

2012



Benefit and Rates Brochure

**HOSMED MEDICAL SCHEME
CONTRIBUTIONS EFFECTIVE 01 JANUARY 2012**

PLUS			
Monthly Income	Member	Adult	Child*
R0 +	2 690	1 630	410

* Member pays for the first three children only

VALUE			
Monthly Income	Member	Adult	Child*
R0 – R4 540	1 680	1 010	260
R4 541 – R6 805	1 850	1 100	280
R6 805 +	2 120	1 270	320

* Member pays for the first three children only

STEP			
Monthly Income	Member	Adult	Child*
R0 – R4 000	588	481	243
R4 001 – R7 000	700	572	317
R7 001 +	1 042	852	542

* Member pays for the first three children only

HOSMED MEDICAL SCHEME

BENEFITS EFFECTIVE 1 JANUARY 2012

OPTION	PLUS	VALUE	STEP
Overall annual limit	No overall annual limit Subject to sub limits not being exceeded	Limited to R 1 000 000 per family per annum. Subject to sub-limits not being exceeded	Limited to R 500 000 per family per annum. Subject to sub-limits not being exceeded
Prorated benefits	Yes	Yes	Yes
Statutory prescribed minimum benefits. Services rendered by public hospitals payable at 100% of cost	No annual limit	No annual limit	No annual limit
3 Month general waiting periods (Subject to the rights of interchangeability)	Yes	Yes	Yes
12 Months condition specific waiting period for pre-existing conditions (Subject to the rights of interchangeability)	Yes	Yes	Yes
Claims received later than the last day of the 4 th month in which the service was rendered will not be covered	Yes	Yes	Yes
Emergency medical cover whilst traveling outside of South Africa. (Subject to PMB's)	100% of SA tariff rates payable in RSA currency	100% of SA tariff rates payable in RSA currency	100% of SA tariff rates payable in RSA currency

1. HOSPITALISATION AND ASSOCIATED COSTS - PROVINCIAL AND PRIVATE

Items 1.01 – 1.24 Limited collectively and subject to authorisation. Note: All admissions to hospitals and services listed below must be pre-authorized by the Scheme/ preferred provider, or within 48 hours in the case of an emergency. Failure to comply with this rule will result in a levy of R 500 per admission. Please note that treatment protocols apply.	<p>State Hospitals: Unlimited benefits for PMB admissions subject to designated service providers, treatment protocols and formulary. State hospitals payable at 100% of cost</p> <p>Private Hospitals: 100% of Scheme tariff*</p> <p>All admissions to hospital and services listed below must be authorized.</p>	<p>State Hospitals: Unlimited benefits for PMB admissions subject to designated service providers, treatment protocols and formulary. State hospitals payable at 100% of cost</p> <p>Private Hospitals: 100% of Scheme tariff* Subject to overall annual limit</p> <p>All admissions to hospital and services listed below must be authorized.</p>	<p>State Hospitals: Unlimited benefits for PMB admissions subject to designated service providers, treatment protocols and formulary. State hospitals payable at 100% of cost</p> <p>Private Hospitals: 100% of Scheme tariff* Subject to overall annual limit</p> <p>All admissions to hospital and services listed below must be authorized.</p>
1.01 Accommodation, theatre fees, medicines, intensive care Subject to Pre-authorisation and PMB's	100% of Scheme tariff*	100% of Scheme tariff*	100% of Scheme tariff* Medicines dispensed on discharge limited to a 5 day supply

1.02 Surgical procedures including GP and specialist consultations Subject to Pre-authorisation and PMB's	100% of Scheme tariff*	100% of Scheme tariff*	100% of Scheme tariff*
1.03 Diagnostic Investigations E.g. Radiology, Pathology, MRI/PET/CAT scans etc. Subject to Clinical protocols and PMB's. Authorisation must be obtained prior to the examination or within 24 hours in case of an emergency. MRI, PET and CT Scans must be authorised by the Scheme	100% of Scheme tariff*	100% of Scheme tariff*	100% of Scheme tariff*
1.04 Blood Transfusions	100% of cost	100% of cost	100% of cost
1.05 Oncology Subject to PMB's as prescribed. Treatment subject to designated service provider guidelines and pre-authorisation	100% of DSP tariff* Limited to R 428 000 per person per annum	100% of DSP tariff* Limited to R 200 000 per person per annum	100% of DSP tariff* Limited to PMB conditions only and subject to DSP protocols
1.06 Diabetes Management Programme Treatment subject to registration and compliance with the diabetes management programme and diabetic medication being obtained from the designated service provider. Subject to pre-authorisation	100% of DSP tariff*	100% of DSP tariff*	100% of DSP tariff* Limited to PMB conditions only and subject to DSP protocols
1.07 Accommodation For Confinement Note: Waiting period may be applied, subject to the rights of interchangeability Subject to Clinical protocols, pre-authorisation and PMB's	100% of Scheme tariff* NVD – Limited to 2 days Caesar – Limited to 3 days Limited to 2 sonar's per pregnancy	100% of Scheme tariff* NVD – Limited to 2 days Caesar – Limited to 3 days Limited to 2 sonar's per pregnancy	100% of Scheme tariff* NVD – Limited to 2 days Caesar – Limited to 3 days Limited to 2 sonar's per pregnancy
1.08 Psychiatric Treatment including Clinical Psychology Subject to PMB's and pre-authorisation by the Scheme Including alcohol and drug dependency which is payable subject to completion of full course of treatment at DSP	100% of Scheme tariff* Subject to a collective limit of R 16 800 per family per annum (Subject to PMB's) Non PMB's – 14 days per family subject to a limit of R 16 800	100% of Scheme tariff* Subject to a collective limit of R 15 700 per family per annum (Subject to PMB's) Non PMB's – 14 days per family subject to a limit of R 15 700	100% of Scheme tariff* Limited to PMB conditions only DSP* State hospital 14 days per family
1.09 Organ Transplants Subject to PMB's and Pre-Authorisation Transplantation benefit for the recipient only Solid organ transplants: The Prescribed Minimum Benefits annexure includes solid organ transplants (liver, kidney and heart) only, where these are provided by the public hospitals, in accordance with public sector protocols and subject to public sector's waiting list	100% of Scheme tariff* Organ transplants and solid organ transplants collectively limited to R 117 000 per family per annum Unlimited benefits for PMB admissions subject to designated service providers, treatment protocols and formulary.	100% of Scheme tariff* Organ transplants and solid organ transplants collectively limited to R 94 000 per family per annum Unlimited benefits for PMB admissions subject to designated service providers, treatment protocols and formulary.	100% of Scheme tariff* Organ transplants and solid organ transplants collectively limited to R 70 000 per family per annum. Donors not covered Unlimited benefits for PMB admissions only subject to designated service providers, treatment protocols and formulary.

