OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND
Healthcare with heart

MEMBER GUIDE

EFFECTIVE 01 APRIL 2026

2026/27

OLDMUTUAL

CONTACT DETAILS

CLAIMS AND BENEFITS ENQUIRIES

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 7:00 to 19:00 Monday – Friday and 8:00 to 13:00 on Saturdays, excluding Public Holidays
EMAIL: enquiries@omsmaf.co.za
WEBSITE: www.omsmaf.co.za

CLAIMS SUBMISSIONS

FOR CURRENT FIRST-TIME CLAIMS:
EMAIL: Claims@omsmaf.co.za
FOR CLAIMS REFUNDS:
EMAIL: Refundme@omsmaf.co.za
FOR CLAIMS FOR SERVICES RENDERED OUTSIDE RSA
EMAIL: foreignclaims@omsmaf.co.za

MEMBERSHIP AND ENQUIRIES PERTAINING TO PLAN SELECTIONS

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 08:00 to 17:00 Monday - Friday
EMAIL: Membership@omsmaf.co.za
WEBSITE: www.omsmaf.co.za

ER24
MEDICAL EMERGENCIES
084 124

PRE-AUTHORISATION: HOSPITAL BENEFIT MANAGEMENT

TEL: 0860 100 076 or +27 11 208 1021 and follow the voice prompts for hospital pre-authorisations
HOURS: **24-hour service (Call Centre)**
EMAIL: authorisations@omsmaf.co.za
Emails will be responded to during office hours

PRE-AUTHORISATION: CHRONIC MEDICINE MANAGEMENT

TEL: 0860 100 076 or +27 11 208 1021 and follow the voice prompts for chronic medicine
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: chronic@omsmaf.co.za

PRE-AUTHORISATION: ONCOLOGY CASE MANAGER (PATIENTS DIAGNOSED WITH CANCER)

TEL: 0860 100 076 or +27 11 208 1021 and follow the voice prompts for oncology
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: oncology@omsmaf.co.za

INDEPENDENT CLINICAL ONCOLOGY NETWORK (ICON)

TEL: 021 944 3600
WEBSITE: www.cancernet.co.za
EMAIL: oncology@omsmaf.co.za

CHRONIC PMB TREATMENT PLAN

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: pmb@omsmaf.co.za

DENTAL AUTHORISATION

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: dental@omsmaf.co.za

SPECIALIST AUTHORISATION

Network and Network *SELECT* Plans
EMAIL: authorisations@omsmaf.co.za

CONTRIBUTIONS

TEL: 0860 100 076
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: contributions@omsmaf.co.za

HIV AND AIDS MANAGEMENT PROGRAMME

TEL: 0860 378 800
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: hivprogramme@omsmaf.co.za

MENTAL HEALTH PROGRAMME

TEL: 0860 100 076
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: mentalhealth@omsmaf.co.za

BACK AND NECK PROGRAMME

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: backandneck@omsmaf.co.za

ACTIVE DISEASE RISK MANAGEMENT PROGRAMME

TEL: 0860 100 076
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: diseasemanagement@omsmaf.co.za

MOTHER AND BABY CARE PROGRAMME

TEL: 0860 100 076 or +27 11 208 1021
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: maternity@omsmaf.co.za

OMSMAF NURTURE, POWERED BY BABY YUM YUM

TEL: 011 039 8950
HOURS: 8:00 to 17:00 Monday – Friday only
EMAIL: info@babyyumyum.co.za

UNIVERSAL HEALTHCARE NETWORK PROVIDERS

EMAIL: network.accounts@omsmaf.co.za

ESCALATIONS (FOR MEMBERS)

Refer to the OMSMAF website for the Escalations process: www.omsmaf.co.za

WHISTLE BLOWERS – FRAUD HOTLINE

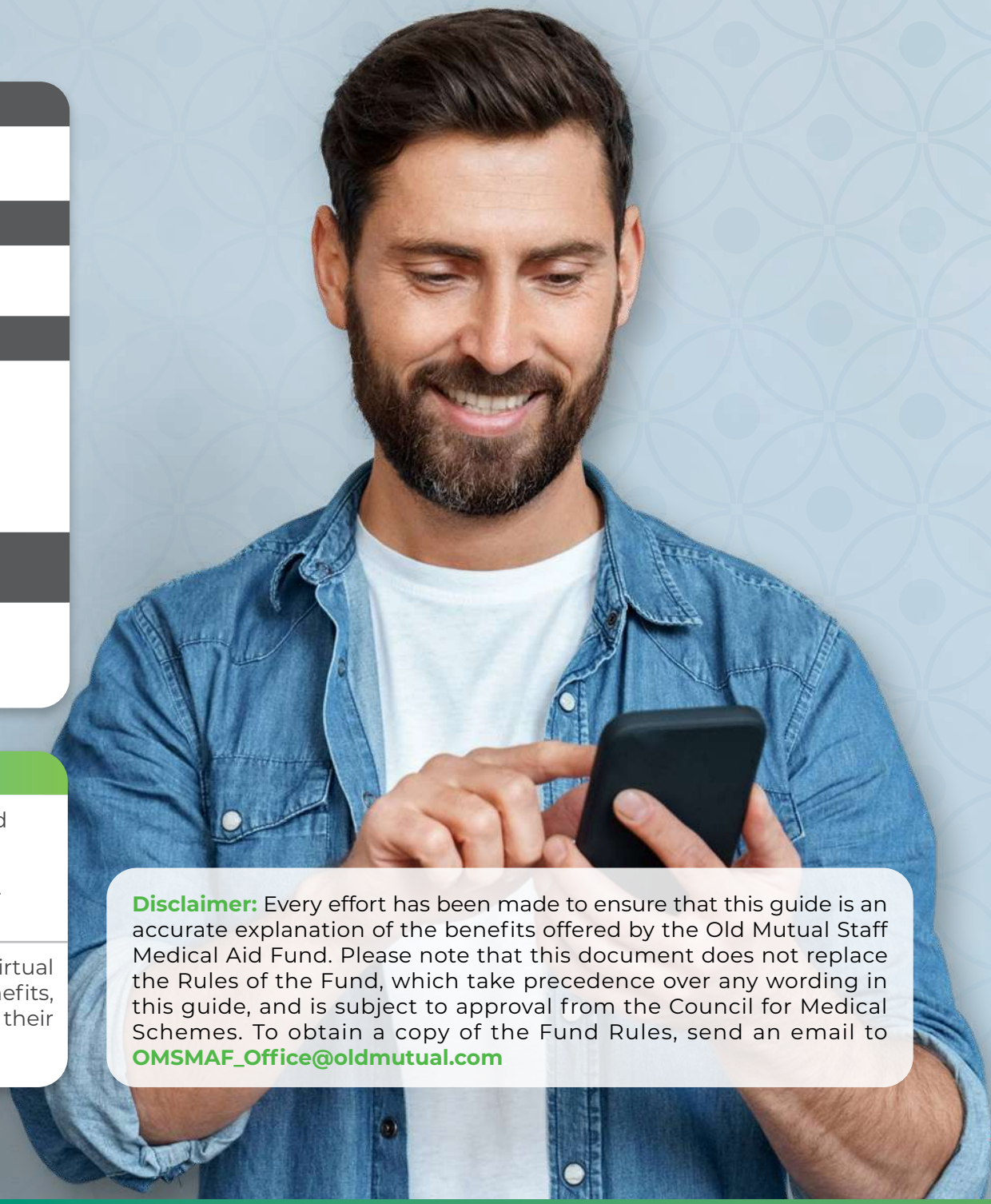
TEL: 080 111 4447 (Toll free number)
EMAIL: fraud@omsmaf.co.za
WEBSITE: www.thehotline.co.za
WEBAPP: www.thehotlineapp.co.za
CALLBACK: (Please call me) 072 595 9139

COUNCIL FOR MEDICAL SCHEMES (IF YOU CANNOT RESOLVE A QUERY WITH THE FUND)

TEL: 0861 123 267 or +27 12 431 0500
EMAIL: complaints@medicalschemes.co.za

DIGITAL TOOLS

www.omsmaf.co.za	OMSMAF Website, for all your latest Fund information, Forms and News Member Portal, where you can view your claims, statements, and personal details.
Universal.one Mobile App	OMSMAF Members can access their virtual Membership card, view available benefits, find a Provider, submit claims, view their statements and chat to a consultant.



Disclaimer: Every effort has been made to ensure that this guide is an accurate explanation of the benefits offered by the Old Mutual Staff Medical Aid Fund. Please note that this document does not replace the Rules of the Fund, which take precedence over any wording in this guide, and is subject to approval from the Council for Medical Schemes. To obtain a copy of the Fund Rules, send an email to **OMSMAF_Office@oldmutual.com**

TABLE OF CONTENTS

WELCOME TO YOUR MEMBER GUIDE

Why have a medical scheme?

You never know when you or one of your family Members may need medical care, which could cost a substantial amount. The Fund provides medical cover to you and your Dependants for a wide range of medical services, prescribed medicine and medical events, such as hospitalisation and surgery.

How can this Member Guide help me?

All your benefits and related conditions and limits are explained in a 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. You are also encouraged to visit the OMSMAF website for additional information **www.omsmaf.co.za**.

What are my responsibilities as a Member?

- Understand how the Fund and your specific Plan works.
- Keep the Fund up to date on any changes to your Membership details including your banking details.
- In order to assist the Fund in combatting the impact of fraudulent claims, please:
  - check the accounts you receive from medical service providers for errors or inconsistencies,
  - check your Member statement, SMS notifications and emails from the Fund to make sure that any claims that have been processed are correct and that there are no claims for services not provided,
  - report any suspicions of fraud by calling the Fraud Hotline on **080 111 4447**, or emailing **fraud@omsmaf.co.za**.

- Before having any medical procedures, please request quotes from Providers and submit to Universal Healthcare, so that you can find out the difference between what the Fund will pay and what you will have to pay directly to the service providers.
- Contact the Fund before you are admitted to hospital to pre-authorise your admission.
- File all your documentation regarding the Fund so that you can refer to it if necessary.
- Keep your Membership card in a safe place so that no one else can use it fraudulently.
- An electronic Membership card can be downloaded via the **Universal.one App**.
- If you are an Employee, ensure that your home address, email address, and any relevant changes, are captured on the Human Capital management system, and if you are on disability or a Pensioner, inform the Fund of any changes, in order to receive all communication.
- If you retire and continue to belong to the Fund, you must ensure that you notify the Fund of your updated postal address, email address and banking details, if applicable.
- If you are a Pensioner, ensure that you notify the Fund of your valid postal address and current email address in order to ensure that you receive your communication.

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

Abbreviations

The following abbreviations appear in this guide.

AFB	Annual Flexi Benefit
CDL	Chronic Disease List
DSP	Designated Service Provider
GP	General Practitioner
HB	Hospital Benefits
ICON	Independent Clinical Oncology Network
LJP	Late Joiner Penalty
MEL	Medicine Exclusion List
MMAP	Maximum Medical Aid Price
MRI	Magnetic Resonance Imaging
MSR	Medical Scheme Rates - the rate at which the Fund will pay for relevant health services. This is adjusted from time to time, by the Board of Trustees.
PCB	Primary Care Benefit
PET	Positron Emission Tomography
PMB	Prescribed Minimum Benefits
PMSA	Personal Medical Savings Account
SEP	Single Exit Price (for medicines)
TTO	To-take-out (medicine to take home from hospital event)

CONTRIBUTIONS, PMSA AND PCB

What are my monthly contributions?

Hospital Plan

An entry-level Plan that offers Hospital Benefits, Basic Chronic Benefits and Wellness Screenings. Does not provide any Primary Care Benefits other than PMBs and Wellness Screenings.

Hospital Plan	Income band	Member	Adult	Child (max 3)
	R0 - R12 700	R1 707	R1 399	R374
	R12 701 - R25 140	R2 323	R1 975	R581
	R25 141 +	R2 722	R2 314	R681

Network and Network SELECT Plans

A value-for-money Plan that offers Hospital Benefits, Primary Care Benefits at a Network Provider, Wellness Screenings, and an enhanced benefit to manage Chronic Conditions, among others, all at an affordable rate for those in lower income groups.

Network Plan	Income band	Member	Adult	Child (max 3)
	R0 - R6 350	R2 095	R1 781	R524
	R6 351 - R9 520	R2 555	R2 172	R639
	R9 521 - R12 700	R2 740	R2 328	R685
	R12 701 - R16 960	R3 213	R2 731	R804
	R16 961 - R25 140	R3 485	R2 963	R872
	R25 141 - R50 000	R3 740	R3 179	R935
	R50 001 +	R3 844	R3 267	R962

Network *SELECT* Plan	Income band	Member	Adult	Child (max 3)
	R0 - R6 350	R1 484	R1 261	R371
	R6 351 - R9 520	R1 809	R1 537	R452
	R9 521 - R12 700	R2 263	R1 923	R565
	R12 701 - R16 960	R2 898	R2 463	R725
	R16 961 - R25 140	R3 143	R2 672	R786
	R25 141 - R50 000	R3 374	R2 868	R844
	R50 001 +	R3 468	R2 948	R867

Savings Plan

A Plan that offers a flexible Day-to-day Benefits, Hospital Benefits, Basic Chronic Benefits, Wellness Screenings and an enhanced Supplementary Benefit that includes maternity.

Savings Plan	Income band	Contribution	Member	Adult	Child (max 3)
	R0 - R12 700	RISK	R2 660	R1 996	R532
		PMSA	R470	R352	R94
		TOTAL	R3 130	R2 348	R626
	R12 701 +	RISK	R3 258	R2 769	R814
		PMSA	R575	R489	R144
		TOTAL	R3 833	R3 258	R958

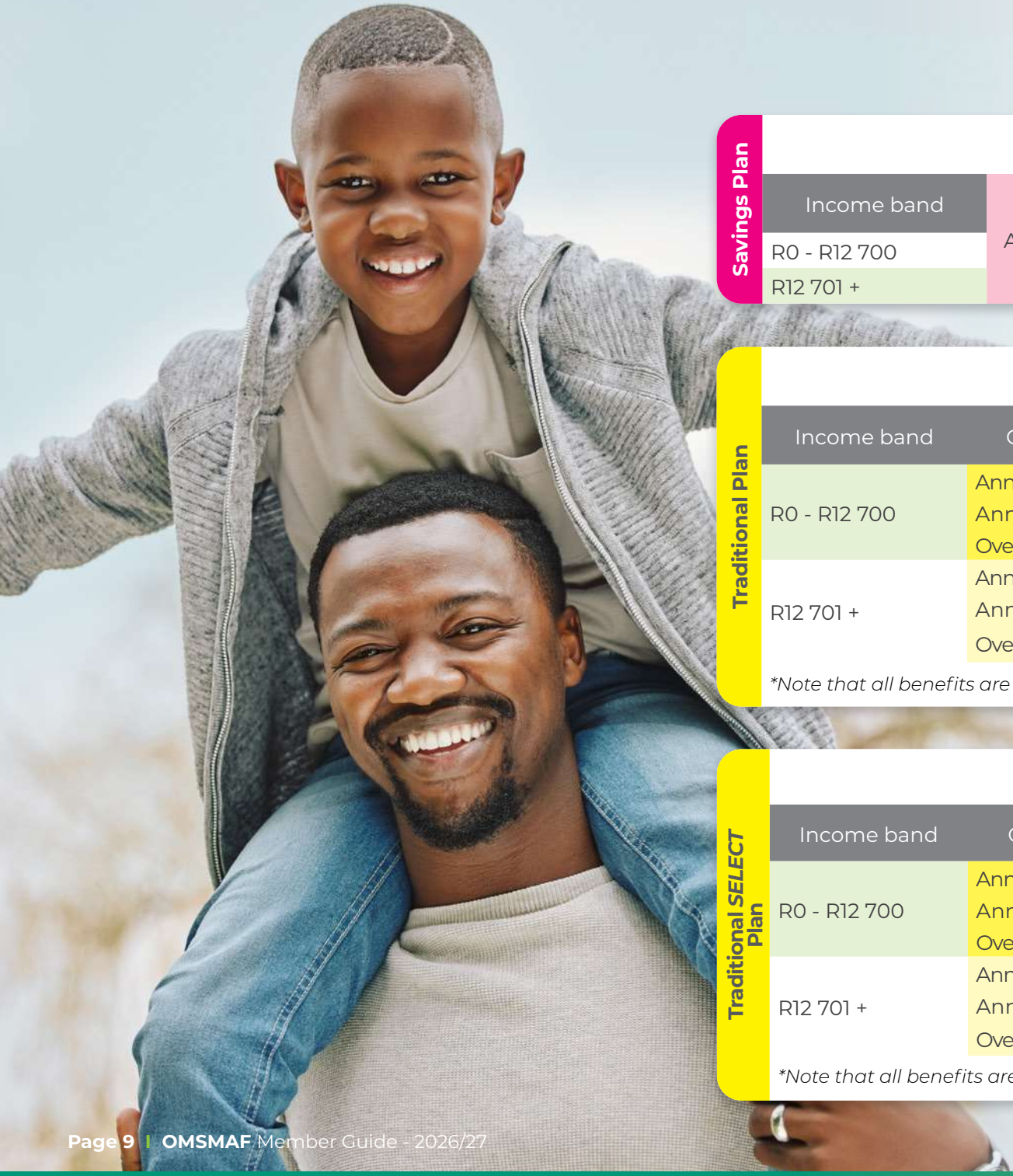
Traditional and Traditional SELECT Plans

Offers Comprehensive Benefits for a variety of Healthcare Services including Hospital Benefits, Day-to-day, a wide-range of Chronic Conditions, an extensive Supplementary Benefit and Wellness Screenings.

