

omsmaf

Old Mutual Staff Medical Aid Fund

Member Guide 2010/11



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Disclaimer:

Every effort has been made to ensure that this Member Guide is an accurate explanation of the benefits offered by the Old Mutual Staff Medical Aid Fund. Please note that this Member Guide does not replace the Rules of the Fund, which take precedence over any wording in this guide, and is subject to approval from the Council for Medical Schemes.

Introduction

You never know when you or one of your family members may need medical care, which could cost a substantial amount. The Fund provides medical cover to you and your dependants for a wide range of medical services, prescribed medication and medical events, such as hospitalisation and surgery. These benefits are subject to certain conditions and limits, which will be explained in summarised form in this guide.

This guide is designed to answer most of the general questions you may have. Read it carefully and keep it for future reference.

Your responsibilities as a member

- Understand how the Fund and your specific Plan works.
- Keep the Fund up to date on any changes to your membership details.
- Check all accounts from service providers as well as your member statements from the Fund to make sure that all your details are correct and that your claims have been processed correctly.
- Inform the Fund before you are admitted to hospital.
- File all your documentation regarding the Fund so that you can refer to it if necessary.
- Keep your membership card in a safe place so that no one else can use it fraudulently.
- All active employees must ensure that their current location and/or home addresses are captured on Oracle and that they inform the Fund of any changes, in order to receive all communication.
- Members who retire and continue to belong to the Fund must ensure that they notify the Fund of their updated postal and e-mail addresses.
- All members who are pensioners must ensure that they notify the Fund of their valid postal and e-mail addresses in order to ensure that they receive their communication.

Monthly contributions to the Fund

The total monthly contribution to the Fund is based on the Plan you have chosen, the number of your dependants and your income (refer to the Pocket Guide for the different income bands).

For non-TGP staff and pensioners who still receive an Old Mutual subsidy, where the subsidy is higher than the contribution on the Plan you have chosen, you will not be required to make monthly contributions to the Fund. The subsidy amount will still be reflected on your salary as a deduction.

Pensioners

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

The difference between medical scheme rates and private provider rates

It is really important that you understand the difference between medical scheme rates (MSR) and private provider rates (PPR).

MSR is the tariff determined by the Board of Trustees and is adjusted from time to time, following consultation with suppliers in the industry.

PPR is the rate charged by private providers (please refer to the Pocket Guide). The Fund covers Private Rates in respect of Day-to-Day on the Traditional Plus Plan up to 300% of MSR. **Please note that Major Medical Benefits are covered at 100% of MSR.**

MSR are generally lower than PPR. Depending on the Plan you are on, claims submitted to the Fund are paid at 100% of MSR, subject to available benefits.

IMPORTANT NOTE

Medical practitioners are under no obligation to charge MSR. Due to the substantial difference between MSR and PPR, you should find out what rate your doctor charges, as you may be responsible for paying the difference between the two rates. It is worth negotiating with the service providers since they are usually willing to reduce their service fee. By paying less, your benefits will last longer.

Prescribed Minimum Benefits (PMB)

In this section:

- What are PMB
- Why do we have PMB
- What PMB are covered

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 Fund are entitled. Prescribed Minimum Benefits (PMB) are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit Plan they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.

PMB are fully covered by medical schemes, provided you follow the guidelines. These costs 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 25 chronic conditions (defined in the Chronic Disease List on page 17 of this member guide).

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

Prescribed Minimum Benefits						
270 Diagnostic Treatment Pairs					25 Chronic Disease List conditions	
Acute Conditions		Chronic Conditions		Hospitalisation	Medical Management of the condition	Medicine for the condition
Medical Management of the condition	Medicine for the condition	Medical Management of the condition	Medicine for the condition			

Why do we have PMB?

There are two main reasons why PMB were created:

- To ensure that medical scheme beneficiaries have continuous healthcare. This means that even if a member's benefits for a year have run out, the medical scheme has to pay for the treatment of PMB conditions.
- To ensure that healthcare is paid for by the correct parties. Medical scheme members with PMB conditions are entitled to the specified treatments and these have to be covered by their medical scheme, even if the patients were treated at a state hospital.

What PMB are covered by the Fund?

Emergency Medical Conditions

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

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

Diagnostic Treatment Pairs (270 medical conditions)

The Regulations to the Medical Schemes Act provide a long list of conditions identified as PMB. The list is in the form of Diagnosis and Treatment Pairs (DTPs). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the 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 dislocations/fractures, open or closed with injury to spinal cord	Repair/reconstruction; medical management; inpatient rehabilitation up to two months

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

PMB Category	Example
Brain and nervous system	Stroke
Eye	Glaucoma
Ear, nose, mouth and throat	Cancer of oral cavity, pharynx, nose, ear, and larynx
Respiratory system	Pneumonia
Heart and vasculature (blood vessels)	Heart attacks
Gastro-intestinal system	Appendicitis
Liver, pancreas and spleen	Gallstones with cholecystitis
Musculoskeletal system (muscles and bones); Trauma NOS	Fracture of the hip
Skin and breast	Treatable breast cancer
Endocrine, metabolic and nutritional	Disorders of the parathyroid gland
Urinary and male genital system	End-stage kidney disease
Female reproductive system	Cancer of the cervix, ovaries and uterus
Pregnancy and childbirth	Antenatal and obstetric care requiring hospitalisation, including delivery
Haematological, infectious and miscellaneous systemic conditions	HIV and AIDS and TB
Mental illness	Schizophrenia
Chronic conditions	Asthma, diabetes, epilepsy, hypothyroidism, schizophrenia, glaucoma, hypertension

If your PMB condition is not an emergency or a chronic condition, but is a once off acute PMB condition as diagnosed by your doctor, you will be covered, subject to Fund Rules and the PMB limits. If you are unsure of whether your acute condition is covered as a PMB you can contact the OMSMAF Call Centre or email healthcaremain@medscheme.co.za retrospectively after your diagnosis to clarify. The agent will require the ICD10 code to determine if 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. If these items have been submitted already, the agent will pass these on to the PMB department. Once the relevant information has been received, qualifying claims will be paid first from your Primary Care Benefit and overall insured benefits, and then from an unlimited PMB benefit. No PMB claims may be paid from your PSA.

Why can you not pay for PMB from your Personal Saving Account?

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

How to avoid rejected PMB claims

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

This becomes very important if you have a PMB condition, as these can only be identified by the correct ICD-10 codes. Therefore, if the incorrect ICD-10 codes are provided, your PMB-related services might be paid from the wrong benefit (such as from your medical savings account), or it might not be paid at all if your day-to-day or hospital benefits limits have been exhausted.

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

Important note: The Fund is obliged by law to treat information about members' conditions with the utmost confidentiality. They are not allowed to disclose even ICD-10 codes to any other party, including employers or family members.

If my PMB claim is rejected who can I call?

You can contact 0860 100 076 to query the rejection. As mentioned above it's important to check that your medical practitioner has placed the correct codes on your invoice. Once diagnosed, please keep all your supporting documents on file as the operator will ask for this information when re-working your claim.

The 25 chronic diseases

The Chronic Disease List (CDL) specifies medication and treatment for the 25 chronic conditions (listed on page 17 of this member guide). To manage risk and ensure appropriate standards of healthcare, so-called treatment algorithms were developed for the CDL conditions. The algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment your medical scheme must provide for may not be inferior to the algorithms.

If you have one of the 25 listed chronic diseases, your medical fund not only has to cover medication, but also doctors' consultations and tests related to your condition. The Fund may make use of protocols, formularies (lists of specified medicines) and Designated Service Providers (DSP) to manage this benefit.

Can the Fund set a chronic medicine limit?

Yes, the Fund can set a limit for your chronic medicine benefit. Any chronic medication you claim for will then reduce that limit, regardless of whether or not it is one of the PMB chronic conditions. However, if you exhaust your chronic medicine limit, the Fund will have to continue paying for any "approved" chronic medication you obtain from its DSP for a PMB condition. More information is available on Chronic Medicine Management on page 17 of this member guide.

No exclusions

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

Major Medical Benefits (MMB)

In this section:

- The cover available for Major Medical Benefits
- What you need to do before being hospitalised
- The benefits and services that are covered under Major Medical Benefits on all the Plans

All members are covered for Major Medical Benefits, no matter which Plan they belong to, except for those services that are specifically excluded (see page 40 of this Member Guide).

COVER AVAILABLE

There is no overall annual limit on the cover you receive on all Plans, except the Hospital Plan, for Major Medical Benefits. The Hospital Plan has a limit of R1 000 000 per beneficiary per benefit year. There are sub-limits for certain services and it is important to understand the level of benefits under each sub-limit, as claims will be paid up to the available sub-limits only. (Refer to the Pocket Guide for more information.)

If your treating doctor charges you more than the sub-limit available for that service, you will have to pay the difference. The difference can be paid from your PSA if there are funds available. Please note that you may not use your PSA to pay for PMB in part or in full.

PRE-AUTHORISATION BEFORE YOU ARE HOSPITALISED

Before you are admitted to any hospital (whether State or Private), you need to notify the Fund at least one working day before every planned admission for surgery/treatment or on the same day for acute admissions. It is recommended that you pre-authorise 10 days before a hip or knee replacement and spinal fusion. You can do this by contacting Hospital Benefit Management, as explained in the process below. This process is known as pre-authorisation.

The purpose of pre-authorisation is not only to manage the cost of hospitalisation, but also to ensure that members receive the most appropriate and effective treatment available. Remember that it is your responsibility, not your doctor's, to pre-authorise where required.

How do I pre-authorise for hospital admission?

- Contact Hospital Benefit Management at 0860 100 081 at least one working day before being admitted to hospital.
- Please note that the Fund has a speech recognition self-service system that allows you to enter information on the system before being redirected. Please ensure that you have the following information on hand when calling:
 - name of patient
 - membership number or main member's identity number
 - patient's date of birth
 - planned date of admission to hospital or treatment
 - name and practice number of the hospital/facility
 - practice number, name and telephone number of the doctor who wishes to admit the patient to hospital
 - proposed treatment or procedure/tariff code
 - ICD-10 code
 - name of contact person while the patient is in hospital
- Hospital Benefit Management will confirm whether the member has enough benefits available to cover the service. They will provide a pre-authorisation number, which the hospital will ask for on admission.
- A Case Manager from Hospital Benefit Management will monitor the patient's progress in hospital. This will ensure that he/she does not have to stay in hospital any longer than necessary. They may also arrange, in consultation with the doctor, that the patient recuperates at home, under the care of professionals. If arranged by the Case Manager, this will still be covered by your Major Medical Benefits.

- Additional pre-authorisations, over and above the hospital admission pre-authorisation, may be required in certain instances during your hospital stay, e.g. for MRI scans.

What if I do not pre-authorise?

If you do not pre-authorise as required before being admitted to hospital, you will have to pay a penalty. (Refer to the Pocket Guide for more information.) This penalty will be paid from your PSA, if you have funds available. If you have no funds available, you will have to pay the Fund directly.

Remember that it is your responsibility, not your doctor's, to pre-authorise where required.

What about emergencies?

In the case of an emergency, you or a family member must arrange to notify Hospital Benefit Management on the first working day after being admitted. If not, you will have to pay a penalty. Please refer to the Pocket Guide for more information.

What if my hospitalisation is postponed or I am re-admitted, even if I have pre-authorised?

You will have to pre-authorise your hospital admission again before you are admitted, even if you are being re-admitted for the same condition.

What about extended stays?

The hospital must obtain approval from the Fund via the Case Manager for stays of more than 10 days or stays that exceed the number of days that were initially pre-authorised.

What about intensive care or high care units?

The hospital must obtain approval from the Fund for accommodation in intensive care or high care units.

What about procedures in doctors' rooms?