1.09.1 Kidney transplants	Full cover provided state protocols, as determined by the Department of Health, are adhered to.	Full cover provided state protocols, as determined by the Department of Health, are adhered to.	Full cover provided state protocols, as determined by the Department of Health, are adhered to.
1.09.2 Liver transplants Heart transplants and all other solid organs	Full cover provided a state facility is used. Private facility – the benefit is payable from limit 1.09 above	Full cover provided a state facility is used. Private facility – the benefit is payable from limit 1.09 above	Full cover provided a state facility is used. Private facility – the benefit is payable from limit 1.09 above
1.09.3 All other non-solid organ transplants not mentioned above.	Benefit is payable from limit 1.09 above (Private/State facilities)	Benefit is payable from limit 1.09 above (Private/State facilities)	No benefit
1.10 Dental Hospitalisation Subject to pre-authorisation, treatment protocols and PMB's	100% of Scheme tariff* Benefit is payable from hospitalisation only in cases of children under 7 years and removal of impacted wisdom teeth, if pre-authorised as a day case only.	100% of Scheme tariff* Benefit is payable from hospitalisation only in cases of children under 7 years and removal of impacted wisdom teeth, if pre-authorised as a day case only.	No benefit
1.10.1 Dental implants: Hospitalisation Only for cancer surgery of the mandible or trauma resulting in bone loss of the mandible	Hospitalisation related to bone augmentation phase, will be covered from the hospital benefit	Hospitalisation related to bone augmentation phase, will be covered from the hospital benefit	No benefit
1.10.2 Implants phase Only for cancer surgery of the mandible or trauma resulting in bone loss of the mandible	Fixed fee of R 21 000 for the placement of implants per family per annum	Fixed fee of R 16 000 for the placement of implants per family per annum	No benefit
1.10.3 Prosthetics phase Only for cancer surgery of the mandible or trauma resulting in bone loss of the mandible	Fixed fee of R 21 000 for the prosthetic phase per family per annum	Fixed fee of R 16 000 for the prosthetic phase per family per annum	No benefit
1.11 Renal Dialysis Subject to PMB's and pre-authorisation	100% of DSP tariff* Unlimited benefits for PMB admissions. Subject to designated service providers, treatment protocols and formulary.	100% of DSP tariff* Unlimited benefits for PMB admissions. Subject to designated service providers, treatment protocols and formulary.	100% of DSP tariff* Unlimited benefits for PMB admissions only. Subject to designated service providers, treatment protocols and formulary.

1.12 Sterilization/Vasectomy Subject to authorisation from the Scheme	100% of Scheme tariff* Sterilization limited to R 11 000 per person per annum Vasectomy co-payment of R 1 100 if procedure is done under general anesthetic or in major theatre	100% of Scheme tariff* Sterilization limited to R 10 500 per person per annum Vasectomy co-payment of R1 100 if procedure is done under general anesthetic or in major theatre	No Benefit
1.13 Internal Prosthesis Subject to PMB's, pre-authorisation and protocols	100% of cost Limited to R 48 500 per family per annum. Sub-Limits: Joint replacements – Limited to one case per annum except in instances of sepsis or trauma Stents – One per lesion, maximum 3 lesions Aphakic Lenses – R 7 300 per lens	100% of cost Limited to R 34 000 per family per annum. Sub-Limits: Joint replacements – Limited to one case per annum except in instances of sepsis or trauma Stents – One per lesion, maximum 3 lesions Aphakic Lenses – R 4 000 per lens	100% of cost Limited to R 15 000 per family per annum Sub limits: Joint replacements – Excluded Stents – Subject to Scheme protocols Aphakic lenses - Excluded
1.14 Physiotherapy and Biokinetics Subject to PMB's and pre-authorisation	100% of Scheme tariff*	100% of Scheme tariff*	100% of Scheme tariff* Subject to PMB's only
1.15 Step Down Facilities In lieu of hospitalisation Subject to PMB's and pre-authorisation	100% of Scheme tariff* Limited to 14 days per person per annum	100% of Scheme tariff* Limited to 14 days per person per annum	100% of Scheme tariff* Limited to 14 days per person per annum
1.16 Private Nursing In lieu of hospitalization Subject to PMB's and pre-authorisation	100% of Scheme tariff* Limited to 14 days per person per annum	100% of Scheme tariff* Limited to 14 days per person per annum	100% of Scheme tariff* Limited to 14 days per person per annum
1.17 Rehabilitation Facilities Subject to PMB's and pre-authorisation	100% of Scheme tariff* Limited to 14 days per person per annum	100% of Scheme tariff* Limited to 14 days per person per annum	100% of Scheme tariff* Limited to 14 days per person per annum
1.18 Circumcision In and out of hospital Subject to pre-authorisation	100% of Scheme tariff*	100% of Scheme tariff*	100% of Scheme tariff* Limited to R 700 per person per annum
1.19 Hyperbaric Oxygen Therapy Subject to PMB's and pre-authorisation	70% of Scheme tariff* Limited to R 36 000 per family per annum	70% of Scheme tariff* Limited to R 31 000 per family per annum	Only PMB's payable
1.20 Negative pressure wound therapy Subject to authorisation from the Scheme	100% of Scheme tariff* Limited to R 20 000 per family per annum	100% of Scheme tariff* Limited to R 20 000 per family per annum	No Benefit
1.21 Medication for age related muscular degeneration Subject to authorisation from the Scheme	70% of cost	70% of cost	No Benefit

