We let you be YOU
maxima EXEC
2019
FEDHEALTH

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Please note: All Fedhealth benefits are subject to registered Scheme Rules, and as such, this document only aims to provide a summary of such benefits. For the full Scheme Rules, please visit fedhealth.co.za or contact the Fedhealth Customer Contact Centre on 0860 002 153 to obtain a copy.

maxima **EXEC**

Complete reassurance for whatever life brings

Our **maxima EXEC**[GRID] core benefit bundle gives our established members and families the peace of mind that most of their healthcare needs will be met.

This comprehensive option does not leave a single thing to chance, especially as our members reach more of a mature age. It features ample in-hospital, chronic, screening, day-to-day cover covered by the core benefit bundle, as well as value-added additional benefits.

In addition, it also features a Medical Savings Account (MSA) for day-to-day expenses and a Threshold benefit.

On **maxima EXEC**[GRID], you've chosen to save 11% on your monthly contribution by committing to use Fedhealth's network of 100 top-class hospitals only for planned procedures. In the case of an emergency for stabilising treatment, you can still use any provide hospital and will be covered without any co-payment.

Please see the following pages for more details on the **maxima EXEC**[GRID] core benefit bundle and what it offers you.

CORE BENEFIT BUNDLE • Paid from Risk

		maxima EXEC/ maxima EXEC[GRID]* A comprehensive benefit bundle with a threshold benefit
IN-HOSPITAL BENEFIT		
Hospitalisation		No overall annual limit*
Maternity		Unlimited
Network GPs and Specialists		Unlimited cover at cost
Non-network GPs		Up to 100% of Fedhealth Rate
Non-network Specialists		Up to 200% of Fedhealth Rate
Other healthcare professionals		Up to 100% of Fedhealth Rate
Oncology		R555 900
Organ Transplant		R555 900
Renal Dialysis		R555 900 at Designated Service Provider. 40% co-payment on use of non-DSP
Specialised Medication		R173 400
In-hospital dentistry for children up to the age of 7		Hospitalisation and anaesthetist covered for children up to the age of 7
CHRONIC DISEASE BENEFIT		
		51 conditions. R7 100 per beneficiary, R13 100 per family subject to comprehensive formulary. Preferred providers: MediRite, Clicks, Dis-Chem, Pharmacy Direct
SCREENING BENEFIT		
Women's health	**Cervical cancer screening (Pap smear)**	Women, ages 21 to 65. 1 every three years
Children's health	**Immunisation Programme (as per state EPI)**	Birth to 12 years
Cardiac health	**Cholesterol screening (full lipogram)**	All lives, aged 20 and older. 1 every five years
General	**Flu vaccination**	All lives; 1 every year
	HIV finger prick test	All lives; 1 every year
	Breast cancer screening with mammography	All lives, aged 45 and older. 1 every three years
Men's health	**Prostate Specific Antigen (PSA)**	Men, ages 45 to 69. 1 every year
Over 50s	**Pneumococcal vaccination**	All lives; aged 65 and older. 1 per lifetime
	Colorectal cancer screening (faecal occult blood test)	All lives; ages 50 to 75. 1 every year
	Bone densitometry	Women; aged 65 and older and Men; aged 70 and older. 1 every two years
Health risk assessments	**Wellness screening (BMI, blood pressure, finger prick cholesterol & glucose tests)**	All lives; 1 every year
	Preventative screening by contracted wellness network provider (waist-to-hip ratio, body fat %, flexibility, posture & fitness)	All lives; 1 every year
ADDITIONAL BENEFITS		
Fedhealth Nurse Line		A 24-hour toll-free line manned by professional nurses for medical and related queries
Emotional Wellbeing Programme		A 24-hour telephonic support to get members through life's ups and downs, with the option to refer to psychologists
Emergency transport/ response		Emergency transport for members through Europ Assistance
Comprehensive managed care programmes		We offer various programmes for our members with specific healthcare needs
MediTaxi		A transport service for members who need follow-up medical visits following a hospital authorisation
SOS Call Me		A USSD call-back service so members can access Emergency Medical Services (EMS), Fedhealth Nurse Line or MediTaxi
Upgrades within 30 days of a life-changing event		Upgrade to a higher option upon the diagnosis of a dread disease or pregnancy
Child rates for financially dependent children up to the age of 27		Provided they're unmarried and don't earn more than the maximum social pension
Good news for bigger families		Fourth and subsequent children are covered for free

*Members on **maxima EXEC**[GRID] should note: Network hospitals only, or a co-payment of R11 500 will apply.