Traditional Plan	Income band	Contribution	Member	Adult	Child (max 3)
	R0 - R12 700	RISK	R5 277	R4 116	R1 319
		PMSA	R585	R457	R146
		TOTAL	R5 862	R4 573	R1 465
	R12 701 +	RISK	R6 146	R5 067	R1 708
		PMSA	R682	R562	R190
		TOTAL	R6 828	R5 629	R1 898

Traditional *SELECT* Plan	Income band	Contribution	Member	Adult	Child (max 3)
	R0 - R12 700	RISK	R4 760	R3 713	R1 190
		PMSA	R528	R412	R132
		TOTAL	R5 288	R4 125	R1 322
	R12 701 +	RISK	R5 543	R4 569	R1 540
		PMSA	R615	R507	R171
		TOTAL	R6 158	R5 076	R1 711

The SELECT Plans offer the same benefits as their main Plans with the added restriction of a hospital network, for a lower contribution.



PMSA and PCB

Savings Plan

PMSA Only

Income band	Annual PMSA	Member	Adult	Child (max 3)
R0 - R12 700		R5 640	R4 224	R1 128
R12 701 +		R6 900	R5 868	R1 728

Traditional Plan

PMSA and PCB

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R12 700	Annual PMSA	R7 020	R5 484	R1 752
	Annual PCB	R5 630	R4 770	R1 690
	Overall Day to Day	R12 650	R10 254	R3 442
R12 701 +	Annual PMSA	R8 184	R6 744	R2 280
	Annual PCB	R5 630	R4 770	R1 690
	Overall Day to Day	R13 814	R11 514	R3 970

**Note that all benefits are first subject to PMSA at 100% of Cost and then PCB at 100% of MSR*

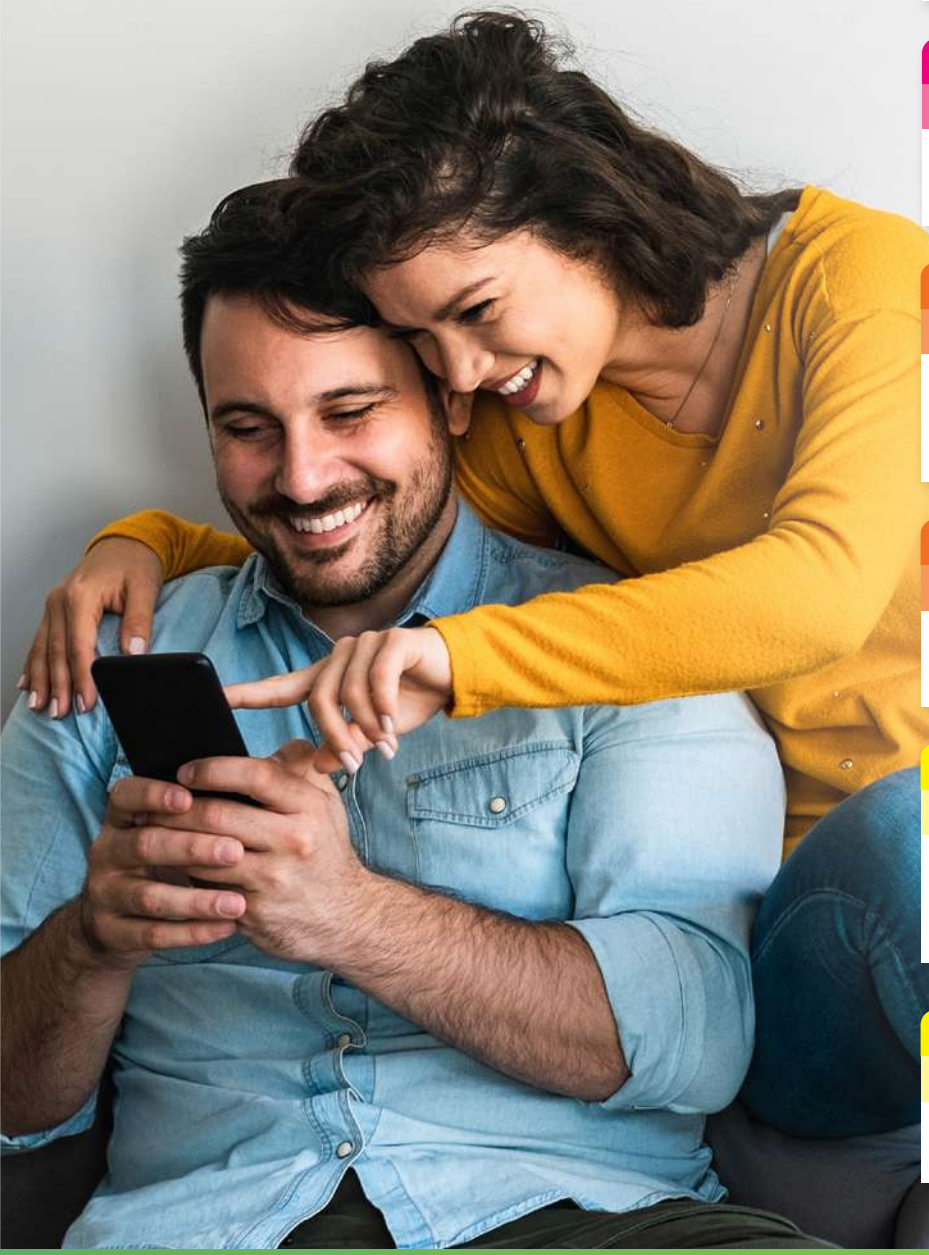
Traditional *SELECT* Plan

PMSA and PCB

Income band	Contribution	Member	Adult	Child (max 3)
R0 - R12 700	Annual PMSA	R6 336	R4 944	R1 584
	Annual PCB	R5 630	R4 770	R1 690
	Overall Day to Day	R11 966	R9 714	R3 274
R12 701 +	Annual PMSA	R7 380	R6 084	R2 052
	Annual PCB	R5 630	R4 770	R1 690
	Overall Day to Day	R13 010	R10 854	R3 742

**Note that all benefits are first subject to PMSA at 100% of Cost and then PCB at 100% of MSR*

OVERVIEW OF BENEFITS



Hospital Plan

Simple, cost-effective cover

An entry-level Plan that offers Hospital Benefits, Basic Chronic Benefits and Wellness Screenings. Does not provide any Primary Care benefits other than PMBs and Wellness Screenings.

Savings Plan

Simple cover with savings

A Plan that offers a flexible Day-to-day Benefits, Hospital Benefits, Basic Chronic Benefits, Wellness Screenings and an enhanced Supplementary Benefit that includes maternity.

Network Plan

Simple cover with benefits

A value-for-money Plan that offers Hospital Benefits, Primary Care Benefits at a Network Provider, Wellness Screenings, Basic Chronic Benefits, among others, all at an affordable rate for those in lower income groups.

Network *SELECT* Plan

Simple cover with benefits at a lower cost

Get all the cover of the Network Plan for a more cost-effective monthly contribution, based on a restriction to select hospital Providers.

Traditional Plan

Complete cover

Offers Comprehensive Benefits for a variety of Healthcare Services including Hospital Benefits, Day-to-day, a wide-range of Chronic Conditions, an extensive Supplementary Benefit and Wellness Screenings.

Traditional *SELECT* Plan

Complete cover at a lower cost

Get all the cover of the Traditional Plan for a more cost-effective monthly contribution based on a restriction to select hospital Providers.

How do these benefits compare across Plans?

	Hospital Plan	Network Plan Network *SELECT* Plan	Savings Plan	Traditional Plan Traditional *SELECT* Plan*
DAY-TO-DAY BENEFITS	✓ No Personal Medical Savings Account.	✓ Primary healthcare benefits via Universal Healthcare Network GP. ✓ No Personal Medical Savings Account. ✓ Annual Flexi Benefit (AFB) for Pathology, Radiology, psychology, Physiotherapy, optometry and auxiliary services. ✓ Limited Specialist consultations. ✓ 2 Out of network visits, event limit is **R1 510**	✓ Limited to Personal Medical Savings Account only; no PCB limits.	✓ Comprehensive; from Personal Medical Savings Account at cost; then from PCB at MSR*.
SUPPLEMENTARY BENEFITS	✓ Limited, paid at MSR.	✓ Limited, paid at MSR.	✓ Limited, paid at MSR.	✓ Comprehensive, paid at MSR.
SCREENING BENEFITS	✓ Standard	✓ Standard	✓ Standard	✓ Standard

Refer to page 6 for all definitions regarding the Fund Acronyms

How do these benefits compare across Plans?

	Hospital Plan	Network Plan Network *SELECT* Plan*	Savings Plan	Traditional Plan Traditional *SELECT* Plan
CHRONIC BENEFITS	✓ Limited	✓ Via Universal Healthcare Network GPs.	✓ Limited	✓ Comprehensive
HOSPITAL BENEFITS	✓ Unlimited Overall Annual Limit (OAL): (subject to certain sub-limits). Certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. Refer to detailed table under Hospital Benefits.	✓ Unlimited Overall Annual Limit (OAL): (subject to certain sub-limits). Certain elective procedures, including hip, knee, shoulder and elbow replacements, are not covered, other than in accordance with Prescribed Minimum Benefits. Refer to detailed table under Hospital Benefits.	✓ Unlimited Overall Annual Limit (OAL): (subject to certain sub-limits).	✓ Comprehensive, with unlimited Overall Annual Limit (subject to certain sub-limits).
	A Doula (birthing coach) on all the plans as part of the In-Hospital Maternity Benefits, subject to a limit of **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.			
	✓ - Subject to the Overall Annual Limit and Managed Care Protocols. - Physiotherapy: **R7 260** per family per benefit year.			✓ Subject to the Overall Annual Limit and Managed Care Protocols.
	✓ Oncology covered within ICON Essential Protocols. PMB only.	✓ Oncology covered within ICON Essential Protocols. PMB only *Please note that under the ***SELECT*** Plan, Members' choice of hospitals is restricted, and your Doctor needs to work at the network hospital - refer to the OMSMAF website at www.omsmaf.co.za for a list of SELECT facilities.	✓ Oncology covered within ICON Core Protocols.	✓ Oncology covered within ICON Enhanced Protocols (higher benefit sub-limit). *Please note that under the SELECT Plan, Members' choice of hospitals is restricted, and your Doctor needs to work at the network hospital - refer to the OMSMAF website at www.omsmaf.co.za for a list of SELECT facilities.

OUT-OF-HOSPITAL
DAY-TO-DAY BENEFITS

The level of Day-to-Day Benefits you receive will depend on the Plan you select. The tables below provide you with an overview of your Day-to-Day Benefits.

	Hospital Plan	Network Plan Network *SELECT* Plan	Savings Plan	Traditional Plan Traditional *SELECT* Plan*
Rate payable	Paid at Medical Schemes Rates (MSR) unless stated otherwise.			
Personal Medical Savings Account (PMSA)	No	No	Yes, depends on your income band and family size - see page 9.	Yes, depends on your income band and family size - see page 9.
Annual Flexi Benefit (AFB)	No	Annual Flexi Benefit (AFB), subject to **R8 370** per beneficiary per benefit year and **R14 000** per family per benefit year.	No	No
Primary Care Benefit (PCB) Limit	No	At Universal Healthcare Network Provider.	No PCB benefit; benefits are payable from available PMSA or, thereafter, from available accumulated savings.	Depends on your family size – see page 9.

uConsult™ Virtual Consultation

Paying the Doctor a visit is being revolutionised with the introduction of **uConsult™**, a virtual consultation platform making home-based care far more accessible in South Africa. Patients are able to use this simple, streamlined platform to search for General Practitioners by name or geolocation, and will soon be able to connect with Providers from other medical disciplines. Best of all, virtual consultations can take place from anywhere and any smart device like laptops, tablets, mobile phones and desktops.

uConsult™ securely connects patients with Providers using safe, scalable technology that enables video chat, screen sharing, electronic prescriptions, Specialist referral letters, lab test forms and Radiology request forms, all on one platform that works on any device. Just another innovative solution from Universal to bring you closer to world-class healthcare experiences.

	Hospital Plan	Network Plan	Savings Plan	Traditional Plan
		Network *SELECT* Plan*		Traditional *SELECT* Plan*
GPs and Specialists	No benefit.	Medically necessary visits to Universal Healthcare Network GPs, subject to Universal Healthcare Network benefits. Specialist consultations subject to referral from a Universal Healthcare Network GP and authorisation. Limited to two consultations per beneficiary per benefit year; four consultations per family per benefit year. *(Please note that no authorisation is required for consultations pertaining to the Wellness Benefits or where the consultation forms part of the chronic PMB treatment plan or registration on the Mother and Baby Care Programme - please refer to page 22 for details on these benefits)*	At cost from PMSA, thereafter from available accumulated savings.	At cost from PMSA, thereafter at MSR from PCB up to overall Day-to-Day limit. Thereafter, available accumulated savings can be used.
Specified procedures in Doctors' rooms	No benefit.	Covers minor trauma treatment and small procedures in Universal Healthcare Network GPs' rooms.		

	Hospital Plan	Network Plan Network *SELECT* Plan*	Savings Plan	Traditional Plan Traditional *SELECT* Plan*
Dentistry	No benefit.	Covers fillings, primary extractions, scaling, polishing and one pair of plastic dentures per beneficiary per three-year period at a Universal Healthcare Network Provider (Dentists only).	At cost from PMSA and then from available accumulated savings, subject to available funds.	At cost from PMSA, then at MSR from PCB, up to overall Day-to-Day limit. Thereafter, available accumulated savings can be used.
Radiology		Specified black and white X-rays as requested by Universal Healthcare Network GP and subject to Universal Healthcare Protocols and limited to available AFB.		
Pathology		Blood tests according to an approved tariff list requested by an Universal Healthcare Network GP and subject to Universal Healthcare Protocols and limited to available AFB.		
Psychology		Limited to AFB, subject to sub-limits: **R2 550** per beneficiary per benefit year; **R4 280** per family per benefit year		
Prescribed (acute) medicines		Acute medicines on the Universal Healthcare Network Acute Medicine Formulary as prescribed by Universal Healthcare Network GP and dispensed by Universal Healthcare Network Dispensing GP or Universal Healthcare Network Pharmacy.	At MMAP or medicine price, whichever is the lesser from PMSA, thereafter from available accumulated savings. (Medicine Exclusion list may apply).	At MMAP or medicine price, whichever is lesser from PMSA, thereafter from PCB up to overall Day-to-Day limit. Thereafter available accumulated savings can be used. (Medicine Exclusion list may apply).
Pharmacy-Advised Therapy (PAT)		Over-the-counter medication available at your Universal Healthcare Pharmacy Network, subject to Network formulary, MMAP and limited to **R520** per family and **R120** per event.		Over the counter medication is subject to available PMSA. PAT medication will not pay from PCB once PMSA limits exhausted.
Auxiliary Services		Auxiliary services limited to available AFB, subject to sub-limits: **R2 550** per beneficiary per benefit year; **R4 280** per family per benefit year.	At cost from PMSA and then from available accumulated savings, subject to available funds.	At cost from PMSA, then at MSR from PCB, up to overall Day-to-Day limit. Thereafter, available accumulated savings can be used. Limited to 1 pair of glasses, lenses and frames every 24 months, per beneficiary. Note there is a sub-limit of **R1 240** for frames per beneficiary.
Physiotherapy				
Optical benefits ▸ Eye tests ▸ Spectacles, Frames, Readers, Contact Lenses (including fitting consultation for Contact Lenses)		Subject to AFB and to Universal Healthcare Optometry Network Protocols and to be obtained from Universal Healthcare Optometry Network Providers. No benefit for readers. Limited to 1 pair of glasses, lenses and frames every 24 months, per beneficiary. Or contact lenses every 12 month subject to the annual contact lens limit.		

SUPPLEMENTARY BENEFITS

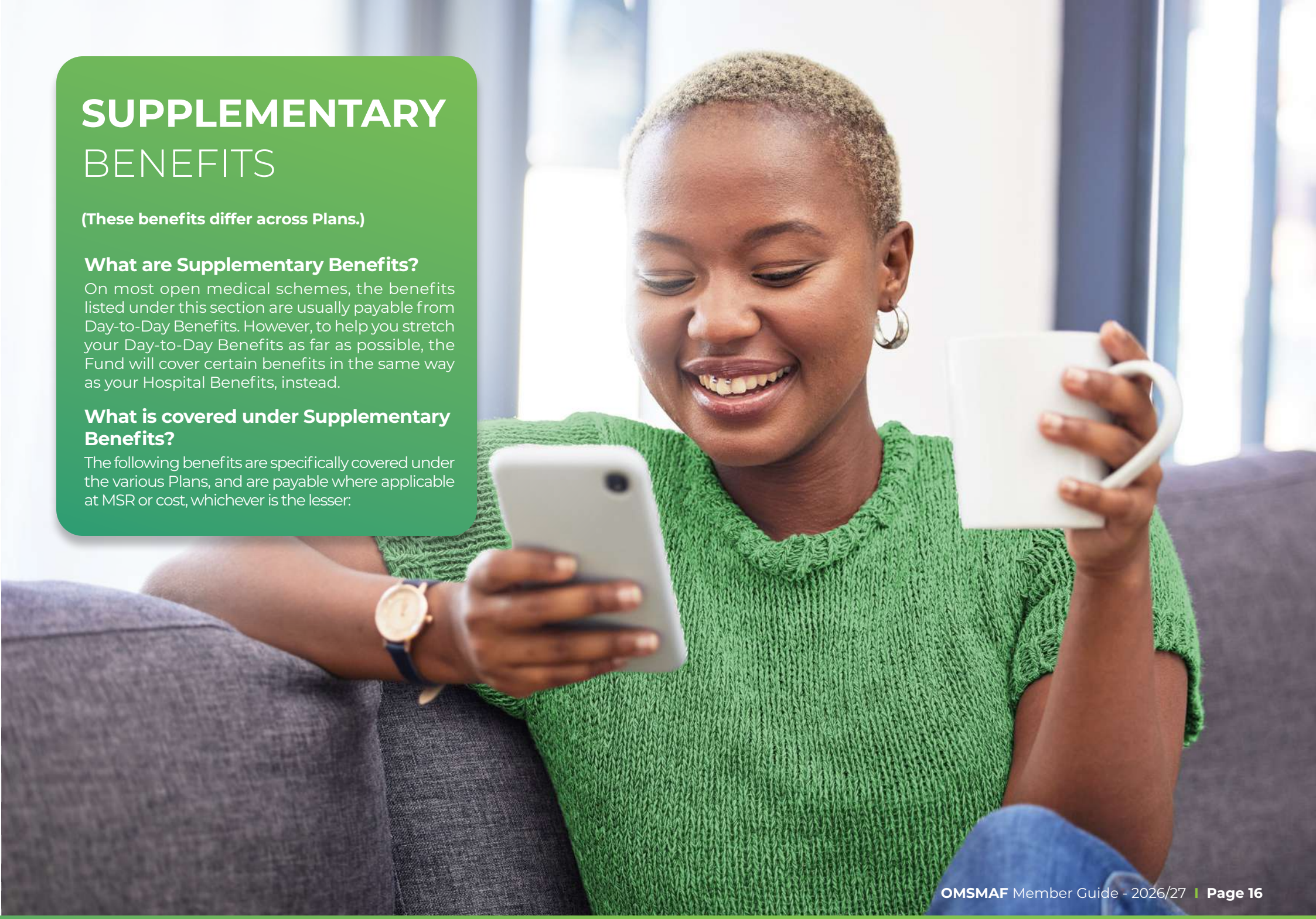
(These benefits differ across Plans.)