<p>1.22 Back surgery</p>	<p>100% of Scheme tariff*</p> <p>Subject to PMB's and pre-authorisation. Fusion, laminectomy, discectomy: Back surgery for the above procedures will only be funded if the Scheme is satisfied that the beneficiary has completed a course of conservative back treatment.</p> <p>If the patient fails to comply with the conservative treatment program and goes for surgery without authorisation a co-payment of 30% on accommodation, medicines, consultations and procedures is applicable</p>	<p>100% of Scheme tariff*</p> <p>Subject to PMB's and pre-authorisation. Fusion, laminectomy, discectomy: Back surgery for the above procedures will only be funded if the Scheme is satisfied that the beneficiary has completed a course of conservative back treatment.</p> <p>If the patient fails to comply with the conservative treatment program and goes for surgery without authorisation a co-payment of 30% on accommodation, medicines, consultations and procedures is applicable</p>	<p>100% of Scheme tariff*</p> <p>Subject to PMB conditions only and pre-authorisation. Subject to back treatment clinical protocols</p>
<p>1.23 STEREOTACTIC RADIO-SURGERY Subject to PMB's and pre-authorisation. Benefit for primary central nervous system tumours only</p>	<p>100% of Scheme tariff*</p>	<p>100% of Scheme tariff*</p>	<p>No Benefit</p>
<p>1.24 LAPAROSCOPIC HOSPITALISATION AND ASSOCIATED COSTS Subject to PMB's and pre-authorisation Laparoscopic hospitalisation and associated costs will attract a 10 % co-payment except for the following circumstances where no co-payment will apply: Purely diagnostic laparoscopy Aspiration/excision ovarian cyst Lap-cholecystectomy Lap-appendectomy for females Repair of recurrent or bilateral inguinal hernias</p>	<p>100% of Scheme tariff*</p>	<p>100% of Scheme tariff*</p>	<p>No Benefit</p>

OUT OF HOSPITAL BENEFITS 2. GENERAL PRACTITIONERS AND SPECIALISTS

OPTION	PLUS	VALUE	STEP
<p>2.01 Consultations (Out-of-Hospital - Including general practitioners, specialists and outpatient facilities)</p> <p>NB: All specialist consultations require general practitioner referral or payment will be made at GP rates only</p>	<p>100% of Scheme tariff*</p> <p>General Practitioners, Specialists and outpatient facilities 16 visits per person limited to 26 visits per family per annum. Additional 5 visits per pregnancy (in addition to normal consultation limit)</p>	<p>100% of Scheme tariff*</p> <p>General Practitioners, Specialists and outpatient facilities 10 visits per person limited to 21 visits per family per annum</p>	<p>100% of Scheme tariff*</p> <p>General Practitioners No annual limit subject to member's choice of nominated GP. Subject to pre-authorisation Non - nominated GP's limited to 5 visits per person and to 14 visits per family per annum</p> <p>Specialist Limited to 3 visits per family per annum only on referral from nominated GP. Subject to pre-authorisation</p> <p>Outpatient facilities – No benefit</p>
<p>2.02 Antenatal care Note: waiting periods may apply subject to the rights of interchangeability Scans subject to hospital benefits</p>	<p>100% of Scheme tariff* Included in benefit available for consultations, medication and hospital limits. Limited to 2 sonars per pregnancy</p>	<p>100% of Scheme tariff* Included in benefit available for consultations, medication and hospital limits. Limited to 2 sonars per pregnancy</p>	<p>100% of Scheme tariff* Included in benefit available for consultations, medication and hospital limits. Limited to 2 sonar's per pregnancy</p>
<p>2.03 Diagnostic Investigations (Out of hospital) Subject to PMB's</p>	<p>100% of Scheme tariff*</p> <p>Pathology Limited to R3 700 per person per annum</p> <p>Radiology Limited to R2 600 per person per annum</p> <p>MRI/PET/CAT scans Limited to two scans per person per annum Subject to pre-authorisation</p>	<p>100% of Scheme tariff*</p> <p>Pathology Limited to R 2 100 per person per annum</p> <p>Radiology Limited to R 1 600 per person per annum</p> <p>MRI/PET/CAT scans Limited to two scans per person per annum Subject to pre-authorisation</p>	<p>100% of Scheme tariff*</p> <p>Pathology Limited to R 600 per person per annum</p> <p>Radiology Limited to R 600 per person per annum</p> <p>MRI/CAT scans – No benefit</p>

