MASSMART HEALTH PLAN 2019

Contributions to the Health Plan are made in arrears and are based on the option you chose. The contribution table detailing the current contributions for all members and their dependants will be sent to you separately. Annually, the trustees of the Health Plan set the amount of contributions that will be paid. This is monitored on a regular basis.

The trustees take the following into consideration when reviewing contribution levels:

- The financial performance of the Health Plan options.
- Tariff increases for the following year.
- The requirements of legislation.

CHOICE:
Contributions to the choice option are billed per Member, adult dependants and child dependants. These contributions remain fixed each month and are increased annually.

NETWORK:
Contributions to the Network option are based on the basic salary plus commission per month and are billed according to an income scale. The contributions may change depending on the member's salary and are increased annually.

ESSENTIAL:
Contributions to the Network option are based on the basic salary plus commission per month and are billed according to an income scale. The contributions may change depending on the member's salary and are increased annually.

The Choice Option was designed to be flexible and cost effective and to encourage you to manage and control your own day-to-day healthcare expenses. Choice consists of a savings account and an insured benefits pool. You can personally monitor and manage the use of your benefits. A significant advantage of this type of Health Plan is that you may carry unused savings in your savings account over to the following year, which means that you can build up a reserve of savings for future healthcare needs. This reserve is referred to as the accumulated savings account.

Your savings account

In accordance with the prevailing legislation, the Health Plan offers one level of savings. You control expenditure in your personal savings account. It is your money; however you should manage it like you would a bank account. Your savings account is used to pay for day-to-day medical expenses such as doctor's consultations and acute medication, i.e. medication for short-term medical conditions such as colds and flu. The Summary of Benefits details the benefits and amount that will be paid from your savings account.

Where specific limits are applicable under the insured benefits pool, the balance of your savings account cannot be used to "top up" these limits, as your savings account is designed to meet the current year's day-to-day medical costs. However, on application to the trustees, any funds in your accumulated savings account may be used for this purpose. You also have the choice to choose to have any amount above scheme tariff and limits to be paid automatically from your savings. Please contact the call centre to authorize the activation of this feature.

How does the savings account work?

Twice a year in, January and July, 20% of your total contribution for a six month period is credited to your Savings Account. If you join the Health Plan at any time after 1 January, the amount credited to your savings account will be adjusted depending on the number of months you will be a member of the Health Plan for that year. If you leave the Health Plan during the year, the amount in your savings account will be adjusted to take account of the number of months that you have been a member. If you have overspent at the time of termination, you will have to pay back the difference and failure to do so will result in legal action. You will receive a claims statement on a monthly basis to indicate the movement and balance of your savings account.

Your accumulated savings account

Every year the unused balance in your savings account from the previous year is transferred to your accumulated savings account. The transfer of funds takes place during May each year. This allows for all outstanding claims from the previous year to be processed and paid. The balance in your accumulated savings account earns interest, credited monthly at a rate determined by the trustees.

What happens if you leave the Choice Option?

If you leave the Choice Option, you will receive the credit balance of your personal savings account and your accumulated savings account. The refund will occur five months after you have left the Health Plan to allow sufficient time for all permissible claims that you have incurred, up to the date of leaving, to be paid.

According to legislation, when leaving a medical scheme and joining a new medical scheme that also has a savings account, any savings or accumulated savings are required to be transferred directly to the new scheme. If you are not joining a new scheme that has a savings portion, these refunds will be transferred electronically into your bank account. To confirm where you would like this money to be transferred, complete the form available from the Employee Benefits Department or the administrator.

Insured benefits pool

Treatments referred to in the summary of benefits as “insured benefits” are paid for out of the insured benefits pool. These treatments are paid for at the scheme tariff.

Provider Networks

It has been proved that when patients consistently consult the same doctor, the overall health of members is better and the overall cost of healthcare is lower than when members visit multiple doctors. With this in mind, a Network of General Practitioners has been established for members where competitive rates have been negotiated with these doctors. This has resulted in the Scheme being able to provide both appropriate affordable healthcare to members. The following two options utilise this network of doctors in order to offer members cover at a much reduced rate.

The Massmart Network Option is a traditional type of Health Plan, thus there is no savings element. This option offers network private hospital cover within an overall annual limit (OAL) for elective procedures. Any prescribed minimum benefits (PMBs) will be covered in full. Day-to-day benefits are available within the network of healthcare providers.

The Network Option requires beneficiaries to select a designated general practitioner from the network of healthcare providers. If you do not have direct access to the internet, you can ask your Human Resource or Employee Benefits Department to make use of the website portal to help you select a doctor in your area. Other day-to-day benefits are payable from an Annual Flexi Benefit (AFB) – refer to the summary of benefits for more detail. The design of this product makes this a very affordable option.

The Massmart Essential Option is similar to the Massmart Network Option except that members are only covered in hospital for PMBs and these will be provided at a network of private hospitals. Beneficiaries are also required to select a designated general practitioner. If you do not have direct access to the internet, you can ask your Human Resource or Employee Benefits Department to make use of the website portal to help you select a doctor in your area. (Refer to the summary of benefits for detail.)

The summary of benefits for all options sets out details of the benefits covered. The benefits are reviewed by the trustees annually. You should study your benefits so that you are fully aware of the cover you and your dependants have.