What are Supplementary Benefits?

On most open medical schemes, the benefits listed under this section are usually payable from Day-to-Day Benefits. However, to help you stretch your Day-to-Day Benefits as far as possible, the Fund will cover certain benefits in the same way as your Hospital Benefits, instead.

What is covered under Supplementary Benefits?

The following benefits are specifically covered under the various Plans, and are payable where applicable at MSR or cost, whichever is the lesser:



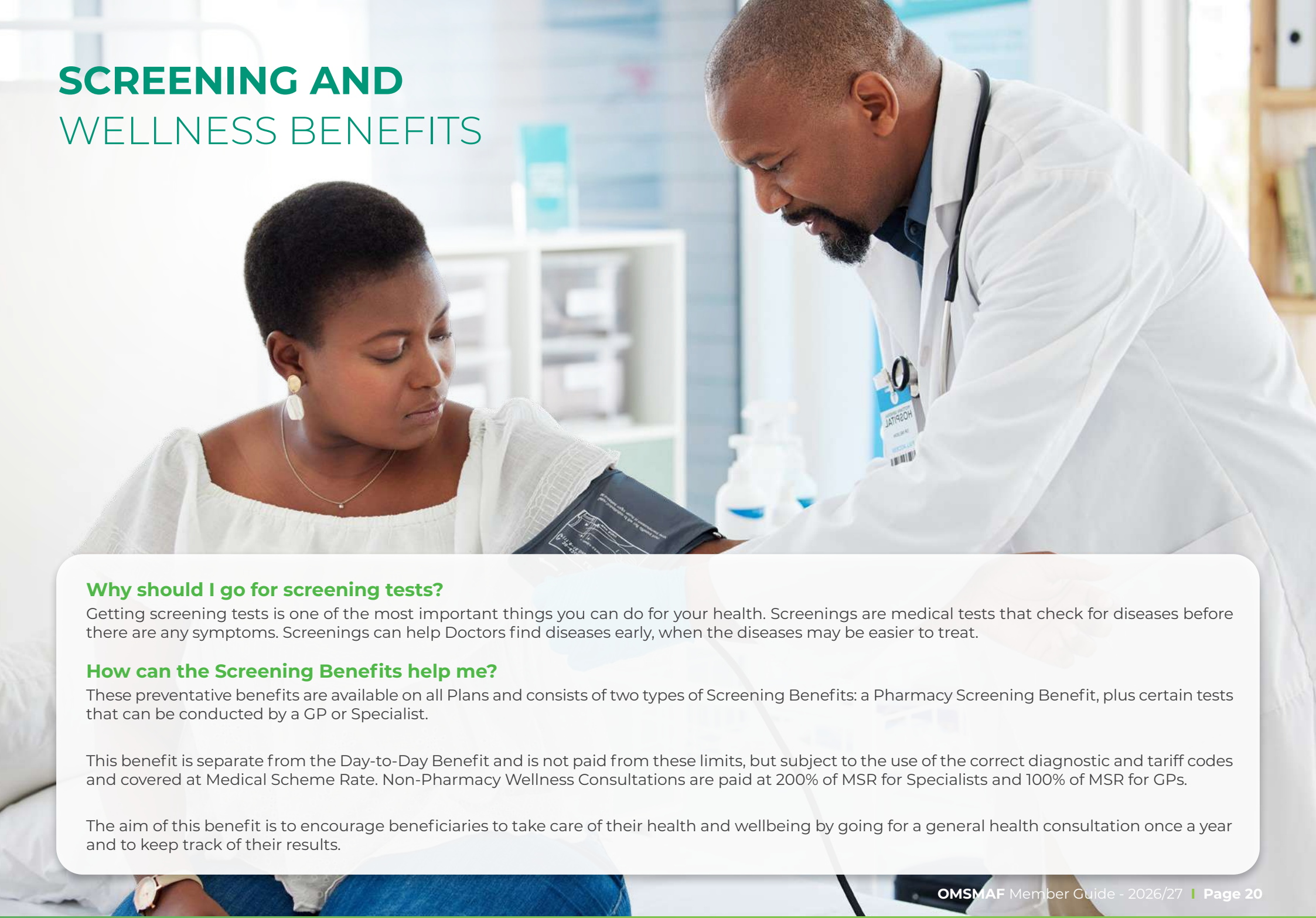
Maternity Benefits*	All pregnant beneficiaries have to register on the Mother and Baby Care Programme. If you are on the Hospital Plan, you will not have additional benefits. Members expecting a baby and considering a ***SELECT*** Plan must please make sure that their Specialist is at one of the ***SELECT*** list of hospitals. Members on the Network and Network ***SELECT*** Plans: Specialist visits are subject to referral from a Universal Healthcare Network GP and authorisation, once registered on the maternity program you can visit the specialist from the balance of your 8 Antenatal consultations.
Antenatal classes	Educational and support services and antenatal classes by a registered Midwife, subject to the following limits per Plan: Hospital Plan: No benefit. Network (including *SELECT*) and Savings Plans: **R1 750** per family per benefit year, paid at MSR. Traditional (including *SELECT*) Plan: **R2 750** per family per benefit year, paid at MSR.
Antenatal visits	Hospital Plan: No benefit. Network (including *SELECT*) Plan: May also choose to consult with an Obstetrician for up to 8 visits per pregnancy, paid at MSR, subject to referral by a Universal Healthcare Network GP and authorisation. Telephone: **0860 100 076** Savings Plan: 8 visits per pregnancy, paid at MSR. Traditional (including *SELECT*) Plan: 12 visits per pregnancy, paid at MSR.
Ultrasound scans (pregnancy)	Hospital Plan: No benefit. Network (including *SELECT*) Plan: Two 2D scans per pregnancy, if done, or referred by a Universal Healthcare Network GP or Specialist. Savings, Traditional (including *SELECT*) Plans: Two 2D scans per pregnancy per beneficiary, Paid at MSR or cost, whichever is lesser.
Out-of-Hospital Pathology tests (pregnancy)	Hospital Plan: No benefit. Network (including *SELECT*) and Savings Plans: **R3 410** per family. Traditional (including *SELECT*) Plan: **R4 260** per family. This benefit is dependent on the patient registering on the Mother and Baby Care Programme. 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. **Please refer to the Maternity Booklet on the website www.omsmaf.co.za** for list of pregnancy related blood tests. 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. ▸ Ensure that the Doctor uses the correct ICD-10 code so that the claim comes off the correct benefit.
Antenatal vitamins	Hospital Plan: No benefit. Network (including *SELECT*) and Savings, Traditional (including *SELECT*) Plans: **Please refer to the Maternity Booklet on the website www.omsmaf.co.za for list of vitamins.** MMAP or medicine price, whichever is the lesser, subject to prescription and formulary.
Lactation Nurse Consultation	Hospital Plan: No benefit. Out-of-Hospital Benefit to access a lactation nurse for a maximum of 8 sessions within 2 weeks of discharge from hospital, paid at MSR to help establish breast feeding. Limited to the Network , Network *SELECT* , Savings , Traditional , Traditional *SELECT* Plans.

Ultrasound scans In-and-Out-of-Hospital	All scans other than for pregnancy. MSR or cost, whichever is the lesser, subject to the following sub-limits per Plan: **In-hospital Ultrasound** benefit: Network (including *SELECT*), Hospital and Savings Plans: **R6 580** per family Traditional (including *SELECT*): **R9 780** per family. **Out-of-Hospital Ultrasound** benefit: Network (including *SELECT*), Savings and Traditional (including *SELECT*): Subject to available day-to-day benefits. Hospital Plan: No out of hospital benefit.
Specialised Radiology* **in and out of hospital** – combined benefit limit (Including MRI, CT and Radio-isotope Scans and Nuclear Medicine.Excluding PET scans.) Unless pre-authorised, benefits will be subject to the relevant available Day-to-Day Benefits.	MSR or cost, whichever is the lesser, subject to the following combined benefit limits per Plan as well as co-payments applicable to Specialised Radiology in and out of hospital. Also see page 41, 'Specialised Radiology In-hospital'. Network (including *SELECT*), Hospital and Savings Plans: **R19 400** per family, with a co-payment of **R1 500** per authorisation. Traditional (including *SELECT*) Plan: **R23 900** per family, with a co-payment of **R1 500** per authorisation. This benefit excludes Oncology and Organ transplant-related MRI, CAT, PET and Radio-isotope scans.
Dental implants*	Subject to pre-authorisation and only available on application prior to obtaining the service. Network (including *SELECT*) and Hospital Plans: No benefit. Savings Plan: PMSA, subject to available funds. Traditional (including *SELECT*) Plan: **R19 900** per family. Subject to a 20% Co-payment All other associated costs, i.e. anaesthetic fees and hospitalisation, will not accumulate to this limit, and are subject to the Hospital Benefit at MSR. A **R1 500** co-payment will apply for all Fund-approved dental admissions to hospital. You will need to submit a quotation for every phase of treatment. If not approved, all costs will be covered from your available Day-to-Day Benefit, which is subject to available PMSA, PCB and available accumulated savings.
Refractive Procedures* (including all related costs)	Subject to pre-authorisation. Network (including *SELECT*) and Hospital Plans: No benefit. Savings Plan: Subject to PMSA. Traditional (including *SELECT*) Plan: MSR or cost, whichever is the lesser, up to a sub-limit of **R21 000** per beneficiary. No benefits shall be paid unless the refraction of the eye is within the guidelines set by the Fund from time to time. The Member must submit all relevant medical reports required by the Fund in order to consider the request.
Medical Appliances (External)* (e.g. wheelchair, crutches, baumanometer, as well as CPAP machines subject to managed care Protocols) plus Foot Orthotics	MSR for hiring or purchasing a medical appliance. This benefit is subject to prior application and approval. Provided that no benefit shall be available for Action Potential Simulation (APS) Machines unless approved by the Fund. Limits per Plan: Network (including *SELECT*) and Hospital Plans: No benefit, unless a PMB. Savings: PMSA, subject to available funds. Traditional (including *SELECT*) Plan: Sub-limit of **R13 200** per family. Repairs are subject to approval and service rendered by an accredited supplier. If not approved, the benefit will be paid from available PMSA. Foot orthotics: **R5 970** per family on Traditional (including *SELECT*) Plan, subject to the overall Medical Appliances benefit, subject to motivation and authorisation.

Hearing Aids*	MSR or cost, whichever is the lesser. Sub-limits per Plan: Network (including *SELECT*) and Hospital Plans: No benefit. Savings Plan: PMSA, subject to available funds. Traditional (including *SELECT*) Plan: **R15 000** per ear per beneficiary, subject to a **co-payment of 10%**. Benefit is available every 3 years for those under the age of 7 and those over 85 years and every 5 years for beneficiaries between the ages of 7 and 84 years. This benefit excludes consultations and associated tests. Benefit is subject to the submission of a motivation by the treating Doctor to the Fund and approval of the purchase of the devices prior to the acquisition of the device. Repairs are subject to approval and service rendered by an accredited supplier. If not approved, the benefit will be paid from available PMSA.
Mental Health Programme* *(Available on all Plans.)*	Limited to **R17 100** per beneficiary, subject to pre-authorisation and relevant managed healthcare Protocols. Please see page 55 for more information.
Back and Neck Rehabilitation Programme* *(Available on all Plans.)*	Please see page 50 for more information on this Programme.

*** Subject to pre-authorisation - Call 0860 100 076**

SCREENING AND WELLNESS BENEFITS



Why should I go for screening tests?

Getting screening tests is one of the most important things you can do for your health. Screenings are medical tests that check for diseases before there are any symptoms. Screenings can help Doctors find diseases early, when the diseases may be easier to treat.

How can the Screening Benefits help me?

These preventative benefits are available on all Plans and consists of two types of Screening Benefits: a Pharmacy Screening Benefit, plus certain tests that can be conducted by a GP or Specialist.

This benefit is separate from the Day-to-Day Benefit and is not paid from these limits, but subject to the use of the correct diagnostic and tariff codes and covered at Medical Scheme Rate. Non-Pharmacy Wellness Consultations are paid at 200% of MSR for Specialists and 100% of MSR for GPs.

The aim of this benefit is to encourage beneficiaries to take care of their health and wellbeing by going for a general health consultation once a year and to keep track of their results.

What is available under the Pharmacy Wellness Benefit?

The Pharmacy Wellness Benefits are available from any of the Fund's preferred Provider Pharmacy Clinics with a qualified nurse. The Fund will cover one visit per beneficiary per benefit year, to assess your state of health and to give advice as tools on how to improve your health.

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

- **Blood pressure** - Limited to 1 test per beneficiary.
- **Blood glucose** - Limited to 1 test per beneficiary.
- **Cholesterol** - Limited to 1 test per beneficiary.
- **HIV and AIDS Test** - Limited to 2 test per beneficiary.
- **Body Mass Index (BMI)** - Limited to 1 test per beneficiary.
- **Flu vaccine** - Limited to 1 vaccination per beneficiary. (The cost of a visit to a General Practitioner is subject to the Day-to-Day Benefit.)
- **Pneumococcal vaccine** - Limited to 2 vaccinations per beneficiary per lifetime and where clinically appropriate. (The cost of a visit to a General Practitioner is subject to the available Day-to-Day Benefit.)
- **Contraceptives** - **R4 090** per beneficiary. **R2 560** sub-limit for oral contraceptives. (Products must be prescribed in accordance with the prescribed list for contraception and not for the treatment of acne or skin conditions, unless otherwise specified as per Managed Care Protocols.) The cost of a visit to a General Practitioner or Gynaecologist will not be covered under this benefit unless it is combined with the wellness consultation.
- **HPV vaccine** has been extended to all females up to the age of 26 years.

Cervarix Vaccine	710020
Gardisal Vaccine	710249
Gardisal 9 Vaccine	3006049

*Gardisal 9 Vaccine is only Funded to Gardisal Vaccine MRP so member will have a co-payment if they select Gardisal 9

IMPORTANT: Please ask the General Practitioner or Gynaecologist or Urologist or Dermatologist (whichever is applicable) to submit the Wellness Consultation claim using the following primary ICD-10 code: Z00.0. If this code is not used, the benefit will be paid from your available Day-to-Day Benefits.

Members on the Network and Network ***SELECT*** Plans:

Specialist visits are subject to referral from a Universal Healthcare Network GP and authorisation, except in instances where the consultation forms part of the chronic PMB treatment plan, registration on the Mother and Baby Care Programme or is for a Wellness Consultation.

Pharmacy-based

- FLU VACCINE
- PNEUMOCOCCAL VACCINE
- CONTRACEPTIVES *Limited amount*
- BLOOD PRESSURE
- BODY MASS INDEX
- BLOOD TESTS *Cholesterol Blood glucose HIV*
- HPV VACCINE *All females up to 26 years*
- HIV PCT SCREENINGS

Non-Pharmacy-based

- BABYLINE *OMSMAF Nurture, powered by Baby Yum Yum*
- HEARING SCREENING *<6 weeks*
- CHILDHOOD IMMUNISATIONS BENEFIT *up to 12 years*
- DENTAL CARIES *<6 years*
- PRE-SCHOOL EYE AND HEARING SCREENING
- NUTRITIONAL ASSESSMENT AND HEALTHY EATING PLAN
- SYPHILIS AND CHLAMYDIA INFECTION SCREENING
- HEALTH RISK ASSESSMENT *by registered healthcare practitioner*
- BONE DENSITY SCAN

Cancer Screening:

- Mammogram
- PAP SMEAR *1 HPV PCR Test and 1 pap smear every 3 years*
- COLORECTAL SCREENING
- PROSTATE SPECIFIC ANTIGEN
- DERMATOLOGIST CONSULTATION *older than 35/ every year*

TIP: Discuss your contraceptive options with your Healthcare Provider when you have your pap smear or HPV PCR test.

In addition to having your blood pressure, cholesterol, blood sugar, height, weight and body mass index measured and monitored, you can also ask the clinic staff for advice on how to improve your health through basic exercise and healthy eating plans.

Please contact your nearest Pharmacy Clinic to make an appointment.

What is available under the Non-Pharmacy-based Wellness Benefit?