3. MEDICINES & INJECTION MATERIAL

<p>3.01 Acute Medicines - Including homeopathic medicines</p>	<p>100% of preferred provider reference price* R 4 050 per person. Limited to R 8 000 per family per annum</p>	<p>100% of preferred provider reference price* R 2 600 per person. Limited to R5 300 per family per annum</p>	<p>100% of preferred provider reference price* Unlimited subject to medicine dispensed by the nominated GP and medicine formulary</p>
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<p>3.02 PMB Chronic Disease List Medicines PMB's subject to registration and pre-authorisation with the Schemes preferred provider. Tel: 0860 119 553 Chronic medication may be obtained from the Schemes preferred provider only. Subject to renewal of prescription every six months.</p>	<p>100% of preferred provider reference price* Unlimited subject to treatment protocols and medicine formulary* Non formulary products will incur a 20% co-payment where these are obtained voluntarily by beneficiaries Benefit initially payable from limit 3.03 below</p>	<p>100% of preferred provider reference price* Unlimited subject to treatment protocols and medicine formulary* Non formulary products will incur a 20% co-payment where these are obtained voluntarily by beneficiaries. Benefit initially payable from limit 3.03 below</p>	<p>100% of preferred provider reference price Unlimited subject to designated service provider, treatment protocols, medicine formulary and registration of the chronic medicine by the nominated GP</p>
<p>3.03 Other Chronic (Non CDL) Medicines Non PMB's subject to pre- authorisation and registration with the Schemes preferred provider. Tel: 0860 119 553 Chronic medication may be obtained from the Schemes preferred provider only Subject to renewal of prescription every six months.</p>	<p>100% of preferred provider reference price* R 10 700 per person. Limited to R 20 400 per family per annum Subject to treatment protocols and medicine formulary* Non formulary products will incur a 20% co-payment where these are obtained voluntarily by beneficiaries</p>	<p>100% of preferred provider reference price R 5 000 per person Limited to R 10 100 per family per annum Subject to treatment protocols and medicine formulary* Non formulary products will incur a 20% co-payment where these are obtained voluntarily by beneficiaries</p>	<p>100% of preferred provider reference price Unlimited subject to designated service provider, treatment protocols, medicine formulary and registration of the chronic medicine by the nominated GP</p>
<p>3.04 Pharmacy Advised Treatment (PAT) Over the counter medication. Consultation with pharmacist, restricted to schedule 0, 1 and 2 medicines</p>	<p>Limited to R 800 per family per annum Maximum R 170 per script Included in limit 3.01 above</p>	<p>Limited to R 500 per family per annum Maximum R 120 per script Included in limit 3.01 above</p>	<p>No Benefit</p>

**4. OPTICAL BENEFIT (Contact the Schemes preferred provider network for availability and locality of network optometrists)
TEL: 0860 10 35 29**

<p>4.01 SPECTACLE LENSES: IN NETWORK Benefit applicable to members who utilize the Scheme's Preferred Provider Network Optometrists</p> <p>Limited to one pair of spectacles per person every 24 months</p>	<p>100% of PPN tariff</p> <p>R 130 per lens – clear aquity single vision or R 290 per lens – clear aquity bifocal vision or R 530 per lens – clear aquilty multifocal vision Fixed tints up to 35%</p> <p>No benefit for contact lenses if spectacles purchased</p> <p>Limited to one pair of spectacles per person every 24 months</p>	<p>100% of PPN tariff</p> <p>R 130 per lens – clear aquity single vision or R 290 per lens – clear aquity bifocal vision or aquilty multifocal vision Fixed tints up to 35%</p> <p>No benefit for contact lenses if spectacles purchased</p> <p>Limited to one pair of spectacles per person every 24 months</p>	<p>100% of cost</p> <p>R 450 per person payable every 24 months. Subject to the Scheme's designated service provider</p> <p>Pre-authorisation is required</p>
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<p>4.02 SPECTACLE LENSES: OUT OF NETWORK Benefit applicable to members who choose to utilise non – Preferred Provider Network Optometrists</p> <p>Limited to one pair of spectacles per person every 24 months</p>	<p>100% of PPN tariff R 130 per lens – clear aquity single vision or R 290 per lens – clear aquity bifocal vision or R 530 per lens – clear aquilty multifocal vision Fixed tints up to 35%</p> <p>No benefit for contact lenses if spectacles purchased.</p> <p>Limited to one pair of spectacles per person every 24 months</p>	<p>100% of PPN tariff R 130 per lens – clear aquity single vision or R 290 per lens – clear aquity bifocal vision or aquilty multifocal vision Fixed tints up to 35%</p> <p>No benefit for contact lenses if spectacles purchased.</p> <p>Limited to one pair of spectacles per person every 24 months</p>	
<p>4.03 CONTACT LENSES: IN AND OUT OF NETWORK</p>	<p>100% of PPN tariff R 2 573 per person per annum</p> <p>No claim for spectacles if contact lenses purchased.</p> <p>One claim per person every 24 months</p>	<p>100% of PPN tariff R 1 615 per person per annum</p> <p>No claim for spectacles if contact lenses purchased.</p> <p>One claim per person every 24 months</p>	No benefit
<p>4.04 FRAMES: IN AND OUT OF NETWORK A frame cannot be claimed alone or with contact lenses</p> <p>One claim per person every 24 months</p>	<p>100% of PPN tariff R 630 per person</p>	<p>100% of PPN tariff R 475 per person</p>	Included in limit 4.01 above
<p>4.05 EYE TESTS: IN NETWORK</p>	<p>100% of PPN tariff One comprehensive consultation per person Limited to R 505 per person</p>	<p>100% of PPN tariff One comprehensive consultation per person Limited to R 505 per person</p>	Included in limit 4.01 above
<p>4.06 EYE TESTS: OUT OF NETWORK One claim per person every 24 months</p>	<p>100% of cost Limited to R 230 per person</p>	<p>100% of cost Limited to R 230 per person</p>	Included in limit 4.01 above

