Benefit And Member Guide

Tiger Brands Medical Scheme 2019

Tiger Brands Medical Scheme

Tiger Brands Medical Scheme is an affordable scheme which offers four alternatives from which members can choose.

Three options with traditional benefits, **Level A, B, C** and **Primary Plus Options** which offers medical cover through a Network environment.

Level A, B and C

Provides members with an unlimited hospital benefit, at any private hospital, a Chronic Medicine Benefit and an Annual Routine Care Benefit with generous day-to-day limits. Benefits are paid at Scheme Tariff, limited to benefit limits.

With the different levels of Annual Routine Care Benefit available to members, members have a choice to select an option that suits their pocket and healthcare needs.

This option provides members with:

- Generous day-to-day benefits (Annual Routine Care Benefit)
- Separate chronic medicine benefit
- Access to any Private hospital for all medically necessary procedures
- Freedom of choice in service provider selection
- A wellness benefit - including flu vaccines and mammograms

Primary Plus Option

Provides extensive and affordable cover through Network Providers for Primary Care benefits, with an unlimited hospital benefit, at any private hospital. This option was previously known as the Mzansi Option.

Some of the many Primary Plus benefits include:

- Unlimited Primary Care Benefits – including GP consultations, acute and chronic medicine at Network Providers
- A large, national network of doctors, pharmacists, dentists and other healthcare providers
- Annual Flexi Benefit – for dentistry, optometry and specialist consultations
- Access to any private hospital for all medically necessary procedures

Index

Introduction	**1**
Index	**2**
Structure of the Scheme	**3**
Traditional Options (Levels A, B and C)	**4**
Contribution Table	4
Benefit Structure	4
Annual Routine Care Benefit (ARCB)	4
Specialist referral and authorisation	6
Hospital Benefit	7
Prosthesis and Devices	8
Alternatives to Hospital	8
Pre-authorisation and co-payments	9
Chronic Medicine Benefit	9
High Cost Appliances Benefit	11
Wellness Benefit	11
Primary Plus Option	**12**
Contribution Table	12
Benefits Schedule	12
Primary Care Benefit	12
Annual Flexi Benefit (AFB)	13
Hospital Benefit	14
Alternatives to Hospital	15
Specific exclusions	15
ER24: Emergency Transport	**16**
Managed Care Initiatives	**17**
Hospital pre-authorisation	17
Oncology Management Programme	17
Specialised Radiology authorisation	18
HIV/Aids Management Programme	18
Disease Management Programme	18
Scheme Rules	**19**
Membership	19
How to claim	20
Designated service providers	21
Exclusions	21
Complaints and Dispute procedure	**24**
Contact Details	**27**

Structure of the Scheme

Level A, B and C

- Annual Routine Care Benefit (ARCB) for day-to-day expenses
- Chronic Medicine Benefit for all authorised chronic medication
- High Cost Appliances benefit
- Hospital for all hospitalisation, oncology, organ transplants etc
- Wellness Benefit

Primary Plus Option

- Primary Care Benefit for GP consultations, acute medicine and authorised chronic medication
- Annual Flexi Benefit (AFB) for dentistry, optical and specialist visits
- Hospitals for all authorised hospitalisation, oncology, organ transplants etc

Abbreviations

PMB	Prescribed Minimum Benefit	**ARCB**	Annual Routine Care Benefit	**MRP**	Medicine Reference Price
MMAP	Maximum Medical Aid Price	**CDL**	Chronic Disease List	***Scheme Rate**	Scheme rate **2018** + **5.4%** or **Agreed Tariff
SAOA	South African Opthalmology Association	**Auxiliary services**	Associated Medical Services e.g. speech therapy	**TBMS**	Tiger Brands Medical Scheme

* **Scheme rate:** the rules of the Scheme make provision for benefits to be paid at a specific tariff, or rate, known as 'the Scheme rate'. This Scheme rate is in line with the industry benchmark tariff.

** **Agreed tariff:** this is a rate negotiated between the Scheme and certain health care providers.

Traditional Options

Level A, B and C Benefits.

Contribution Table (Effective 1 December 2018)

	PRINCIPAL MEMBER	ADULT	CHILD
Level A	R 4 896	R 2 466	R 1 236
Level B	R 4 104	R 1 890	R 942
Level C	R 3 354	R 1 638	R 822

Contributions increase annually, effective 1 December. The benefits and limits increase annually, effective 1 January. There is one contribution increase and one benefit increase in a 12-month period.

Child dependants pay child rates up to the age of 25, and their membership will be terminated at the end of the year in which they turn 25.

Benefit Structure

There are 5 benefit pools on the Traditional Options, namely:

- Annual Routine Care Benefit
- Hospital Benefit
- Chronic Medicine Benefit
- High Cost Appliances Benefit
- Wellness Benefit

Annual Routine Care Benefit (ARCB)

	Level A	Level B	Level C
Member	R 15 000	R 11 400	R 7 500
Adult	R 8 900	R 6 400	R 4 600
Child	R 2 800	R 1 900	R 1 100

Annual Routine Care Benefit (ARCB)

ARCB BENEFITS	LEVEL A	LEVEL B	LEVEL C	COMMENT
Consultations				
GP's	Subject to the ARCB			
Specialists	Subject to the ARCB			Subject to GP referral and pre-approval
Auxiliary services				
Emergency room visits				
Optical				
Eye test	One per beneficiary, per annum			Per beneficiary at IsoLeso Optometrist;
Frames LensXtend	R 950 R 1 600	R 870 R 1 340	R 800 R 1 100	
Lenses: • Single vision OR • Bi-focal OR • Multi-focal OR	One set of lenses every 24 months per beneficiary			Members can either have glasses or contact lenses, not both
• Contacts	R 3 400	R 3 140	R 2 900	Per annum
Radial Keratotomy				
ARCB	R 6 300	R 6 300	R 6 300	Per family
Hospital benefit	R 6 300	R 6 300	R 6 300	Per family
Appliances				
External fixator	R 19 030	R 19 030	R 19 030	
BP Monitor	R 820	R 820	R 820	
Glucometer	R 820	R 820	R 820	
Humidifier	R 360	R 360	R 360	
Nebulizer	R 1 310	R 1 310	R 1 310	
Elastic stocking	R 950	R 950	R 950	
Foot arch support	R 4 020	R 4 020	R 4 020	
Elbow crutch	R 460	R 460	R 460	
CPAP machine	R 12 650	R 12 650	R 12 650	
Foam walker	R 2 360	R 2 360	R 2 360	
Walker	R 410	R 410	R 410	
Braces & Calliper	R 820	R 820	R 820	
Commode	R 1 310	R 1 310	R 1 310	
Stocking (thigh)	R 950	R 950	R 950	
Anti-embolic stocking	R 950	R 950	R 950	
Sling clavicle brace	R 230	R 230	R 230	
Wig	R 2 490	R 2 490	R 2 490	
Bra	R 1 650	R 1 650	R 1 650	
Medicine				
1. Pharmacy Advised Therapy	R 190	R 180	R 170	Per Script Subject to acute medicine sub-limit
2. Acute: Member Adult Child	R 4 070 R 2 310 R 1 580	R 2 860 R 1 760 R 550	R 1 760 R 1 100 R 360	MMAP
3. Oral contraceptives and devices - female	R 1 500	R 1 500	R 1 500	Per beneficiary Subject to acute medicine sub-limit
Dentistry				
Basic dentistry	Subject to the ARCB			of Scheme rate
Specialised dentistry	Limited to R 10 000 per beneficiary and R 21 200 per family			of Scheme rate