If you have obtained a pre-authorisation number, certain procedures will be covered under the Primary Care Benefit (PCB). Please refer to Annexure B1 in the Pocket Guide for a full list of the procedures covered by the Fund. If you have exceeded the PCB limit, benefits will be paid from your Major Medical Limit provided that members pre-authorise and that the procedure is still performed in the doctor's rooms.

ADDITIONAL INFORMATION ABOUT SERVICES AND PROCEDURES UNDER MAJOR MEDICAL BENEFITS

The following services and procedures are covered at 100% of tariff or cost, whichever is the lesser, unless otherwise stated. You will find a list of the services and procedures covered under Major Medical Benefits, as well as the sub-limits that apply, in your Pocket Guide.

Service category	Benefit
1. Prescribed Minimum Benefits	100% of the cost for services received in a State hospital. These services will "clock up" to the sub-limits.
2. Hospital costs (subject to sub-limits where applicable)	<p>Subject to pre-authorisation, 100% of tariff</p> <ul style="list-style-type: none"> ■ General and private wards (private wards are paid at general ward rates unless authorised by a doctor as medically essential and approved by the Case Manager) ■ Intensive and high care units ■ Surgical and theatre fees ■ Labour and recovery wards ■ Hospital procedures <p>On the day of discharge, you should arrange to leave the hospital before 12:00 wherever possible.</p> <p>If scheduled to undergo an operation in the afternoon, you should ask your doctor to admit you after 12:00. In this way, you can avoid incurring additional hospital costs.</p>
3. Drugs & medicines (subject to sub-limits where applicable)	<ul style="list-style-type: none"> ■ Medicines supplied during hospitalisation ■ Disinfectants and other material used during hospitalisation ■ Theatre drugs
4. Medicine dispensed on discharge from hospital (to-take-out medicine)	This benefit will be limited to what is needed for 7 days; thereafter it will be paid from your Day-to-Day Benefits.
5. Chronic medication	<p>100% of the Medicine Price or cost, whichever is the lesser, for medication prescribed in respect of chronic conditions, subject to the Plan-specific Formularies, application and pre-authorisation obtained from CMM (see pages 17-20).</p> <p>Non-PMB conditions:</p> <ul style="list-style-type: none"> ■ Network Plan: Only those conditions and medicines included on CareCross's Formulary ■ Hospital Plan: No benefit ■ Savings Plan: Subject to PSA ■ Traditional and Traditional Plus Plans: Sub-limit per family per benefit year.
6. Medical services (subject to sub-limits where applicable)	<ul style="list-style-type: none"> ■ Surgery and procedures that require hospitalisation ■ Anaesthetics ■ Perfusion services ■ Pathology during hospitalisation ■ Radiology during hospitalisation

6. Medical services (continued)	<ul style="list-style-type: none"> ■ Physiotherapy during hospitalisation ■ Visits and consultations by a GP or specialist during hospitalisation ■ Blood transfusions ■ Occupational therapy during hospitalisation ■ Other services performed by registered medical practitioners <p>Certain services related to the initial pre-authorized hospitalisation may be covered from Major Medical Benefits, subject to approval by the Case Manager.</p>
7. Dental implants	<p>On certain Plans, there is a Rand sub-limit per family per benefit year (refer to your Pocket Guide for details)</p> <p>The sub-limit covers the cost of the dental implant only, is subject to pre-authorization and only available on application prior to service. Any associated hospital costs (e.g. theatre, certain dental specialist tariff codes, anaesthetist and accommodation) are covered under Major Medical Benefits.</p>
8. Maxillo-facial and oral surgery	<p>100% of tariff, subject to pre-authorization.</p>
<p>9. Organ transplants</p> <p>Anti-rejection drugs</p> <p>Organ donors</p>	<p>100% of tariff for transportation of the organ needed for the transplant, as well as hospital accommodation and surgically related services and procedures. The transplant and the relevant treatment plan must be pre-authorized.</p> <p>Subject to pre-authorization, 100% of Medicine Price of anti-rejection drugs up to the sub-limit, provided that drugs from an approved provider are used.</p> <p>100% of cost or MSR, whichever is the lesser, for a donor body or live donor, including any services related to the organ donor, the cost of organ search or transportation. Transportation must be by a registered service provider. Subject to pre-authorization. No benefits for any services related to an organ donor who is not a beneficiary of the Fund (see definition of "beneficiary" in Explanation of Terms).</p>
10. Renal dialysis	<p>This covers the treatment cost, including all related pathology and approved medication. Authorisation will be granted through Hospital Benefit Management and are subject to clinical protocols and relevant pathology tests results.</p> <p>Automated Peritoneal Dialysis will only be approved subject to the Fund's criteria.</p>
11. Ultrasound scans	<p>All scans other than for pregnancy</p> <p>There is a sub-limit per family per benefit year that differs per Plan.</p>
12. Home oxygen therapy	<p>There is a sub-limit per beneficiary per benefit year</p> <p>Subject to pre-authorization</p>

<p>13. Refractive procedures (e.g. radial keratotomy, excimer laser, phakic lenses, intra-ocular lenses)</p>	<p>There is a sub-limit per family per benefit year</p> <p>Subject to pre-authorisation and approval, 100% of tariff up to a sub-limit. No benefits paid unless the refraction of the eye is within the guidelines set by the Fund from time to time. You must submit all relevant medical reports required by the Fund in order to approve benefit.</p>
<p>14. Psychiatric treatment & psychotherapy</p>	<ul style="list-style-type: none"> ■ Accommodation ■ Medicine ■ Anaesthetists ■ Dieticians ■ General practitioners ■ Occupational therapists ■ Pathology ■ Psychiatrists ■ Psychologists ■ Radiology ■ Social workers <p>There is a limit of 21 days per beneficiary per benefit year</p> <p>The treatment must be at an approved psychiatric treatment facility or outpatient psychotherapy for up to 15 contacts.</p>
<p>15. Drug and Alcohol Abuse</p>	<ul style="list-style-type: none"> ■ Accommodation ■ Medicine ■ Anaesthetists ■ Dieticians ■ General practitioners ■ Occupational therapists ■ Pathology ■ Psychiatrists ■ Psychologists ■ Radiology ■ Social workers <p>There is a limit of 21 days per beneficiary per benefit year at an approved treatment facility.</p>
<p>16. Artificial limbs & artificial eyes</p>	<p>There is a sub-limit per beneficiary per leg, arm and eye</p> <p>Benefit is available every two to five years, as per clinical protocol. You will have to apply for this benefit before obtaining the service. This benefit is also subject to approval.</p>
<p>17. Medical appliances (external)</p>	<p>On certain Plans there is a sub-limit per family (subject to approval)</p> <p>You will have to apply for this benefit and submit three quotations before obtaining the service.</p> <p>This only applies to hiring or purchasing a medical appliance that does not form an integral part of an operation.</p> <p>Benefit is available at intervals as per clinical protocol; in some instances every two years.</p> <p>Repairs are subject to approval and services rendered by an accredited supplier. If not approved, the benefit will be paid from your PSA.</p>

18. Hearing aids	<p>On certain Plans, there is a sub-limit per beneficiary (subject to approval and as per clinical protocol) every two years</p> <p>Benefit is subject to motivation by the treating doctor and approval of the purchase or hire of the device prior to the acquisition of the device.</p>
19. Stoma care products	<p>100% of cost, subject to pre-authorisation, clinical guidelines and protocols</p>
20. Ambulance & paramedical services	<p>There is a sub-limit per family per benefit year</p> <p>100% of tariff for travelling expenses of a medical practitioner and/or ambulance up to sub-limit. No benefit available for travel in urban areas other than for ambulance charges where the patient's physical condition precludes the use of any other means of conveyance.</p> <p>Services supplied by ER24 on 084 124.</p>
21. Nursing services and hospice	<ul style="list-style-type: none"> ■ Private nursing (not for general or chronic care) ■ Hospice services (including medication supplied) ■ Acute care services (not for frail care) ■ Care after birth services <p>There is a sub-limit per beneficiary per benefit year</p> <p>This benefit covers the acute phase after or instead of hospitalisation, but not long-term or chronic care.</p> <p>You will have to apply for this benefit before obtaining the service. Benefits are subject to approval.</p> <p>This benefit does not include:</p> <ul style="list-style-type: none"> ■ Long-term care including health, social and/or personal care services required on a long-term basis by those with chronic illnesses. ■ Old age and/or associated frail care, or care owing to a disability or mental retardation, or supervising someone in the completion of tasks or reminding him/her to complete tasks.
22. MRI, CAT and radio-isotope scans (excluding PET scans)	<p>There is a Plan-specific sub-limit per family per benefit year</p> <p>You will have to apply for this benefit through the pre-authorisation process, even if you have pre-authorised for your hospital admission.</p> <p>If you do not pre-authorise for this procedure, your claim will be paid from your available Day-to-Day Benefits.</p>
23. Acute rehabilitation	<p>There is a sub-limit per beneficiary per benefit year</p> <p>This benefit, which is subject to pre-authorisation and the submission of a motivation by the treating medical practitioner, covers members who have become temporarily disabled as a result of an acute injury, caused by trauma, hypoxia, infection, surgery, bleeding or infarction, that results in spinal cord or brain damage.</p> <p>This benefit applies immediately after the acute phase in hospital. Progressive conditions such as multiple sclerosis and Parkinson's disease are not included. Long-term or chronic care is not covered.</p>

<p>24. Oncology (including MRI, CT and radio-isotope scans, mammograms, chemotherapy, drugs associated with chemotherapy, radiotherapy, oncologists' consultations, radiology and pathology fees) (see page 23 for more information)</p> <p>PET scans</p>	<p>The patient must enrol on the Oncology Benefit Management Programme.</p> <p>There are Plan-specific sub-limits per beneficiary per benefit year</p> <p>A treatment plan from your treating doctor must be submitted to the Case Manager. This plan should provide information such as the date of diagnosis, the ICD-10 code, any prior surgery or treatment, new treatment requested, as well as approximate costs.</p> <p>Subject to pre-authorisation, 100% of Medicine Price for medication and drugs, other than biologicals. 90% of Medicine Price for biologicals other than Herceptin and biologicals approved during treatment for prescribed minimum benefit conditions.</p> <p>100% of Medicine Price for Herceptin for the adjuvant treatment of early breast cancer subject to a maximum of nine weeks. 90% of Medicine Price for Herceptin for the treatment for metastatic breast cancer subject to a maximum of twelve months in a patient's lifetime. No benefit for Herceptin for subsequent treatment of metastatic breast cancer during the patient's lifetime.</p> <p>There are Plan-specific sub-limits per beneficiary per benefit year</p> <p>Subject to approval and subject to the Oncology sub-limit relevant to your Plan.</p>
<p>25. HIV and AIDS (see page 22 for more information)</p>	<p>Subject to registration on the HIV and AIDS Management Programme. This Programme includes: Chronic medication, pathology and doctors' visits as set out in PMB legislation.</p>
<p>26. Internal prostheses (see complete list on page 15 and 16)</p>	<p>Specific sub-limits apply for the following prostheses:</p> <ul style="list-style-type: none"> ■ Aortic stents ■ Cardiac stents ■ Cardiac pacemakers ■ Cardiac valves ■ Total hip replacement ■ Total knee replacement ■ Total shoulder replacement ■ Spinal instrumentation ■ Any other prosthesis <p>You will have to apply for this benefit before obtaining the service. Benefits are subject to approval and you should obtain a quote from your doctor.</p>
<p>27. Cochlear implants</p>	<p>There is a sub-limit per beneficiary per benefit year for beneficiaries up to the age of six years. Subject to pre-authorisation and approval.</p>
<p>28. Hyperbaric oxygen therapy</p>	<p>Subject to pre-authorisation and the submission of a motivation by a specialist, 100% of tariff.</p> <p>Not for treatment of strokes, cerebral palsy, diabetic wounds and ulcers.</p>