5. DENTISTRY

<p>5.01 Conservative Dentistry (e.g. Fillings, extractions and x-rays)</p>	<p>100% of Scheme tariff* No annual limit Subject to treatment protocols</p>	<p>100% of Scheme tariff* Subject to overall annual limit Subject to treatment protocols</p>	<p>100% of Scheme tariff* Subject to overall annual limit Pre-authorisation required.</p>
<p>5.02 Dental Therapist Subject to treatment protocols.</p>	<p>100% of Scheme tariff* R 800 per person limited to R 1 600 per family per annum</p>	<p>100% of Scheme tariff* R 550 per person limited to R 1 100 per family per annum</p>	No Benefit

5.03 Special Dentistry (e.g. crowns, bridgework, orthodontics and periodontics)	100% of Scheme tariff* R 4 800 per person. Limited to R 6 050 per family per annum Subject to pre-authorisation by the Scheme and treatment protocols. If not pre-authorised there will be a 20% co-payment.	100% of Scheme tariff* R 3 150 per person. Limited to R 4 500 per family per annum Subject to pre-authorisation by the Scheme and treatment protocols. If not pre-authorised there will be a 20% co-payment.	No Benefit Dentures: one set of plastic dentures per beneficiary every 4 years Pre-authorisation required.
5.04 Maxillo Facial and Oral Surgery (Consultations, surgical procedures and operations) Subject to pre-authorisation by the Scheme and treatment protocols.	100% of Scheme tariff* (included in limit 5.03) Benefit is payable from hospitalisation in cases of accidents, injury, congenital abnormalities and oncology related procedures only	100% of Scheme tariff* (included in limit 5.03) Benefit is payable from hospitalisation in cases of accidents, injury, congenital abnormalities and oncology related procedures only	No Benefit

6. ALTERNATIVE SERVICES

6.01 Homeopathy, Naturopathy Chiropractic and Podiatry	100% of Scheme tariff* Collectively limited to R2 800 per family per annum	100% of Scheme tariff* Collectively limited to R2 625 per family per annum	No Benefit
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7. REMEDIAL AND OTHER THERAPIES

7.01 Audiology, Speech therapy, Dieticians, Hearing aid acousticians, Occupational therapy, Orthotics, social workers and speech therapy	100% of Scheme tariff* Collectively limited to R3 600 per family per annum	100% of Scheme tariff* Collectively limited to R2 520 per family per annum	No Benefit
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8. APPLIANCES

8.01 e.g. Hearing aids, wheelchairs and calipers Subject to pre-authorisation by the Scheme. If not pre-authorised there will be a 20% co-payment.	100% of cost Limited to R 10 800 per family per annum. Stoma Care subject to a sub limit of R5 250 per family per annum Wheelchairs – one claim per person every 36 months subject to pre-authorisation. Hearing aids – one claim per person every 24 months subject to pre-authorisation	100% of cost Limited to R 9 700 per family per annum Stoma Care – subject to a sub limit of R5 250 per family per annum Wheelchairs – one claim per person every 36 months subject to pre-authorisation. Hearing aids – one claim per person every 24 months subject to pre-authorisation.	Hearing aids limited to R 1 800 per person every four years. Subject to pre-authorisation
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9. EXTERNAL PROSTHESIS

9.01 e.g. Artificial limbs and eyes Subject to pre-authorisation	100% of cost Limited to R 14 300 per family per annum	100% of cost Limited to R 12 900 per family per annum	Subject to PMB's Subject to pre authorisation
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10. PHYSIOTHERAPY (out of hospital)

10.1 Biokinetics and Physiotherapy	100% of Scheme tariff* R 1 900 per person limited to R 3 200 per family per annum	100% of Scheme tariff* R 1 200 per person limited to R 2 050 per family per annum	Back pain protocol only No Benefits
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11. OTHER BENEFITS

11.1 Air/Road Ambulance and Emergency Services. The Schemes preferred provider must be contacted should you require an ambulance – failure to adhere to this could result in you being held liable for costs incurred.	100% of cost Non-emergency: Subject to pre-authorisation beforehand Emergency: Subject to authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only Tel: 082 911 (Netcare)	100% of cost Non-emergency: Subject to pre-authorisation beforehand Emergency: Subject to authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only Tel: 082 911 (Netcare)	100% of cost Non-emergency: Subject to pre-authorisation beforehand Emergency: Subject to pre- authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. Tel: 082 911 (Netcare)
11.2 HIV / AIDS MANAGEMENT PROGRAMME Benefits are subject to the Scheme's Designated Service Provider's protocols.	100% of cost Benefits are subject to prior enrolment in and adherence to the HIV/AIDS Management programme administered by the Schemes preferred provider. Tel: 0860 50 60 80 Members not registered with the Schemes preferred provider are not entitled to benefits in private institutions. Benefit is payable as a PMB subject to designated service suppliers, treatment protocols and formulary	100% of cost Benefits are subject to prior enrolment in and adherence to the HIV/AIDS Management programme administered by the Schemes preferred provider. Tel: 0860 50 60 80 Members not registered with the Schemes preferred provider are not entitled to benefits in private institutions. Benefit is payable as a PMB subject to designated service suppliers, treatment protocols and formulary	100% of cost Hospitalisation payable as a PMB at state facilities only. Management programme administered by the Schemes preferred provider. Tel: 0860 50 60 80 Members not registered with the Schemes preferred provider are not entitled to benefits in private institutions. Benefit is payable as a PMB subject to designated service suppliers, treatment protocols and formulary
11.3 PSYCHOLOGY AND PSYCHIATRY SERVICES Benefit includes outpatient consultation and treatment, consultations, medication and pathology examinations Subject to PMB's	Annual limit: M - R3 650 M 1 - R5 450 M 2+ - R7 300	Annual limit: M - R2 250 M 1 - R3 990 M 2+ - R5 670	Subject to PMB's