CORE BENEFIT BUNDLE • Paid from Risk

	maxima EXEC/ maxima EXEC^{GRID}
DAY-TO-DAY BENEFIT	
Unlimited Network GP consultations	Unlimited GP visits at Fedhealth Network GPs once savings is depleted
Specialised radiology	Unlimited specialised radiology paid from the Core Benefit Bundle if pre-authorised. First R2 200 for non-PMB MRI/ CT scans is for the member's account
Fedhealth Baby Maternity Programme	All pregnant members and dependants
Fedhealth Toddler Programme	Access to sound advice for parents with toddlers up to the age of 24 months
Doula benefit	R1 300 per delivery
Postnatal midwifery benefit	4 consultations with a midwife in and out-of-hospital per pregnancy
Infant hearing screening benefit	1 test with an audiologist up to Fedhealth Rate
Paed-IQ	Telephonic support for paediatric related illness
Take-home medicine benefit	Up to 100% of MPL. Limited to 7 days medication per hospital event
Post-hospitalisation treatment	For up to 30 days after discharge from hospital like physiotherapy, x-rays or pathology i.e. follow-up treatment for a full 30-day period is covered
Trauma treatment at a casualty ward	Unlimited at 100% of Fedhealth Rate. Co-payment of R570 per visit for non-PMBs
Female contraception benefit	Oral, patches, contraceptive rings, certain injectables as well as IUDs that include Mirena
BENEFITS PAID FROM THRESHOLD	
Annual Threshold Levels	
Member	R13 651
Adult Dependant	R10 482
Child Dependant (Up to a maximum of 3 children)	R3 511
Limits	Limits may apply when calculating certain claims for accumulation to Threshold. These limits also apply for refunds from Threshold
Additional medical services	In and out-of-hospital: Subject to Savings. Does not accumulate to Threshold. Paid from Threshold up to R17 400 per family per year including psychiatrists out-of-hospital
Antenatal scans	Two 2D antenatal scans per pregnancy per beneficiary per year
Advanced dentistry	Limit of R7 400 per person per year, up to an overall annual limit of R22 100 per family per year
Appliances, external accessories and orthotics	In and out-of-hospital: Subject to Savings. Does not accumulate to Threshold. Paid from Threshold up to R15 500 per family per year with a sub-limit of R4 340 for foot orthotics
Optometry	Limit of R3 340 per person per year, up to an overall annual limit of R10 190 per family per year
Prescribed medication	Limit of R7 100 per person per year, up to an overall annual limit of R13 100 per family per year
Basic dentistry, non-Fedhealth Network GPs, pathology, general radiology	Unlimited at 100% of the Fedhealth Rate
Fedhealth network specialists	Unlimited at cost. 10% co-payment if GP referral not obtained
Non-Fedhealth network specialists	Unlimited at 100% of Fedhealth Rate. 10% co-payment if GP referral not obtained
Alternative healthcare, over-the-counter medication	Does not accumulate to or pay from threshold

SAVINGS

	maxima EXEC/ maxima EXEC^{GRID}	
DAY-TO-DAY BENEFIT		
Available for day-to-day expenses	**maxima EXEC** SAVINGS	**maxima EXEC^{GRID}** SAVINGS
Member	R9 024	R8 040
Adult Dependant	R7 824	R6 960
Child Dependant (Up to a maximum of 3 children)	R2 820	R2 508

Risk and Savings benefits

Your scheme works by taking your contribution and dividing it into two parts. The one part goes towards Risk Benefits, the other goes to a Savings Account.

Risk benefits

For risk benefits, the scheme pools together members' contributions and uses the money to fund a set of benefits, including the In-Hospital Benefit, Chronic Disease Benefit, Screening Benefit, Day-to-day Benefits, value-added additional benefits and Threshold Benefit known as the Core Benefit Bundle.

The scheme has rules for when each of the risk benefits is allowed to pay out. These scheme rules give limits for what the benefit can pay out for particular conditions, treatments and medicines. Because the scheme applies its rules consistently, we can be confident that:

- We treat all members fairly and do not discriminate against any members
- The medical scheme is sustainable and will not run out of money.

Savings Account

The part of your contribution that is paid to the Savings Account is not pooled with other members' contributions. The money in the Savings Account is your money and it gives you a level of control on your spending. The money that is not used in one year is carried over to the following year and this is called Carry-over Savings. This may be used after your new year's day-to-day benefits have been depleted. Any savings balance not used will be paid out if you leave the scheme.

Some important words

Here are explanations of some important words used in this booklet:

About healthcare providers

Fedhealth network: The Fedhealth network includes doctors, specialists, pharmacies and facilities that Fedhealth has an agreement with. It is always in your best interest to use a healthcare provider in the network as we have agreed rates with them. Please use the network locator on our website or contact us if you want to find a healthcare provider in the Fedhealth network.

maxima EXEC^{GRID} hospital network: The **maxima EXEC^{GRID}** hospital network is a prescribed list of facilities that Fedhealth has an agreement with for your option. It is always in your best interest to use a facility in the network as we have agreed rates with them. If you use any other hospital, you must pay R11 500 of the cost of the hospital account. Please see page 21 for a list of **maxima EXEC^{GRID}** prescribed hospitals.

Designated Service Provider: This is a healthcare provider (for example, a doctor, pharmacy or hospital) that members must use in order for them not to incur a co-payment on their treatment.

About medicines and payment for medicines

Medicine Price List: For every originator medicine which has one or more generic alternatives, the scheme has determined a ceiling price (the maximum we will pay) for that group of generic medication. This ceiling price will be high enough to pay in full for at least one of the generic medicines for that particular group of medicine.

Generic medicines: Generic medicines are medicines that are brought to market after patents have expired on originator medicines. They contain the exact same active ingredients, strength and formulation as the originator product. However, they are usually much cheaper than the originator product. Choosing medicine that the scheme covers in full ensures that you will have no out of pocket co-payments. For example, if an originator product has seven generics, the Medicine Price List price will be set – not at the cheapest – but at the cost of one of these generics. When a new generic is introduced for the originator product, the Medicine Price List amount may be recalculated.

Originator: Originator medicines are medicines that have been newly developed and subsequently patented by a pharmaceutical company.

Formulary: This is an approved list of medicine for each of the chronic conditions covered by the scheme. If a formulary applies, we only cover medicine that is listed on the formulary. The Medicine Price List (MPL) also applies to medicines in a formulary.

About limits to what we pay

Fedhealth Rate: These are the rates that the scheme sets every year for each and every medical service, procedure, treatment etc. These rates are adjusted annually by inflation and are used as the basis for all tariff negotiations.