<p>29. Maternity</p> <p>Ultrasound scans</p> <p>Midwife delivery</p> <p>Antenatal vitamins</p> <p>Educational and support services</p> <p>Antenatal visits</p>	<p>Benefits are subject to registration on the Mother and Baby Care programme before the twentieth week of pregnancy.</p> <p>If you register after the twentieth week, antenatal classes, antenatal vitamins and certain services will be paid from your available Day-to-Day Benefits. Please refer to page 24 for registration information.</p> <p>100% of tariff in respect of the following subject to the overall annual limit:</p> <ul style="list-style-type: none"> ■ Medical practitioner services while hospitalised ■ Theatre and recovery rooms ■ Normal delivery limited based on protocols ■ Caesarean delivery limited based on protocols ■ Material used in hospital ■ 100% of the Medicine Price for medicines <p>There is a sub-limit per family per benefit year that differs per Plan</p> <p>100% of the Society for Private Nursing Practitioners of South Africa (SPNP) rate for midwife (for midwife delivery or home delivery) – including birth attendant. Midwife must be registered with BHF and Nursing Council.</p> <p>100% of cost of registered prenatal supplements. If you do not register, these services will be paid from the Day-to-Day Benefits, where applicable.</p> <p>Benefits in respect of educational and support services and antenatal classes by a registered midwife subject to the sub-limits per family per benefit year that differs per Plan.</p> <p>100% of cost or MSR, whichever is the lesser, subject to the sub-limits per pregnancy per benefit year that differs per Plan.</p>
<p>30. Auxiliary services while in hospital</p>	<p>Certain services related to the initial pre-authorised hospitalisation will be covered, subject to approval by the Case Manager. Otherwise, these services will be covered from Day-to-Day Benefits. (See Explanation of Terms for a full list of services.)</p>
<p>31. Radiology and pathology</p>	<p>No limit while hospitalised, excluding MRI, radio-isotope, CT and ultrasound scans.</p>
<p>32. Procedures in doctors' rooms</p>	<p>Subject to pre-authorisation, 100% of tariff</p> <ul style="list-style-type: none"> ■ Bone marrow biopsy ■ Colonoscopy ■ Cystoscopy ■ Functional endoscopy of sinuses ■ Gastroscopy ■ Hysteroscopy ■ Intravenous therapy ■ Keloids (subject to motivation and approval) ■ Laser to scars (subject to motivation and approval) ■ Schlerotherapy (subject to motivation and approval) ■ Sigmoidoscopy ■ Surgical biopsies (needle biopsies) (subject to motivation and approval) ■ Tonsillectomy (laser) ■ Vasectomy ■ 0307 Excision and repair ■ 0255 Drainage of subcutaneous abscess & avulsion of nail ■ 0259 Removal of foreign body superficial to deep fascia ■ 2133 Circumcision - clamp ■ Minor surgical procedures (subject to motivation and approval)

Please note:

References to a general practitioner, midwife, medical practitioner, specialist, surgeon, anaesthetist, pharmacist or medical auxiliary mean a person who is registered as such with the relevant professional body.

Where multiple procedures are performed during the same procedure or operation, these may be covered at different percentages as set out in the tariff guideline.

Hospital cover

If you are hospitalised, your stay will be subject to the period that was pre-authorised and any additional days that may be further certified by the Case Manager. No further benefits will be paid unless such a stay is further authorised.

Basic dentistry

Hospitalisation will only be considered for basic dentistry performed on persons who are 12 years or younger. All dental-related cases requiring surgery need to be motivated by the attending dental practitioner and are subject to approval. This includes simple extractions. The hospital and anaesthetist's accounts will be covered under your Major Medical Benefits, while the dentist's account will be paid from your Day-to-Day Benefits.

Psychiatric services

Members with a psychiatric illness must be admitted to a registered psychiatric unit or hospital, where they will benefit from the normal case management process or will be able to benefit from outpatient psychotherapy for up to 15 contacts. If a member is admitted to a hospital that does not have a registered psychiatric unit, the cost will be subject to their available funds in PCB and PSA.

A psychiatrist must assess these admissions as appropriate. If the member chooses treatment at a non-approved facility, the balance may be for the member's account, subject to Fund Rules.

The Fund does not pay for sleep therapy.

Remember that you also have access to counselling and support on Old Mutual's Employee Wellbeing Programme. Call the Helpline at 0800 006 068 or email the Care Centre at ewp@carewaysgroup.com.

Internal prostheses

These are fabricated or artificial substitutes, which are surgically implanted for a diseased or missing part of the body, or to improve the function of a diseased or damaged organ.

The following is a list of these prostheses:

- Aortic grafts (arterial)
- Aortic modular stents (M)
- Artificial sphincter (M)
- Bone
- Bone cement
- Breast prostheses (M)
- Cables
- Cardiac stents
- Cardiac valves and rings
- Cochlear implants (M)
- Coral implants (M)
- Cortex dual mesh (M)
- Ear-bone implants (M)
- Exo-skeletal apparatus
- Hepatic stents
- Hip (cement included)

- Internal defibrillator (M)
- Intra-ocular lens (where the lens is removed for a cataract condition, otherwise subject to refractive benefit)
- Knee (cement included)
- Male sling for urinary incontinence (M)
- Mesh
- Mirena device (M)
- Pacemaker (M)
- Plates, screws, orthopaedic staples, K-wires and rods (cement included)
- Shoulder (cement included) (M)
- Silicone bands (intra-ocular surgery)
- Staples (bone)
- Tension-free vaginal tape/sling
- Ventriculo-peritoneal/pleural shunt

Other procedures that require motivation:

- All spinal fusion surgery (M)
- Double balloon enteroscope (M)
- Hip, wrist or elbow arthroscopy (M)
- Kyphoplasty/Vertebroplasty (M)
- Meniscal transplant (M)
- Spinal or dorsal column stimulation (M)

The items above indicated by an “M” must be motivated for by a medical practitioner and approved by the Fund’s medical adviser.

This list is constantly reviewed and updated. Where new products or technology are considered, these should be motivated by a medical practitioner. Application for or use of any item not on the list must always be submitted with a motivation from the treating practitioner to the Fund’s medical adviser.

In the case of hip or knee replacements and spinal fusions, it is recommended that you pre-certify 10 days before the operation so that the Case Manager has enough time to negotiate discounts with the service provider. It is in your best interests to get a quotation from the treating doctor to ensure that the benefit limit is enough to cover the cost of the prosthesis.

Pathology

Pathology testing (or blood tests) plays a very important role in the lives of patients. The Administrator has therefore adopted a sound policy of achieving maximum benefits for members of the Fund, both in and out of hospital, through partnerships with acknowledged experts in certain fields of medical care provision.

You can assist the Fund by doing the following when blood tests are required:

- Ask your doctor about the need for specific tests in aiding medical diagnosis. Perhaps you can suggest single tests rather than multiple tests for every possible condition.
- Ask your doctor about the cost of the tests you are due to have done.
- Ask your doctor if he/she can recommend a supplier who charges reduced rates.
- Ensure that the doctor uses the correct ICD-10 code so that the claim comes off the correct benefit.

Ambulance services

Once you have exhausted your annual sub-limit for ambulance services (see the Pocket Guide for this year’s sub-limit), or if you need additional funding for this service, you can apply to the Fund for approval by submitting a clinical letter of motivation.

For ambulance services 24 hours a day, please contact the ER24 on 084 124.

Important benefits and programmes under Major Medical Benefits

In this section:

- Obtaining your chronic medication
- Disease Management Programmes
- The benefits and services you will receive if you join the HIV and AIDS Management Programme
- The benefits and services you will receive if you are diagnosed with cancer
- The benefits and services you will receive if you join the Mother and Baby Care Programme

CHRONIC MEDICINE MANAGEMENT (CMM)

This benefit is available only to members on the Hospital, Savings, Traditional and Traditional Plus Plans. Members on the Network Plan must apply for, and obtain, their chronic medication through CareCross (see page 18 for more information).

A chronic condition is a condition that requires ongoing long-term or continuous medical treatment. However, not all of these conditions are necessarily covered by the Fund's Chronic Medicine Benefit. The Fund subscribes to a Chronic Ailments List, which specifies those conditions that qualify for this benefit.

All five Plans have an unlimited chronic medicine benefit for PMB Chronic Disease List conditions specified by the Minister of Health. All medicine claims are paid at 100% of medicine price or cost, whichever is the lesser. The chronic medicine benefit is subject to the **CareCross, Basic or Advanced Formulary** according to your Plan, and any applicable waiting periods (refer to page 38 of this Member Guide for more information on when waiting periods will apply to PMB conditions).

Definition of a Formulary

A formulary is a list of cost effective evidence-based medicines that the Fund will cover for the treatment of your chronic condition. These lists are compiled by the Administrator's Clinical team and are constantly reviewed.

- The **Basic Formulary**, applicable to the Hospital and Savings Plans, contains a list of medicines that provide adequate cover if you are newly diagnosed or if your condition is mild to moderate in terms of severity.
- The **Advanced Formulary**, applicable to the Traditional and Traditional Plus Plans, provides access to a range of medicines for moderate to severe conditions.

Definition of Medicine Price

The single exit price (see page 45 for definition) plus the dispensing fee authorised by the Board for such medicine.

The conditions covered under the Chronic Medicine Management are as follows:

PMB Chronic Disease List (CDL) conditions

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic obstructive pulmonary disease (emphysema)
- Chronic renal disease
- Coronary artery disease (angina pectoris and ischaemic heart disease)
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension (high blood pressure)
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

Other Chronic Diseases (Non-PMB and PMB)

Network Plan	Traditional and Traditional Plus Plans
<p>The following non-PMB chronic conditions are covered by CareCross. Registration and approval required and medicines subject to CareCross</p> <p>Medicine formulary.</p> <ul style="list-style-type: none"> ■ Acne ■ Allergic rhinitis ■ Cardiac Arrhythmia ■ Depression ■ Gout ■ Female Hormone Replacement Therapy ■ Migraine ■ Osteoarthritis 	<p>The following conditions are subject to the Chronic Medicine Benefit limit:</p> <ul style="list-style-type: none"> ■ Acne (cystic nodular) ■ Allergic rhinitis (if beneficiary has asthma or is under 12 years) ■ Alzheimer’s disease ■ Anxiety (if linked to another chronic condition) ■ Attention deficit syndrome (if diagnosed by a specialist) ■ Cushing’s disease* ■ Cystic fibrosis* ■ Deep vein thrombosis* ■ Depression ■ GORD (if linked to another PMB condition) ■ Gout ■ Hormone replacement therapy* ■ Hyperfunction of pituitary gland* ■ Hyperthyroidism (thyrotoxicosis)* ■ Hypofunction of pituitary gland* ■ Hypoparathyroidism* ■ Migraine (prophylactics therapy) ■ Myasthenia gravis and myoneural disorders* ■ Osteoarthritis ■ Osteoporosis ■ Psoriasis

*Once you have exceeded your Chronic Medicine Management limit, cover for these conditions is unlimited.

Please note: For all chronic conditions, if you follow the Fund’s protocols, your medication will be covered at 100% of medicine price. If not, you will be liable for a co-payment.

Savings Plan: Payment of Non-PMB conditions are subject to available funds in your PSA.

What if I’m on the Network Plan and I need chronic medication?

If you are on the Network Plan and require chronic medication, visit your CareCross practice for confirmation of your diagnosis. The doctor will complete the CareCross chronic medication application form with you and will arrange for it to be faxed to CareCross for assessment. Clinical Entry Criteria will be applied as your application must meet certain clinical criteria before benefits will be authorised.