11.4 INFERTILITY Subject to PMB's at state/public facilities only	Subject to PMB's	Subject to PMB's	Subject to PMB's
11.5 HOSPICE AND PRIVATE NURSING Subject to PMB's	100% of Scheme tariff Subject to combined limit of a maximum period of 14 days per annum	100% of Scheme tariff Subject to combined limit of a maximum period of 14 days per annum	100% of Scheme tariff Subject to combined limit of a maximum period of 14 days per annum
12. OVERALL ANNUAL LIMIT ON OUT OF HOSPITAL BENEFITS Overall annual limit, collectively on out of hospital benefits for: 3.01 Acute Medicines - Including homeopathic medicines 5.03 Special Dentistry 6.01 Homeopathy, Naturopathy Chiropractic and Podiatry 7.01 Audiology, Speech therapy, Dieticians, Hearing aid acousticians, Occupational therapy, Orthotics, social workers and speech therapy 8.01 Hearing aids, wheelchairs and calipers 9.01 Artificial limbs and eyes 10.1 Biokinetics and Physiotherapy 11.3 Psychology and Psychiatry services 11.4 Infertility	100% of Scheme tariff* Collectively limited to per family per annum M: R 8 400 M+1: R 17 850 M+2: R 19 425 M+3 R 21 525		

* **Scheme tariff:** The Scheme tariffs have been set at the NHRPL as published by the Department of Health. The Board of trustees of the Scheme reserves the right to amend this.

* **Preferred Provider Reference Price – Mediscor Reference Price** as made available by Mediscor

* **Formulary – As provided by Mediscor.** Mediscor formulary with MRP applied

* **UPFS – Uniform Patient Fee Schedule**

* **DSP – Designated Service Provider**

Premium penalties for persons joining late in life:

Premium penalties for persons joining late in life. Premium penalties will be applied in respect of persons over the age of 35 years, who were without medical Scheme cover for the period indicated hereunder after the age of 35 years as follows:

- **1 - 4 @ 0.05 multiplied by the relevant contribution above**
- **5 - 14 @ 0.25 multiplied by the relevant contribution above**
- **15 - 24 @ 0.50 multiplied by the relevant contribution above**
- **25 + years @ 0.75 multiplied by the relevant contribution above**

“creditable coverage” means any period of verifiable medical Scheme membership of the applicant or his or her dependant, but excluding membership as a child dependant, terminating two years or more before the date of the latest application for membership. Any years of creditable coverage which can be demonstrated by the applicant or his or her dependant shall be subtracted from his or her current age in determining the applicable penalty.

Disclaimer:

Every effort has been made to ensure that this brochure is an accurate explanation of the benefits offered by Hosmed Medical Scheme. Please note that this document does not replace the Rules of the Scheme, which take precedence over any wording in this guide.

HOSMED MEDICAL SCHEME

Exclusions and limitations of benefits

1. PRESCRIBED MINIMUM BENEFITS

Notwithstanding the limitations and exclusions set out in this Annexure, beneficiaries shall be entitled to the prescribed minimum benefits as provided for in the Regulations to the Medical Schemes Act.

2. LIMITATIONS AND RESTRICTIONS OF BENEFITS

- 2.1. The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme. The procedure to be followed in obtaining a second opinion is outlined in the relevant Scheme protocol (Protocol Regarding Requests For Second Opinions).
- 2.2. In cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.
- 2.3. Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.
- 2.4. If the Scheme or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of clinical guidelines.
- 2.5. If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure A, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its managed healthcare organisation may impose. "Medical necessity" is defined in the Scheme policy: Definition of Medical Necessity.
- 2.6. The Scheme reserves the right not to pay for any new technology. Coverage of new technology will be assessed by the Scheme with due consideration given to:
 - 2.6.1. medical necessity;
 - 2.6.2. clinical evidence of its use in clinical medicine including outcome studies;
 - 2.6.3. its cost-effectiveness;
 - 2.6.4. its affordability;
 - 2.6.5. its value relative to existing services or supplies;
 - 2.6.6. its safety.New technology is defined as any clinical intervention of a novel nature as well as those that the Scheme has not had previous experience with.
- 2.7. A 10% co-payment will be applied on the following procedure codes:
 - 2.7.1. 1034 - Autogenous nasal bone transplant: Bone removal included
 - 2.7.2. 1035 - Functional endoscopic sinus surgery: Unilateral
 - 2.7.3. 1036 - Functional endoscopic sinus surgery: Bilateral
 - 2.7.4. 1087 - Sub-total reconstruction consisting of any two of the following:
 - 2.7.5. Septum plasty, nasal osteotomy, nasal tip reconstruction
- 2.8. Mirena device Fund according to Scheme protocol:
40 years of age. Not covered if used for contraception. Cover for abnormal uterine bleeding.
Insertion in rooms no co-payment applicable
Insertion in theatre – co-payment R 800.00 even if done in conjunction with another procedure
Mirena device – cost from acute medicine benefit
- 2.9. The Scheme reserves the right to impose and apply exclusions and limits to the benefits that will be paid for medicines/procedures/interventions which have been accepted into the practice of clinical medicine through a process of health technology assessment/evaluation.
- 2.10. XDR - extreme drug resistant and MDR – Multi drug resistant TB
Admission will be covered at step down rates.
Scheme will restrict benefits for isolation to UPFS rates.
The following will be required:
Motivation
Lab results to confirm XDR. Payment of such claims will not be withheld pending the motivation and lab results.
- 2.11. Benefits in respect of the cost of emergency medical treatment, whilst abroad, are covered at the applicable South African tariff rates and RSA currency;
- 2.12. High myopia – payable as per Scheme protocols