Annual Routine Care Benefit (ARCB)

ARCB BENEFITS	LEVEL A	LEVEL B	LEVEL C	COMMENT
Mental health, (including substance abuse) (Out-of-hospital consultations visits)				
Clinical psychologist	100%	100%	100%	of Scheme rate
Psychiatry	100%	100%	100%	of Scheme rate
Radiology				
Basic Radiology	R 3 500	R 2 600	R 1 870	Per beneficiary
Pathology				
Basic Pathology	R 3 500	R 2 600	R 1 790	Per beneficiary
Physiotherapy				
Physiotherapy (in-and-out-of hospital Sub limit) Member Adult Child	 R 4 600 R 2 000 R 1 600	 R 3 500 R 1 500 R 1 100	 R 2 200 R 1 200 R 6 00	Combined sub-limit with in-hospital
Other benefits				
Hospital emergency room/casualty emergency visits (not requiring admissions, excluding facility fees)	100% of Scheme rate			
Auxiliary services (e.g. speech therapists, social workers and physiotherapists)	100% of Scheme rate			
Maternity Consultations	Consultations 100% of Scheme rate; Scans limited to two 2D scans per pregnancy.			

Specialist Referral and Authorisation Process (out of hospital only)

Members and their beneficiaries are required to obtain a referral from a GP before going to a specialist for a consultation and treatment. This is only for out-of-hospital consultations.

The authorisation process will support the process that is used by your GP. When you obtain the referral letter from your GP, the referral letter should be submitted to Universal Health. Based on the referral letter, an authorisation will be created in the administration system. If a referral has been obtained the claim will be paid, subject to limits and the scheme rate.

The referral letter can be submitted via:

- E-mail to **specauth@universal.co.za**;
- Fax to **086 503 8038**;
- The call centre on **0800 002 636**.

The authorisation will be:

- Granted for a period of three months in order to give the member a chance to obtain an appointment with a specialist.
- Limited to one consultation.
- For the speciality and not a particular specialist.

The following will be excluded from the specialist authorisation requirement process:

1. One gynaecologist visit per female, over the age of 16, per annum;
2. One urologist visit per male beneficiary, over the age of 40, per annum;
3. Paediatrician consultations for children under the age of 3;
4. Pregnancies;
5. Oncology (will be approved as part of the oncology management programme).
6. Ophthalmologist
7. Orthodontists

Hospital Benefits

BENEFITS	LIMITS		
Overall annual limit (OAL)	Unlimited		
Private and public hospitals and day clinics	100% of Scheme rate, subject to pre-authorisation		
Ward fees: general, high care and intensive care	100% of Scheme rate, subject to pre-authorisation		
Theatre fees	100% of Scheme rate, subject to pre-authorisation		
GP consultations, visits and procedures	100% of Scheme rate		
Specialists consultations, visits and procedures	**Level A**	**Level B**	**Level C**
	150% of Scheme rate	125% of Scheme rate	100% of Scheme rate
Emergency assistance and ambulance transportation	Unlimited, provided by ER24, subject to pre-approval		
Surgical prostheses, Artificial limbs and Electronic/nuclear devices	Sub-limits apply, subject to pre-authorisation and protocols		
Radiology: general (X-rays in hospital)	100% of Scheme rate		
Radiology: MRI, CT/PET scans (combined in-and out-of hospital benefit)	100% of Scheme rate while hospitalised. Subject to ARCB, unless prior approval from Universal Care. A 'Scan for Life' is subject to pre-authorisation and a 20% co-payment		
Pathology	100% of Scheme rate		
Physiotherapy in hospital	Sublimits apply combined with the Out-of-hospital limit		
Organ transplants (includes all related expenses)	100% of Scheme rate. R 422 300 per family per annum. Subject to pre-authorisation and clinical protocols		
Renal dialysis	100% of Scheme rate. R 333 490 per family per annum. Subject to pre-authorisation and clinical protocols		
Oncology (including radiotherapy & chemotherapy)	**Level A**	**Level B**	**Level C**
	R 596 900 pb 100% of Scheme rate	R 299 300 pb 100% of Scheme rate	R 149 700 pb 100% of Scheme rate
	Subject to registration on Oncology Programme.		
Biological medicine for oncology	R 168 900 (incl in the above limit) per family, pre-authorisation and clinical protocols apply		
Confinements/deliveries	Hospitalisation limited to three days for uncomplicated normal delivery and four days for uncomplicated caesarean delivery		
Blood, blood equivalents & blood products	100% of cost while hospitalised		
Substance abuse and mental health (in hospital)	**Level A**	**Level B**	**Level C**
	R 21 210 per family	R 16 900 per family	R 14 100 per family

Prosthesis and Devices: Sub-Limits

SURGICAL PROSTHESIS	SUB-LIMITS	COMMENTS
Stent	R 17 500	Per stent, max 3
Medical Stent	R 27 100	Per stent, max 3
Abdominal aortic aneurysm stent	R 79 500	
Hip prosthesis	R 61 900	
Knee prosthesis	R 52 500	
Shoulder prosthesis	R 52 500	
Spinal instrumentation	R 35 000	Per level, max 2
Spinal cage	R 17 500	
Heart valve	R 35 000	
Normal bladder sling	R 12 600	
ELECTRONIC AND NUCLEAR DEVICES		
Defibrillator	R 190 600	
Single pace maker	R 71 500	
Dual pace maker	R 87 400	
Internal nerve stimulator	R 159 100	
Cochlear implant	R 201 300	
Insulin pump	R 35 00	
ARTIFICIAL LIMBS		
Through knee prosthesis	R 79 500	
Below knee prosthesis	R 60 500	
Above knee prosthesis	R 69 600	
Partial foot prosthesis	R 30 400	

Alternatives to Hospitalisation

The Tiger Brands Medical Scheme offers cover for step-down nursing facilities, hospice and rehabilitation. Cover is subject to pre-authorisation, protocols and case management. For pre- authorisation, phone **0860 102 312**.