The CareCross Clinical Division will evaluate the application and will approve cover for the medications listed on the CareCross Chronic Formulary. Chronic medicines will be approved from the date that we receive your application, provided it is fully completed and includes all supporting documentation. We will not backdate chronic authorisations and we recommend that you take careful note of the information in the Member Guide and the instructions on the application form. If necessary, they will contact your doctor for more information regarding your case.

Please note: It will take a maximum of five working days for your application to be processed.

A letter of confirmation will then be sent to your doctor and the approved chronic medication will be sent to your preferred address, i.e. either your doctor or nearest post office.

The Network Plan allows for unlimited GP visits, as well as specified radiology and pathology visits. Should the management of your PMB condition require services outside of these benefits, your medical practitioner must submit a clinical motivation to cmm@medscheme.co.za that includes:

- Frequency of consultations
- Medication
- Tariff codes

Subject to approval from the medical adviser. Contact the CMM department for more information.

What if I'm on one of the other four Plans and I need chronic medication?

If you are on the Traditional and Traditional Plus Plans, you have chronic medicine benefit cover for the chronic ailments listed on pages 17 & 18 subject to the annual sub-limit. You can apply to use this benefit as indicated below.

If you are on the Savings Plan and your chronic ailment is not a PMB, your chronic medication will be paid from your PSA.

There is no non-PMB chronic medication benefit for members on the Hospital Plan.

How to apply for the Chronic Medicine Benefit on the Hospital, Savings, Traditional and Traditional Plus Plans

- Check the PMB and non-PMB chronic disease lists to ensure that your disease is covered under your current Plan.
- If it is covered, you will need to complete a Chronic Medicine Application Form, which you can obtain from the Chronic Medicine Management (CMM) Call Centre at 0860 100 608, via GroupNet or on the OMSMAF Member Zone.
- Certain diseases require additional test results, motivation and supporting documentation, and in some cases a specialist must complete the application form. This information is specified in the application form.
- Incomplete application forms will not be processed.
- Submit your completed application form to CMM.
- Do not submit your prescription. It must be presented to your pharmacist.

Authorisation of your chronic medication on the four Plans

Your chronic application will be processed as follows:

- Clinical Entry Criteria will be applied. This means that your application must meet certain clinical criteria before chronic benefits will be authorised. This step ensures the cost-effective and sustainable funding of chronic medication.
- Our pharmacists, supported by medical advisers, will review your application to ensure that cost-effective medication is authorised. The use of cost-effective medication ensures cost containment without compromising the quality of care.
- Medicines for PMB will be covered in full, without co-payments, if they are listed on your Plan-specific Formulary (see page 17). You can obtain this list from the CMM Call Centre.
- Chronic medicines will be approved from the date that we receive your application, provided it is fully completed and includes all supporting documentation.
- We will not backdate chronic authorisations and we recommend that you take careful note of the information in the Member Guide and the instructions on the application form.
- Should you be accepted onto the Chronic Medicine Management Programme, you will be informed in writing. You will receive a medicine "access card" with your authorisation letter, which lists the medicines to be paid from the Chronic Medicine Benefit. The access card, together with a valid prescription, must be presented to your pharmacist. Pharmacies will not dispense your chronic medication without a valid prescription.

Please note: It will take a maximum of five working days for your application to be processed.

Your Chronic PMB Medical Management Care Plan

This applies only to members on the Hospital, Savings, Traditional and Traditional Plus Plans.

CareCross offers unlimited PCB and therefore, does not issue a written Care Plan. If a Network member requires services, relating to their PMB condition, that are not covered by CareCross, the Fund will be notified and services, such as specialist visits and additional medication, will be authorised, subject to Fund Rules and PMB protocols.

If your application for chronic medication is approved and you have submitted your first claim for a doctor's visit, pathology or radiology relating to this condition, you will receive a PMB Care Plan for the chronic diseases for which you are being treated.

The Care Plan consists of a standard set of consultations and tests that the Fund will cover for PMB conditions, and it will stipulate the number and frequency of the consultations and tests that will be covered.

The Care Plans have been set up to ensure that members receive sufficient benefits to control their PMB chronic condition/s and improve their quality of life. No Care Plans will be allocated for non-PMB chronic conditions.

If you are diagnosed with a new chronic disease

You must follow the same process as outlined on page 19.

Changes to your chronic medication

If you need any change to your medication for a registered disease, your medical practitioner or pharmacist can contact a pharmacist on the Medicine Motivation Line at 0860 100 608 to process the change.

Alternatively, you may fax or post a copy of your new prescription to Chronic Medicine Management. It will take a maximum of five working days for your application to be processed.

Service provider

Currently, you may use a service provider, i.e. pharmacist, licensed doctor, etc., of your choice to obtain authorised chronic medication. Although you are free to use any service provider, including your local pharmacy, the Fund has appointed the Clicks Group as a preferred provider. They offer cost-saving options that will make your medical aid benefits last longer, through low medicine prices and generic substitution, as well as not charging additional administration fees.

Clicks pharmacies offer you a choice of how you would prefer to access your chronic medication.

Patient-ready parcels

- To avoid queuing, you can lodge your prescription with your Clicks pharmacy for pre-packing, ready for pick up each month at the collection counter. You will receive a reminder call five days before your medication is due for collection. On collection, you will have access to your pharmacist for any questions and advice.

Delivered to your door

- Should it be more convenient for you to have your chronic medication delivered to you, you can register with Clicks Direct Medicine and they will deliver your medication, wherever you are, for no extra charge. Once your chronic medication has been approved by the Fund, you can call 0861 444 405 to register for delivery.

For further savings we encourage you to become a Clicks ClubCard member, which entitles you to earn ClubCard points on your acute medication purchases, use of the clinic services and on the dispensing fee every time you collect your chronic medication, even if it is being pre-packed or delivered. Your ClubCard is also needed in order to access the Clicks Pharmacy Wellness benefit. More details on this are available on page 26 of this Member Guide and page 18 of the Pocket Guide.

Contact details for CMM

Telephone: 0860 100 608
Fax: 0800 223 670/680
E-mail: Members: cmm@medscheme.co.za
Doctors and pharmacists: nmmqueries@medscheme.co.za

Business hours: Monday – Friday, 08:30 – 17:00

DISEASE MANAGEMENT PROGRAMMES

Diabetes Management Programme

This Programme identifies members who are in the high-risk category of diabetes and its associated conditions, i.e. high cholesterol and hypertension. Through working with Care Managers, affected members can minimise the rate of hospitalisation, which in turn will result in reduced costs and the impact on available benefits.

Your confidentiality is assured.

Members receive one-on-one contact with a personal Care Manager as well as advice on medicine management and personalised Care Plans.

Asthma Management Programme

Members and their registered beneficiaries are identified according to the risk levels through the Fund's clinical data. Care Managers will assist by offering education and support in managing available benefits, through proper medicine management and appropriate lifestyle changes.

Your confidentiality is assured.

Members receive one-on-one contact with a personal Care Manager as well as advice on medicine management and personalised Care Plans.

Additional Disease Management Support

In addition to the above chronic disease management programmes, members with chronic obstructive pulmonary disease and congestive cardiac failure can receive education, guidance and support in managing their condition(s) and benefits effectively.

Contact the Disease Care Managers at 0860 101 306.

HIV AND AIDS MANAGEMENT PROGRAMME

The HIV and AIDS Management Programme will be managed by Aid for AIDS (AfA). Aids for AIDS has been providing services to people in sub-Saharan Africa since 1998 and currently provides benefits to more than 50 000 people living with HIV and AIDS.

The HIV and AIDS Management Programme has been designed to improve the health status of members living with HIV and AIDS. If you are diagnosed with HIV and AIDS, the HIV and AIDS Care Manager will not only help you to manage the high costs associated with treatment, but will also offer help, support and education on your condition. This will enhance your health status and quality of life.

The Programme provides specialised treatment and support through its access to well-researched treatment guidelines.

It offers the following benefits:

- One HIV and AIDS test per beneficiary per year
- Telephone counselling to members and their family
- Advice on lifestyle and supplements to enhance immune status
- Regular monitoring through diagnostic pathology and other services
- Authorisation of antiretroviral medication, where appropriate
- Management of patients with opportunistic infections and/or end stage disease, to ensure appropriate care in terms of access

If you or a registered dependant is HIV-positive, you should immediately register on the Programme to access the above benefits.

The HIV and AIDS benefit, under the PMB, covers medical management and medication. This includes the provision of antiretroviral therapy as per the national guidelines that apply in the public sector. This benefit is available to all members.

Who should join?

Any member or registered dependant on the Fund who has tested positive for HIV should join the HIV and AIDS Management Programme.

Why should I join the Programme?

Early treatment, close monitoring and appropriate drug regimens can help members who are HIV-positive to enjoy healthier, more productive lives. Where the condition is treated sooner rather than later (in line with a professionally developed and managed programme), the need for frequent hospitalisation and visits to the doctor are likely to reduce.

How do I register on the Programme?

Contact the HIV and AIDS Care Manager at 0860 100 646. Doctors and pharmacists can contact AfA on 0800 227 700.

Fax: 0800 600 733

E-mail: afa@afadm.co.za

If I register, will other people find out about my HIV status?

No, your HIV status is strictly confidential. Nobody, not even your employer or the Board of Trustees of the Fund, is notified about a member's enrolment on the Programme or the HIV status of the member. Communication between registered members and the appointed Care Manager is treated confidentially and with discretion.

What is the role of the HIV and AIDS Care Manager?

The HIV and AIDS Care Manager can assist with all your questions regarding the condition, its treatment, social issues or any concerns that you may have. You can contact the Care Manager at 0860 100 646.

ONCOLOGY BENEFIT MANAGEMENT PROGRAMME FOR CANCER PATIENTS

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

By joining the Programme when you are diagnosed with cancer, you will qualify for the Oncology Benefit per year. This benefit forms part of your Major Medical Benefits, subject to the Oncology sub-limit. It is envisaged that in most cases this limit will be enough to cover well-managed costs.

How do I apply for this benefit?

If you are diagnosed with cancer, you will need to submit a proposed care plan from your treating oncologist for pre-authorisation before your treatment can begin. This care plan should provide information such as the date of diagnosis, ICD-10 code, the area to be treated, any prior surgery or treatment plus histology report, treatment history, new treatment requested, as well as approximate costs.

Submit the care plan to Hospital Benefit Management by sending a fax to 021 466 2303 or e-mail to cancerinfo@medscheme.co.za.

Your care plan will be evaluated and, where necessary, discussed with the treating oncologist in order to manage your condition in relation to the benefits available to you. If this care plan changes at any time, your oncologist must inform the Oncology Case Manager by submitting a revised care plan before beginning the new treatment.

What services are covered?

The Oncology Benefit will cover:

- Pathology
- MRI, radio-isotope, CAT and PET scans (the latter to be motivated and approved)
- Radiotherapy
- Chemotherapy and drugs associated with chemotherapy (e.g. anti-nausea)
- Approved related medication
- Radiology
- Oncologists' consultations
- Mammograms (if it forms part of your care plan)
- Palliative care

The following will be covered under your Day-to-Day Benefits, provided you have enough benefits available. You should therefore take this into account when choosing a new Plan:

- Prescribed vitamins
- Antibiotics
- Alternative medicine
- Sleeping tablets
- Medicines for depression and anxiety

What is the role of the Oncology Case Manager?

You can contact the Case Manager with any queries you may have regarding the Oncology Benefit Management Programme or your condition. The Case Manager can also provide help, support and education on your condition.

Please contact the Oncology Case Manager at 0860 100 572.

Unfortunately, the Case Manager does not handle account queries. You should contact the OMSMAF Call Centre at 0860 100 076 in this regard.