3. BENEFITS EXCLUDED

General exclusions mentioned in this paragraph are not affected by any specific exclusion. Unless otherwise decided by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme), expenses incurred in connection with any of the following will not be paid by the Scheme:

- 3.1. all costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure A, for the benefits to which the member is entitled in terms of the rules;
- 3.2. all costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons;
- 3.3. if, in the opinion of the medical advisor, the healthcare service in respect of which a claim is made, is not appropriate and necessary for any aspect of the management of the medical condition at an affordable level of service and cost;
- 3.4. all costs for treatment, if the efficacy and safety of such treatment cannot be proved;
- 3.5. the Scheme shall not be liable for the payment of any costs incurred by a member which arose, or may have arisen, as a result of the actions or omissions of another party. If the Scheme in its sole and absolute discretion elects to effect payment of any costs incurred by the member arising from the actions or omissions of any other party, then in such an event the member shall:
 - 3.5.1. be liable to repay the Scheme amounts recovered by or on behalf of the member from the party responsible to compensate such member, free of any legal costs or deductions that may have been incurred in the recovery of such amount;
 - 3.5.2. ensure that, prior to the settlement of any claim instituted against such other party, all the amounts set out above and paid by the Scheme, are included in such claim and form part of any settlement amount, whether globular or separately;
 - 3.5.3. disclose to the Scheme, alternatively, instruct his legal representative to disclose to the Scheme, the full extent of any compensation awarded in respect of past and future medical expenses;
 - 3.5.4. sign all documentation as may be required by the Scheme to obtain copies of all such information not in the Scheme's possession, relating to the member's medical accounts and records from the relevant practitioners and/or medical institutions;
 - 3.5.5. sign all documentation as may be required by the Scheme, to proceed with a claim in the member's name to recover any amounts expended by the Scheme, subject to the Scheme indemnifying the member against any costs which may arise as a result of the institution of such claim, if the Scheme is satisfied that a valid claim exists and the member elects not to proceed with it;
 - 3.5.6. be deemed to be liable to repay amounts refunded to the Scheme, as above, in the event of the member's claim being finalised and paid in circumstances where no specific or separate award is made for the payment of medical or hospital expenses incurred;
 - 3.5.7. either personally or through his legal representative keep the Scheme informed, whether called upon by the Scheme to do so or not, as to the ongoing progress of his claim;
 - 3.5.8. when requested by the Scheme, whether prior to or subsequent to the Scheme effecting any payments as referred to above, provide the Scheme with a written undertaking signed by both the member and his legal representative so as to give full effect to what is contained in paragraphs 3.88 and 3.6.1 to 3.6.7.
- 3.6. cost incurred from a member which arose or may have arisen as a result of the actions or omission of another party.
 - 3.6.1. Where such cost is a result of an injury sustained by the member the Scheme will require a full injury report.
 - 3.6.2. If such cost results from a work related injury the Scheme will cover it and will be referred to the COID commissioner and any amounts paid out will be refunded to the Scheme.
 - 3.6.3. Where such cost result from negligence of another party that may result in a public liability insurance claim the Scheme will cover the cost arising, subject to PMB's and annual benefits available in terms of the rules of the Scheme.
 - 3.6.4. Where such cost result from a motor vehicle accident the following will apply in term of the Regulations of the RAF Act.:
 - 3.6.4.1. Member and attorney must submit to the Scheme a signed letter of undertaking that, if there is a successful RAF claim, all money paid with respect to medical expenses will be reimbursed in full to the medical Scheme.
 - 3.6.4.2. If a valid RAF claim exists and the member opts not to claim from the RAF the Scheme will only cover medical expenses related to the accident, up to and including PMB's and annual benefits available.
 - 3.6.4.3. The cost of any injury not covered by the RAF will be borne by the Scheme at UPFS (Uniform Patient Fee Schedule) rates.
 - 3.6.4.4. Cost for emergency treatment will be covered at the tariff published by the RAF in the regulations.
- 3.7. all costs for services rendered by:
 - 3.7.1. persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
 - 3.7.2. any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law;
- 3.8. abdominoplasties (including the repair of divarication of the abdominal muscles);
- 3.9. accommodation and services provided in a geriatric hospital, old age home, frail care facility or the like (unless specifically provided for in Annexure A);