Healthcare professional tariff: This is the reimbursement rate that has been negotiated or set for the payment of professional services and will usually be a multiple of the Fedhealth Rate.

Co-payment: This is an amount that you must pay from your own pocket for a particular treatment or service.

About treatment and payment for treatment

Treatment protocol: A plan for a course of treatment.

360 Care: Let the healing begin (with your GP)

Do you recall there was a time when the family doctor treated Mom, Dad, the kids and Granny as well? He or she got to know the family inside and out, and was aware of all their ailments and allergies. This meant that everyone knew where to turn when they felt poorly – a single medical professional they could trust for expert medical advice.

This is the inspiration behind our 360 Care initiative, in which your General Practitioner or GP becomes the coordinator of your care, working directly with you, the member, to ensure that your health needs are met safely, timeously and cost effectively. In a nutshell, this means that your GP, who will have the best understanding of your health status and treatment history, will refer you to the appropriate specialists to deliver the right care at the right time.

We believe that 360 Care improves the quality of healthcare by facilitating access to the appropriate specialist care, and that it prevents unsafe combinations of treatments including medicines. It also prevents unnecessary duplication of costly clinical tests and treatments – which contribute to rising health care costs and increases in members' contributions. Finally, we have introduced electronic health records which allow the healthcare providers treating you to easily access and exchange your medical information.

In addition, your GP will refer you and should be able to make an appointment for you with a specialist much quicker than you might be able to do yourself. So, simply visit your Network GP (an unlimited benefit on your option) for a referral to the relevant specialist. Non-network GPs may also be consulted, but these visits will be paid from your Savings and may result in a co-payment from you.

Under 360 Care, you will require a GP referral to visit any one of the following specialists: cardiologists, dermatologists, gastroenterologists, gynaecologists, neurologists, neurosurgeons, orthopaedic surgeons, otorhinolaryngologists (ENT), paediatric cardiologists, paediatricians, physicians, plastic and reconstructive surgeons, psychiatrists, pulmonologists, rheumatologists, surgeons and urologists. A GP referral is not necessary for: children under the age of two visiting a paediatrician, female members visiting a gynaecologist for their annual check-up, visits to oncologists, ophthalmologists, radiologists (general or specialised) or pathology services. Referral must be obtained from a GP if specialist consultation is payable from the risk benefit. If referral is not obtained there will be a 10% co-payment on specialist claims paid from the risk benefit.

Trusting your GP to coordinate your specialist care means having a healthcare practitioner with the information at hand to give you and your loved ones the best possible care. Just what your precious family deserves.

Prescribed Minimum Benefits (basic level of cover for a defined set of conditions)

All medical schemes are required by law to cover the treatment of 270 hospital based conditions and 25 chronic conditions, the Chronic Disease List (CDL), in full without co-payment or deductibles, as well as any emergency treatment and certain out of hospital treatment. This means that all schemes must provide PMB level of care at cost for these conditions.

The Medical Schemes Act 131 of 1998 allows schemes to require members to make use of Designated Service Providers (DSPs) in order for a member to be entitled to funding in full. Schemes may also apply formularies – a list of medicines which should be used to treat PMBs, and managed care protocols – based on evidence-based medicine and cost-effectiveness principles to manage this benefit.

Fedhealth has appointed their network specialists, network GPs and four preferred provider pharmacies, Clicks, Dis-Chem, MediRite and Pharmacy Direct for the provision of PMBs. These pharmacies can guarantee price certainty although members are welcome to use any pharmacy of their choice without penalty. Members must make use of a Fedhealth network specialist and a network GP in order for the cost to be refunded in full. Should the member not use these DSPs for the treatment of a PMB condition, the scheme will reimburse treatment at the non-Fedhealth network rate. Co-payments are applicable to the voluntary use of non-DSPs. Referral must be obtained from a GP for consultations with Fedhealth Network Specialists. If referral is not obtained there will be a 10% co-payment on specialist claims paid from the risk benefit. It is important to note that qualification for reimbursement as a PMB is not based solely on the diagnosis (condition) but also on the treatment provided (level of care).

This means that although your condition may be a PMB condition, the scheme would only be obliged to fund it in full if the treatment provided was deemed to be PMB level of care.

You are covered for emergency medical expenses

This table shows that the cost of medical care in emergencies will be paid from the Core Benefit Bundle.

To qualify as an emergency, the condition must be unexpected and need immediate treatment. (This means that if there is no immediate treatment, the condition might result in lasting damage to organs, limbs or other body parts, or even in death).

Ambulance Services: **call 0860 333 432**	**Unlimited cover with Europ Assistance**
Treatment in casualty	**Claims will be paid from the Core Benefit Bundle only if...** A member visits the trauma unit of a clinic or hospital and is admitted into hospital immediately for further treatment. A member visits the trauma unit of a clinic or hospital for emergency treatment for a fracture, for example. **Claims will be paid from the Day-to-Day Benefit if...** A member visits the trauma unit of a clinic or hospital for a non-emergency and is not immediately admitted into hospital. Please note that if a member visits their GP for an emergency treatment such as stitches and the procedure takes place in the doctor's consulting rooms, this will be paid from day-to-day benefits and not from the Core Benefit Bundle. A R570 co-payment will apply to all visits to the trauma unit of a clinic or hospital if the member is not admitted to hospital directly.
Emotional Wellbeing Programme	Fedhealth's Emotional Wellbeing Programme, available to all Fedhealth members and beneficiaries through the Fedhealth Family Room, offers a psychosocial wellbeing service for members that equips them to make the necessary changes to improve their quality of life. Call **087 365 8664**
Emergency medical services: **call 0860 333 432**	You can contact Europ Assistance for a range of emergency services on **0860 333 432**. These services include: Emergency road or air response Medical advice in any emergency situation Delivery of medication and blood Patient monitoring Care for stranded minors or frail companions 24-hour Fedhealth Nurse Line.