BENEFITS	LIMITS
Private nursing (in lieu of hospitalisation)	R 23 900 per family, subject to pre-authorisation

Pre-authorisations and Co-payments

Pre-authorisation is required from Universal Care for all hospital admissions. To ensure that beneficiaries receive cost-effective, appropriate care, Universal Care performs pre-authorisation and case management services.

If pre-authorisation is not obtained at least 48 hours prior to a non-emergency hospital admission, or if Universal Care is not advised within 24 hours of the emergency admission, a R 1 000 co-payment will apply. For pre-authorisation, call **0860 102 312.**

The following procedures will attract a R 1 000 co-payment on all Levels if not performed in a day clinic, subject to PMBs:

- Colonoscopy
- Cystoscopy
- Functional nasal surgery
- Gastroscopy
- Hysteroscopy
- Myringotomy
- Sigmoidoscopy
- Tonsillectomy and adenoidectomy
- Varicose vein surgery
- Arthroscopy and diagnostic laparoscopy

Co-payment of R 1 500 (Level B) or R 2 500 (Level C) for the following Scopes subject to PMBs

- Colonoscopy,
- Cystoscopy,
- Gastroscopy,
- Hysteroscopy,
- Myringotomy,
- Sigmoidoscopy,
- Arthroscopy and
- Diagnostic laparoscopy.

Chronic Medicine Benefit

The Scheme offers a separate Chronic Medicine Benefit. Once the Chronic Medicine Benefit is depleted, your chronic medication will be paid from the ARCB, subject to available benefits. Once the ARCB limit is reached, the Scheme will continue to pay PMB CDL medicines.

Beneficiaries must apply for authorisation for chronic medication benefits by submitting a prescription to **chronicmedicine@universal.co.za** or can contact **0860 102 312. Please note – with any changes to your chronic medicine, even if it is just the dosage, you need to update the authorisation.**

The Scheme covers all the PMBs as well as other conditions, as listed below, from the Chronic Medicine Benefit.

		LEVEL A	LEVEL B	LEVEL C
Chronic medicine	Subject to approval on the Chronic Medicine Programme	R 9 000 per beneficiary	R 7 600 per beneficiary	R 6 200 per beneficiary
Biological medicine	Limited to R 168 900 per family; Scheme approval required			
HIV/Aids	Unlimited, subject to registration on the Universal HIV/Aids programme			

Tiger Brands Medical Scheme offers cover for the 27 listed **PMB Chronic Disease** List (CDL) conditions below, subject to authorisation. These conditions are legislated. Chronic medication is subject to the basic formulary and reference pricing. A 20% co-payment is payable from the voluntary use of non-formulary medicines.

PMB CHRONIC DISEASE LIST		
Addison's disease	Crohn's disease	Hyperlipidaemia
Asthma	Diabetes mellitus type 1 & 2	Hypothyroidism
Bipolar mood disorder	Diabetes insipidus	Multiple sclerosis
Bronchiectasis	Dysrhythmias	Parkinson's disease
Cardiac failure	Epilepsy	Rheumatoid arthritis
Chronic renal disease	Glaucoma	Schizophrenia
Chronic obstructive pulmonary disorder	Haemophilia	Systemic lupus erythematosus
Cardiomyopathy disease	HIV	Ulcerative colitis
Coronary artery disease	Hypertension	

Tiger Brands Medical Scheme also offers cover for additional non-PMB chronic conditions on Level A and B respectively, subject to available limit.

Non-PMB Chronic medication is subject to the basic formulary, reference pricing and a 20% co-payment.

ADDITIONAL CHRONIC CONDITIONS: LEVEL A	
Ankylosing spondylitis	Osteoarthiritis
Attention deficit hyperactivity disorder	Vertigo
Allergic rhinitis	Gastro-oesophageal reflux disease
Depression	Osteoarthiritis
Gout	Osteoperosis
Incontinence	Psoriasis
Myasthenia gravis	

ADDITIONAL CHRONIC CONDITIONS: LEVEL B	
Attention deficit hyperactivity disorder	Gastro-oesophageal reflux disease
Allergic rhinitis	Osteoarthiritis
Depression	Osteoporosis
Gout	Psoriasis

High-Cost Appliances

Because of the high cost of some appliances, it will be paid from the in-hospital benefit

BENEFITS	LIMITS (available in a five-year cycle)
Wheelchairs (Can only be replaced after 5 years)	R 18 700 per beneficiary, subject to pre-authorisation
Hearing aids (Can only be replaced after 5 years)	R 17 300 per beneficiary, subject to pre-authorisation
Other eg. Ocular prosthesis (Can only be replaced after 5 years)	R 18 700 per beneficiary, subject to pre-authorisation
Stoma bags for non-oncology	Unlimited

Wellness Benefit

The wellness claims will not be paid from your Annual Routine Care Benefit, but from the hospital benefit – assisting you in remaining healthy and well.