- 3.10. acupuncture;
- 3.11. anabolic steroids, immunostimulants (except for immunoglobulins and growth hormones, which are subject to pre-authorisation by the relevant managed healthcare programme);
- 3.12. ante and postnatal exercises;
- 3.13. appointments which a beneficiary fails to keep;
- 3.14. appliances, devices and procedures not scientifically proven or appropriate;
- 3.15. arch supports including shoe inserts;
- 3.16. aromatherapy;
- 3.17. autopsies;
- 3.18. ayurvedics;
- 3.19. back rests and chair seats;
- 3.20. bandages and dressings (except medicated dressings subject to authorisation by the relevant managed healthcare programme);
- 3.21. beds and mattresses;
- 3.22. bilateral gynaecomastia in beneficiaries under the age of 18 years (in beneficiaries over 18 years Scheme protocol will apply);
- 3.23. blepharoplasties;
- 3.24. breast augmentation;
- 3.25. breast reconstruction (unless necessitated by pre-authorized surgical mastectomy, traumatic mastectomy or congenital unilateral absence of a breast which is subject to Scheme protocol);
- 3.26. breast reductions;
- 3.27. nasal surgery done by a plastic surgeon, nasal cautery (procedure code 1069) if done with other intranasal procedures;
- 3.28. external cardiac assistive devices;
- 3.29. colored or cosmetic effect contact lenses, and contact lens accessories and contact lens solutions;
- 3.30. contraception, (excluding tubal ligation and vasectomy), IUD's for contraceptive purposes and contraceptive foams;
- 3.31. cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, not including coal tar products and the treatment of lice infestation, scabies and other microbial infections (subject to PMB regulations);
- 3.32. dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable; and costs for:
 - 3.32.1. anesthetics in respect of dental services:
 - general anesthetics, conscious analgo-sedation and hospitalisation for dental work except in the case of patients under the age of 7 years and bony impaction of third molars;
 - 3.32.2. labial frenectomies in respect of beneficiaries under the age of 12 years;
 - 3.32.3. orthodontic treatment over the age of 21 years;
 - 3.32.4. periodontal plastic procedures for cosmetic reasons;
 - 3.32.5. use of high impact acrylic and precious metal in dentures or the cost of precious metal as an alternative to semi-precious or non-precious metal in dental prosthesis;
 - 3.32.6. osseo-integrated tooth implants; genioplasty and dental osteotomy
- 3.33. diagnostic kits, agents and appliances unless otherwise stated except for diabetic accessories (subject to PMB regulations and Scheme protocols);
- 3.34. treatment of depression using sleep therapy;
- 3.35. electric tooth brushes;
- 3.36. treatment for erectile dysfunction and loss of libido;
- 3.37. food and nutritional supplements including baby food and special milk preparations;
- 3.38. gender re-assignment treatment;
- 3.39. genioplasties;
- 3.40. headaches: oral appliances and the ligation of temporal artery and its branches for the treatment of headaches;
- 3.41. hirsutism;
- 3.42. HIV resistance testing unless registered on the relevant managed healthcare programme in which case Scheme protocols will apply;
- 3.43. holidays for recuperative purposes;
- 3.44. humidifiers;
- 3.45. hyperbaric oxygen therapy subject to PMB regulations and Scheme protocols;
- 3.46. infertility treatment, subject to PMB regulations;
- 3.47. ionizers and air purifiers;
- 3.48. iridology;
- 3.49. surrogate pregnancy;

- 3.50. keloid surgery, except for burns and functional impairment deemed by the Scheme to medically necessary;
- 3.51. laxatives, subject to Scheme protocols;
- 3.52. medical, surgical and orthopedic appliances, devices and products, including oxygen hire or purchase and attachments, subject to PMB regulations and Scheme protocols;
- 3.53. medication in respect of substance abuse treatment unless specifically authorised by the relevant managed healthcare programme, subject to PMB regulations;
- 3.54. medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines (except for schedule 0,1 and 2 medicines supplied by a registered pharmacist);
- 3.55. medicine not approved by the Medicines Control Council or other statutory body empowered to approve/register medications;
- 3.56. MRI scans ordered by a general practitioner, subject to Scheme protocols;
- 3.57. obesity treatment;
- 3.58. oral and parenteral contraceptives;
- 3.59. optical devices excluded by the relevant managed healthcare programme;
- 3.60. donor costs related to organ and tissue donations;
- 3.61. orthopedic shoes and boots, subject to Scheme protocols;
- 3.62. osteopathy;
- 3.63. otoplasties;
- 3.64. pain relieving machines e.g. TENS, APS;
- 3.65. medicines, household remedies and propriety preparations and preparations not otherwise classified;
- 3.66. Positron Emission Tomography (PET) scans where applicable;
- 3.67. refractive surgery;
- 3.68. excimer laser treatment;
- 3.69. reflexology;
- 3.70. revision of scars;
- 3.71. rhinoplasties;
- 3.72. smoking cessation and anti-smoking preparations;
- 3.73. stethoscopes;
- 3.74. sphygmomanometers/blood pressure monitors;
- 3.75. sunglasses and repairs to spectacle frames;
- 3.76. counseling, subject to prescribed minimum benefits;
- 3.77. telephone consultations;
- 3.78. tonics, evening primrose oil, fish liver oils, nutritional supplements, multivitamin preparations and minerals except prenatal vitamins as approved by the Scheme's pharmacy benefit management programme;
- 3.79. topical preparations excluding topical steroid and acne preparations;
- 3.80. travelling expenses;
- 3.81. uvulo-palatal pharyngoplasty (UPPP and LAUP);
- 3.82. veterinary products;
- 3.83. pharmacy service fees;
- 3.84. facility fees;
- 3.85. fentonplasty;
- 3.86. Insulin pumps except for children 7 years or younger
- 3.87. Green laser prostatectomy
- 3.88. services rendered during any waiting periods that are imposed on the member or any dependent joining the Scheme;
- 3.89. medical expenses resulting from the treatment of occupational diseases and injuries;
- 3.90. all claims where ICD-10 codes are missing, invalid or incomplete will be rejected;
- 3.91. It is recorded that the relationship between the Scheme and its members shall at all times be deemed to be one of the utmost good faith.

The member therefore acknowledges that, notwithstanding anything to the contrary, or not specifically set out in the rules or Annexures of the Scheme, the member is under a duty of care to disclose all and any information or matters to the Scheme, which may in any manner impact upon or affect a decision or discretion which vests in the Scheme, concerning such member or his claim.

E.&O.E.





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