NB! You must contact us within two working days if it was an emergency

In an emergency you must get an authorisation number from us within two working days after going to hospital.
If you do not, you will have to **pay a penalty of R1 000**.

If you cannot contact the Authorisation Centre yourself, then your doctor or a family member or the hospital can contact us on your behalf.

Contact us within two working days if you needed trauma treatment

If you visit casualty for trauma treatment, you must get an authorisation number from us **within two working days** of the treatment.
If you do not, the claim will be paid from the Day-to-Day Benefit.

Going to hospital in an emergency:

AN EXAMPLE	
What the member does	**How the expense is funded**
Kate is involved in a car accident. A bystander calls the number that they see on the Fedhealth sticker on Kate's car. An ambulance is sent by Europ Assistance to transport her to hospital. She receives emergency medical care in casualty and is discharged the same day.	Kate will have to pay the first R570 of the account. The Scheme will pay the balance from the Core Benefit Bundle, as long as Kate contacts the scheme within two working days of the emergency treatment.

About limits and co-payments for hospital stays

No overall yearly limit

There is no overall yearly limit for the Core Benefit Bundle.

There are limits and restrictions for specific treatments and conditions

Hospital costs are covered from the Core Benefit Bundle. Members on **maxima EXEC^{GRID}** need to use a hospital on the Fedhealth hospital network (see page 21), while members on **maxima EXEC** can use any private hospital. Case management and managed care protocols apply to certain benefits. These protocols have been introduced to ensure best quality treatment at best rates. Consult the core benefit bundle tables in this section for detail on these protocols and limits.

For some treatments and procedures you must pay an amount out of your own pocket. This is called a co-payment. Co-payments apply to the hospital bill and are usually paid upfront to the hospital.

Where a co-payment will apply for not using a network hospital on maxima EXEC^{GRID}

- **maxima EXEC^{GRID}** has a prescribed list of hospitals to use (see page 21). If you use any other hospital, you must pay R11 500 of the cost of the hospital account.
- Treatment of an emergency medical condition may take place at any hospital (see section 2 on page 11), but once your condition has stabilised and you can be safely transferred to a network hospital, the R11 500 co-payment will apply if you opt not to be transferred.

Different cover for different types of hospital treatments

When you go to hospital, there are different accounts from different providers. We cover these accounts differently. Here is a summary. Please read the full section for details.

- The account for hospital costs. Examples of what this would include are: ward fees, theatre fees, supplies, and medicine that was dispensed by the hospital. In most cases, hospital costs will be covered in full by the Core Benefit Bundle. However, for some treatments:
  - You might have to pay an amount out of your own pocket, referred to as a co-payment
  - There might be limits to the amount we cover. For example prosthesis.
- The accounts from doctors or specialists. For example, if you had an appendectomy, you would receive a separate account from the specialist who performed the procedure. If the doctor or specialist is in the Fedhealth network, we will cover this in full.
- The separate accounts from other various providers, for example, physiotherapists, X-ray departments. We cover these at different rates. See page 14.

Hospital costs we cover in full

We have agreed rates with hospitals and we will therefore pay the full hospital bill for:

- Accommodation in a general ward (you pay the difference if you go to a private ward)
- High care ward and intensive care unit
- Theatre fees.

Medicine you receive in hospital

Medicine that you use while you are in hospital	No limit, we pay the full cost, subject to managed care protocols
Medicines that are prescribed in hospital for you to use when you go home (take-out medicines)	Seven days of medicine for each hospital event. We pay the full cost
Specialised medicine (also see page 16)	We pay the full cost, up to a limit of R173 400 per family per year subject to managed care protocols

Doctor visits while you're in hospital

While you are in hospital, you are under the care of specialists (such as paediatricians or cardiologists) and other doctors (such as General Practitioners). These are covered differently to doctor appointments out of hospital.

You must remember that the reimbursement rates below are for the professional fees only.

Specialists who are in the Fedhealth network	We pay professional fees in full
Specialists who are not in the Fedhealth network	We pay 200% of the Fedhealth Rate for professional fees. You must pay the rest direct to the specialist
General Practitioners who are in the Fedhealth network	We pay professional fees in full
General Practitioners who are not in the Fedhealth network	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the healthcare professional
Dietetics, occupational therapy and speech therapy	Paid from the Day-to-Day Benefit. Does not accumulate to threshold. Paid from threshold up to R17 400 per family per year
Physical therapy (physiotherapy)	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the healthcare professional. Must be pre-authorised and subject to treatment protocols

Before you go to hospital, you should try to make sure that your doctor and specialist are in the Fedhealth network.

Going to hospital for an operation:

AN EXAMPLE

What the member does	How the expense is funded
Alice's son needs to have his tonsils out. Alice made sure that the surgeon and the anaesthetist are in the Fedhealth network. She gathers the required information from her doctor and then phones Fedhealth to get an authorisation number. The child has the operation and leaves the hospital on the same day. Alice receives two invoices by email: - An invoice from the anaesthetist - An invoice from the surgeon She sends the accounts to the scheme for payment. The hospital sends its account direct to Fedhealth.	The scheme covers the cost of the anaesthetist and the specialist in full because they are in the Fedhealth network. The scheme covers the hospital account in full. Benefits, limits and managed care protocols apply. Note: if the surgeon and the anaesthetist were not in the Fedhealth network, Alice would pay the difference between 200% of the Fedhealth Rate and the cost directly to the healthcare service provider.