BENEFITS	LIMITS
Flu Vaccine	One per beneficiary per year
Pneumococcal vaccine	One per beneficiary over the age of 65
Tetanus vaccine	One injection when required
Prophylaxis malaria	As required
Mammogram	One per annum per female beneficiary over the age of 40
Pap smear	One per annum per female beneficiary over the age of 18
HPV (cervical cancer) vaccine	One course (3 doses) per female beneficiary between the ages 12 and 18
PSA (Prostate Specific Antigen)	One per annum per male beneficiary over the age of 40
Fitness Assessment and exercise prescription	Access to Universal Network Biokineticists for an annual assessment, exercise programme prescription and monthly monitoring
Nutritional Assessment and healthy eating plan	Access to Universal Network Dieticians for an annual assessment, healthy eating plan and monthly monitoring

Primary Plus Option

Contribution Table – Primary Plus Option

R 1 - R 4 400	R 666	R 666	R 210
R 4 401 - R 5 700	R 768	R 768	R 228
R 5 701 - R 7 600	R 972	R 972	R 294
R 7 601 - R 8 900	R 1 056	R 1 056	R 312
R 8 901 - R 10 300	R 1 152	R 1 152	R 348
R 10 301 - R 12 000	R 1 254	R 1 254	R 372
R 12 001 - R 13 300	R 1 416	R 1 416	R 378
R 13 301 - R 17 100	R 1 680	R 1 680	R 378
R 17 101 - R 20 500	R 2 010	R 2 010	R 384
R 20 501 - R 24 900	R 2 172	R 2 172	R 390
R 24 901 - R 28 100	R 2 256	R 2 256	R 390
R 28 101 +	R 2 292	R 2 292	R 390

Contributions increase annually, effective 1 December. The benefits and limits increase annually, effective 1 January. There is one contribution increase and one benefit increase in a 12-month period.

Child dependants pay child rates up to the age of 25, and their membership will be terminated at the end of the year in which they turn 25.

Primary Care Benefits

To confirm the Univeral Network Service Providers please call: **0800 002 636**.

BENEFITS	LIMITS
GP Consultations	100% of Agreed Tariff, unlimited, subject to clinical necessity. Each beneficiary must select a contracted Universal Network GP for day-to-day care. Two out-of-area visits per beneficiary, per year. Member required to pay the out-of-area provider in cash and claim back. Limited to R 1 000 per event including the GP consultation and all related costs.
Acute Medication	100% of Agreed Tariff, unlimited if prescribed by a Universal Network GP, or by a specialist provided member referred by a Universal Network GP. Subject to formulary. No cover for non-formulary medicines, unless otherwise pre-authorised. No cover in cases of voluntary use of non-Universal Network Provider, or voluntary use of a specialist without referral by a Universal Network GP.

Specialised Radiology including MRI, CT and PET Scans	PMBs only, subject to pre-authorisation and case management by the Scheme's designated agent. Please contact 0860 102 312
Basic Radiology	100% of Agreed Tariff, unlimited when clinically appropriate within the Universal Network and subject to referral by a Universal Network GP. Limited to list of codes. Subject to case management. No benefit if not referred by a Universal Network Provider, or by a specialist following referral by a Universal Network GP (except when involuntary).
Basic Pathology	100% of Agreed Tariff, unlimited when clinically appropriate within the Universal Network and subject to referral by a Universal Network GP. Limited to list of codes. Subject to case management. No benefit if not referred by a Universal Network Provider, or by a specialist following referral by a Universal Network GP (except when involuntary).
Auxiliary Services	PMB rules apply, subject to protocols.
Clinical Psychologist	PMB rules apply, subject to protocols.
Psychiatry	PMB rules apply, subject to protocols.
Surgical and Medical Appliances	PMB rules apply, subject to protocols. No benefit for hearing aids.
Wellness, Lifestyle and Preventative Care	Blood pressure, blood sugar and cholesterol test, limited to R 130 per beneficiary and Universal Network Pharmacy

Annual Flexi Benefit

Day-to-day services are subject to the utilisation of the Universal Provider Network. Services rendered will be paid at an agreed tariff up to specified limits. Benefits are subject to the Annual Flexi Benefit (AFB). The AFB will be pro-rated if you join during the year.

AFB Limits:
R 2 700 per beneficiary; subject to a maximum of R 4 000 per family

BENEFITS	LIMITS
Specialists	100% of Agreed Tariff, paid from the AFB. Two visits per beneficiary, subject to a maximum of three per family, per year. Two additional antenatal visits per pregnancy. **Specialist visits are subject to referral by a Universal Network GP.** **Pre-authorisation required for each specialist visit.**
Basic dentistry	100% of Agreed Tariff, paid from the AFB. One consultation per beneficiary, per year. Preventative care, infection control, fillings, extractions and dental x-rays, subject to protocols, list of applicable dental codes and use of a **Universal Network Dentist.** No benefit for out-of-network dental visits/ procedures except for PMB emergencies.

Specialised Dentistry	PMB only
Optometry	100% of Agreed Tariff, paid from the AFB. Test – One per beneficiary, every second year. Lenses, frames - clear plastic single vision OR bifocal lenses every second year. Basic range of frames. No benefit for contact lenses. Subject to use of a Universal Network Optometrist.
Hospital emergency room/ casualty emergency visits (not requiring admissions, excluding facility fees)	No benefit, unless a bona-fide emergency that results in a hospital admission.

Hospital Benefits

BENEFITS	LIMITS
Overall Annual Limit (OAL)	Unlimited
Private Hospitals and Nursing Homes	100% of Agreed Tariff, subject to pre-authorisation
Take home medication (TTO)	Limited to seven days' supply, subject to OAL
GP and Specialist Cost	100% of Agreed Tariff, subject to OAL
Surgical Prosthesis and Electronic Nuclear Devices	PMB benefits Subject to pre-authorisation, protocols and OAL
Radiology and Pathology	100% of Agreed Tariff, subject to OAL
MRI, CT Scans/PET Scans	100% of Agreed Tariff, subject to OAL, pre-authorisation required
Physiotherapy in hospital	100% of Agreed Tariff, subject to OAL
Organ Transplants, Renal Dialysis (includes transportation of the organ, surgically related procedures, professional fees and services, as well as immunosuppressant drugs)	100% of Agreed Tariff, PMB's only, subject to OAL, pre-authorisation and protocols
Emergency Room/Casualty	100% of Agreed Tariff, subject to OAL, for emergency medical conditions and injuries resulting from accidents or trauma on application