Preventative Care Benefits, Childhood Immunisation, Nutritional Assessment and Health Eating Plan, OMSMAF Nurture and Wellness Maximiser Benefit

One consultation per beneficiary per benefit year with a GP paid at 100% of MSR or a Gynaecologist or a Urologist or a Dermatologist paid at 200% of MSR from the Wellness Benefit for any of the following Non-Pharmacy wellness benefits:

- **Pap Smear and HPV PCR tests:** limited to 1 pap smear and 1 HPV PCR test every 3 years per female beneficiary, including consultation with Registered Nurse, General Practitioner or Gynaecologist. This will also be an opportunity to discuss contraceptive options and get a script, if relevant.
- **Mammogram** – limited to 1 test per female beneficiary, including consultation with a Gynaecologist or GP. (Please note for the above Pap smear, HPV PCR test and Mammogram, only one Gynaecologist or GP consultation per benefit year will be funded from the Screening benefit).
- **Syphilis and Chlamydia infection screening** – limited to 1 test per female beneficiary, including consultation with a Gynaecologist or General Practitioner. (Please note for the Pap smear, HPV PCR test, Mammogram and Chlamydia screening, only one Gynaecologist consultation per benefit year will be funded from the Screening Benefit).
- **Prostate Specific Antigen** – limited to 1 test per male beneficiary, including consultation with General Practitioner or Urologist.
- **Colorectal screening** – limited to one fecal sample pathology test per beneficiary.
- **Health Risk Assessment** – limited to 1 test per beneficiary. Only for services rendered by a registered healthcare practitioner (for example, a General Practitioner).
- **Audiology screening** – limited to 1 test per beneficiary up to the age of 6 weeks.
- **OMSMAF Nurture** - a structured, proactive and personalised mother and baby programme, powered by Baby Yum Yum, providing support during pregnancy and early parenting.
- **Nutritional assessment and healthy eating plan** – Access to Universal Network of Dieticians - subject to pre-authorisation and registration - for annual assessment, healthy eating plan prescription and regular monitoring. An additional assessment for pregnant beneficiaries.
- **Pre-School readiness** – Eye and hearing screening for children aged 5 and 6.
- **Dental caries (prevention and oral fluoride supplementation)** – limited to beneficiaries up to age 6 years, subject to Managed Care Protocols, by oral-hygienist consultation.
- **Childhood immunisations** – Children up to the age of 12 years, as per recommendation by the Department of Health.
- **Dermatologist Consultation** – limited to 1 consultation for cancer screening per beneficiary every year, for beneficiaries 35 years and older.
- **Bone Density Scan** - limited to 1 bone density scan performed by a Radiology laboratory, similar to a Mammogram, no additional GP or Specialist consultations will be covered other than one GP or Specialist Wellness Consultation per beneficiary, per annum.

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

Wellness Maximiser Benefit *- 2 virtual GP consultations (incl. the cost of acute medicine) per family and unlimited nurse advice online chats via the Universal.one App. Only available once all adult beneficiaries have completed all their Pharmacy-based Wellness Screening test and available Day-to-Day benefits being depleted.*

MEDICINE BENEFITS

(These benefits differ across Plans.)

What is a chronic condition?

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 specifies a list of chronic diseases that qualify for this benefit.

Which chronic conditions are covered by all Plans?

All four Plans (including *SELECT*) have an unlimited chronic medicine benefit for Prescribed Minimum Benefits (PMB) conditions specified in the Government Gazette by the Minister of Health. In addition, you qualify for certain additional Fund-approved chronic conditions, depending on the Plan you have selected (Please see page 26-27 for more information).

To better understand this benefit, it helps to be familiar with the following terms and what they mean:

Chronic Medicine Formularies

A formulary is a list of cost effective evidence-based medicines that the Fund will cover for the treatment of your chronic condition. These lists are compiled by the Universal Healthcare Chronic Medicine Programme and are constantly reviewed.

Reimbursement is subject to the following Universal Healthcare Chronic Medicine Programme clinical guidelines and protocols, and the MMAP. The Fund applies one of the following formularies as part of the guidelines:

- The Universal Healthcare Restrictive Formulary, applicable to the Hospital and Savings Plans, contains a list of medicines for the covered chronic conditions.
- The Universal Healthcare Comprehensive Formulary, applicable to the Traditional (including *SELECT*) Plan, provides access to a wider range of medicines than the Universal Healthcare Restrictive Formulary.
- The Universal Healthcare Network Formulary, applicable to the Network (including *SELECT*) Plan.

If you choose to use a medicine that is not in your Plan's formulary, you will have to pay a 25% co-payment. The formularies are updated throughout the benefit year. It is important for you to discuss changing to an alternative medicine with your treating Doctor or you will have to make co-payments.

Maximum Medical Aid Price (MMAP)

All medicine claims are paid at the medicine price or MMAP, whichever is the lesser.

MMAP is a reference pricing system that uses a benchmark or reference price for generically similar products. The fundamental principle of any reference pricing system is that it does not restrict a Member's choice of medicines, but instead limits the amount that will be paid. The MMAP is updated regularly and there may be a change to the amount your Fund will pay for your medicine. Check in with your Pharmacist regularly to keep up to date with the MMAP changes.

Speak to your Pharmacist or consult with your treating Doctor about an alternative treatment. A clinical motivation from your Doctor, requesting the Fund to cover a non-MMAP medicine in full, may be considered if criteria are met.

Medicine Exclusion List (MEL)

The Fund makes use of a MEL, which excludes medicines from payment from the Acute Medicine Benefit for a number of reasons. These include:

- medicines not proven to have relevant clinical value;
- medicines more expensive compared to equally effective and safe cheaper alternatives;
- some expensive chronic medicines that require pre-authorisation;
- some combination products, where it is more appropriate to use single ingredient products; and
- newly registered products under review.

MMAP co-payments

A MMAP co-payment is the difference between the cost of the medicine and the reference price. These co-payments will be payable if you claim for chronic medicine that is not within the MMAP instead of choosing an alternative from the list, e.g. an appropriate generic equivalent.

Out-of-formulary co-payments

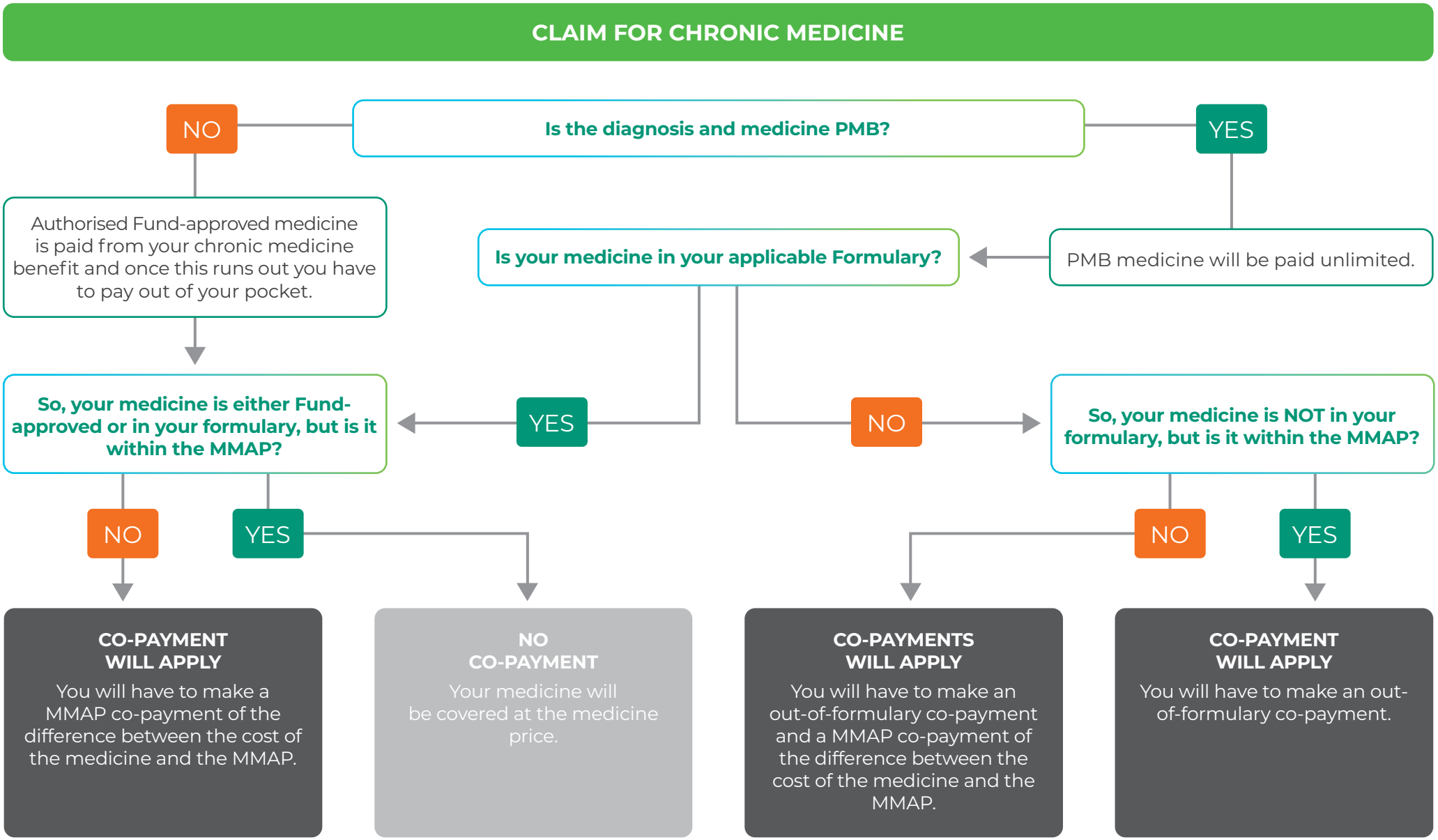
These co-payments will be payable whenever you claim for chronic medicine that is not in your Plan formulary.

If you are unsure of which medicine is in or out of formulary and the effect this will have on your chronic medicine benefits, please contact us. To avoid co-payments, discuss alternative therapies with your treating Doctor or Pharmacist and ensure that you avoid co-payments.

Please note that the Fund has appointed Preferred Providers that have contracted to dispense medicine at the Fund's agreed Dispensing Fees.

Co-payments

Co-payments are payable at the point of dispensing and can be attracted in one of two ways, as set out in the diagram below:



More information on the chronic registration process, chronic conditions and the formularies is available over the next few pages of the guide. If you need more information, contact the Fund on **0860 100 076** or email **chronic@omsmaf.co.za**.

PMB Chronic medicine

MMAP or the medicine price, whichever is the lesser, for medicine prescribed in respect of PMB chronic conditions, unlimited.

On the Network (including *SELECT*) Plan the Universal Healthcare Network Formulary will apply.

On the Hospital and Savings Plans the Universal Healthcare Restrictive Formulary will apply.

On the Traditional (including SELECT) Plan the Universal Healthcare Comprehensive Formulary will apply.

PMB Chronic Disease List (CDL) Conditions Covered on All Plans

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

Additional PMB Conditions Covered (DTP)

- Chronic Hepatitis
- Cushing's syndrome
- Cystic fibrosis
- Deep vein thrombosis
- Hyperfunction of the pituitary gland
- Hyperthyroidism
- Hypofunction of the pituitary gland
- Hypoparathyroidism
- Menopause
- Myasthenia gravis

Additional Chronic Conditions

In addition to the chronic conditions covered as PMBs, the Fund offers chronic medicine benefit cover for certain additional conditions and up to different limit amounts, depending on the Plan you are on.

Did you know?
OMSMAF offers more non-PMB Chronic conditions on ALL Plans than many open schemes out there!

	Hospital Plan	Network Plan Network *SELECT* Plan	Savings Plan	Traditional Plan Traditional *SELECT* Plan*
PMB Chronic Disease List (CDL)	Covered on **ALL** plans.			
Additional List of non-PMB Chronic limit	**R8 530** per family.	Registration and approval required and medicine subject to the Universal Healthcare Network Formulary.	**R8 530** per family.	**R16 800** per family.
Additional Chronic Conditions Covered	Anxiety | Depression | General Anxiety Disorder | Obsessive Compulsive Disorder | Panic Disorder | Post-Traumatic Stress Disorder			
	Only the above listed additional mental health related conditions, which apply to all plans.	Only the above listed additional mental health related conditions, which apply to all plans.	Anorexia Nervosa | Bulimia Nervosa | Cardiac Arrhythmia | Acne | Allergic Rhinitis | Migraine	Alzheimer's Disease | Attention Deficit Hyperactivity Disorder (ADHD) | GORD (if linked to one of the following PMB conditions: Asthma, Crohn's Disease, Rheumatoid Arthritis or Ulcerative Colitis)| Myoneural Disorders | Osteoporosis | Psoriasis | Cushing's Disease | Cystic Fibrosis | Allergic Dermatitis/Eczema | Ankylosing Spondylitis | Anorexia Nervosa | Bulimia Nervosa | Neuropathies | Systemic Sclerosis | Acne | Allergic Rhinitis | Migraine | Gout | Osteoarthritis | Macular Degeneration | Macular Oedema | Cardiac Arrhythmia

Prescribed Minimum Benefits (PMBs) are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. This includes any emergency medical condition; a limited set of 271 medical conditions (defined in the Diagnosis Treatment Pairs); and 26 chronic conditions (defined in the Chronic Disease List).

Specialised drugs for non-Oncology The non-Oncology specialised drug list is a continuously evolving list of high-cost drugs used for the treatment of chronic conditions. This list includes but is not limited to biological drugs (biological therapy for Inflammatory Arthritis, Inflammatory Bowel Disease, Chronic Demyelainating Polyneuropathies, Chronic Hepatitis, Botulinum Toxin, Palivizumab). Unless otherwise stated, for any other diseases where the use of the drug is deemed appropriate by the managed health care organisation, drugs will be funded from this benefit. Subject to a published list that can be obtained by logging into **www.omsmaf.co.za**.	Network (including *SELECT*), Hospital and Savings Plans: PMB only (only Multiple Sclerosis is covered). Traditional (including *SELECT*) Plan: MMAP or medicine price, whichever is the lesser, limited to **R267 000** per beneficiary per benefit year, included in the Overall Annual Limit. Subject to the relevant managed healthcare Programme and pre-authorisation.
Drugs applicable for treatment of Macular Degeneration and Macular Oedema	Network (including *SELECT*), Hospital and Savings Plans: PMB only. Traditional (including *SELECT*) Plan: MMAP or medicine price, whichever is the lesser, limited to **R84 600** per beneficiary and included in the specialised drugs for non-Oncology benefit. Subject to approval and pre-authorisation by the managed healthcare Programme.
Drugs for the treatment of Multidrug Resistant (MDR) and Extensively Drug Resistant Tuberculosis (XDR-TB)	MMAP or medicine price, whichever is the lesser, subject to the relevant managed healthcare Programme and pre-authorisation.

How do I apply for the Chronic Medicine Benefit?

To register for treatment of your chronic condition, your Pharmacist, your Doctor, or you can follow the telephonic process shown below.

Have the following information on hand:

- a copy of your current prescription.
- your Membership number.
- the date of birth of the person applying.
- the ICD-10 code.
- Doctor's practice number.
- medicine details.

To authorise certain medicine you may also need to supply:

- the clinical examination data, e.g. weight, height, BP. readings, smoking status, allergy information.
- test results, e.g. lipogram results, HbA1C, lung function tests.
- motivation provided by your prescribing Doctor.

Telephonic process:

- Call Universal Healthcare Chronic Medicine Programme between 08:00 and 17:00 Monday to Friday at **0860 100 076** and follow the voice prompts for chronic medicine.
- Once you select the appropriate option your call will be routed through to a consultant who will guide you through the process.

Where more clinical information is needed, Members of the clinical team will review the information supplied and correspond with you and your Doctor either telephonically or in writing.

The outcome of your application will be communicated to you in writing by means of an authorisation letter. The letter lists the medicines authorised as chronic medication for you. The authorisation letter, together with a valid prescription, must be presented to your Pharmacist. Pharmacies will not dispense your chronic medicines without a valid prescription.

MMAP and out-of-formulary co-payments will still apply to medicine that is pre-approved. Contact the Universal Healthcare Chronic Medicine Programme on **0860 100 076** to check for medicines that may have a co-payment. Formularies and MMAP information are available on **www.omsmaf.co.za**.

How do I update my chronic medication if my Doctor prescribes a new medicine?

If your Doctor provides you with a new script or a change in your current treatment, it is best to go straight to your Pharmacy to update your medicine there. Your Pharmacist can simply submit the claim. Ask your Pharmacist to inform you of any co-payments or additional costs. He or she can also recommend a generic alternative, if needed.

An updated script will only be needed if:

- your medicine is not in the formulary; or
- you are diagnosed with a new chronic condition.

Important to note: Authorisation of your chronic medicine on all Plans

- Each beneficiary needs to be registered individually on the Programme.
- Clinical Entry Criteria will be applied. This means that your application must meet certain clinical criteria before chronic medicine benefits will be authorised. This step ensures the cost-effective and sustainable funding of chronic medicine, without compromising the quality of care.
- Medicines for PMB will be covered without a co-payment if they are on your Plan-specific Formulary and you obtain your medicine from a Preferred Provider. A MMAP co-payment may still apply. This can be avoided by choosing an appropriate generic equivalent.

Please note: If your medicine or condition does not meet the required criteria, your claims will be subject to the available Day-to-Day Benefits (where applicable).

How does the Chronic PMB Treatment Plan work?

If your application for a PMB CDL condition is approved, you will receive a PMB Care Plan for the chronic disease for which you are being treated. The Care Plan has been set up to ensure that Members receive sufficient benefits to control their PMB chronic conditions and improve their quality of life. No Care Plans will be allocated for Fund-approved chronic conditions.

Your Care Plan assigns you a basket of care specific to your PMB condition. Chronic medicine is not included in the Care Plan and is covered by your chronic medicine limit, where appropriate. Your Care Plan is a list of the type and number of services that are likely to be needed by a patient with your diagnosis and that the Fund will cover. It includes Out-of-Hospital treatment such as Doctor consultations, Radiology and Pathology tests. If you need treatment and care in excess of your Care Plan. A clinical motivation needs to be provided by your treating Doctor and approved before more services will be covered.

Which service Providers should I use?

Although you are free to use any service Provider, the Fund has appointed a Universal Healthcare Preferred Provider Network contracted to dispense acute and chronic medicine at the Fund's agreed Dispensing Fees. This is a comprehensive network consisting of more than 1800 Pharmacies and includes Independent Community Pharmacies, big retail groups as well as Courier Pharmacies.