Blood and pathology services while you're in hospital

Blood, blood equivalents and blood products	We cover the full cost
Pathology (blood tests)	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the healthcare professional

Maternity benefit

Medical expenses during pregnancy	See Day-to-Day benefits on page 37
Medical expenses related to the delivery	Paid from Core Benefit Bundle
Expenses for ward, medicines, materials etc. Includes delivery in hospital, a registered birthing unit or at home Includes the hire of a water bath	We cover the full cost
Gynaecologist and paediatrician	Will be covered in full if in the Fedhealth network. If they are not in the Fedhealth network, they will be covered up to 200% of the Fedhealth Rate
Funding for Doula (labour support during natural childbirth)	R1 300 per delivery
After delivery: Post-natal midwifery benefit	Four consultations in- and out-of-hospital per pregnancy at 100% of the Fedhealth Rate
Infant hearing screening benefit	Hearing test done with an audiologist until the age of eight weeks

Spinal surgery

There is a R4 200 co-payment on the hospital bill. There is no benefit if the Conservative Back and Neck Rehabilitation Programme has not been completed.

Conservative Back and Neck Rehabilitation Programme

Following headaches, back and neck pain is the most common cause of ill health and incapacity amongst human beings. It often has significant financial and social implications, and is a major source of discomfort.

The Fedhealth Conservative Back and Neck Rehabilitation Programme is designed to ease the pain of eligible members and help them avoid spinal surgery. Qualifying members and beneficiaries will be enrolled in either a physiotherapy programme, or a six-week multidisciplinary programme that involves assessment and treatment by a General Practitioner, physiotherapist and biokineticist.

Positive outcomes include improved flexibility, reduced pain and stiffness, and therefore a better quality of life. The programme has also been proven to postpone, limit or assist in avoiding surgery. Where surgery is warranted, it will be permitted within Scheme Rules.

Please note: Should you decline to participate in the programme prior to surgery, there will be NO benefit for spinal surgery. In other words, the Scheme will not pay for the hospital, surgeon, prosthesis or anything related to the procedure. And, if spinal surgery is still necessary following successful completion of the programme, and you do receive authorisation from the Scheme, you will still have a co-payment of R4 200 on the hospital bill. This does not apply to emergency treatment/PMB.

How can you access the programme? There are a number of ways to access the programme:

- The telephonic helpline on **0860 002 153**
- You could be identified by the Scheme through predictive modelling
- The Scheme might intervene prior to authorising your back and neck surgery
- Managers might refer their employees to be assessed for eligibility
- Referral by your GP or specialist.

Oncology (cancer)

Full cover for services through ICON

The scheme has contracted with Independent Clinical Oncology Network (ICON) for oncology treatment. If you have not reached your limit for the oncology benefit and if you use an ICON service provider, the Core Benefit Bundle will cover your treatment for the following in full according to the scheme's level 2 protocols:

- Oncologist consultations
- Visits, treatment and materials for chemotherapy and radiotherapy
- Approved medication
- Radiology and pathology

ICON is a network of oncologists that includes 75% of all practicing oncologists in South Africa. For information, visit **www.cancernet.co.za** or call **0860 100 572**. If you do not use an ICON oncologist, then we cover your treatment only up to 100% of the Fedhealth Rate.

If you have reached your limit for the Oncology benefit

Once your benefit limits have been reached we will only cover PMBs. You must make use of the Designated Service Provider, ICON. If you use any other service provider, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.

Limits for specific treatments

Oncology: chemotherapy, radiotherapy, approved medication, related consultations, pathology and general radiology	We pay up to a limit of R555 900
Specialised medicine (eg, biologicals)	Limit of R173 400 per family per year (Note that the use of specialised medicine, including biologicals, cannot total more than this limit for both oncology and for other use)
Brachytherapy materials	Limit of R55 500

Oncology Disease Management Programme (ODM)

On diagnosis of cancer, it is important that you register on the Oncology Disease Management Programme (ODM). You or your treating doctor can call them on 0860 100 572 and register. The programme aims to help your doctor to ensure best treatment and support. Changes in your oncology medicine need to be given to ODM as soon as possible. Please fax the changed treatment plan to **021 466 2303** or email **cancerinfo@fedhealth.co.za**

Specialised radiology (for example, MRI or CT scans)

We cover specialised radiology (for example MRI or CT scans) up to 100% of the Fedhealth Rate, whether you have it in- or out-of-hospital. You must pay the first R2 200 for non-PMB scans. You must get separate authorisation for a specialised radiological procedure, whether it takes place in- or out-of-hospital.

Other treatments or procedures that you receive in hospital

All limits in this section are per family per year, unless otherwise explained. All co-payments in this section are per event and applicable on the hospital/facility bill only.