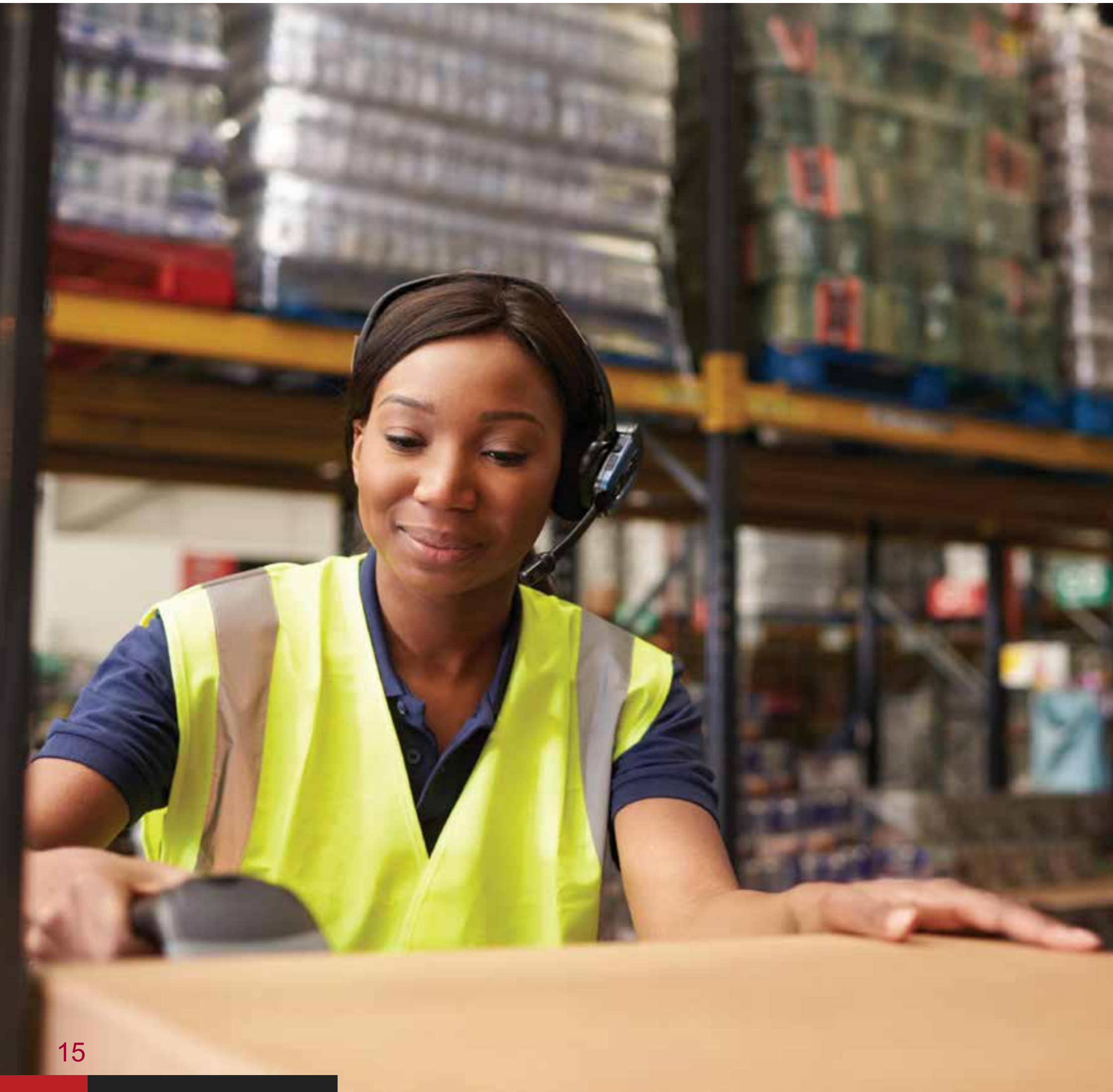
Alternatives to Hospitalisation

The Primary Plus option offers cover for step down nursing facilities, Hospice and rehabilitation. Cover is subject to pre-authorisation, protocols and case management.

Exclusions

The following in-hospital procedures are not covered on the Primary Plus option, unless it is a PMB:

Dentistry, back and neck surgery, hip and knee replacement, cochlear implants, auditory brain implants and internal nerve stimulators, Nissen fundoplication (reflux surgery), treatment for obesity, skin disorders, functional nasal problems, elective caesarean section, refractive eye surgery, brachytherapy for prostate cancer and fibroadenoma.



Emergency Transport Services

ER24 offers a 24-hour/7 days a week integrated service to all Tiger Brands Medical Scheme members. The clinical staff are all highly specialised in emergency care and include friendly and helpful professional nurses and paramedics.

What to do in the case of an emergency

- Call 084 124.
- If someone else is calling on your behalf, tell them to call 084 124.
- Tell the ER24 operator that you are a Tiger Brands Medical Scheme member – they will prompt you or the caller for all the information they require to get help to you.

Medical Information and Assistance Line – 084 124 ER24 medical personnel, including doctors, paramedics and nurses, will be available 24 hours a day to provide general medical information and advice. This is an advisory and information service, as a telephonic conversation does not permit an accurate diagnosis.

24 hour "Ask the Nurse" Health Line

- Members are encouraged to utilise this 24-hour cost-saving service.
- Our trained medical staff use documented medical algorithms and protocols to advise members on healthcare solutions.
- Members can first seek advice as to:
    - Urgency of attention needed: dispatch ambulance, go to the hospital, go to the doctor.
    - Generic medication advice: go to the pharmacy for over-the-counter medication;
    - Self-medicate from home.

Trauma lines

In addition, the members have access to a 24-hour Crisis Counselling line where trained healthcare professionals will telephonically assist with advice/counselling for:

- Domestic violence
- Family, domestic and child abuse
- Bereavement
- Hijacking
- Armed robbery
- Assault
- Kidnapping
- HIV/AIDS information
- Trauma counselling
- Rape/referral to rape centres
- Substance abuse
- Poison advice
- Suicide hotline

Useful tips

- Teach your family members to call 084 124 in case of an emergency.
- In an accident, take note of road names and numbers as this will expedite the emergency services.

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Managed Care Initiatives and Pre-Authorisation

At Tiger Brands Medical Scheme (TBMS), taking good care of our members is what matters most. It is for this reason that we have implemented managed care initiatives designed to ensure that members receive the right type of quality care at an affordable cost, while safeguarding the long-term sustainability of the Scheme.

Hospital Utilisation Management

One such initiative is the full hospital management service that we provide to our members. In order to ensure that our members experience the highest possible levels of service, certain systems have been put in place. This enables us to meet the needs of our members efficiently and effectively.

For non-emergency admissions, members must contact the Scheme at least two working days in advance for an hospital authorisation. In the case of an emergency admission, the Scheme should be contacted on the first working day following hospital admission. Please note that failure to obtain authorisation will result in non-payment of the account and/or a R 1 000 penalty. Members should please take note that they are responsible for ensuring that all hospital admissions are authorised. However, the hospital or healthcare provider may assist with obtaining authorisation.