A list of the Preferred Provider Network Pharmacies is available on the Member portal, and can also be obtained by contacting the Universal Healthcare Contact Centre on **0860 100 076**. Members can download the Universal.One mobile app, from their app store , the app will show you where the closest Network Provider is based on your location.

Contact details for Chronic Medicine Management

Telephone: 0860 100 076
Email: chronic@omsmaf.co.za
Business hours: Monday - Friday, 08:00 – 17:00

HOSPITAL BENEFITS

What are Hospital Benefits?

Hospital Benefits generally cover the major medical expenses that you would incur when undergoing surgery or while in hospital. In most cases, the services that would normally be provided in Doctors' rooms, dental surgeries, etc. are excluded. **Please note that a visit to a hospital's Emergency Room does not qualify to be paid from your Hospital Benefits, or a facility fee could be charged which is not typically covered by the Fund, unless the incident is of such a serious nature that you are admitted to a ward in the hospital itself, for further treatment.**

If your treating Doctor charges you more than the sub-limit available for that service, you will have to pay the difference.

The difference can be paid from your PMSA or accumulated savings, if any. Please note that you may not use your PMSA or accumulated savings to pay for PMB in part or in full.

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

Healthcare costs rise at a faster rate than inflation each year and impact Member contributions. The Fund is therefore always exploring ways to contain costs without compromising quality. One such measure is the Network ***SELECT*** and Traditional ***SELECT*** Plans, where the Fund negotiated discounted rates with certain hospitals. The *SELECT* Plans are based on offering the same benefits as those on the standard Plans, but at a reduced contribution – in return for Members then using the *SELECT* list of hospitals (refer to the website for a list of the *SELECT* hospitals).

For example:

A Traditional Plan Member moving to the Traditional ***SELECT*** Plan:

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

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

What if I am on a *SELECT* Plan, but voluntarily get admitted to a non-*SELECT* hospital?

A co-payment of 20% of the total hospital bill will apply if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals (Refer to the list on the website).

How does pre-authorisation before hospitalisation work?

What to do before you are hospitalised

Before having any medical procedures, please request quotes from Providers and submit it to **enquiries@omsmaf.co.za** so that you can find out the difference between what the Fund will pay and what you will have to pay directly to the service Providers.

Before you are admitted to any hospital you or your Doctor must pre-authorise with the Fund. Pre-authorisation is informing the Fund of your hospital admission and obtaining approval for your hospital stay.

We highly recommend that you or your Doctor contact the Fund at least five (5) working days before every planned admission. It is recommended that you or your Doctor obtain authorisation at least ten (10) working days before your hospitalisation for a procedure where an implant or an internal prosthesis will be necessary, for example, a hip, knee, shoulder or elbow replacement or spinal surgery. Please ensure that your Doctor provides a comprehensive quote.

An authorisation will not be provided unless all of the following information is available:

- Member or Dependant number: Who is being admitted?
- Place of service practice number: Where is the person being admitted to?
- Treating healthcare professional practice number: Who is the Doctor admitting the person?
- Treatment date: When is the person being admitted?
- Relevant diagnosis and/or procedure codes: Why is the person being admitted?

You will receive an authorisation letter to advise you of the status of the authorisation. It is still your responsibility to ensure that you have received an authorisation. You may contact the OMSMAF Contact Centre on **0860 100 076** if you have any queries.

How do I pre-authorise for hospital admission?

Contact Hospital Benefit Management at **0860 100 076** and follow the voice prompts for hospital pre-authorisations, or email: **authorisations@omsmaf.co.za** at least five (5) working days (where possible) before being admitted to hospital.

What if there is no pre-authorisation?

A R500 co-payment may apply when a treatment is not pre-authorised. This will be in addition to any other co-payments that may apply. If there is a change to your original pre-authorisation, this may be subject to additional approval.

Why it's important to pre-authorise

If authorisation has been granted it is payable from the relevant benefit subject to the Fund's rules and limits. Additional pre-authorisations, over and above the hospital admission pre-authorisation, may be required in certain instances during your hospital stay, e.g. for MRI scans.

Please note:

- You or your Doctor have to pre-authorise every admission to hospital, even if you are re-admitted the next day.
- Authorisation is not a guarantee of payment. Payment will depend on your Membership being active and benefits being available on the date of treatment.

In the case of a major hospitalisation event, a Case Manager from Hospital Benefit Management will monitor the patient's progress, including their stay in high care and intensive care. This will ensure that he/she does not have to stay in hospital any longer than necessary. They may also arrange, in consultation with the Doctor, that the patient recuperates at home, under the care of professionals.

Remember that it is your responsibility to ensure that the Doctor's rooms have obtained pre-authorisation where required.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

What about emergencies?

In the case of an emergency, you or a family Member must ensure that the Doctor's rooms have notified Hospital Benefit Management on the first working day after being admitted. If not, you may have to pay a co-payment of R500.

What if my hospitalisation is postponed after I have already received pre-authorisation?

Please ensure that the Doctor's rooms contact the Contact Centre to update your admission dates.

What if I am re-admitted?

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

What about extended stays?

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

What about procedures in General Practitioners' and Specialists' rooms?

You must obtain a pre-authorisation number for procedures that are undertaken in Doctors' rooms in order for the procedure to be funded from your Hospital benefits at MSR or cost, whichever is the lesser, subject to Managed Care Protocols. These include, but are not limited to, the following:

- Bone marrow biopsy
- Colonoscopy
- Cystoscopy
- Gastroscopy
- Hysteroscopy
- Intravenous therapy
- Keloids (subject to motivation)
- Laser to scars (subject to motivation)
- Sclerotherapy
- Flexible sigmoidoscopy
- Surgical biopsies (needle biopsies) (subject to motivation)
- Tonsillectomy (laser)
- Upper GI Endoscopy
- Vasectomy
- Excision and Repair (Tariff Code 0307)
- Drainage of subcutaneous abscess and avulsion of nail (Tariff Code 0255)
- Removal of foreign body superficial to deep fascia (Tariff Code 0259)
- Any other minor procedures
- Excision of lymphoma
- Biopsy of skin

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Your Doctor can still authorise your treatment on the first working day after the procedure, if your circumstances do not allow you to do so beforehand. These procedures are more cost effective when performed in a Doctor's room and will be paid from your Hospital Benefits, provided the procedure is authorised.

What do I need to know before I go for a knee or hip replacement?
If you are on the Savings and Traditional (including *SELECT*) Plans* and meet the necessary criteria on examination by the Orthopeadic Surgeon, you can use the Fund's Designated Service Provider (DSP) for knee and hip replacements to ensure that you do not incur a co-payment for your surgery.

The DSP, Improved Clinical Pathway Services (ICPS), is a group of Orthopeadic Surgeons that specialise in performing hip and knee replacements according to standardised clinical care pathways. These care pathways have been developed in accordance with evidence-based outcomes to ensure that the quality of the hip and/ or knee replacement is of the highest standard and to ensure the best health outcomes.

ICPS use multidisciplinary teams dedicated to assist with rapid and successful recovery, keeping the patient as comfortable as possible during the healing period.

If you need a hip or knee replacement:

- Call the Contact Centre on **0860 100 076** and you will be given the details of a DSP Orthopeadic Surgeon closest to you.
- Consult with the DSP Orthopeadic Surgeon to see whether you meet the criteria for their clinical care pathway.
- If you meet the criteria, an application for an authorisation number will be arranged on your behalf by the practice. This will ensure payment in full, with no co-payment for the procedure.

To alleviate the administrative burden of submitting accounts, the DSP will submit one account to the Fund for payment that will include:

- All hospital costs.
- Surgeons' and Anaesthetists' fees.
- Prosthesis (subject to your prosthesis benefit).
- Physiotherapist (pre-, intra- and post-operative).

For further enquiries regarding the DSPs for hip and knee replacements, please call the Contact Centre on **0860 100 076**.

Members on the **Hospital or **Network** (including SELECT) Plans are not covered for procedures such as hip, knee, shoulder and elbow replacements, other than in accordance with Prescribed Minimum Benefits.*

What if I have multiple procedures under the same anaesthetic?

Sometimes multiple procedures are done during the same operation. In some cases, these are planned and pre-authorised, while in some cases these are not planned, but are necessary and will therefore be authorised. There are also cases where additional procedures will not be covered at all. The following are some typical examples of the three possibilities above:

- A typical case of multiple procedures being planned and pre-authorised would be a child having a tonsillectomy, adenoidectomy, grommets insertion and removal of warts in one theatre event. These codes as well as the full theatre time will be approved, if clinically indicated. Using an industry 'modifier code', the procedures will be covered at a sliding scale, with the first procedure covered at 100% and the rest at a lesser percentage.
- The second scenario is where a patient complains of abdominal pain, for which the Doctor books a diagnostic laparoscopy. The Doctor then finds that the appendix is inflamed and that the Member has endometriosis on the ovaries. The Doctor may then, without pre-authorisation, do a laparoscopic appendectomy and laparoscopic ovarian cystectomy. These procedures, as well as the full theatre time, will be updated by the hospital Case Managers and be approved retrospectively by the Fund. These procedures will then be covered the same as if pre-authorisation had been obtained.
- Multiple procedures will not be covered, for example, where a patient has a laparotomy for the removal of the colon (hemicolectomy) due to cancer, but is overweight and asks the Doctor to also do a lipectomy (removal of excess abdominal fat) while he/she is in theatre. The hemicolectomy and the theatre time for the hemicolectomy will be covered, but the Member will be liable for the lipectomy as well as for the additional theatre time in which this was performed, as a lipectomy is a Fund exclusion.

What is important to know is that even when authorised, not all procedures should be claimed at 100%, as, for example, the same incision is used and cannot be claimed as a separate 'code'. These reimbursement rules are in accordance with guidelines set up by professional medical associations

What services and procedures are covered during hospitalisation?

You will find a list of the services and procedures covered under Hospital Benefits, as well as the sub-limits that apply, in the tables on the following pages.

Quro Medical - The technology-enabled Hospital at Home (HAH) gives patients the option to receive active treatment for a specified period at home instead of a general hospital ward, without compromising on the quality of care. Subject to referral from treating Doctor.

Terms used in the table:

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

Service category	Benefit
Unless otherwise stated, benefits will be paid at MSR or cost, whichever is the lesser.	
Overall Annual Limit:	Hospital, Network (including *SELECT*) Plan Savings, Traditional (including *SELECT*) Plans: Unlimited.
Prescribed Minimum Benefits (PMBs)	Cost for services received in accordance with State Hospital level of care. Refer to the OMSMAF website for more information on PMBs.
Co-Payments	Co-payments may apply to certain procedures – these procedures and co-payments are listed under this section in the Member Guide. Please note that these are some of the most common co-payments, there may be specific co-payments related to your authorisation. Your pre-authorisation letter will also provide you with the details of your co-payments applicable to your authorisation. You may submit a quotation prior to your admission, to find out if there is a difference between what your Specialist has quoted and what the Fund will cover at MSR. ***SELECT* Plans: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and are voluntarily admitted to hospital not on the *SELECT* list of hospitals. The co-payment is payable to the hospital either upfront or at the time of discharge.**

Please note that you need to pre-authorise for services marked with an asterisk (*) or risk having them paid from your Day-to-Day benefits. All authorisations are subject to managed healthcare Protocols and guidelines. Please note that authorisation is not a guarantee of payment. If you are uncertain about any of these benefits, and would like to find out more, please call **0860 100 076**.

Service category	Benefit
1. Hospital Services* If you are hospitalised, your stay will be subject to the period that was pre-authorised and any additional days that may be further authorised by the Case Manager. No further benefits will be paid unless such a stay is further authorised.	**Subject to managed healthcare protocols and guidelines and pre-authorisation, MSR** in respect of the following: ▸ Wards - unless otherwise specified, general ward on all options ▸ Intensive and high care units. ▸ Surgical and theatre fees. ▸ Labour and recovery wards. ▸ Hospital procedures. Private wards are paid at general ward rates unless pre-authorised and subject to clinical Protocols. On the day of discharge, you should arrange to leave the hospital **before 12h00** wherever possible. If scheduled to undergo an operation in the afternoon, you should ask your Doctor to admit you **after 12h00**. In this way, you can avoid incurring additional hospital costs.
2. Maternity Benefits*	All pregnant beneficiaries have to register on the Mother and Baby Care Programme.
Confinement **in-hospital** Please note that, if your newborn baby needs phototherapy for jaundice an authorisation can be issued for the treatment to be performed at your home by a registered nurse. This treatment, if authorised, will be funded from your Hospital Benefits.	**MSR or cost, whichever is the lesser**, in respect of the following, subject to the Overall Annual Limit: ▸ Medical practitioner services whilst hospitalised. ▸ Theatre and recovery rooms. ▸ Normal delivery limited based on Protocols. ▸ Caesarean delivery limited based on Protocols. ▸ Material used in-hospital. ▸ Medicine price for medicines. ▸ Medicine taken on discharge from hospital, limited to **R750** per beneficiary per admission. ▸ A Doula (birthing coach) benefit limited to **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/ out-of-hospital follow-ups.
Confinement **in a registered birthing unit**	**Society for Private Nurse Practitioners of South Africa (SPNP) rate (for Midwife or home delivery). Midwife must be registered with the BHF and the Nursing Council.** **Limited to and including the following Maternity Benefits:** ▸ Delivery by a Midwife; ▸ Hire of water bath included in Maternity Benefit; ▸ 4 Post-natal Midwife consultations per event if a Gynaecologist is not used. ▸ A Doula (birthing coach) benefit limited to **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/ out-of-hospital follow-ups.

Service category	Benefit
Confinement **Out-of-Hospital**	**Negotiated fee, the Society for Private Nurse Practitioners of South Africa (SPNP) rates, or in the absence of such fee, the lower of MSR or cost, or Uniform Patient Fee Schedule for public hospital for the delivery by a General Practitioner or Midwife. Midwife must be registered with the Board of Healthcare Funders and the Nursing Council.** **Limited to and included in the Maternity Benefit:** ▸ Hire of water bath and oxygen cylinder included in the Maternity Benefit. ▸ 4 Post-natal Midwife consultations per event if a Gynaecologist is not used. ▸ A Doula (birthing coach) benefit limited to **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/ out-of-hospital follow-ups.
3. Medical Services Refer to page 31-32 for details on the pre-authorisation process.	MSR or cost, whichever is the lesser, in respect of the following: ▸ Visits and consultations by a GP or Specialist during hospitalisation. ▸ Surgery and medical procedures that require hospitalisation. ▸ Anaesthetics. ▸ Perfusion services. ▸ Pathology during hospitalisation. ▸ Radiology during hospitalisation. ▸ Physiotherapy during hospitalisation. ▸ Clinical technology during hospitalisation. ▸ Speech Therapy during hospitalisation. ▸ Occupational Therapy during hospitalisation. ▸ Dietetic services during hospitalisation. ▸ Social worker services during hospitalisation. ▸ Other services performed by registered medical practitioners. ▸ Cost of blood. ▸ Certain services related to the initial pre-authorised hospitalisation may be covered by Hospital Benefits, subject to approval. **PLEASE NOTE: Cover for claims for auxiliary medical services in-hospital, such as Physiotherapy, Occupational Therapy, Speech Therapy and dietetics, will be subject to referral by the treating healthcare professional.** The following in-hospital sub-limit applies to the Savings, Network (including *SELECT*) and Hospital Plans: ▸ Physiotherapy: **R7 260** per family
4. Ultrasound scans - in-hospital	(All scans other than for pregnancy) **MSR or cost, whichever is the lesser**. Limited to the sub-limits for ultrasound scans - please see page 18.

Service category	Benefit
5. Basic Dentistry - in-hospital* (performed by a Dental Practitioner, including minor oral surgery)	Network (including *SELECT*) and Hospital: No benefit Savings, Traditional (including *SELECT*) Plans: **MSR or cost, whichever is the lesser**. Subject to the relevant managed healthcare Programme and pre-authorisation. General anaesthetic, conscious sedation, theatre fees and hospitalisation for dental work will only be granted for: • Beneficiaries under the age of 8 years. In such case the hospital, Dentist's and Anaesthetist's account will be paid from your Hospital Benefits.. • Bony impactions of the third molars. In such a case the hospital, Anaesthetist's and Dentist's accounts will be covered under your Hospital Benefits. • Lingual and Labial Frenectomies under general anaesthesia granted for beneficiaries under the age of 8 years, subject to the relevant managed healthcare Programme and pre-authorisation, will be covered from your Hospital Benefits. All dental-related cases requiring surgery need to be motivated by the attending Dental Practitioner and are subject to approval. This includes simple extractions. A **R1 500** co-payment will apply for Fund-approved dental admissions to hospitals, including Day Hospitals.
6. Maxillo-facial and oral surgery (including orthognathic surgery where clinically appropriate)*	Network (including *SELECT*) and Hospital Plans: Limited to PMB admissions only. Savings, Traditional (including *SELECT*) Plans: **MSR or cost, whichever is the lesser,** subject to the relevant managed healthcare Programme and pre-authorisation. This benefit excludes the following for the Network (including *SELECT*) and Hospital Plans: • Orthognathic surgery. • Osseo-integrated implants. • Advanced Dentistry. • Oral surgery not applicable to dental PMB. • Removal of impacted wisdom teeth. **A R1 500 co-payment will apply for Fund-approved dental admissions to hospitals including Day Hospitals.**
7. Physiotherapy – after hospitalisation	**MSR or cost, whichever is the lesser**, provided that Physiotherapy is related to the relevant hospital admission. Limited to ten (10) appointments per beneficiary per hospital admission.
8. Procedures in Doctors' Rooms*	**MSR or cost, whichever is the lesser**, subject to pre-authorisation. Major Medical Procedures (normally performed in-hospital) performed in Doctors' rooms.
9. Drugs and medicine (other than chronic)	**Cost or medicine price** for the following: • Material used during hospitalisation. • Theatre drugs. • Medicine price for medicines supplied during hospitalisation.