Appliances, external accessories, orthotics (e.g. compression stockings for DVT)	Paid from the day-to-day benefit. Does not accumulate to threshold. Paid from threshold up to R15 500 per family per year. Sub-limit of R4 340 per beneficiary for foot orthotics
Arthroscopic procedures: Hip and wrist	You pay a co-payment of R2 400 on the hospital bill. (See page 14 for cover for doctors and specialists)
Arthroscopic procedures: Other	You pay a co-payment of R2 400 on the hospital bill. (See page 14 for cover for doctors and specialists)
Colonoscopy, Upper GI endoscopy	You pay a co-payment of R2 400 on the hospital bill. (See page 14 for cover for doctors and specialists)
Corneal graft	We pay up to a limit of R20 700 per person registered on the scheme. (See page 14 for cover for doctors and specialists)
Joint replacements	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists)
Single hip and knee replacements with CP*	No co-payment if you use one of the scheme's CPs, ICPS or JointCare, for non-PMB hip and knee joint replacements. See page 20
Single hip and knee replacements-voluntary use of non-CP	You pay a co-payment of R26 200 on the hospital bill
Involuntary use of non-CP for single hip and knee replacements	You pay a co-payment of R4 200 on the hospital bill
All open hernia repairs	No co-payment on the hospital bill. (See page 14 for cover for doctors and specialists)
HIV: Immune deficiency related to HIV infection	Unlimited cover. (See page 14 for cover for doctors and specialists)
Organ transplant including immunosuppression medication	We pay up to a limit of R555 900. (See page 14 for cover for doctors and specialists)
Rhizotomies and facet pain blocks (limited to one of either procedure for each beneficiary each year)	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists)
Balloon sinuplasty	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists)
Laparoscopic hernia repairs (bilateral inguinal, repeated inguinal hernias and nissen/ toupey repairs only)	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists)
Laparoscopic procedures	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists)
Maxillo-facial surgery	Unlimited cover. (See page 14 for cover for doctors and specialists)
Post-hospitalisation benefit	We pay for up to 30 days after discharge at 100% of the Fedhealth Rate. See page 19.
Psychiatric Services: accommodation in a general ward, procedures, ECT, materials and hospital equipment, consultations and visits, medicines and injection material	We pay up to a limit of R32 000. (See page 14 for cover for doctors and specialists)
Renal dialysis (chronic): consultations, visits, all services, materials and medicines associated with the cost of renal dialysis	We pay up to a limit of R555 900 at 100% of the contracted rate at Designated Service Provider. 40% co-payment on non-use of DSP
Specialised radiology (for example, MRI or CT scans), whether the procedure is performed in- or out-of-hospital	Unlimited at 100% of the Fedhealth Rate (as long as you get separate authorisation). You pay a co-payment of R2 200 for non-PMB scans.
Spinal surgery	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists). No benefit unless Conservative Back and Neck Rehabilitation Programme has been completed. See page 15. Subject to internal prosthesis benefit limit. See page 20
Terminal care	We pay up to a limit of R31 000 at 100% of the Fedhealth Rate
Wisdom teeth (surgical removal of impacted wisdom teeth)	You pay a co-payment of R4 200 on the hospital bill. (See page 14 for cover for doctors and specialists)

* Contracted Provider: Must use ICPS or JointCare for single non-PMB hip and knee joint replacements. Non-use of Contracted Provider (CP) will result in co-payment.

Some treatment and procedures done out of hospital

To save your Day-to-Day Benefit, we pay for various treatments that are not done in hospital from the Core Benefit Bundle. This helps members because it means that your Day-to-Day Benefit will last longer each year.

Services like physical rehab and treatment in sub-acute facilities

In many cases, you might be able to be treated in a sub-acute facility rather than a hospital. There is no limit for the cover we give for this and it is paid from the Core Benefit Bundle. Subject to managed care protocols.

Nursing instead of hospitalisation

If it is possible to use nursing services (including private nurse practitioners and nursing agencies) instead of going to hospital, we will cover the expense from the Core Benefit Bundle. Subject to managed care protocols.

Procedures performed in day wards, day clinics and doctor's rooms

The Core Benefit Bundle (not Day-to-Day Benefits) covers more than 60 procedures that do not require an overnight stay in hospital and can safely be performed in day wards, day clinics and the doctor's rooms. An example is a tonsillectomy.

Doctor appointments with network GPs when your savings has run out

If you use a GP in the Fedhealth network and your savings has run out, the appointment is paid out of the Core Benefit Bundle.

Female contraception

In most cases, female contraception, including the contraceptive pill, contraceptive rings and IUDs, is covered by the Core Benefit Bundle. However, the Core Benefit Bundle will not cover:

- Female contraception that is prescribed for reasons other than contraception (for example, for skin problems). Examples of contraceptive pills that we do not cover are Cyprene-35 ED, Diane-35, Tricilest, Ginette and Minerva
- Costs of consultations or other expenses related to the IUD. The Core Benefit Bundle covers the cost of the IUD itself, (for example, Mirena) but does not cover any related costs. We cover the cost of an IUD every second year.

Other costs for contraception will usually be covered by the Day-to-Day Benefits.

Some treatment after a hospital visit

Medicine you get while in hospital to take at home
The scheme covers up to seven days of medicine that a doctor prescribes for you in hospital to take home with you (take-out medicine).

To get cover from the Core Benefit Bundle, the medicine must both be dispensed by the hospital and be shown on the original hospital account. If you are given a prescription for take-out medicine and take this prescription to a pharmacy, the claim will be paid from your Day-to-Day Benefit (Savings Account) and not from the Core Benefit Bundle.

Treatment in the 30 days after your hospital visit (post-hospitalisation benefit)
To protect your Day-to-Day Benefit, the scheme covers certain treatments up to 30 days after discharge from hospital from the Core Benefit Bundle. This treatment is subject to protocols. The day that you are discharged counts as the first day of the 30 days of cover.

This benefit covers treatment at 100% of the Fedhealth Rate. It pays for:
- Complications that might arise from hospitalisation.
- Physiotherapy, occupational therapy, speech therapy, general radiology, pathology tests and dietetics (limited to two consultations with a dietician per hospital admission).