What information should you have ready when you apply for an authorisation?
- TBMS membership number;
- The name and date of birth of the patient;
- Date of admission and procedure;
- Name and practice number of the treating healthcare provider;
- Name and practice number of the hospital;
- Reason for the admission, treatment and diagnosis;
- Tariff and ICD 10 codes for the procedure;

Please contact Universal Care on **0860 102 312** to apply for authorisation for a hospital admission.

Please note:
- The Scheme has the right to apply managed care principles, protocols and exclusions.
- While the Scheme may authorise the hospital stay and procedure, this is not a guarantee of payment.
- All claims will be paid at Scheme tariffs. In order to avoid a co-payment, members are advised to enquire in advance as to whether their healthcare provider charges at Scheme tariff or above.

Oncology Management Programme

At TBMS we understand that battling with cancer is a difficult and emotional experience. Our Oncology Management Programme offers members with cancer the support they need to manage this condition.

It is important that your treating doctor contacts the Scheme as soon as you are diagnosed with cancer and that he/she registers you on the TBMS Oncology Management Programme. Your doctor will devise a proposed treatment plan to treat your condition, which should be sent to TBMS as soon as possible. A medical professional will review the treatment plan according to accepted treatment guidelines and protocols. If necessary, your doctor will be contacted to discuss more appropriate treatments. Once the treatment plan has been approved, treatment can commence. You will not have to obtain a separate medicine authorisation, as this will form part of your approved oncology treatment plan. Most oncology treatment takes place on an outpatient basis. Please remember to get a separate authorisation if you require hospitalisation during your oncology treatment period. You can contact us on **0860 111 900** for further information.

Authorisation for Specialised Radiology

When a patient requires specialised radiology, such as an MRI scan, PET scan or a CT scan, he/ she must contact TBMS for authorisation. An appropriate motivation must accompany the request for the scan. This is a requirement for both in- and out-of-hospital patients. Please contact us on **0860 111 900** for further information.

HIV/AIDS Management Programme

As with any chronic condition, a holistic healthcare management approach can help to ensure that an HIV-positive person enjoys a healthy and fulfilled life. It is important to know your status. Only when you know you are HIV-positive can you take the necessary steps to protect your partner and family, and to manage your own health and wellness for the future.

TBMS has the utmost respect for patient confidentiality and will not disclose any information about your status to anyone but you.

If your tests show that you are HIV-positive, you or your treating doctor should contact us to register you on the TBMS HIV Management Programme. This programme is operated by highly skilled, dedicated nurses who provide continuous telephonic support and counselling to HIV-positive individuals. These 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. The sooner you are registered, the quicker the appropriate treatment can commence.

Please contact us on **0860 111 900** for further information.

Disease Management Programme

All TBMS members with a chronic disease condition such as asthma, cardiac failure, chronic obstructive pulmonary disease (COPD) or diabetes mellitus will be contacted by Universal Care to enrol on the TBMS Disease Management Programme.

This programme provides telephonic support and personalised health and wellness information to assist members in managing their chronic conditions. If you have been diagnosed with one of these chronic conditions, you may enrol on the programme, your doctor may enrol you, or the Scheme will identify you through claims, chronic medicine registrations and hospital admissions. Members are also invited to contact the Disease Management Call Centre should they wish to speak to a nurse counsellor.

For more information, you can contact us on **0860 111 900**. Please remember to register your chronic medication with MediKredit.

Scheme Rules

1. Rules of the Scheme

The Scheme is governed by a set of rules, submitted to and approved by the Registrar for Medical Schemes. All terms and conditions are set out in detail in the rules of the Scheme, which can be viewed at the office of the administrator. The rules of the Scheme always take precedence during a dispute resolution.

2. Membership

Membership is restricted to all eligible employees.

2.1 Registration of dependants

A member may apply for the registration of his/ her dependants at the time of applying for membership. The following persons qualify as a dependant:

- A spouse or partner; divorced spouses are not allowed to stay on the scheme as dependants
- Dependent children under the age of 25;
- Disabled/mentally challenged children.

2.2 Child dependants

Membership for child dependants will be cancelled at the end of the year in which he/ she turns 25 years old. This does not apply to disabled or mentally challenged dependants.

2.3 Waiting periods

Prospective members are required to disclose to the Scheme, on the application form, details of any sickness or medical condition for which medical advice, diagnosis, care, or treatment was recommended and/or received prior to the 12-month period ending on the date on which application for membership was made.

The Scheme may impose waiting periods and late- joiner penalties. Please contact the Scheme to confirm if this will be applicable to your membership.

2.4 Membership card

Every member shall be furnished with a membership card. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership. Members may apply for additional membership cards or replacement cards.

2.5 Change of address

A member must notify the Scheme within 30 days of any change of address, including his/ her domicilium citandi et executandi (address at which legal proceedings may be instituted). The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member neglecting to comply with the requirements of this rule.

2.6 Deceased members

The dependants of a deceased member, who are registered with the Scheme as his/her dependants at the time of the member's death, shall be entitled to continued membership of the Scheme without any new restrictions, limitations or waiting periods. Where a child dependant has been orphaned, the eldest child may be deemed to be the member, and any younger siblings, the dependants.

3. Benefits

3.1 Choosing a benefit level

Members are entitled to benefits during a financial year, as per the rules of the Scheme, and such benefits extend from the member to his/her registered dependants. A member must, on admission, elect to participate in any one of the available levels, detailed in the rules of the Scheme.

3.2 Level changes

A member is entitled to change from one benefit level to another, subject to the following conditions:

- The change may be made only with effect from 1 January of any financial year.
- Application to change from one benefit level to another must be in writing and lodged with the Scheme within the period notified by the Scheme.

3.3 Pro-rating benefits

If members join the Scheme later than 1 January during a specific year, pro-rata annual benefits will apply until the end of the year. From 1 January the following year, members will qualify for the full annual benefit.

4. How to claim

4.1 Electronic claims

Most suppliers, e.g. hospitals, pharmacies and general practitioners, etc. submit claims electronically on behalf of members. However, it remains the member's responsibility to ensure that the claim reaches the Scheme within four months from treatment date and to check remittance advices for accuracy and validity of the supplier's claim.

