not enjoy benefits until the fourth month of membership) ;

- **Any pre-existing condition will be excluded for twelve months** (i.e. if the member has seen the doctor for a problem such as diabetes, back pain, heart condition, etc., during the twelve months prior to joining, then that specific problem will be excluded from benefits for the first twelve months of membership); and
- **A late-joiner penalty will be applied** to any employee over the age of 35 who has not been on a medical scheme before. The late-joiner penalty is a loading payable on monthly contributions, over and above the normal monthly contribution. This loading ranges from 5 to 75% depending on the number of years after the age of 35 that the member has not been on any medical aid:
 - 1 - 4 years: 5%
 - 5 - 14 years: 25%
 - 15 - 24 years: 50%
 - 25 years and more: 75%

Note: The participating companies do NOT subsidise this late joiner penalty.

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

Benefits cease upon the last day of employment and the Salaries, Payroll or HR Department must be advised immediately when an employee resigns. The membership card must then be returned to the Salaries, Payroll or HR Department on the last day of employment. From the date of termination the member and beneficiaries will not be entitled to any further benefits.

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 an adoptive parent, 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.



8. How to claim

➔ In this section

- [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?](#)

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 or where no day-to-day cover is available on the option, 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 using the CareCross Option need not submit any claims.

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.

All claims must be posted to:

Horizon Medical Scheme
P O Box 74
Vereeniging
1930
South Africa



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.

9. Frequently asked questions

In this section

- [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?](#)
- [How can I keep my medical costs low?](#)
- [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 rules apply if I have been involved in a motor car accident?

In certain circumstances you may not be covered by the Scheme for injuries resulting from a motor vehicle accident. If you are involved in a motor vehicle accident, you should consult an attorney to find out whether you have a claim against the Road Accident Fund. If you have a valid claim,

your attorney must submit an indemnity letter to the Scheme, in which case the Scheme will pay for your medical costs. This will be done on the undertaking that the Scheme will be reimbursed once the claim is paid by the third party, i.e. the Road Accident Fund. You should always inform the Scheme when you claim from another source. If the attorney finds that there is no claim against the Road Accident Fund, the Scheme will consider paying for the medical costs you incurred.

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 Council of Medical Schemes governs 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 this Council.

- A complaint form is available on their website (www.medicalschemes.com).
- Complaints can be submitted through fax, e-mail or in person at the Council's office.
- 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 R2000 is payable for Section 50 Appeals.

How can I keep my medical costs low?

- Negotiate with your doctor to charge the recommended tariff or give you a discount, if he or she has opted out of medical aid.
- Talk to your doctor about prescribed medicines. An alternative generic drug may do the job just as well and cost you considerably less. If you are shy to approach the doctor, the dispensing chemist can do this for you.
- Try to avoid all unnecessary treatments. This is wasteful and costly to you and the Scheme.
- If your doctor recommends a particular line of treatment and you feel uncertain about whether it is necessary, ask for a second opinion.
- If an operation is scheduled for the afternoon or evening, please arrange for the hospital admission after 12pm - the Scheme then only pays for the afternoon (i.e. a half-day).

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 your form to:

Horizon Medical Scheme
 Attention: Ex-gratia Department
 PO Box 74
 Vereeniging
 1930
 South Africa

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 letter to the Administrator, giving authority to your representative (PA or family member, etc.) to contact us on your behalf. This letter can be emailed, faxed or posted to us using the contact details on the back page of this newsletter. Please see that you include the following information in the letter:

- your membership number;
- your identity number;
- name and surname of the person who you have nominated as your representative;
- identity number of the person who you have nominated as your representative; and
- the mandate.

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.

Contact Details

Claims and Benefit Enquiries	Tel: 0860 101 103, +27 011 671 6837 Fax: 0860 111 785, +27 011-758 7033 Email: horizon@medscheme.co.za
Claims Submission	Postal address: PO Box 74, Vereeniging, 1930
Horizon Member Zone website	www.medscheme.co.za
CareCross Call Centre	Members: 0860 103 491 Providers: 0860 101 159 Chronic: 0860 102 182 Email: horizon@carecross.co.za Website: www.carecross.co.za
Your choice of Plan, Membership and PSA contributions Administration (Member Registrations)	Tel: 0860 101 103 Fax: 0860 111 785 Email: horizon@medscheme.co.za
Hospital Benefit Management (pre-authorisation)	Tel: 0860 100 081 Fax: 0860 21 22 23 Email: authorisations.cpt@medscheme.co.za
Chronic Medicine Management	Tel: 0860 100 081/608 Fax: 0800 223 670/680 E-Mail: cmm@medscheme.co.za
Clicks Direct Medicines	Tel: 0861 444 405 Fax: 0861 444 414 Postal address: P O Box 751902, Gardenview, 2047
Oncology Case Manager (for patients diagnosed with cancer)	Tel: 0860 100 572 Fax: 021 466 2303 Email: cancerinfo@medscheme.co.za
HIV and AIDS Management Programme with Aid for AIDS	Tel: 0860 100 646 Fax: 0800 600 773 Email: afa@afadm.co.za
ER24 (24-hour emergency transport approvals)	Tel: 084 124
Whistle Blowers - Fraud Hotline	Tel: 0800 11 28 11 Email: fraud@medscheme.co.za