The following conditions apply to the 30-day post-hospitalisation benefit:
- Only treatment as a result of a hospital event will be covered. The treatment must be related to the original diagnosis.
- You must get an authorisation number for this benefit in addition to the authorisation number for the hospital admission. If you do not get a separate authorisation number from us, the claim will be paid from the Day-to-Day Benefits and not from the Core Benefit Bundle.

Prosthesis benefit table

External prosthesis
We pay for external prostheses up to a limit of R17 300 per family per year at cost. This is paid out of the Core Benefit Bundle.

Internal prosthesis
There is a separate benefit for internal prosthesis. The benefit does not include osseo-integrated implants for replacing teeth. Hip and knee bilateral replacements will be allowed for up to double the amount for a single hip and knee replacement.

Internal prosthesis	Cover	Limits per family
Aorta stent grafts	100% of cost	R58 500
Detachable platinum coils	100% of cost	R50 700
Cardiac stents	100% of cost	R50 100
Cardiac valves	100% of cost	R44 500
Cardiac pacemakers	100% of cost	R48 700
Intraocular lenses (per lens)	100% of cost	R3 200
Shoulder replacement	100% of cost	R34 800
Elbow replacement	100% of cost	R34 800
Single hip replacement (See ICPS & JointCare below)	100% of cost	R34 800
Single knee replacement (See ICPS & JointCare below)	100% of cost	R34 800
Total ankle replacement Bone lengthening devices Spinal plates and screws Carotid stents Peripheral arterial stent grafts Embolic protection devices Other approved spinal implantable devices	100% of cost 100% of cost 100% of cost 100% of cost 100% of cost 100% of cost 100% of cost	See combined benefit limit for all unlisted internal prostheses*
* Combined benefit limit for all unlisted internal prostheses	100% of cost	R29 200

Improved Clinical Pathway Services (ICPS) and JointCare for non-PMB single hip and knee replacements

We're all about the coordination of your care to ensure you recover quicker and more effectively. That's why we have appointed Improved Clinical Pathway Services (ICPS) and JointCare as the contracted providers (CPs) for non-PMB hip and knee replacements. A clinical pathway means that a network of relevant healthcare practitioners will oversee every step of your hip or knee replacement journey with your GP, from GP referral to surgery, right through to your full rehabilitation. As the patient, you benefit since this coordinated approach has been proven to result in better health outcomes and patient satisfaction. So, you'll be back on your feet before you know it thanks to a managed process that includes your pre-op assessment, a rapid recovery plan, with pre-operative strengthening, physiological anaesthesia, minimally traumatic surgery, and postoperative physiotherapy.

Since ICPS and JointCare are the Fedhealth CPs for single hip and knee replacements, you will have a R26 200 co-payment if you voluntarily decline to use them for non-PMB hip or knee replacements.

Please note: non-PMB double hip and knee replacements (both at the same time) are not part of the CPs service model. Should a double replacement of either hips or knees occur, the fee for service model will be used – applicable specialist rates, network hospitals, prosthesis benefits and joint replacement co-payments will apply. Subject to authorisation and managed care protocols.

Contact ICPS on **0860 002 153** or via **www.icpservices.co.za**, and JointCare on **011 883 3310**.

Prescribed list of **maxima EXEC**[GRID] hospital facilities you must use

Please note that this list may change/expand during the year. Please contact the **Fedhealth Customer Contact Centre on 0860 002 153** or refer to the website for the latest Network Hospital and Day Clinic list.