4.2 Paper claims

Claims must be submitted within four months from date of service and may be sent to the details below:

Fax: (011) 208 1028

Email: Correspondence@universal.co.za

Post: Tiger Brands Medical Scheme, Private Bag X131, Rivonia 2128

Before submitting a claim, please ensure that the following details appear on the account:

- Membership number;
- Principal member's details (name, address, etc.);
- Supplier's details (name, address, practice number);
- Treatment date;
- Patient's details;
- Details of treatment (diagnosis, tariff and ICD10 codes, amount charged, etc.).

4.3 Payment of claims

Tiger Brands Medical Scheme has two payment runs per month to suppliers and to members. Members will receive a monthly statement containing details of all payments made to suppliers.

4.4 Claims against the Road Accident Fund (RAF) and other third parties

- TBMS helps you by paying for medical and hospital expenses incurred as a result of a motor vehicle accident or other incident where a third party is liable. To do this, TBMS has appointed an attorney that specialises in recovering RAF claims, to help members with the submission and administration of medical claims. In the unfortunate event that you and/or one of your beneficiaries are involved in an accident, this is what you need to do to make a claim:

- **STEP 1:** Let TBMS or the appointed attorney know about the accident as soon as possible.

- **STEP 2:** TBMS or the appointed attorney will send you an Accident Report Form. It is very important that you complete the form and return it to the appointed service provider as quickly as possible. This will let the assessors determine whether there are merits to your claim against the RAF. In some cases, you may not be aware that a different party is liable for the payment of your medical costs – that is where the appointed service provider can be a great help.

- **STEP 3:** If your injuries were caused by a third party, our attorney will act on your behalf in order to recover expenses from the RAF. Our attorney will advise you on all aspects of your claim, including items such as loss of income and compensation for pain and suffering, as well as medical expenses.

- **STEP 4:** You and your appointed attorney will need to complete a document that says you will reimburse TBMS for any monies which may be recovered from the RAF for past medical and hospital expenses paid by TBMS.

- **STEP 5:** As soon as this undertaking is provided, TBMS will pay for all medical costs arising from a third party claim. Should you have an existing claim where you have already instructed an attorney, you have a legal obligation to inform TBMS and the appointed service provider of the claim. Failure to do so will constitute fraud and TBMS has the discretion to hold you civilly and criminally liable.

- Should you face these challenges, do not hesitate to contact our Trauma Department on (Tel) 011 208 1168 or email trauma@universal.co.za

Designated service providers

In an effort to assist members with the management of their medicine benefit, the following pharmacies have offered the Scheme a favourable dispensing fee for medicines. These pharmacies have also agreed to dispense generic equivalents that fall within the Scheme's maximum reference price limit where generic products are available:

- Clicks, Dischem, Link, MediRite, ScriptSaver, Optipharm, Optime and Chronic Medicines Dispensary

This means that you may obtain your acute and chronic medicines from any of the above pharmacies without having to make a co- payment for dispensing fees or generic equivalents. The arrangement with the above pharmacies relates specifically to the dispensing fee and generic equivalents. It is possible that you may have a co-payment should your doctor prescribe a drug that does not appear on the Scheme's medicine formulary.

You may continue to obtain your medicine from the pharmacy of your choice; it should however be noted that different dispensing fees are being charged by the various pharmacies and this may result in a co-payment if the dispensing fee charged by your pharmacy is higher than that of our preferred providers.

The scheme will pay in full for the diagnosis, treatment and care of the prescribed minimum benefits as per regulation 8 of the Act.

Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, based on clinical evidence, the scheme will fund the cost of the appropriate substitution treatment, without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

Exclusions:

Unless otherwise provided for or decided by the Board, expenses incurred in connection with any of the following will not be paid by the Scheme:

1. Where a member has recourse in terms of a third party claims, the member must refund the Scheme for payments received from third parties in lieu of claims paid by the Scheme for the injury/event. Where the member refuses to refund the Scheme it constitutes unlawful enrichment and the Scheme will reverse claims payments made in respect of the injury/event.

2. Claims and expenses incurred by a member or dependant of a member in the case of or arising out of wilful self-inflicted injury, professional sport, speed contests and speed trails will be paid, subject to PMB's only. Any treatment that does not fall within the scope of level of care for PMB's will be for the members own account.

3. Consultations, visits, examinations and tests for insurance, school camps, visas, employment or similar purposes.

4. Cosmetic and Treatment for Obesity:
- All costs for operations, medicines, treatment and procedures for cosmetic purposes and obesity, eg Bariatric Surgery, gastric bypass, slimming preparations and appetite suppressants; including tonics, slimming products and drugs as advertised to the public. Consultations and treatments as provided by General Practitioners and Dieticians as part of a conservative lifestyle based protocol will be paid subject to the ARCB.
- Keloid and scar revisions, excluding PMB's which will be paid accordingly.
- Sclerotherapy

5. Dental:
- Bone Augmentations
- Bone and tissue regeneration procedures
- Crowns and bridges for cosmetic reasons and associated laboratory costs
- Enamel micro abrasion
- Fillings: the cost of gold, precious metal, semi precious metal and platinum foil
- Laboratory delivery fees
- Othognatic surgery
- Sinus lift
- Gum guards or mouth protectors

6. Holidays for recuperative purposes, accommodation and/or treatment in headache and stress relieve clinics, spas and resorts for health, slimming recuperative or similar purposes.

7. Infertility:
   Investigations, operations and/or treatment whether advised for psychiatric or similar reasons in respect of artificial insemination and treatment for infertility. Including but not limited to: Assisted Reproductive Technology, In-vitro fertilization, Gamete Intrafallopian Tube Transfer, vasovasostomy(reversal of vacestomy) and salpingostomy (reversal of tubal ligation), subject to PMB's, which will be covered as per Regulation

8 Medicine:
- Medicines not registered with the Medicines Control Council and proprietary preparations;
- The purchase of medicine prescribed by a person not legally entitled to prescribe medicine;
- Purchase of chemist supplies not included in the prescription from a medical practitioner or any other person who is legally entitled to prescribe medicine. Provided that this excludes benefits payable under Pharmacy Advisory Therapy;
- Applications, toiletries and beauty preparations;
- Aphrodisiacs and/or any products to induce, enhance, maintain and promote penile erection or to address erectile dysfunction such as erectile appliances and drugs, including but not limited to Viagra; unless pre-authorised on the chronic management programme according to PMB guidelines.
- Anabolic steroids such as, but not limited to Deca Durabolin;
- Bandages, cotton wool and similar aids; unless prescribed by a General Practitioner or Specialist.
- Non-scheduled soaps, shampoos and other topical applications;
- Stop smoking products, such as but not limited to Nicorette, Nicoblock, unless the member can prove that they have stopped smoking. Member must apply before use of products start and claim will be paid after member has tested negative for nicotine.
- Sun screens and tanning agents;
- Household and biochemical remedies;
- Vitamins and minerals (excluding pregnancy specific supplements)
- homemade remedies;
- alternative medicines:
- Patent foods, including baby foods; unless prescribed by a General Practitioner or Specialist, subject to PMB guidelines.