Service category	Benefit
10. Medicines dispensed on discharge from hospital [to-take-out medicine (TTO)]	MMAP or medicine price limited to **R750** per beneficiary per admission. Subject to the Overall Annual Limit, **excluding anti-coagulants after surgery**, which are subject to the managed healthcare Programme Protocols. This medicine may also be provided by any other Pharmacy on the day of discharge from the hospital, if not provided by the hospital at the time of discharge.
11. Specialised Radiology including MRI, CT and Radio-isotope Scans and Nuclear Medicine* Unless pre-authorised, benefits will be subject to the relevant available day-to-day benefit.	**In-hospital** **MSR or cost, whichever is the lesser**, limited to the overall combined benefit amount for Specialised Radiology (please see page 18). A **R1 500** co-payment per authorisation for Fund-approved Specialised Radiology services rendered In and out of hospital. This benefit excludes Oncology and Organ Transplant-related MRI, CAT, PET and Radio-isotope scans.
12. Intra-ocular Lenses*	Subject to a sub-limit of **R4 720** per lens per beneficiary.

Please note: Reference to a General Practitioner, Midwife, Medical Practitioner, Specialist, Surgeon, Anaesthetist, Pharmacist or Medical Auxiliary means a person who is registered as such with the relevant professional body. Where multiple procedures are performed during the same procedures or operation, these may be covered at different percentages. See page 35 for more information.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
13. Psychiatric Treatment & Psychotherapy* Members on *SELECT* Plans will need to ensure they are admitted to one of the *SELECT* facilities. A list of the *SELECT* facilities can be found on the OMSMAF website at **www.omsmaf.co.za**.	Subject to pre-authorisation. MSR or cost, whichever is the lesser, up to a maximum of twenty-one (21) days per beneficiary or outpatient psychotherapy, up to fifteen (15) contacts. Only at Registered Psychiatric treatment facilities or at facilities of healthcare Providers registered to provide psychotherapy. This benefit includes Accommodation, Medicine, Anaesthetics, Dieticians, General Practitioners, Occupational Therapists, Pathology, Psychiatrists, Psychologists, Radiologists and Social Workers. Maximum of three (3) days' hospitalisation for beneficiaries admitted by a General Practitioner or Specialist. Members with a psychiatric illness must be admitted to a registered psychiatric unit or hospital, where they will benefit from the normal case management process or will be able to benefit from out-patient psychotherapy for up to fifteen (15) contacts. If a Member is admitted to a hospital that does not have a registered psychiatric unit, the authorisation will be subject to the relevant Managed Healthcare Programme. For example, if a Member is not stable enough to be moved to a hospital with a psychiatric unit, the stay will be authorised. However if the Member elects to stay in a hospital without a psychiatric facility, claims could be paid from Day-to-Day Benefits, subject to the Fund Rules. **Remember that**, as an Employee, you and your household Dependants have access to short-term counselling and support on Old Mutual's Employee Wellbeing Programme. Call the Helpline on **0800 006 068**. (You also have access to the Fund's Mental Health Programme, as part of the Fund's Managed Care Programmes. See page 55 for more information.)
14. Drug and Alcohol Abuse Rehabilitation*	Subject to pre-authorisation. **MSR or cost, whichever is the lesser**, up to a maximum of twenty-one (21) days per beneficiary. (You also have access to the Fund's Mental Health Programme, as part of the Fund's Managed Care Programmes. See page 55 for more information.)

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
15. Surgical Implants (Internal Prostheses)* [Prostheses and internal devices (surgically implanted), including all temporary prostheses, or/ and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices]	Internal prostheses are fabricated or artificial substitutes, which are surgically implanted for a diseased or missing part of the body, or to improve the function of a diseased or damaged organ. The list is constantly reviewed and updated. Where new products or technology are considered, these should be motivated by a Medical Advisor. 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 Advisor. In the case of hip, knee, elbow or shoulder replacement and spinal fusion, it is recommended that you pre-authorise ten (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 interest to get a quotation from the treating Doctor to ensure that the benefit limit is enough to cover the cost of the prosthesis. On application and approval, cost subject to the following sub-limits (which include bone cement and antibiotic cement, where applicable): **INTERNAL PROSTHESES COVERED THE SAME ON ALL PLANS:** ▸ **Aortic stents: R207 000** per stent (including the delivery system) per beneficiary, limited to one stent per beneficiary. ▸ **Carotid stents: R29 900** per stent per beneficiary. ▸ **Detachable platinum coils: R74 600** per beneficiary. ▸ **Embolic protection devices: R74 300** per beneficiary. ▸ **Peripheral arterial stent grafts: R61 400** per beneficiary. ▸ **Cardiac Stents: R43 500** per stent per beneficiary. Limited to three stents per beneficiary. ▸ **Cardiac Pacemakers** [including Implantable Cardioverter Defibrillators (ICDs)]: **R102 000** per beneficiary. ▸ **Cardiac Valves: R60 400** per valve per beneficiary. Limited to two valves per beneficiary. Included in this benefit are percutaneous valve replacements, including transcatheter aortic valve implantation (TAVI). ▸ **Neuro-stimulation/ ablation devices for Parkinson's: R67 800** per beneficiary. ▸ **Vagal stimulator** (for intractable epilepsy): **R57 400** per beneficiary. ▸ **Bone lengthening devices: R66 800** per beneficiary ▸ **Any other prosthesis**, including total ankle replacement: **R78 700** per beneficiary.

Service category	Benefit
NOTE: Under the Hospital and Network (including *SELECT*) Plans, elective procedures will only be covered in accordance with PMB. This means that procedures such as hip, knee, shoulder or elbow replacements will typically only be approved in the case of a fracture (normal wear and tear and arthritis of a joint would not qualify as PMB). An emergency admission where loss of limb has to be prevented will also qualify as PMB. For Members on the Savings Traditional (including *SELECT*) Plans, ICPS will be the Designated Service Providers (DSPs) for Fund-approved hip and knee replacements. **A R5 000 co-payment will apply if the DSP is not used.** Members on *SELECT* Plans will not incur a 20% hospital bill co-payment if they use the DSP, but not one of the *SELECT* list of hospitals. Please refer to the OMSMAF website for a list of the *SELECT* facilities.	INTERNAL PROSTHESES NOT COVERED ON THE NETWORK (INCLUDING ***SELECT***) AND HOSPITAL PLANS, EXCEPT FOR PMB, BUT ON THE OTHER PLANS THE FOLLOWING LIMITS APPLY: ▸ Hip replacement subject to the following limits: – Network (including *SELECT*) and Hospital Plans: PMB only. – Savings Plan: **R73 500** per hip per beneficiary, per annum. – Traditional (including *SELECT*) Plan: **R79 300** per hip per beneficiary, per annum. ▸ Knee replacement subject to the following limits: – Network (including *SELECT*) and Hospital Plans: PMB only. – Savings Plan: **R73 500** per knee per beneficiary, per annum. – Traditional (including *SELECT*) Plan: **R79 300** per knee per beneficiary, per annum. ▸ Shoulder replacement subject to the following limits: – Network (including *SELECT*) and Hospital Plans: PMB only. – Savings Plan: **R73 500** per shoulder per beneficiary, per annum. – Traditional (including *SELECT*) Plan: **R79 300** per shoulder per beneficiary, per annum. ▸ Elbow replacement subject to the following limits: – Network (including SELECT) and Hospital Plans: PMB only. – Savings, Traditional (including *SELECT*) Plans: **R65 900** per elbow per beneficiary, per annum.

Service category	Benefit

NOTE: An initial assessment is compulsory for Fund-approved cases. Please see page 50 for more information on the Back and Neck Rehabilitation Programme.	**SPINAL DEVICES COVERED ON ALL PLANS** ▸ **Spinal plates and screws: R54 600** per beneficiary. per annum ▸ **Other approved spinal implantable devices and intervertebral discs: R74 600** per beneficiary per annum. **A R5 000 co-payment on spinal surgery will apply to beneficiaries who declined to follow the Back and Neck Rehabilitation Programme before going for spinal surgery.** **Non-PMB spinal surgery is only covered on the Savings, Traditional (incl. *SELECT*) Plans. It is not covered on the Hospital and Network (incl. *SELECT*) Plans, these Plans only cover PMB spinal surgery.**
16. Artificial limbs & artificial eyes*	Cost subject to the following sub-limits: ▸ **Artificial leg: R108 000** per leg per beneficiary per annum. ▸ **Artificial arm: R108 000** per arm per beneficiary per annum. ▸ **Artificial eye: R37 300** per eye per beneficiary per annum. Benefit is available every 2-5 years. Subject to application and approval prior to the services being rendered.
17. Home Oxygen Therapy (including cylinders and home concentrators)* (CPAP machines and portable concentrators are excluded)	**MSR or cost, whichever is the lesser**. Sub-limit of **R28 100** per beneficiary per annum. This benefit is subject to pre-authorisation. This includes the cost of the appliance, provided that the appliance is obtained from a preferred Provider.
18. Bariatric (obesity) surgery* (including all related costs)	**MSR or cost, whichever is the lesser**, subject to pre-authorisation and clinical guidelines and Protocols. Network (including *SELECT*) and Hospital Plans: No benefit Savings Plan: PMSA, subject to available funds. Traditional (including *SELECT*) Plan: **R150 000** per beneficiary per benefit year.
19. Paramedical and auxiliary services in-hospital*	**MSR or cost, whichever is the lesser**, of certain services related to the initial pre-authorised hospitalisation will be covered, subject to referral by the treating healthcare professional. Otherwise, these services will be covered from Day-to-Day Benefits.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

20. ER24 Ambulance

MSR or cost, whichever is the lesser for travelling expenses of a medical practitioner and/or ambulance and/or emergency service Provider, up to a maximum sub-limit of **R13 100** per family.

Provided that no benefit shall be available in respect of travel in urban areas other than in respect of ambulance charges where the patient's physical condition precludes the use of any other means of transport.

Keep in mind that if you are transported to hospital by an ER24 ambulance (even though approved), and on examination you are found to be fit enough to return home, you will be responsible for arranging your own transport home.

Unfortunately, due to the high number of attacks on emergency staff, ER24 has taken several measures to ensure the safety of their staff. Some of these measures include requesting the aid of security services and local authorities when responding to incidents in high-risk areas. This can have an impact on the response times in certain areas. ER24 strives to maintain prompt response times to various incidents, even when utilising the services of security and local authorities.

What should we do in an emergency situation?

You and your registered Dependants have access to emergency medical transportation 24 hours a day, 7 days a week via **084 124** (within South Africa) or /+27 10 205 3052 for Members outside the borders of South Africa.

ER24's trained staff will note the details of your condition and immediately authorise the dispatch of the closest appropriate Emergency Medical Services Provider to assist you.

Services offered by ER24 include:

- 24-hour access to the ER24 Emergency Call Centre.
- Dispatch of emergency response.
- Medical transportation by ambulance or aircraft.
- Authorised inter-facility transfers.

In addition to emergency transportation, you will also receive emergency medical advice and assistance. ER24's operators will guide you through a medical crisis situation, provide emergency advice and organise for you to receive the support you need – available at all times.

Emergency services outside the borders of South Africa

Members outside the borders of South Africa (Members in Namibia, Lesotho and Swaziland) may call ER24 by dialling +27 10 205 3052 for the following services:

- Life-threatening emergency (primary response).
- For primary service, but not life-threatening.
- Any inter-facility transfers.

ReMember that, in the case of an emergency where you (or your Dependants) are admitted to hospital, you must arrange to notify the Fund on the first working day after being admitted.

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

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
21. Nursing Services* (excluding long-term care or social care)	**MSR or cost, whichever is the lesser**, for nursing services by registered nurses or nurse aids for the acute phase after hospitalisation or in lieu of hospitalisation up to a sub-limit of **R25 000** per beneficiary. Benefits are subject to prior application and approval. Network (including *SELECT*) Plan: Benefits are subject to obtaining a Universal Healthcare Network Provider's report. This benefit includes private nursing (not for general or social care).
22. Hospice* (excluding long-term care or social care)	**MSR or cost, whichever is the lesser**, for hospice services for end-of-life care in lieu of hospitalisation up to a sub-limit of **R47 800** per beneficiary for non-PMBs. PMBs are unlimited. Benefits are subject to prior application and approval. Network (including *SELECT*) Plan: Benefits are subject to obtaining a Universal Healthcare Network Provider's report.
23. Oncology Cancer treatment, including Pathology, X-rays, MRI, Cat and Radio-isotope scans, Chemotherapy, drugs associated with Chemotherapy, medicine for terminal illness, Oncologist consultations, radiotherapy, Mammograms and nutritional supplements. Subject to registration on the Oncology Benefit Management Programme, and the sub-limits indicated below:	
General Oncology*	**Cost at DSP, or negotiated fee, or, in the absence of such fee, 100% of the lower of the MSR or cost, or Uniform Patients Fee Schedule for public hospitals for Oncologists, Haematologists, and credentialed medical practitioners.** **Limits per Plan:** Network (including *SELECT*) and Hospital Plans: PMB only with ICON Essential Protocols. Savings Plan: **R518 000** per beneficiary per benefit year with ICON Core Protocols. Traditional (including *SELECT*) Plan: **R846 000** per beneficiary within ICON Enhanced Protocols. Benefit is subject to pre-authorisation and is available upon diagnosis and the submission of a treatment plan by the treating Oncologist to the Case Manager before treatment begins. Subject to pre-authorisation, medicine price for medicine and drugs, subject to the appropriate ICON Protocols per Plan. Where MMAP is applicable, medicine will be reimbursed up to a maximum of the MMAP. A 20% co-payment for consultation will apply if service is obtained from a non-ICON Oncologist. Approved related medicine and nutritional supplements subject to the above limits per Plan. Vitamins, antibiotics, alternative medicine, sleeping tablets, anti-anxiety medicine and medicines for depression are subject to applicable and available Day-to-Day Benefits.

Service category	Benefit
Specialised drugs for Oncology*	Network (including *SELECT*), Hospital Plans: PMB only Savings and Traditional (including *SELECT*) Plans: **MMAP or medicine price, whichever is the lesser**, limited to **R267 000** per beneficiary, included in the Oncology benefit. Subject to the relevant managed healthcare Programme and to pre-authorisation. The Oncology Specialised Drug List is a continuously evolving list of drugs used for the treatment of cancers and certain haematological conditions. This list includes but is not limited to targeted therapies e.g. biologicals, tyrosine kinase inhibitors and other non-genericised chemotherapeutic agents. Subject to a published list. Please access the oncology drug list via **www.omsmaf.co.za**.
PET Scans*	**Subject to the Oncology limit, PET Scans are covered up to the following sub-limits per Plan:** Hospital, Network (including *SELECT*) Plans: PMB only. Savings, Traditional (including *SELECT*) Plans: **R44 400** per beneficiary. This benefit is subject to the submission of a motivation by the treating Oncologist and approval by the Case Manager.
Brachytherapy materials* (including seeds and disposables) and equipment	Hospital, Network (including *SELECT)* Plans: PMB only Savings, Traditional (including *SELECT*) Plans: limited to **R67 700** per beneficiary.
Terminal illness benefit for all terminally ill patients, including cancer patients	**Cost or MSR, whichever is the lesser** for consultations with a registered psycho-social practitioner such as a social worker, up to a sub-limit of **R4 720** per family. This benefit is subject to referral from the treating healthcare Provider and managed care Protocols.
24. Renal dialysis*	**MSR or cost, whichever is the lesser.** Automated Peritoneal Dialysis will only be approved subject to the Fund's criteria. Subject to pre-authorisation, medicine price for all related approved medicine provided that medicine from an approved Provider is used.
25. Acute Rehabilitation*	Subject to pre-authorisation and the submission of a motivation by the treating medical practitioner to the Case Manager. **MSR or cost, whichever is the lesser**, up to a sub-limit of **R114 000** per beneficiary provided that treatment is at a registered facility. The condition must be non-progressive. The acute conditions which are covered are as follows: severe motor vehicle accidents, strokes, brain injuries, spinal cord injuries, debilitating bacterial illnesses, debilitating viral neurological illnesses and amputations. Progressive neurological conditions are excluded.

NOTE: You will incur a co-payment of 20% of the total hospital bill if you choose a *SELECT* Plan and then voluntarily get admitted to a hospital that is not on the *SELECT* list of hospitals. This co-payment will be payable to the hospital and might be charged upfront or at the time of discharge.

Service category	Benefit
26. Organ Transplants*	**MSR or cost, whichever is the lesser**, in respect of the transportation of the organ needed for the transplant, as well as hospital accommodation and surgically related services and procedures. The transplant and the relevant treatment plan must be pre-authorised and are subject to clinical guidelines and Protocols. Organ harvesting is limited to the Republic of South Africa. Non-PMB Organ Transplant is only covered on the Traditional (incl. *SELECT*) Plan, and not on the Hospital, Network (incl. *SELECT*) and Savings Plans.
Anti–rejection drugs*	**MMAP or medicine price** of anti-rejection drugs provided that drugs from an approved Provider are used. Subject to pre-authorisation.
Organ donor*	**MSR or cost, whichever is the lesser** for the work up and harvesting of the organ/s or Haemopoietic stem cells (bone marrow) and the transplantation thereof. Organ harvesting is limited to the Republic of South Africa.
27. Corneal graft (local or imported)*	Subject to pre-authorisation. **MSR or cost, whichever is the lesser**, up to a sub-limit of **R45 600** per eye per beneficiary.
28. Hyperbaric Oxygen Therapy*	**MSR or cost, whichever is the lesser**. Exclusively for anaerobic life-threatening infections and specific conditions, subject to pre-authorisation and clinical guidelines and Protocols.
29. HIV/AIDS*	Subject to pre-authorisation and clinical guidelines and Protocols. **MMAP or medicine price** for HIV-related chronic medicine. **MSR or cost, whichever is the lesser**, for the medical management and related Pathology tests and Doctors' visits as required. HIV drug-resistance testing (Tariff code 4766) excluded unless pre-authorised on the relevant HIV Disease Management Programme. Polymerase Chain Reaction tests to be paid from Hospital Benefits for babies < 18 months where the diagnosis refers to HIV testing (Tariff code 3974). For Members on the Network (including *SELECT*) Plan only cover for PMBs is applicable at cost or **MSR, whichever is the lesser**, for the medical management and the related Pathology tests required. Medicine price for HIV related chronic medicine for PMB only.
30. Stoma Care Products	**100% of cost, or MSR, whichever is the lesser**, subject to pre-authorisation.