MOTHER AND BABY CARE PROGRAMME

This Programme is available to members or their dependants during their pregnancy, the birth and after the birth. The Programme, which falls under your Major Medical Benefits, offers education and support to all pregnant mothers, with special emphasis on high-risk pregnancies. You need to register on the Programme as early as possible in your pregnancy and your additional benefits will automatically be activated. Your confidentiality is assured.

Who can join this Programme and when?

All pregnant members or their dependants must register on the Programme before their 20th week of pregnancy. Early registration gives the Case Manager of the Programme an opportunity to identify high-risk conditions. It also allows enough time to find out about benefits, antenatal classes and other information.

To obtain your antenatal vitamins you should:

- register on the Programme before the 20th week of pregnancy
- obtain a script from your doctor or gynaecologist and present it to your pharmacist and the claim will be processed electronically

You can register on the Programme by contacting Hospital Authorisations:

Tel: 0860 100 081

Fax: 0860 212 223, +27 11 466 1913

E-mail: authorisations.cpt@medscheme.co.za

What services are covered under the Programme?

The following services are covered under the Mother and Baby Care Programme in addition to the benefits you receive under Major Medical Benefits, provided you register before your 20th week of pregnancy:

- Antenatal visits subject to the sub-limits per pregnancy.
- 100% of the SPNP rate for midwives (for midwife delivery or home delivery), including a birth attendant.
- 100% of the medicine price for antenatal vitamins.
- Education and support services as well as antenatal classes performed by a registered midwife (services of a physiotherapist or aerobics instructor are not covered) for the registered beneficiary.
- Care after the birth services, e.g. home visits by a registered nurse and phototherapy treatment for your baby at home, if required (this will be monitored by the Case Manager).

What if I do not register on the Programme or if I register after 20 weeks?

Benefits such as antenatal classes, antenatal vitamins and care after the birth services are payable from your Major Medical Benefits only if you register on the Programme before 20 weeks. If not, these benefits will be paid from your available Day-to-Day Benefits.

Do I need a pre-authorisation number for my stay in hospital?

Yes, on the day of your admission or within one working day, you have to pre-authorise your stay by contacting Hospital Authorisation at 0860 100 081. Remember that if you do not pre-authorise your stay in hospital, you will have to pay a penalty on your hospital account.

Must I register my baby as a dependant?

Yes, even though you have pre-authorised your confinement, you will still have to notify the Fund of the birth of your baby, and arrange for him/her to be registered as a dependant on the Fund. When you register on the Programme, you will receive a registration form for easy registration of your baby.

If you do not register the baby as a dependant within 30 days of birth, the Fund will not register your baby from date of birth and therefore will not pay for any medical claims incurred for the baby during that time. See page 35 for the procedure to register a dependant and pages 34-36 to find out which dependants are covered.

Day-to-Day Benefits

In this section:

- The Wellness Benefit
- The Primary Care Benefit
- Your Day-to-Day Benefits under each Plan

Day-to-Day Benefits cover the medical treatment that you receive out of hospital or at the outpatient facility of a hospital, except for those services that are specifically excluded (see page 40 and 41).

Day-to-Day Benefits consist of a Wellness Benefit, a Primary Care Benefit and a PSA. The level of benefits you receive will depend on the Plan you select, as shown in the diagram below.

A comparison of the Day-to-Day Benefits on each Plan

Network Plan	Hospital Plan	Savings Plan	Traditional Plan	Traditional Plus Plan
Wellness Benefit	Wellness Benefit	Wellness Benefit	Wellness Benefit	Wellness Benefit
Unlimited primary healthcare via CareCross GP	Essential Primary Care Benefit	Essential Primary Care Benefit	Comprehensive Primary Care Benefit	Comprehensive Primary Care Benefit
Personal Savings Account (1%)	No Savings	Personal Savings Account (17%)	Personal Savings Account (1%)	Personal Savings Account (1%)

THE WELLNESS BENEFIT

Wellness Benefit

This preventive benefit is available on all Plans and consists of two types of Wellness Benefits: the GP Wellness Benefit and the Clicks Pharmacy Wellness Benefit. This benefit is separate from the Primary Care Benefit and PSA and is not paid from these limits, but subject to the use of the correct diagnostic and tariff codes as well as the correct DSP. The aim of this benefit is to encourage members to take care of their health and wellbeing by going for a general health consultation once a year and to keep track of their results.

GP Wellness Benefit

The GP Wellness Benefit provides for an annual medical check-up per beneficiary at a GP of your choice, including a range of preventive tests. In order to gain from this benefit you need to ensure that your doctor uses the correct diagnostic and tariff codes. If you choose to visit a specialist or gynaecologist, you will be covered at applicable GP rates, provided that the correct wellness consultation codes are used (refer to Annexure A in the Pocket Guide).

The benefit covers:

GP consultations

- Limited to one consultation per beneficiary

Pathology tests

- Urine – limited to one test per beneficiary
- Blood glucose – limited to one test per beneficiary
- Haemoglobin – limited to one test per beneficiary
- Pap smear – limited to one test per female beneficiary
- Prostate specific antigen – limited to one test per male beneficiary

Pathology/Radiology

- Lipogram – limited to one test per beneficiary
- Mammography – limited to one test per female beneficiary

Refer to Annexure A on page 32 of the Pocket Guide for a list of the correct codes that your doctor must use to ensure that your tests are covered according to the applicable benefit limits. Any medical expenses not covered under this benefit will be paid from either your PCB or PSA. All benefits are paid at 100% of tariff or cost, whichever is the lesser.

Clicks Pharmacy Wellness Benefit – the HealthTracker

The Clicks Pharmacy Wellness Benefit gives you access to the HealthTracker Programme, where you have the opportunity to visit your nearest clinic at a Clicks pharmacy, and a qualified nurse will assess your current state of health and give you advice as well as tools on how to improve your health. Please note that you will be covered for one visit per beneficiary per benefit year.

At the clinic they will measure your:

- Blood pressure
- Cholesterol
- Blood sugar
- Body mass index
- Height
- Weight

The nurse will also provide you with a customised exercise and healthy eating plan, based on your results. **In order to access the benefit you will need to apply for a Clicks ClubCard which will enable the Fund to obtain your results efficiently and to pay for your visit.** If you have an existing Clicks ClubCard, please call 0860 254 257 to register or fill in an application form available from any Clicks store. Please contact your nearest Clicks Pharmacy clinic to make an appointment. A list of Clicks Pharmacy clinics, and their contact details, is available on the member zone (www.medscheme.co.za) and on GroupNet.

THE PRIMARY CARE BENEFIT (PCB)

This benefit, with Plan-specific limits, is available to all members on the Hospital, Savings, Traditional and Traditional Plus Plans. On the Hospital Plan, this benefit is to cover the cost of pre-authorised and approved procedures performed in doctors' rooms.

The aim of this benefit is to provide members with cover for their primary healthcare needs. Please refer to the Pocket Guide for a detailed list of the essential services that are covered. Any medical expenses not covered under this benefit will be paid from your PSA.

PCB is subject to a limit which is either a specified limit or a calculated amount based on family size (member + adult + child). This limit is accessible to all members for the period of a benefit year and may be utilised by any dependants up to the full limit and not only the individual limit allocations.

Please note that sub-limits apply. No claims applicable to sub-limits will be paid if your full Primary Care Benefit has been exceeded. Clinical audits will be performed on all tariff codes. You might therefore find that, in certain instances, the tariffs that are charged on your account do not comply with these clinical guidelines and will therefore not qualify for benefits.

DAY-TO-DAY BENEFITS PER PLAN

The Network Plan

Your Day-to-Day Benefits consist of two parts:

- The Wellness Benefit, which covers a prescribed list of annual check-ups and preventive health screening tests, subject to the use of the correct diagnostic and tariff codes.
- Unlimited access to primary healthcare through the CareCross network

Any other services will be paid from your PSA.

The Network Plan is a value-for-money option that aims to curb escalating medical costs, while still offering you the basic primary healthcare cover that you need.

Where can I find out whether there is a CareCross practice near my home or place of work?

Please contact the CareCross Helpline at 0860 103 491 or log onto www.carecross.co.za. You can also contact 0860 100 076. CareCross service providers are mainly based in Southern Africa, therefore the Network Plan may not be appropriate for members who live in Namibia or other outlying countries.

Can I choose which doctor I wish to consult?

Yes, as long as the doctor you choose is on the list of CareCross practitioners. You can only consult the doctor at the CareCross practice chosen by you at the time you joined this Plan. When choosing this Plan, you must therefore make sure that there is a CareCross practice within easy reach of your home or work. CareCross has contracted with private GPs across the country who are now part of their network of doctors – you might find that your GP is linked to this network. You may change your chosen CareCross practice once during the year by contacting the Fund.

Will I have to wait in a queue for treatment?

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

Do I pay each time I visit a CareCross practice?

No. There are no limitations on the number of visits you make to the CareCross doctor, as long as you visit the CareCross practice during working hours. Your doctor has committed to ensuring that your medical scheme Plan remains affordable and will treat you professionally, without yielding to any demands by patients that are not strictly medically necessary.

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

You and your family have three additional visits at any other practice in the country in the event of an emergency (including events after hours as well as over weekends and public holidays or when you are out of town, e.g. on holiday).

You will be required to pay for all treatment received at the point of service. The costs of these services may, however, be claimed back from CareCross by completing a reimbursement form obtainable from the CareCross website. The reimbursement will be subject to a limit of R1 000 per family per year.

What if I need to consult a doctor after hours?

The consultation will be treated as an emergency and will be counted as one of your three out-of-network visits.

Which services are covered by CareCross?

You and your family are covered for the following:

- Consultations with GPs (at a CareCross practice)
- Minor procedures in doctors' rooms
- Specified radiology and pathology (specified black and white X-rays and basic blood tests)
- Dentistry (fillings, extractions, scale and polish only; no specialised treatment)
- Acute prescribed medicines as per the CareCross Medicine Benefit List
- Specified optical services (limited to one optical test per beneficiary per year and a set of spectacles from a specified selection per beneficiary every two years at contracted CareCross providers)

You can also receive the following services, which are not supplied by a CareCross practice. These will be paid from your PSA if there are funds available:

- Specialists out of hospital
- Psychology out of hospital
- Physiotherapy
- Auxiliary services (please refer to the Explanation of Terms for a full list of services)
- Advanced dentistry and orthodontic treatment
- Services received as a result of a referral to a specialist, psychologist and physiotherapist – even if referred by your CareCross practitioner.

Can I go to any dentist or must I go to a dentist on the network?

You need to consult a dentist on the dental network. The benefits for basic dentistry will be paid according to a CareCross approved tariff list. Please visit the CareCorss website (www.carecross.co.za) to access the dental network list to find a dentist in your area.

Which services are NOT covered by CareCross?

- All out of hospital specialist visits
- Any non-emergency hospital incidents not authorised
- Any claims from non-CareCross service providers, apart from those covered under your three additional consultations
- Travel expenses
- Cosmetic treatment, operations, procedures and applicators, toiletries, etc.
- Reports, examinations and tests for insurance policies or legal reasons
- Injuries arising from or appliances for professional sport, bungee or parachute jumps
- Accommodation in an old age home, general care institutions, spas, health or holiday resorts
- Obesity, alcohol or drug abuse (admission for alcohol or drug abuse is covered under Major Medical Benefits)
- Treatment and operations of choice and non-essential medical items
- Chronic psychiatric conditions and mental disorders (admission into an institution is covered under Major Medical Benefits)
- Pathology and Radiology tests not included on the approved tariff list
- Treatment of and medication for tuberculosis (general health management by a GP is covered by CareCross)
- Ptosis
- Injuries sustained during participation in strikes, illegal picketing, riots or physical struggle
- Nutritional supplements, tonics, stimulants, vitamins, minerals
- Contraceptives and devices to prevent pregnancy
- Stimulant laxatives
- Infertility and sexual dysfunction (those procedures and interventions not covered under PMB)

What medicines can I get through CareCross?