9. Mental Health:
   Sleep therapy and hypnotherapy

10. Optical:
- Sunglasses (lenses with a tint greater than 35%
- Coloured contact lenses
- Corneal cross linking
- Phakic implants

11. Radiology and Radiography
- PET scans; unless pre-authorised by oncology management for the appropriate diagnosis, staging, the monitoring of response to treatment and investigation of residual tumour or suspected recurrence (restaging). Metastatic breast cancer.
- CT Colonoscopy

12. All costs in respect of sickness conditions that were specifically excluded from benefits when the member joined the Scheme; as per waiting periods and exclusions applied as per the Medical Schemes Act.

13. In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending medical practitioner. In such a case, if the medical specialist's proposed treatment is not acted upon, no further benefits will be allowed for that particular illness.

14. All costs that are more than the Annual Routine Care Benefit to which a beneficiary is entitled in terms of the rules of the Scheme, the payment of PMB claims will accumulate to, but exceed any benefit limit as stipulated in these rules and annexures.

15. Cost of accommodation in respect of old age homes, and other custodial care facilities.

16. No member shall be entitled to any benefits or portion thereof, payable in terms of these Rules, where such benefit or portion thereof is recoverable by such member.

- Under the Compensation for Occupational Injuries and Diseases Act; or
- Are invalidated as claims under the Compensation for Occupational Injuries and Diseases Act through failure of the member to report the accident in the manner required; or
- Would have arisen if the member had been able to, and had made use of the facilities provided by the Employer at factories to treat the results of accidents at work, or
- Are covered by any ex-gratia compensation from the Employer; or
- From third party {including an insurance company registered under Act 29 of 1942} who is liable therefore;
- Any amount recovered or recoverable by the member or dependant as aforesaid in respect of any illness or accident must be disclosed by the member of the Scheme.

17. Prosthesis and appliances:
    Where not introduced as an integral part of a surgical operation; Transcatheter Aortic Valve Implantation (TAVI); Replacement batteries for hearing aids or other devices;

18. Not with standing the provisions of this Rule, the Board shall be entitled, but at no stage obliged, in its role and absolute discretion, to pay the whole or part of any account which may otherwise be excluded in terms of the Rules.

19. Omnibus Rule – "Unless otherwise decided by the Board, no claim shall be payable by the Scheme if, in the opinion of the Medical Advisor, the health care service in respect for which such claim is made, is not appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition at an acceptable and reasonable level of care".

20. The maximum benefits to which a beneficiary shall be entitled in any financial year shall be limited as set out in Annexure "B".

21. In cases where a specialist, except an eye specialist or gynaecologist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, in the discretion of the Board, be limited to the amount that would have been paid to a general practitioner for the same service.

22. Charges for appointments which a beneficiary fails to keep.

23. Costs for services rendered by –
    - Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
    - Any institution, nursing home or similar institution not registered in terms of any law except a state or provincial hospital.

24. Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in Annexure B of the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

25. Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof.

Complaints and Dispute Procedure

Members may submit their complaints to the Scheme in writing or telephonically.

The Scheme's contact details are as follows:
Dedicated telephone number: 0800 002 636
Email address: Correspondence@universal.co.za
Fax number: 0866 151 509
The Customer Service Department will assist you.

Any queries that have not been resolved to the satisfaction of the member within 30 days of the initial complaint, or if the member is not satisfied with the outcome of the query, then this query or dispute can be escalated to the Customer Service Manager or the Fund Manager. Email escalations can be sent to escalations@universal.co.za, or the call centre agent can transfer the member to the appropriate senior official. Please note: all escalations will have to be accompanied by supporting evidence of non-delivery. Queries that have not been submitted on call centre level will be referred back to a call centre agent.

Should a member still not be satisfied with the outcome of his query or dispute, a member is entitled to escalate the matter to the Principal Officer. This will only be allowed if the processes above have been followed, or in cases of extreme emergencies. The Principal Officer will investigate the matter and revert to the member with a final decision, in accordance with the rules of the Scheme and subject to the provisions of the Medical Schemes Act, 131 of 1998.

Any member who is aggrieved by any decision of the Scheme may lay a complaint with the Office of the Registrar of Medical Schemes, who is the regulator for all medical schemes established in terms of the Medical Schemes Act, 131 of 1998. The contact details of the Complaints Call Centre of the Office of the Registrar are as follows:

Tel: 0861 123 267
Email: complaints@medicalschemes.com
fax: (012) 431 0608

Such complaints will be dealt with in terms of Section 47 of the Medical Schemes Act.

If the member still feels aggrieved, the matter can be escalated to the Council for Medical Schemes. The Council will give the Scheme an opportunity to respond. The Council's ruling will be final.

NOTES

NOTES

Contact Us

Universal Healthcare Administrators (Administrative)	
Client Services Call Centre	0800 002 636 | 011 208 1010
Fax number	(011) 208 1028
E-mail	correspondence@universal.co.za
Website	www.universal.co.za | www.tbms.co.za

Universal Care	
Hospital pre-authorisation	0860 102 312
Prescribed minimum benefit (PMB) management	0860 111 900
HIV/AIDS Disease Management Programme	0860 111 900
Chronic medicine	0860 111 900

Emergency Services	
ER 24	084 124

This brochure is a summary of the benefits of TBMS. A copy of the current rules of the Scheme may be obtained from the Administrator, if required. The rules of the Scheme will always take precedence over this summary.

Tiger Brands Medical Scheme
Universal House, 15 Tambach Road, Sunninghill Park, Sandton Private Bag X131, Rivonia, 2128
Tel: 0800 002 636 | Fax: 011 208 1028
Email: correspondence@universal.co.za | Website: www.tbms.co.za

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