Service category	Benefit
31. Cochlear Implants*	**R434 000** per beneficiary. Subject to managed healthcare Protocols and pre-authorisation. Amounts in excess of the Cochlear Implants limit may, at the discretion of the Medical Advisor be paid as part of the Overall Annual Limit. Repairs to and replacement of the external components of the Cochlear Implant will be limited as below: Hospital and Network Plans (including *SELECT*): No benefit. Savings: Subject to the PMSA. Traditional (including *SELECT*) Plan: Limited to **R15 000** per ear per beneficiary, subject to a co-payment of 10%. Benefit is available every 3 years for lives under 7 years and lives 85 years and older. Benefit is available every 5 years for lives aged 7 to 84 years.
32. Poloysomnograms (Sleep Studies): Diagnostic Polysomnograms (whether In or Out-of-Hospital)	Hospital Plans and Network (including *SELECT*): No benefit. Savings, Traditional (including SELECT) Plans: PMSA, subject to available funds.
CPAP titration in-hospital*	**Cost or MSR**, whichever is the lesser, subject to pre-authorisation and clinical guidelines and Protocols. Network (including *SELECT*) Plan: PMB only.
33. Laparoscopic procedures	Laparoscopic procedures are subject to prior authorisation and a **R2 500** co-payment will apply.
34. Scopes	Scopes are subject to prior authorisation and a **R1 500** co-payment will apply for procedures performed in an acute hospital. **For the scope done in a day hospital no co-payment will apply**.
35. Breast Reduction	Subject to submission of a motivation by the treating Provider and submission of medical reports as required by the Fund. Benefits are subject to the approval by the Fund's Medical Advisor on the ground that the patient meets the clinical criteria (e.g. Body Mass Index) applied by the Fund subject to the Fund's Managed Care Protocols.

MANAGED CARE PROGRAMMES

(These benefits differ across Plans.)

As part of the Fund's aim of identifying and managing beneficiaries' disease risks in good time, there are a number of Programmes that form part of the Fund's Managed Care approach.

Back and Neck Rehabilitation Programme

A description of the Programme

Second only to headaches in the ranking of painful disorders that affect humans, back and neck pain is a common cause of ill health and incapacity and is associated with significant social and financial problems. To reduce your suffering and possible need for invasive surgery, the Fund offers a Conservative Back and Neck Rehabilitation Programme.

Members enrolled on the Programme will be identified for either a Physiotherapy Programme or an intensive six-week multidisciplinary Programme where a Medical Doctor and Physiotherapist are involved in the assessment and treatment of your condition. This intensive Programme is provided at a DBC (Documentation Based Care) Clinic, which is one of the Designated Service Providers (DSPs) for this Programme. Where there is no DBC Centre close to you, you may be referred to Workability who run a similar rehabilitation Programme.

How does it benefit you?

The successful management of back and neck pain via the Fund's Conservative Back and Neck Programme will improve your quality of life and reduce your pain and suffering. The Programme is based on internationally successful care pathways that reduce pain and stiffness and improve flexibility. It is also proven to limit, avoid or postpone surgery. Where surgery is truly warranted, this will be permitted within Fund rules.

It is important that you understand that since the success rate of this Programme is very high, there will be a **R5 000** co-payment on spinal surgery if you decline participation in the Conservative Back and Neck Programme prior to surgery. This co-payment will not apply to emergency admissions or PMB surgeries.

How can you access the benefit?

To ensure that all eligible Members are enrolled, there are a number of ways to access the Programme:

The telephonic helpline on **0860 100 076** for registration on the Programme and intervention prior to pre-authorisation.

- Intervention prior to pre-authorisation of back and neck surgery.
- For Employees, your line manager may refer you to Universal Healthcare to assess your eligibility for one of the Programmes.
- Referral from your family practitioner or Specialist.

Oncology Benefit Management Programme for cancer patients

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

By joining the Programme when you are diagnosed with cancer, you will qualify for the Oncology Benefit. This benefit forms part of your Hospital Benefits, subject to the Oncology sub-limit.

How do I apply for this benefit?

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

The Care Plan must be submitted to Oncology Benefit Management by sending an email to **oncology@omsmaf.co.za**.

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

What services are covered?

The Oncology Benefit will cover:

- Pathology.
- BRCA gene testing.
- MRI, Radio-isotope, CAT and PET scans (the latter to be motivated and approved).
- Radiotherapy.
- Chemotherapy and drugs associated with chemotherapy (e.g. anti-nausea).
- Approved related medicine.
- Radiology.
- Oncologists' consultations.
- Consultations with a social worker.
- Mammograms (if it forms part of your Care Plan).
- Medicine for terminal illness.
- Approved nutritional supplements.

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

- Prescribed vitamins.
- Antibiotics.
- Alternative medicine.
- Sleeping tablets.

What is the role of the Oncology Case Manager?

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

The Case Manager does not handle account queries. For this you must contact the OMSMAF Contact Centre at **0860 100 076**.

Designated Service Provider (DSP) for Oncology Treatment

The Fund has appointed the Independent Clinical Oncology Network (ICON) as the DSP for Oncology treatment. ICON is a dedicated network of Oncologists committed to the comprehensive management of Members with cancer.

The Fund subscribes to the following ICON Protocols:

- Hospital Plans and Network (including *SELECT*): PMB only with ICON Essential Protocols
- Savings Plan: **R518 000** per beneficiary with ICON Core Protocols.
- Traditional (including *SELECT*) Plan: **R846 000** per beneficiary with ICON Enhanced Protocols.

The ICON Essential Protocols would typically be based on what is available from the State, whereas the ICON Enhanced Protocols will have a wider range of treatments for the Oncologist to choose from. The Core Protocol is positioned between the Essential and Enhanced Protocols.

Oncology claims will be covered as follows:

- If you consult with a non-ICON Oncologist a **co-payment** will be imposed on the Oncologist account. The Fund will cover 80% of the claim and you will be liable for the other **20% of the claim**. This is applicable to the consultations performed by a non-ICON Oncologist only.
- If you are currently on the Oncology Programme and you want to find out if your treating Oncologist is part of ICON, contact Oncology Benefit Management by visiting **www.cancernet.co.za** or calling the Contact Centre on **0860 100 076**.

Can I upgrade to another Plan to enjoy more benefits?

If you or one of your Dependants is diagnosed with cancer or has to undergo oncology treatment and your Plan does not provide adequately for the cancer treatment, you can apply to upgrade to a more comprehensive Plan within two months (60 days) after the date of the first diagnosis of cancer, or having had to undergo oncology treatment.

To upgrade Plans, the following guidelines are important:

- The application to upgrade your Plan must reach the Fund within sixty (60) days after the first diagnosis;
- Upgrading is only allowed to the Savings, Traditional (including *SELECT*) Plans, you cannot upgrade from the Hospital Plan to one of the Network Plans;
- The Member and all his/her Dependants must upgrade to the new Plan;
- Upgrading requests will be considered in consultation with the Fund's Medical Advisor, who will decide if the cancer meets the criteria according to the Fund's Rules;
- All existing waiting periods and late-joiner penalties will still apply; and
- Upgrading will be effective from the month after the month in which the Fund approves your application to upgrade Plans.

NOTE: Please remember to renew your care plan well in advance of its end date, to avoid interrupting your treatment while your care plan is being evaluated.

HIV and AIDS Management Programme

For most people HIV and AIDS is a frightening disease, but today effective treatment is available that allows the majority of people living with HIV to lead healthy and productive lives for many years.

Action and information

The first step is to find out whether you have been infected with HIV and what you can do to protect your loved ones and stay healthy. Medicines called Antiretroviral Therapy (or ARVS) are available to suppress the virus, while good nutrition and exercise can play a critical role in keeping your body strong and healthy. Starting treatment at the right time and taking your medication correctly ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infections or other complications. Our HIV and AIDS Management Programme can help you access benefits to assist you in managing HIV and AIDS. Members must register on the Fund's HIV and AIDS Management Programme.

Contact details for the HIV and AIDS Programme
Tel: 0860 378 800; follow prompts for HIV and AIDS Programme

We can help you to manage your condition

The Fund has a benefit in place specifically for HIV/AIDS-related medicines and tests. This benefit is used to pay for medicines to suppress the virus and medicines to protect against illnesses such as TB and serious pneumonia as well as regular monitoring tests. The Fund will also pay for one HIV test per beneficiary per annum.

Your condition will stay confidential

HIV is a sensitive matter and every effort is made to keep your condition confidential. The HIV and AIDS Management Programme uses separate contact details (please see details at the front of this Guide). Members are encouraged to use these contact details directly in order to protect confidentiality.

Nobody, not even your Employer or the Board of Trustees of the Fund, is notified about a Member's enrolment on the Programme or the HIV status of the Member.

You must register on the HIV and AIDS Management Programme

If a test shows you are HIV positive you must register with the HIV and AIDS Management Programme as soon as possible to make use of this benefit.

Contact them telephonically, in confidence on **0860 378 800**, follow the prompts for HIV Disease Management team.

Your Doctor can also contact the HIV and AIDS Management Programme on your behalf and may also contact the Case Manager for advice.

After you have registered

After you receive the application form, you and your Doctor must complete it and return it to the HIV and AIDS Management Programme by using this email: **hivProgramme@omsmaf.co.za**. A highly qualified medical team will review the information provided and, if necessary, discuss cost-effective and appropriate treatment with your Doctor.

Once treatment has been agreed upon, you and your Doctor will be sent a detailed Treatment Plan, which lists the approved medicines and how to take them, as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

If you are exposed to HIV infection through sexual assault or needle-stick injury, please ask your Doctor to contact the HIV and AIDS Management Programme to authorise special Post-Exposure Prophylaxis (PEP) medications to help prevent possible HIV infection.

It is best to take this medicine as soon as possible (within hours) after exposure. If the incident putting you at risk occurs over the weekend, make sure you get the necessary medicine on time.

You or your Doctor can contact the HIV and AIDS Management Programme on the Monday morning to arrange authorisation of the drugs for payment by the Fund.

Remember that, as an Employee, you and your household Dependants have access to short-term counselling and support on Old Mutual's Wellbeing Programme. Call the Helpline on **0800 006 068**.

The HIV and AIDS Management Programme is available for telephonic nurse support, education and monitoring of patients who have been diagnosed with HIV to ensure that an HIV-positive person enjoys a healthy and fulfilled life.

It is operated by highly skilled, dedicated nurses who provide regular telephonic support and counselling to HIV-positive beneficiaries. The nurses are trained and experienced in assisting people to develop life skills for the optimal management of HIV and in ensuring that effective, appropriate medical care is provided.

What benefits are available for HIV and AIDS?

If you have been diagnosed with HIV you have access to the following benefits:

- Regular, ongoing, HIV Disease Management nurse telephonic support and counselling.
- Regular visits to your Doctor for your condition. Network (including *SELECT*) Plan Members should visit their Universal Healthcare Network Doctor.
- Regular Pathology testing to monitor your health and immune status.
- Antiretroviral treatment prescribed by your Doctor to suppress the HI virus.
- Multivitamins to aid in strengthening your immune status.
- Access to vaccines to protect against pneumonia, flu etc.
- PreP treatment for serodiscordant couples and conception planning.
- Post-exposure prophylaxis (PEP) for exposure through sexual assault or needle-stick injury.

What services does the HIV and AIDS Management Programme offer?

- The HIV nurse counsellors provide regular telephonic counselling, support and personalised health and wellness education to assist you in the management of your condition.
- The nurses will work with you and your GP to ensure you receive the appropriate care for the management of your condition.
- The nurses will provide information to you on the benefits available, and how to utilise these benefits, for the appropriate management of your condition according to evidence based treatment guidelines and Protocols.The nurses will contact you regularly to monitor your condition.
- The nurses will obtain clinical information on the tests conducted and use it to monitor the progress of your condition.
- Together with you, the nurse will recommend lifestyle and /or behavioural changes to enhance your quality of life for your condition.
- Medicine to treat HIV (including medicines to prevent mother-to-child transmission and infection after sexual assault or occupational exposure) at the most appropriate time.
- Treatment to prevent opportunistic infections like serious pneumonias and TB.
- Best practice clinical guidelines and support from experienced HIV clinical experts.

Mental Health Programme

A description of the Programme

The Mental Health Programme can support you with mental health conditions or substance-abuse issues that you may have, such as Depression, General Anxiety, Bipolar Mood Disorder or Post-Traumatic Stress Disorder.

How does it benefit you?

The Programme provides effective collaboration between family practitioners, Psychiatrists and other healthcare professionals, for example, Psychologists and Social Workers and a Case Manager, who will work together to ensure that you are supported in a way that suits your individual needs. Your adherence and active participation in treatment is required to achieve the desired outcomes and we encourage you to make the most of the opportunities and support with which this Programme will provide you. While enrolled on the Programme you can expect to receive the following support:

- Education for you and your family.
- Access to community support groups.
- A listening ear to provide support and guidance.

How can you access the benefit?

There are a number of ways to access the Programme:

- The Contact Centre is one way to contact us – simply call **0860 100 076** and speak to a consultant.
- You can also email **mentalhealth@omsmaf.co.za**.
- Referral from Old Mutual's Wellbeing Programme (with your consent).

You will be contacted to enrol on the Programme by the Fund's Administrator.

Active Disease Risk Management Programme

The Programme provides support and guidance to assist with managing your health. A team of Care Managers will provide you with relevant information and advice regarding your chronic condition.

The Active Disease Risk Management Programme is a telephonic nurse based support program for patients diagnosed with chronic conditions. The Program is staffed by specially trained nurses and Care Managers who will:

- provide telephonic support to you in order to monitor your compliance to the treatment plan your healthcare Provider has recommended.

- provide further health education and guidance regarding your chronic condition and other supportive care you may require.
- ensure that you understand your own role in the management of your condition and support you in order to prevent any unnecessary hospitalisation.

The Programme applies to beneficiaries with the following chronic conditions:

- Asthma.
- Cardiovascular Disease i.e. Cardiac Failure, Coronary Artery Disease.
- Chronic Obstructive Pulmonary Disease.
- Chronic Renal Disease.
- Diabetes Mellitus Type 1 and 2.
- Hypertension.
- Hyperlipidaemia.

Contact details for the Active Disease Risk Management Programme:

Tel: **0860 100 076**
Hours: **08:00 to 17:00 Mondays to Fridays**
Email: **diseasemanagement@omsmaf.co.za**

Mother and Baby Care Programme

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

If you are on the Hospital Plan, you will be covered for your confinement and delivery from your Hospital Benefits, but you will not qualify for the additional Maternity Benefits that form part of the Fund's Supplementary Benefits (see page 17).

Who can join the Programme and when?

All members, or their Dependants, who are pregnant must register on the Programme. Early registration gives the Programme an opportunity to identity high-risk conditions. It also allows you enough time to find out about benefits, antenatal classes and other information, depending which Plan you are on.

You are entitled to certain vitamins that are registered as antenatal supplements. Once registered on the Programme you will receive a list of those antenatal vitamins that are covered by this benefit. Vitamins not covered on this benefit will be paid from your available PMSA or accumulated savings.

Please take the vitamin prescription from your Doctor to your Pharmacy, where your claim will be processed electronically, at MMAP or the medicine price, whichever is the lesser.

A maternity booklet, providing more information, is available on the OMSMAF website, **www.omsmaf.co.za**.

What services are covered?

The following services are covered:

- SPNP rate for midwives (for Midwife delivery or home delivery).
- Education and support services.
- Care after the birth services, e.g. home visits by a registered nurse and phototherapy treatment for your baby at home, if required, subject to managed healthcare Protocols and pre-authorisation.
- A Doula (birthing coach) on all the options as part of the in-hospital Maternity Benefits, subject to a limit of **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.

In addition, the following services are available to Members on the Network , Savings, Traditional (including *SELECT*) Plans (not available to Members on the Hospital Plan).

- Antenatal visits subject to the sub-limits per pregnancy.
- Medicine price or MMAP for antenatal vitamins, subject to prescription and Formulary.
- Antenatal classes performed by a registered Midwife (services of a Physiotherapist or aerobics instructor are not covered) for the registered beneficiary.
- Out-of-Hospital Pathology tests subject to the sub-limits per family.