CareCross has a Medicine Benefit List, which contains a wide range of cost-effective medication (mostly generics) that cover most ailments, both acute and chronic. This list excludes certain non-generic branded medicines. If you insist on these non-generic medicines, you will be responsible for the cost of such medications.

To apply for chronic medication, complete a CareCross Chronic Medication Form together with your CareCross doctor. If the medication is approved by CareCross Health's Clinical Department, your chronic medication will be delivered to your CareCross doctor's consulting rooms, the nearest post office or the nearest contracted pharmacy.

You cannot obtain chronic medication through Chronic Medicine Management.

Please note: Accounts for services obtained at a CareCross practice should not be sent to the Fund for payment. You should not receive any accounts for treatment and services received at a CareCross practice. The practice must send their account directly to CareCross for payment.

THE HOSPITAL PLAN

Your Day-to-Day Benefits consist of:

- The **Wellness Benefit**, which covers a prescribed list of annual check-ups and preventive health screening tests, subject to use of the correct diagnostic and tariff codes.*
- The **Primary Care Benefit**, which covers specified procedures in doctors' rooms only, subject to a sub-limit. Services are covered at MSR or cost, whichever is the lesser.**
- No **PSA** contributions can be made on this Plan.

THE SAVINGS PLAN

Your Day-to-Day Benefits consist of:

- The **Wellness Benefit**, which covers a prescribed list of annual check-ups and preventive health screening tests, subject to use of the correct diagnostic and tariff codes.*
- The **Primary Care Benefit**, which covers essential primary care subject to an annual sub-limit. Benefits are available for the following standard tests and services and will be covered at MSR or cost, whichever is the lesser: specified procedures in doctors' rooms, essential radiology and essential pathology, and basic dentistry.**
- The **PSA**, to which you contribute a fixed percentage of your total monthly contributions. It can be used to cover day-to-day expenses that are not covered by the Primary Care Benefit as well as any co-payments or shortfalls, except for those relating to PMB.

The following services are covered at cost from your PSA:

- GP and specialist consultations
- Supplementary pathology
- Supplementary radiology
- Acute medication, paid at medicine price (see page 17 for a definition)
- Advanced dentistry
- Optometry
- Psychology and psychiatry
- Physiotherapy
- Auxiliary services

THE TRADITIONAL PLAN

Your Day-to-Day Benefits consist of:

- The **Wellness Benefit**, which covers a prescribed list of annual check-ups and preventive health screening tests, subject to use of the correct diagnostic and tariff codes.*
- The **Primary Care Benefit**, which covers comprehensive primary care subject to an annual sub-limit. Services are covered at MSR or cost, whichever is the lesser.**
- The **PSA**, to which you contribute a fixed percentage of your total monthly contributions. It can be used to cover day-to-day expenses that are not covered by the Primary Care Benefit as well as any co-payments or shortfalls, except for those relating to PMB.

* Refer to the Pocket Guide: Annexure A and pages 26 of this Member Guide and 17 of the Pocket Guide.

** PCB includes access to certain specified procedures and services in doctors' rooms (Annexure B1-B4 in the Pocket Guide).

What is covered under the Primary Care Benefit?

There is an overall annual limit for primary care services, with sub-limits for certain services.

The following standard tests and services are covered up to applicable sub-limits:

- GP and specialist consultations
- Specified GP procedures
- Pathology: essential and supplementary
- Radiology: essential and supplementary
- Acute medication, paid at medicine price (see page 17 for a definition)
- Basic and advanced dentistry, including dental implants if not approved
- Psychology
- Physiotherapy
- Auxiliary services (please refer to the Explanation of Terms for a full list of services)
- Optometry
- Pharmacy Advised Therapy (PAT)

Any services not covered under the Primary Care Benefit will be payable from your PSA, if there are funds available, or you will have to pay for it yourself. (Please refer to page 32 for more information on how the PSA works.)

THE TRADITIONAL PLUS PLAN

Your Day-to-Day Benefits consist of:

- The **Wellness Benefit**, which covers a prescribed list of annual check-ups and preventive health screening tests, subject to use of the correct diagnostic and tariff codes.*
- The **Primary Care Benefit**, which covers comprehensive primary care subject to an annual sub-limit. Services are covered at 300% of MSR or cost, whichever is the lesser.**
- The **PSA**, to which you contribute a fixed percentage of your total monthly contributions. It can be used to cover day-to-day expenses that are not covered by the Primary Care Benefit as well as any co-payments or shortfalls, except for those relating to PMB.

What is covered under the Primary Care Benefit?

There is an overall annual limit for day-to-day services, with sub-limits for certain services.

The following standard tests and services are covered up to the available sub-limits and are paid at PPR:

- GP and specialist consultations
- Specified GP procedures
- Pathology: essential and supplementary
- Radiology: essential and supplementary
- Acute medication, including Pharmacy Advised Therapy (PAT), paid at medicine price (see page 17 for a definition)
- Basic and advanced dentistry, including dental implants if not approved
- Psychology
- Physiotherapy
- Auxiliary services (please refer to the Explanation of Terms for a full list of services)
- Optometry

Any services not covered under the Primary Care Benefit will be payable from your PSA, if there are funds available, or you will have to pay for it yourself. (Please refer to page 32 for more information on how the PSA works.)

* Refer to the Pocket Guide: Annexure A and pages 26 of this Member Guide and 17 of the Pocket Guide.

** PCB includes access to certain specified procedures and services in doctors' rooms (Annexure B1-B4 in the Pocket Guide).

Personal Savings Account (PSA)

In this section:

- What you can use the money in your PSA for
- The interest earned in your PSA
- Settling claims if you do not have enough money left in your PSA
- The upfront credit facility available on your PSA
- What will happen to the money in your PSA if you are no longer a member of the Fund

Your PSA contribution will be fixed for a benefit year. Regulations do not allow members to have variable contributions to a PSA. The monthly contribution is therefore fixed.

The fixed contribution, however small, ensures that you continue to have access to your accumulated PSA balances. If the Fund did not include these fixed contributions to a PSA on these Plans, it would have to pay out all existing accumulated savings balances to members when they choose those plans, as required by the regulations of the Medical Schemes Act. A reminder to all members that the Hospital Plan has no PSA contributions and therefore no PSA balance.

You will find the annual amount that is available in your PSA under each Plan in the Pocket Guide.

What can the money in my PSA be used for?

You can use the money in your PSA to pay for:

- Any services that are deemed medically necessary, but are not covered under the Wellness Benefit and Primary Care Benefit.
- Services that are generally or specifically excluded according to the Rules of the Fund. These services should be obtained from a registered practitioner, and you must advise the Fund in writing to ensure that these services are paid from your PSA.
- The difference between the actual cost of a service and the tariff, other than PMB.
- Any co-payments for Major Medical Benefits, other than for PMB.
- Penalty for not pre-authorising.

You cannot use the money in your PSA to pay for:

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

Will the money in my PSA earn interest?

Any money in your PSA will earn interest at a rate of 90% of the actual average interest rate earned by the Fund. For example, if the Fund earns interest at 10%, you will earn 9% on any money in your PSA.

Can I withdraw money from my PSA?

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

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

The Fund will pay these claims up to the available PSA balance and you will need to settle the difference directly with your supplier.

Is there a credit facility?

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

How will I know what the balance in my PSA is?

You can view a detailed statement of all your transactions, available benefits, and the balance in your PSA on the OMSMAF Member Zone and on your monthly member statements.

What will happen to the balance of my PSA should I decide to change to the Hospital Plan which has no PSA allocation?

Your PSA balance will be paid out to you after five (5) months. PSA is subject to tax. Members currently on the Hospital Plan can continue to use their accumulated savings until they are depleted.

What if I have Unit Trusts and decide to change to the Hospital Plan?

Your Unit Trusts will be paid into your PSA and the full balance will be paid out to you via the same process as above.

What happens to the last benefit year's PSA balance that I haven't spent?

The balance of your PSA balance will automatically be carried over to be included with the following year's savings balance. If you choose to change to another Plan that does not have savings, then it will be paid out to you after five (5) months. PSA is subject to tax.

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

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

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

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

Five months after your membership has ended, the balance in your PSA and/or the balance of your Unit Trusts will be calculated and paid out into the banking account recorded by the Fund as follows:

- If you do not join another medical aid
- You join another medical aid on a Plan that does not have a savings account
- You join another medical aid as a dependant
- If you move to the Hospital Plan

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

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

Members and dependants

In this section:

- Who can be a member of the Fund?
- Who is regarded as a dependant of the member?
- The waiting periods that may apply
- What you need to do if your membership details change
- What will happen if you are no longer employed by Old Mutual?

It is a condition of employment that all employees must belong to the Fund, unless they wish to remain a dependant on their spouse's/partner's medical aid, only where it is a condition of employment for the spouse/partner to be a member of such a scheme. Old Mutual's contract of employment requires all permanent employees who were appointed from 1 July 2005, to belong to the Fund, unless they provide proof of their membership on their spouse's or partner's employer-sponsored medical scheme.

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

Who qualifies to be a member?

Employees

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

Retirees/pensioners

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

Widow/widower and dependants of a deceased member

If a member of the Fund dies, his/her dependants may choose to remain with the Fund as other continuation members.

Who qualifies to be a dependant?

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

Spouse

Your spouse to whom you are legally married and who is not a member of another medical scheme.

Spouse(s) in polygamous and traditional marriages

Your spouse(s) to whom you are married in terms of any law or custom and who is not a member of another medical scheme.

Ex-spouse

Your ex-spouse for whose medical expenses you are responsible in terms of a divorce settlement.

Partner

A person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

Children up to the age of 30

Your or your spouse's/partner's child who is dependent on you or your spouse/partner, including a step-child, legally adopted child of the member, or a child placed in the care and custody of a member/spouse/partner by virtue of a court order. Note that the contribution rate for adults will apply from age 21.

After the age of 30, you will need to provide proof of the child's financial dependence on you if he/she is not earning an income for whatever reason, e.g. full-time student or incapable of earning an income owing to mental or physical disabilities or any similar cause. You will be notified if they qualify for membership. If not, their membership will be terminated.

Grandchild(ren)

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

Dependent parent(s)/sibling(s) of member

A parent, brother or sister for whom you as the member are liable for family care and support.

NOTE: According to the Rules of the Fund, all adult dependants other than a spouse, partner or child under 30, should provide appropriate proof of financial dependency on the member every benefit year. If the Fund does not receive satisfactory proof, the dependant will be removed from the Fund. Rule 7.9.2 states that no person shall be a member or a dependant of more than one medical scheme.

Do waiting periods apply to new members?

Yes, waiting periods apply to new members and new dependants individually. Please see page 38 for a comprehensive explanation of waiting periods.

How do I add or remove a dependant?

You should apply to register a new dependant (e.g. spouse or adopted child) within 30 days after they become eligible to join the Fund as a dependant. If you do not notify the Fund within 30 days, waiting periods will apply during which no benefits will be paid for that dependant.

You will need to complete a Change of Membership Form which you can obtain on GroupNet and the OMSMAF Member Zone.

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

Marriage in terms of any law or custom

A copy of your marriage certificate or signed affidavit (available on GroupNet).

Birth/adoption of a child

A copy of the child's birth certificate and adoption papers in the case of an adopted child.

Child in your custody

Birth certificate and court order.

Grandchild(ren)

An affidavit and birth certificate. Member will need to apply annually.

Divorce

The date of divorce, as well as proof that you are legally responsible for your ex-spouse's medical expenses.

Partners

A signed affidavit (available on GroupNet).

Indigent parents/siblings

A signed affidavit (available on GroupNet). You will have to submit proof of your liability for support. You will also need to prove that the person is financially dependent on you.

Over-age dependent children (over age 30)

A signed affidavit must be provided annually and is available on GroupNet, as well as financial details and education registration documents (if applicable).

Although your number of dependants may change during the benefit year, you may not change Plans until the beginning of the next benefit year.

Please notify the Fund immediately in the case of death or as soon as a dependant must be removed. Should the Fund not receive notification immediately, the dependant will only be cancelled on the date of notification and no contributions will be refunded.

How will changes affect my contributions?

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

If you cancel the membership of a dependant on the 15th or later of a month, contribution for the full month will be due. In cases where a membership cancellation takes place up to and including the 14th of the month, no contribution is due for that month. Benefits will cease from the date that the dependant member has been removed.

What if my details change?

You must notify the Fund immediately of:

- A change in bank details
- A change in marital status
- The birth of an infant or adoption of a child
- Death
- Your child becoming independent/self-supporting
- A dependant becoming a member of another medical scheme
- Change of address, where applicable (please ask your line manager to update Oracle as soon as your location changes).

What happens if I terminate my membership?

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

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

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

Claiming made easy

In this section:

- How much time you have to submit a claim
- How to submit a claim
- Electronic submission of claims by service providers to the Administrator
- The payment of claims if you have a PSA
- The waiting periods that may apply
- How shortfalls are recovered

What must I do if I have a claim?

Simply sign all original accounts, invoices and prescriptions and submit them directly to the Old Mutual Staff Medical Aid Fund (Claims). Remember to keep a copy for your records. Please note that claims that are faxed or submitted as scanned documents will only be processed if legible and received within the four-month claiming period.

Members on the Network Plan do not need to submit accounts for any services received at a CareCross practice as the practice will submit its accounts directly to CareCross. Only claims for services received from a practice that is not part of the CareCross network must be submitted to the Fund for payment.

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

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

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

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

2. Check that the account details are correct and that you have been charged the correct amount.
3. If you have already paid the account, write "Account Paid" clearly on the account and attach the receipt.
4. Sign the original account and keep a copy for your records.
5. Submit your claim to OMSMAF via internal mail, post or e-mail (see below and page 46).
6. Old Mutual Staff Medical Aid Fund (Claims) undertakes to settle the account within 30 days of receipt, and any money owing to you will be paid directly into your bank account via Electronic Fund Transfer.

Where do I submit my claim?

Via internal mail:

Old Mutual Staff Medical Aid Fund (Claims)
Mutualpark

Via the post office:

Old Mutual Staff Medical Aid Fund (Claims)
PO Box 74
Vereeniging
1930

Via the claims boxes:

Situated at main reception, Help Desk at the Client Service Centre and Ground Floor L Block Mutualpark, Cape Town and at Grayston Drive mailroom on the ground floor of the Umnotho Building in Sandton.

How much time do I have to submit my claim?

You must submit your claim as soon as possible after receiving the service. If your claim is received later than four months after the date of service, your claim will be stale and your account will not be paid by the Fund. For example, if you visit the dentist on 20 April, you must submit your claim for that service before 20 August, not on or before the last day of the fourth month.

If the Fund changes any of the benefits offered, claims submitted after these changes will be paid according to the rules that existed at the date of the service and not the rules that exist at the date when the claims are submitted or received.

How do electronic claims work?

The majority of service providers submit claims electronically to the Old Mutual Staff Medical Aid Fund (Claims). They are then paid directly, which means that you do not have to submit the account.

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

How are claims paid?

- All claims will be paid directly to the service provider, up to the available benefit limit only. Once you have exceeded any limit (or sub-limit), any claims over that limit will not be paid unless you have sufficient funds available in your PSA at the time that the account is being processed or if that particular condition falls under the PMB. Once a claim has been processed, but not paid, it cannot be re-worked at a later date when you have funds available in your PSA.
- If your account has not been charged at tariff and your PSA has been exhausted, the Fund will pay the service provider directly, up to your available benefit limit. You will then be responsible for any difference and will have to settle the balance of the account directly with the service provider.
- If your account is not charged at tariff and you have sufficient funds in your PSA to cover any shortfalls, the Fund will pay the full account directly to the service provider. If there are not sufficient funds available in your PSA, you will be responsible for any difference and will have to settle the balance of the account directly with the service provider.

How soon after joining the Fund can I claim?

- No waiting period will apply for new employees who apply to join the Fund within 90 days of first becoming an employee of Old Mutual or within 30 days of their return to employment after a period of unpaid leave or secondment.
- No waiting period will apply if you change jobs and apply for membership of the Fund within three months of cancellation of membership of your previous medical scheme. Only the balance of a condition-specific waiting period will still apply.
- No waiting period will apply to a dependant whose application is submitted within 30 days after they became eligible to join the Fund as a dependant.

Waiting periods will apply as follows:

- If you have never belonged to a medical scheme and you do not apply for membership within 90 days of employment or were not covered for a period of more than 90 days before your application to the Fund, your benefits will be subject to a condition-specific and general waiting period (see page 45 for a definition).
- If you have been a member of a medical scheme for less than 24 months and apply for membership within three months of resigning from your previous medical scheme (not due to change of job), the condition-specific waiting period will apply.
- If you have been a member of a medical scheme for more than 24 months and apply for membership within three months of resigning from your previous medical scheme (not due to change of job), a general waiting period will apply.

The waiting periods apply to new members and new dependants individually.

What if I do not have enough benefits left to settle claims?

When you submit a claim, the Old Mutual Staff Medical Aid Fund (Claims) will automatically check to see whether you have reached your benefit limit or if there is enough money in your PSA to pay the amount you owe. If there is not enough money in your PSA, you will be responsible for payment of the difference directly to the service provider.

How are shortfalls created?

A shortfall may be created as a result of a penalty for failing to pre-authorise. Before you submit a claim, make sure that there is enough money in your PSA so that you do not have a shortfall. Once a claim has been processed and there is a shortfall, it will be deducted from your salary or commission – the claim and shortfall cannot be reversed.

Remember that service providers offer discounts if they are paid in cash.

How are shortfalls recovered?

If you have a shortfall, the outstanding amount will be deducted from your salary or commission. Pensioners must pay shortfalls directly to the Fund.

Pensioners

Your shortfalls will be reflected on your monthly statement. You can pay by cheque, debit order or direct payment (a set credit policy is in place).

Whom should I contact if I have any queries?

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

General

In this section:

- The medical scheme cover you will receive while outside South Africa on holiday or on business
- The rules that apply if you are involved in a motor vehicle accident
- Claims in terms of the Compensation for Occupational Injuries and Diseases Act
- The benefits that are not covered by the Fund
- The management structure of the Fund

Can I claim for medical expenses incurred outside South Africa?

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

Please note that if your account is in a foreign language, it must be fully translated and detailed.

The benefit will be paid according to the equivalent South African MSR and will be refunded in Rands. If you are intending to travel abroad, it is wise to take out additional medical cover. Your travel agent will be able to assist you with this.

Will I be covered for motor vehicle accidents?

Motor vehicle accident (MVA) claims have certain procedures, which must be strictly adhered to, although PMB claims that are related to an MVA are exempt from this procedure and subject to normal PMB protocols. When you are involved in a motor vehicle accident **where a third party is liable**, inform the Fund at 0860 100 076 as soon as possible. All accounts will be held until you have appointed an attorney to handle your claim from the Road Accident Fund.

The Fund will assist you, provided that a written undertaking is submitted, signed by both the member and his/her legal representative, confirming that the Fund will be refunded by the Road Accident Fund for all claims that are paid out by the Fund free of any legal fees. This will enable the Fund to process claims timeously. Claims will be paid to the service providers (such as the hospitals and doctors concerned) up to the individual member's limits. **Any delay in lodging a claim or in appointing an attorney will delay payment of claims.**

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

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

No, such claims are not covered by the Fund.

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

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

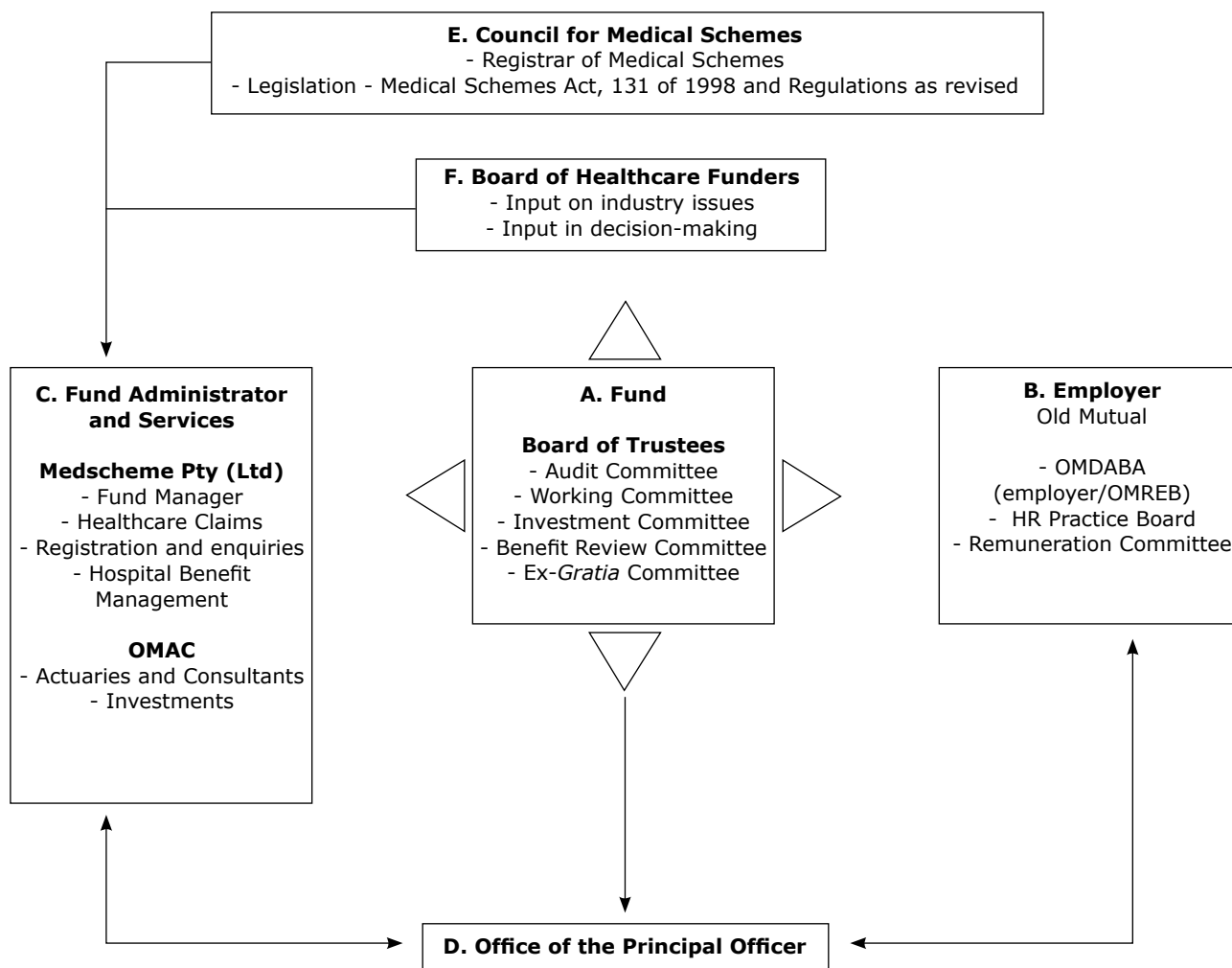
What benefits are excluded by the Fund?

The following services are NOT covered in terms of the Rules of the Fund:

- All costs incurred for treatment of conditions or injuries for which any other party may be liable (such as a personal accident policy, the Road Accident Fund, Compensation for Occupational Injuries and Diseases Act, etc.)
- Any willful or self-inflicted injury.
- Injuries resulting from professional sport, speed contests or speed trials.