You can register on the Programme by contacting the Contact Centre:

Telephone:	0860 100 076 (Follow the voice prompts.)
Hours:	08:00 to 17:00 Mondays to Fridays
Email:	maternity@omsmaf.co.za

The following benefits are all paid at MSR, up to the specified limits:

Maternity Benefits	Paid from	All pregnant beneficiaries have to register on the Mother and Baby Care Programme.
Antenatal classes	Supplementary benefits	**Educational and support services and antenatal classes by a registered Midwife, subject to the following limits per Plan:** ▸ Hospital Plan: No benefit, but education and support is available via the Mother and Baby Care Programme and website **www.omsmaf.co.za**. ▸ Network (including *SELECT*) and Savings Plans: **R1 750** per family. ▸ Traditional (including *SELECT*) Plan: **R2 750** per family.
Antenatal visits	Supplementary benefits	▸ Hospital Plan: No benefit. ▸ Network (including *SELECT*) Plan: May also choose to consult with an Obstetrician for up to 8 visits per pregnancy, paid at MSR, subject to referral by a Universal Healthcare Network GP and authorisation. ▸ Savings Plan: 8 visits per pregnancy, paid at MSR. ▸ Traditional (including *SELECT*) Plan: 12 visits per pregnancy, paid at MSR.
Ultrasound scans (pregnancy)	Supplementary benefits	**Limits per Plan per benefit year:** ▸ Hospital Plan: No benefit. ▸ Network (including *SELECT*) Plan: Two 2D scans per pregnancy, if done, or referred by Universal Healthcare Network GP or Specialist. ▸ Savings, Traditional (including *SELECT*) Plans: Two 2D scans per beneficiary.
Hospital benefits	Supplementary benefits	▸ **A Doula (birthing coach) on all the options** as part of the In-Hospital Maternity Benefits, subject to a limit of **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Out-of-Hospital Pathology tests (pregnancy-related)	Supplementary benefits	▸ Hospital Plan: No benefit. ▸ Network (including *SELECT*) Plan: Basic blood tests, if requested by Universal Healthcare Network GP or Specialist and on the approved tariff list. **R3 410** per family. ▸ Savings Plan: **R3 410** per family per benefit year. ▸ Traditional (including *SELECT*) Plan: **R4 260** per family. This benefit is dependent on the patient registering on the Mother and Baby Care Programme (not available to Members on the Hospital Plan).
Antenatal vitamins	Supplementary benefits	Hospital Plan: No benefit. Network (including *SELECT*), Savings, Traditional (including *SELECT*) Plans: MMAP or medicine price, subject to prescription from an approved list and Formulary and included in the Overall Annual Limit.

In addition to the previously detailed benefits, the Fund offers the following Confinement Benefits as part of its Hospital Benefits:

Confinement	Paid from	
Confinement In-Hospital	Hospital benefits	**MSR or cost, whichever is the lesser**, in respect of the following: ▸ Medical practitioner services whilst hospitalised. ▸ Theatre and recovery rooms. ▸ Normal delivery-limited, based on Protocols. ▸ Caesarean delivery-limited, based on Protocols. ▸ Material used In-Hospital. ▸ Maximum Medical Aid Price (MMAP). ▸ Medicine taken on discharge from hospital, limited to **R750**. ▸ Doula (birthing coach) on all the options as part of the In-Hospital Maternity Benefits, subject to a limit of **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Confinement in a registered birthing unit	Hospital benefits	**Society for Private Nurse Practitioners of South Africa (SPNP) rate (for Midwife or home delivery). Midwife must be registered with the Board of Healthcare Funders and the Nursing Council. Limited to and including the following Confinement Benefits:** ▸ Delivery by a Midwife; ▸ Hire of water bath included in Confinement Benefits; ▸ 4 Post-natal Midwife consultations per event if a Gynaecologist is not used. ▸ Doula (birthing coach) as part of the maternity benefit, limited to **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.
Confinement Out-of-Hospital	Hospital benefits	**Negotiated fee, or Society for Private Nurse Practitioners of South Africa (SPNP) rates, or in the absence of such fee, the lower of MSR or cost, or Uniform Patient Fee Schedule for Public Hospital for the delivery by a General Practitioner or Midwife. Midwife must be registered with the Board of Healthcare Funders and the Nursing Council.** ▸ Limited to and included in the Maternity Benefit: ▸ Hire of water bath and oxygen cylinder included in the Maternity Benefit. ▸ 4 Post-natal Midwife consultations per event if a Gynaecologist is not used. ▸ Doula (birthing coach) as part of the maternity benefit, limited to **R3 270** per pregnancy, specifically for the confinement (delivery). No post-natal/out-of-hospital follow-ups.

Please note that if your newborn baby needs phototherapy for jaundice, an authorisation can be issued for the treatment to be performed at your home by a registered nurse. This treatment, if authorised, will be funded from your Hospital Benefits.

NOTE: Members expecting a baby and considering a *SELECT* Plan must make sure that their Specialist practices at one of the *SELECT* list of hospitals.

What if I do not register on the Programme?

Depending on the Plan you have chosen, benefits such as antenatal classes and antenatal vitamins are payable from your Supplementary Benefits only if you register on the Programme. If not, these benefits will be paid from your available PMSA or available accumulated savings. Members on the Hospital Plan can also access education and support via the Mother and Baby Care Programme.

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

Yes, please pre-authorise your stay at least five (5) days before (or, in an emergency, within one (1) working day after) your date of admission. Remember that if you do not pre-authorise your stay in-hospital, you may have to pay a co-payment on your hospital account.

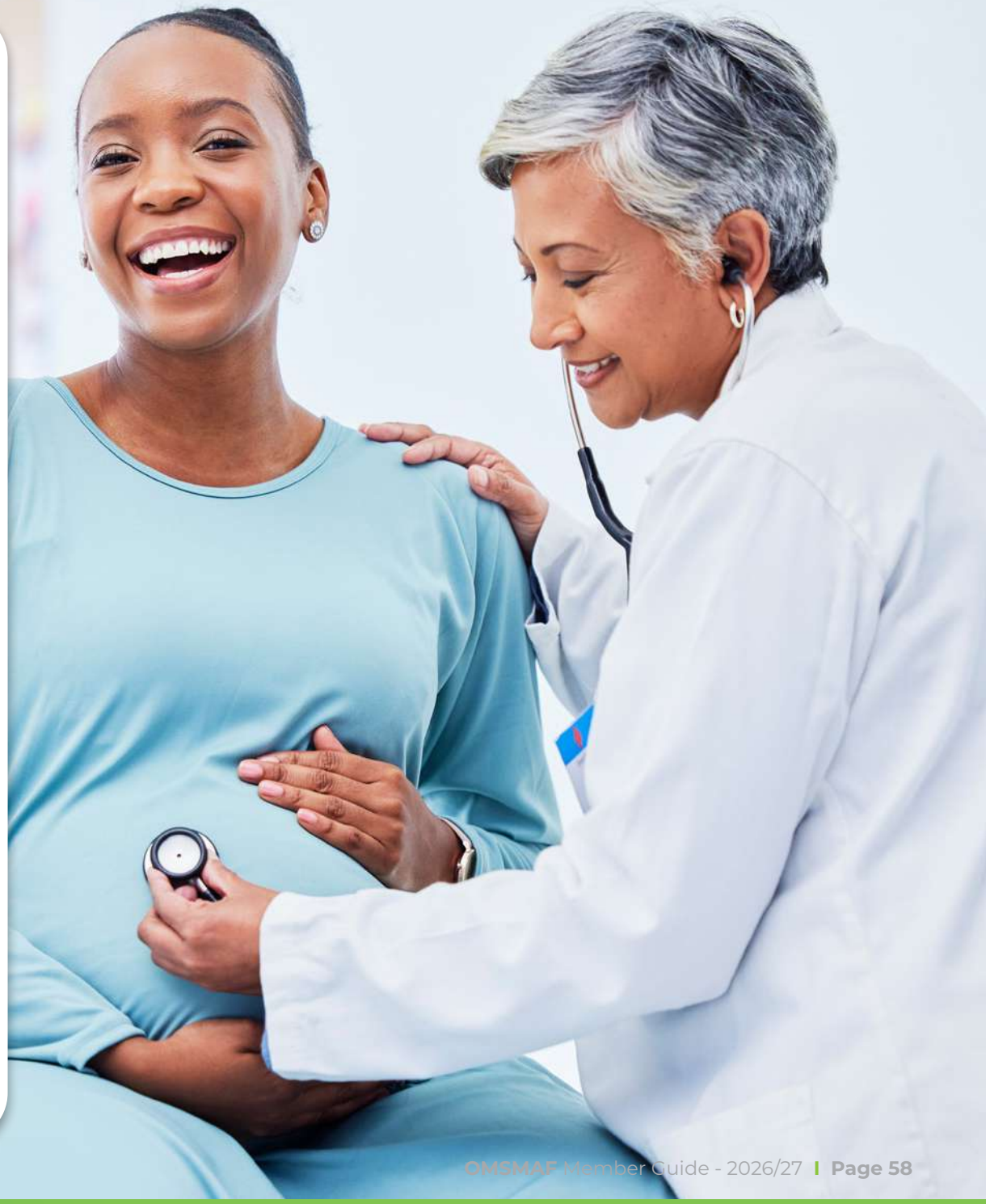
To pre-authorise:
Call **0860 100 076**
Hours **8:00 to 17:00**
Email **maternity@omsmaf.co.za**.

SELECT Members: Please ensure that for a booked admission you make use of one of the ***SELECT*** Hospitals that are listed on **www.omsmaf.co.za**.

Must I register my baby as a Dependant?

Yes, even though you have pre-authorised your confinement, Members on all OMSMAF Plans still have to notify the Fund of the birth of your baby, and arrange for him/her to be registered as a Dependant on the Fund. This must happen within thirty (30) days of birth. Members on all OMSMAF Plans still have to register their newborn baby as a dependant on the Fund, via Workday for employees who have access. For employees who do not have access to Workday, you can register your newborn by calling **0860 100 076**. We will require the full name, surname and ID number / date of birth of the baby.

If you do not register the baby as a Dependant within thirty (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. Refer to **www.omsmaf.co.za** for the procedure to register a Dependant.



EXPLANATION OF TERMS

Term	Explanation
Accumulated savings	Savings that build up in the PMSA from previous years and can then be used to cover certain expenses (such as expenses beyond the PCB limit on Traditional (including *SELECT*) Plan.

Annual Flexi Benefit (AFB)	An Out-of-Hospital Annual Flexi Benefit (AFB) on the Network and Network ***SELECT*** Plans, subject to beneficiary and family limits per benefit year, covering the following benefits:
	▸ Blood tests according to an approved tariff list
	▸ Specified black and white X-rays
	▸ Optometry
	▸ Auxiliary services, subject to the following sub-limits *(Refer to page 15 for sub-limits)*.
	  ▸ Psychology
	  ▸ Physiotherapy

Auxiliary and Para-medical services	Acupuncture, Anthroposophical Treatment, Applied Kinesiology, Audiometry/Audiology, Autologous Donation Of Blood, Ayurvedic Treatment, Biokinetics, Chiropody, Chiropractic Services, Clinical Technology, Dieticians, Herbalists, Genetic Counselling, Homeopathy, Naturopathy, Occupational Therapy, Orthoptic Treatment, Osteopathy, Phytotherapy, Podiatry, Private Nursing Services, Reflexology, Speech Therapy and Social Work. PLEASE NOTE: Cover for claims for auxiliary medical services In-Hospital, such as Physiotherapy, Occupational Therapy, Speech Therapy and dietetics, will be subject to referral by the treating healthcare professional.
Beneficiary	A Member and/or Dependant registered with the Fund.
Benefit year	The period for which benefits and contributions apply, in this case **1 April to 31 March**. 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. Should you resign during the course of a benefit year, your PMSA will similarly be pro-rated and you may be liable for a clawback if you have overspent on your PMSA.

Term	Explanation
Child Dependant	"CHILD", shall mean a Member's or a Member's spouse's or partner's: (a) natural child and/or (b) grandchild and/or (c) great grandchild and/or (d) stepchild of the Member and/or (e) a foster child or a child in the process of being placed in foster care; who has been placed by order of the court in the custody of the Member or his spouse or partner, as defined in Section 1 of the Children's Act, 20015 (Act No. 38 of 2005); and/or (f) a child for whom the Member has a duty of support; and/or (g) a child who is factually being cared for by the Member including an orphaned child and/or (h) a legally adopted child or a child in the process of being adopted and who has been placed in the custody of the Member or his spouse or partner, as defined in Section 1 of the Children's Act, 2005 (Act No. 38 of 2005).
Day-to-Day Benefits	These cover smaller medical expenses that occur more frequently, e.g. GP or Dentist consultations and prescribed medicines. Treatment is usually received out of hospital or at the outpatient facility of a hospital. A visit to a hospital's emergency rooms (ER) would also be covered from this benefit, unless the patient was admitted to the hospital itself for further treatment.
Designated Service Provider (DSP)	A healthcare Provider selected and formally contracted by the Fund as its preferred service Provider to provide diagnosis, treatment and care in respect of one or more conditions. The Fund's current DSPs include the *SELECT* list of hospitals, ICON, ICPS and DBC.
Dispensing Fee	Fee to be charged by Pharmacies when dispensing medicine to Members of the Fund.
Exclusions	Services that are not covered in terms of the Rules of the Fund.
Hospital Benefits	These generally cover the major medical expenses that you would incur when undergoing surgery or while in hospital. This does not include a visit to a hospital's emergency rooms (ER), unless the condition warrants admission to hospital.
ICD-10 code	International Classification of Diseases (ICD)-10 coding is a system that classifies diseases and the complications connected to these diseases according to a specific category.
Income	▸ For Employees whose remuneration is structured as a Total Guaranteed Package received from the Employer: Income = Total Guaranteed Package received from the Employer. ▸ For Employees whose remuneration is pensionable remuneration received from the Employer: Income = Pensionable Remuneration divided by 90%. ▸ For Employees whose remuneration is deemed commission received from the Employer: Income = deemed commission received from the Employer. ▸ For Employees who earn a fixed income and commission, the medical scheme contribution will be based on the fixed income only. ▸ For any Members other than retirees: Income = their gross monthly income. ▸ For retirees: Income will be your gross annual income as taxable by SARS in terms of the Income Tax Act. However, during the first year of retirement, income will be based on the value of the last monthly salary received from the employer or your gross income, whichever is the greater, until such time that the Member provides proof of their gross income post-retirement. Confirmation of income may be required annually from time to time, through the provision of a copy of the South African Revenue Service tax return. ▸ For Members who are on disability, the medical scheme contribution will be based on the monthly disability income benefit.
ICON Protocols	A protocol is a plan for a course of medical treatment. ICON, the service Provider for oncology care, offers three (3) Protocols to Fund Members, depending on the Plan they are on. The ICON Essential Protocols would typically be based on what is available from the State, whereas the ICON Enhanced Protocols will have a wider range of treatments for the Oncologist to choose from. The Core Protocol is the middle point between the Essential and Enhanced Protocols.

Term	Explanation
Late Joiner Penalty	A penalty imposed on Members (or Dependants) who join a medical scheme after the age of 35, or who have never been medical scheme Members, or who have not belonged to a medical scheme for a specified period of time. The penalty aims to compensate for potentially increased claims by people who join a medical scheme when they are already older or infirm, and ranges from 5% to 75% of contributions.
Medical Scheme Rates (MSR)	The rate at which the Fund will pay for relevant health services, as determined by the Board of Trustees from time to time.
Medicine Exclusion List (MEL)	The list of medicines used by the Fund, which excludes medicines from payment from the Acute Medicine Benefit for a number of reasons.
Medicine price	Amount payable by the Fund in respect of medicines. This amount is the sum of the Single Exit Price and Dispensing Fee.
Member portion	Any amount paid by the Fund on your behalf that exceeds the amount to which you are entitled.
Maximum Medical Aid Price (MMAP)	MMAP is a reference pricing system that uses a benchmark or reference price for generically similar products. The fundamental principle of any reference pricing system is that it does not restrict a Member's choice of medicines, but instead limits the amount that will be paid.
Overall Annual Limit (OAL)	An Overall Annual Limit per beneficiary and per family per benefit year, applicable to all Plans.
Personal Medical Savings Account (PMSA)	A savings account held by a Member's medical scheme to which a certain percentage of a Member's contribution is paid on a monthly basis. These funds can only be used to defray health care expenditure and are trust monies held on behalf of the Member by the medical scheme and do not form part of scheme assets. From the beginning of each benefit year, the Personal Medical Savings Account is credited with a percentage of a Member's contribution, as determined in the medical scheme rules. This savings fund is made available prospectively to a Member; in other words, the full year's savings funds are made available at the beginning of each benefit year. If a Member leaves during the course of the benefit year that the overspent pre-allocation will be due to the Fund.
Pre-authorisation	The process whereby a Member applies for approval for a procedure or treatment from the Fund. This may include the submission of quotations. Co-payments may be payable if you do not pre-authorise.
Preferred Provider	A Provider of a healthcare service contracted to the Fund to deliver quality healthcare services and to participate in the managed healthcare Programme. The Fund has the following preferred Providers: ER24 for emergency services, and any Pharmacy appointed as a Preferred Provider by the Fund.
Prescribed Minimum Benefits (PMB)	The unlimited benefit to which all Members are entitled, for treatment related to the conditions specified in the Medical Schemes Act, provided that this treatment is obtained at a DSP. The Fund's current DSPs include the *SELECT* list of hospitals, ICON, ICPS and DBC.
Universal Healthcare Comprehensive Formulary	Applicable to the Traditional (including *SELECT*) Plan. It provides access to a wider range of medicines than the Universal Healthcare Restrictive Formulary.
Universal Healthcare Restrictive Formulary	Applicable to the Hospital and Savings Plans. Contains a list of medicines that provide cover for the listed chronic conditions.
Universal Network Formulary	Applicable to the Network (including *SELECT*) Plan.
Single Exit Price (SEP)	Price of medicine as determined by the State, and the manufacturer, at which it is marketed and purchased by the Pharmacist.
SPNP	Society of Private Nursing Practitioners of South Africa.
Sub-limit	The maximum amount of cover you have for specified medical expenses during the benefit year.
Supplementary benefits	A list of benefits offered by the Fund that are paid from the Hospital Benefits limit, although they are, strictly speaking, Out-of-Hospital benefits.
Waiting period	The period during which you will not be covered for any medical expenses incurred, even though you may be making contributions to the Fund. There are two types of waiting periods: ▸ Condition-specific waiting period: A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve (12)-month period ending on the date on which an application for Membership was made. This will also apply to PMB if there is a break in membership of more than ninety (90) days. ▸ General waiting period: A period not exceeding three (3) months during which a beneficiary is not entitled to claim any benefits. This will also apply to PMB if there is a break in membership of more than ninety (90) days. Members who join the Fund within ninety (90) days of employment will not be subjected to underwriting.

Healthcare with *heart*

VISION
To be the medical scheme of choice for the Old Mutual Group.

MISSION
To be an affordable medical scheme that guarantees best-of-class member experience, value and quality.

Universal®

OLDMUTUAL