- Investigations, operations or treatments for cosmetic purposes, obesity, artificial insemination, impotence and erectile dysfunction.
- Examinations for insurance, employment, visas, pilot and driver's licences.
- Holidays for recuperative purposes.
- Treatments of an experimental nature.
- Sleep therapy.
- The purchase of:
 - patent medicines, vitamins and proprietary preparations
 - applicators, toiletries and beauty preparations
 - bandages, cotton wool and similar aids
 - contraceptives
 - patented foods, including baby foods
 - tonics, slimming preparations and drugs as advertised to the public
 - household and biochemical remedies
 - sunglasses and domestic remedies
 - exercise equipment.
- Unregistered medicines (i.e. those not approved by the Medicines Control Council), including chemotherapy or medicines not registered for that specific condition.
- Laparoscopic surgery (the Fund will not pay for laparoscopic surgery to remove an appendix, owing to the high cost implication compared to conventional surgery).
- Fertility treatment (those procedures and interventions not covered under PMB legislation) including medical and/or surgical procedures related to gamete intrafallopian transfer, in vitro fertilisation, zygote intrafallopian transfer, pronuclear stage tubal transfer or any other transfer or egg or sperm collection.
- Breast reductions, except where associated with breast reconstruction following a diagnosis of cancer or the beneficiary is diagnosed with gigantomastia of pregnancy accompanied by complications such as ulceration of breast tissue, massive infection, tissue necrosis with slough, significant haemorrhage or gynaecomastia and delivery is not imminent.
- Treatment or surgery for scars, keloids and excision of a tattoo for cosmetic purposes, except in the case of severe burn scars on the face and neck and functional impairment such as contractures.
- Diagnostic tests or examinations performed, but not resulting in confirmation of a PMB diagnosis, except for an emergency medical condition or a test requested by the Fund's DSP for day-to-day services.
- Services that are not regarded as medically necessary, i.e. treatment, procedure, supply, medicine, hospital or specialised centre stay unless:
 - appropriate and essential to the diagnosis and treatment of illness or injury of the member
 - it does not exceed in scope, duration or intensity of the level of care which is needed to provide a safe, adequate and appropriate diagnosis or treatment
 - it has been prescribed by a doctor
 - it is consistent with the widely accepted professional standards of medical practice in South Africa and, for overseas cover, the United States of America
 - in the case of in-patient care, it cannot be provided safely on an out-patient basis
- An otoplasty (repair of bat ears) will only be approved on children under 12 years of age.

Who manages the Fund?



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

The Board of Trustees has the following five sub-Committees:

- The Audit Committee consists of representatives from the Board of Trustees and independent members. The primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Fund's accounting policies, internal control systems and financial reporting practices. The external auditors formally report to the Committee on critical findings arising from audit activities.
- The Working Committee consists of the Principal Officer of the Fund, member-elected trustees, representatives from various business units, OMREB, the Old Mutual Pensioners Association, and actuaries and consultants from OMAC and the Administrator. This Committee makes recommendations and provides guidance to the Board of Trustees on operational and industry-related issues and assumes the functions of a Risk Committee.
- The Benefit Review Committee consists of 10 members of which four are members of the Board of Trustees. The primary responsibility of the Committee is to act in an advisory capacity for the benefit and contributions reviews, make recommendations to the Board regarding the choice and appointment of new and existing third party agreements, and approve provider tariffs on behalf of the Board within the guidelines set by the Board.

- The Investment Committee consists of five members, two of whom are Trustees of the Fund. The primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the investment policy of the Fund. These include meeting benefit and operating expense commitments; managing financial risk; satisfying regulatory requirements that apply to medical scheme investments; and maximising investment returns.
- The *Ex-Gratia* Committee has the responsibility of assisting the Board of Trustees in the receiving of all *Ex-gratia* applications from the members and making decisions on them for the Fund.

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

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

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

OMAC also manages the Fund's investments.

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

Explanation of Terms

Auxiliary services	Acupuncture, anthroposophical treatment, applied kinesiology, audiometry/audiology, autologous donation of blood, ayurvedic treatment, biokinetics, chiropody, chiropractic services, clinical technology, dieticians, herbalists, homeopathy, naturopathy, occupational therapy, orthoptic treatment, osteopathy, phytotherapy, podiatry, reflexology, remedial therapy, speech therapy, social work.
Beneficiary	A member and/or dependant registered with the Fund.
Benefit year	The period for which benefits and contributions apply, in this case 1 July to 30 June. If you join the Fund during a benefit year, you are only entitled to a pro rata portion of the benefits and limits for that year.
Child dependant	A member's natural child, stepchild or legally adopted child or a child in the process of being legally adopted or a child in the process of being placed in foster care, or a child for whom the member has a duty to support or a child who has been placed in the custody of the member or his/her spouse or partner and who is not a beneficiary of any other medical scheme.
Clock up	Where there is a sub-limit available and a service has been used by a member who has received treatment for a PMB condition from any supplier, including the State, treatment will first be paid until the sub-limit is exhausted. Further treatment will be paid from the general risk pool, provided it is received from a State facility (DSP).
Comprehensive primary care	Day-to-Day Benefits that could include access to basic dentistry, essential radiology and pathology as well as specified procedures performed in doctors' rooms; access to GP and specialist consultations, advanced dentistry, supplementary radiology and pathology, optometry, physiotherapy and psychology benefits, subject to specified sub-limits.
Day-to-Day Benefits	These cover smaller medical expenses that occur more frequently, e.g. GP or dentist consultations and prescribed medicines. Treatment is usually received out of hospital or at the outpatient facility of a hospital.
Designated service provider (DSP)	Appointed by the Fund to provide certain specified medical services under PMB to members. The Fund's current DSP include the State and all pharmacies.
Essential primary care	Day-to-Day Benefits that could include access to basic dentistry, essential radiology and pathology as well as specified procedures performed in doctors' rooms, subject to specified sub-limits.
Exclusions	Services that are not covered in terms of the Rules of the Fund.
ICD-10 code	International Classification of Diseases (ICD)-10 coding is a system that classifies diseases and the complications connected to these diseases according to a specific category.

Income	<ul style="list-style-type: none"> ■ Employees whose remuneration is structured as a total guaranteed package received from the employer: Income = total guaranteed package (TGP) received from the employer ■ Employees whose remuneration is pensionable remuneration or deemed commission received from the employer: Income = pensionable remuneration received from the employer divided by 90% or the deemed commission from the employer, whichever is applicable.
Major Medical Benefits (MMB)	These generally cover the major medical expenses that you would incur when undergoing surgery or while in hospital.
Medical scheme rates (MSR)	The rate as determined by the Board of Trustees from time to time.
Personal Savings (PSA) Account	A medical savings account to create additional benefits.
Pre-authorisation	The process whereby a member applies for approval for a procedure or treatment from the Fund. This may include the submission of quotations. Penalties are payable if you do not pre-authorise.
Prescribed Minimum Benefits (PMB)	The unlimited benefit to which all members are entitled, for treatment related to the conditions specified in the Medical Schemes Act, provided that this treatment is obtained at a DSP.
Shortfall	Any amount paid by the Fund on your behalf that exceeds the amount to which you are entitled.
Single Exit Price (SEP)	Price of medication as determined by the State, and the manufacturer, at which it is marketed and purchased by the pharmacist.
SPNP	Society of Private Nursing Practitioners of South Africa.
Sub-limit	The maximum amount of cover you have for specified medical expenses during the year.
Tariff	MSR on all Plans except for Day-to-Day services on Traditional Plus Plan.
Waiting period	<p>The period during which you will not be covered for any medical expenses incurred, even though you may be making contributions to the Fund:</p> <ul style="list-style-type: none"> ■ Condition-specific waiting period: A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. This will also apply to PMB. ■ General waiting period: A period during which a beneficiary is not entitled to claim any benefits. This will also apply to PMB.

Contact details

Claims and Benefits

Claims Enquiries

Telephone 0860 100 076, +27 11 671 6834
Fax 0860 111 783, +27 11 758 7087
Internal mail Old Mutual Staff Medical Aid Fund
E-mail healthcaremain@medscheme.co.za

OMSMAF Member Zone

Website www.medscheme.co.za

CareCross Call Centre (for Network Plan members only)

Telephone 0860 103 491
E-mail omstaff@carecross.co.za
Website www.carecross.co.za

Your choice of Plan, membership and PSA contributions

Administration (Member Registrations)

Telephone 0860 100 076, +27 11 671 6834
Fax 0860 111 783, +27 11 758 7087
E-mail register@medscheme.co.za

Old Mutual Unit Trusts for Balance Enquiries on PSA (unit trust portion)

Old Mutual Unit Trusts Client Support 021 503 1770

Hospital Benefit Management (pre-authorisation/mother & baby care programme)

Telephone 0860 100 081
Fax 0860 212 223, +27 21 466 1913
E-mail authorisations.cpt@medscheme.co.za

Chronic Medicine Management (CMM) (chronic medication/medical management)

Telephone 0860 100 081, 0860 100 608
Fax 0800 223 670/680
E-mail cmm@medscheme.co.za

Oncology Case Manager (patients diagnosed with cancer)

Telephone 0860 100 572
Fax 021 466 2303
E-mail cancerinfo@medscheme.co.za

HIV and AIDS Management Programme with Aid for AIDS

Telephone 0860 100 646
Fax 0800 600 773
E-mail afa@afadm.co.za

Disease Management

(for diabetes, asthma, congestive cardiac failure and chronic obstructive pulmonary disease)

Telephone 0860 101 306
Fax 021 466 2302
E-mail diseasemanagement@medscheme.co.za

Service Provider/Healthcare Professional Call Centre

Telephone 0860 100 456

ER24 (24 hour evacuation & emergency transport)

Telephone 084 124

Metropolis Pathologists

Telephone 021 551 6372
E-mail results@metpath.co.za

Whistle Blowers – Fraud Hotline

Telephone 0800 112 811
E-mail fraud@medscheme.co.za

Walk-in centres

Bloemfontein Suite 13, Westdene Office Park
Pres. Reitz Avenue
Westdene
Bloemfontein

Ellisras Onverwacht Business
Mienie Building, Block C
Walter Sisulu Avenue
Ellisras

Johannesburg Office No. 1
Vusa House
Mezzanine Floor
Gandhi Square
Johannesburg

Kimberley Ground Floor
Trust Centre
George Street
Kimberley

**Mmabatho
(Mafikeng)** Shop No 5
Capital Place
Victoria Street
Mafikeng

Nelspruit The Upper Ground Floor
11 Ferreira Street
Colfin House
Nelspruit

Polokwane Ground Floor
Bonitas House
22 Hans van Rensburg Street
Polokwane

Pretoria Benstra Building
Ground Floor
473B Church Street
Arcadia

Kathu 6 Rietbok Street
Kathu
Northern Cape

Roodepoort 37 Conrad Road
Florida North
Roodepoort

Durban 67 Old Fort Road
Durban
4000

Cape Town Medscheme 15th Floor
Atterbury House
No 9 Riebeek Street
Cape Town

Pinelands Ground Floor
Mutualpark
Jan Smuts Drive
Pinelands

East London Medscheme House
39 Balfour Road
Vincent
5247

Port Elizabeth Block 6, Greenacres
Office Park
2nd Avenue
Newton Park
Port Elizabeth

Vereeniging 36 Merriman Avenue
2nd Floor
Vereeniging

Secunda Shop 1
Sanlam Plaza
Horwood Street
Secunda

**Exxaro
(Pretoria)** Exxaro Corporate Centre
c/o Roger Dayson &
Voortrekker Road
Pretoria West



Licensed Financial Services Provider