HOSPITAL NAME	PROVINCE	TOWN
Life Beacon Bay Hospital	Eastern Cape	East London
Life St James Hospital	Eastern Cape	East London
Greenacres Hospital	Eastern Cape	Greenacres
Port Alfred Hospital	Eastern Cape	Port Alfred
Settlers Hospital	Eastern Cape	Grahamstown
East London Eye Hospital	Eastern Cape	East London
Matatiele Private Hospital	Eastern Cape	Matatiele
Cuyler Clinic	Eastern Cape	Uitenhage
Mthatha Private Hospital	Eastern Cape	Mthatha
Queenstown Private Hospital	Eastern Cape	Queenstown
Pelonomi Private Hospital	Free State	Bloemfontein
Universitas Private Hospital	Free State	Bloemfontein
Vaalpark Hospital	Free State	Sasolburg
Riemland Clinic	Free State	Frankfort
Cairnhall Hospital	Free State	Bloemfontein
Kroon Hospital	Free State	Kroonstad
St Helena Hospital	Free State	Welkom
Clinix Botshelong-Empilweni Private Hospital	Gauteng	Vosloorus
Clinix Dr SK Matseke Memorial Hospital	Gauteng	Soweto
Clinix Solomon Stix Morewa Memorial Hospital	Gauteng	Johannesburg
Clinix Tshepo-Themba Private Hospital	Gauteng	Dobsonville
Akasia Hospital	Gauteng	Akasia
Bougainville Hospital	Gauteng	Daspoort
Clinton Hospital	Gauteng	Alberton
Femina Hospital	Gauteng	Arcadia
Garden City Hospital	Gauteng	Mayfair West
Jakaranda Hospital	Gauteng	Muckleneuk
Krugersdorp Hospital	Gauteng	Krugersdorp
Linksfield Hospital	Gauteng	Linksfield West
Linkwood Hospital	Gauteng	Linksfield West
Linmed Hospital	Gauteng	Benoni
Milpark Hospital	Gauteng	Parktown West
Montana Hospital	Gauteng	Montana Park
Moot Algemene Hospital	Gauteng	Rietfontein
Mulbarton Hospital	Gauteng	Mulbarton
N17 Hospital	Gauteng	Springs
Olivedale Hospital	Gauteng	Olivedale
Optiklin Eye Hospital	Gauteng	Benoni
Park Lane Hospital	Gauteng	Parktown
Pinehaven Hospital	Gauteng	Krugersdorp
Pretoria East Hospital	Gauteng	Moreleta Park
Rosebank Hospital	Gauteng	Rosebank
Sunward Park Hospital	Gauteng	Boksburg
Union Hospital	Gauteng	Alberton
Unitas Hospital	Gauteng	Centurion
Waterfall City Hospital	Gauteng	Midrand
Arwyp Medical Centre	Gauteng	Kempton Park
Botshilu Private Hospital	Gauteng	Soshanguve
Lakeview Hospital	Gauteng	Benoni
Lenmed Health Ahmed Kathrada Private Hospital	Gauteng	Lenasia
Lenmed Health Daxina Private Hospital	Gauteng	Lenasia
Lenmed Health Randfontein Private Hospital	Gauteng	Randfontein
Lenmed Health Zamokuhle Private Hospital	Gauteng	Tembisa
Louis Pasteur Private Hospital	Gauteng	Pretoria
Medfem Clinic	Gauteng	Bryanston
Urolocare Hospital	Gauteng	Hatfield
Zuid-Afrikaanse Hospitaal	Gauteng	Pretoria
Naledi-Nkanyezi Private Hospital	Gauteng	Sebokeng
Cormed Clinic	Gauteng	Vanderbijlpark
Midvaal Private Hospital	Gauteng	Vereeniging
Kingsway Hospital	KwaZulu-Natal	Amanzimtoti
Parklands Hospital	KwaZulu-Natal	Overport
St Augustine's Hospital	KwaZulu-Natal	Durban
Umhlanga Hospital	KwaZulu-Natal	uMhlanga Rocks
Ethekwini Hospital And Heart Centre	KwaZulu-Natal	Durban
Gateway Private Hospital	KwaZulu-Natal	Umhlanga Rocks
Hillcrest Private Hospital	KwaZulu-Natal	Hillcrest
Lenmed Health Shifa Private Hospital	KwaZulu-Natal	Mayville
Alberlito Hospital	KwaZulu-Natal	Ballito
Hibiscus Hospital	KwaZulu-Natal	Port Shepstone
La Verna Private Hospital	KwaZulu-Natal	Ladysmith
Margate Private Hospital	KwaZulu-Natal	Margate
St Anne's Hospital	KwaZulu-Natal	Pietermaritzburg
The Bay Hospital	KwaZulu-Natal	Richards Bay
Kokstad Private Hospital	KwaZulu-Natal	Kokstad
Ahmed Al-Kadi Private Hospital	KwaZulu-Natal	Overport
Pholoso Hospital	Limpopo	Polokwane
Quality Care Private Hospital	Limpopo	Louis Trichardt
Zoutpansberg Private Hospital	Limpopo	Louis Trichardt
St Vincent's Hospital	Limpopo	Bela-Bela
Emalahleni Private Hospital	Mpumalanga	Witbank
Kiaat Private Hospital	Mpumalanga	Nelspruit
Lowveld Hospital	Mpumalanga	Nelspruit
Nelspruit Surgiclinic Private Hospital	Mpumalanga	Nelspruit
Life Cosmos Hospital	Mpumalanga	Witbank
Ferncrest Hospital	North West	Rustenburg
Fochville Hospital	North West	Fochville
The Fountain Private Hospital	North West	Carletonville
MooiMed Private Hospital	North West	Potchefstroom
Rustenburg Medi Care Hospital	North West	Rustenburg
Sunningdale Hospital	North West	Klerksdorp
Vryburg Private Hospital	North West	Vryburg
Wilmed Park Private Hospital	North West	Klerksdorp
Clinix Victoria Private Hospital	North West	Mafikeng
Jane Keyser Clinic	Northern Cape	Hartswater
Lenmed Health Kathu Private Hospital	Northern Cape	Kathu
The Royal Hospital and Heart Centre	Northern Cape	Kimberley
Mediclinic Cape Gate	Western Cape	Brackenfell
Life Bay View Hospital	Western Cape	Mossel Bay
Life West Coast Private Hospital	Western Cape	Vredenburg
Blaauwberg Hospital	Western Cape	Sunningdale
Ceres Hospital	Western Cape	Ceres
Christiaan Barnard Memorial Hospital	Western Cape	Cape Town
Kuils River Hospital	Western Cape	Kuils River

HOSPITAL NAME	PROVINCE	TOWN
N1 City Hospital	Western Cape	Goodwood
Bellville Medical Centre	Western Cape	Bellville
Busamed Paardevlei Private Hospital	Western Cape	Somerset West
Cape Eye Institute	Western Cape	Bellville
Gatesville Medical Centre	Western Cape	Gatesville
Mitchells Plain Medical Centre	Western Cape	Mitchells Plain
Tokai Medical Centre	Western Cape	Tokai
Rondebosch Medical Centre	Western Cape	Lansdowne
Mediclinic Louis Leipoldt	Western Cape	Bellville
Mediclinic Stellenbosch	Western Cape	Stellenbosch
Mediclinic Durbanville	Western Cape	Durbanville

Prescribed list of **maxima EXEC**[GRID] day clinics you must use

Please note that this list may change/expand during the year. Please contact the **Fedhealth Customer Contact Centre on 0860 002 153** or refer to the website for the latest Network Hospital and Day Clinic list.

HOSPITAL NAME	PROVINCE	TOWN
Med Forum Theatre	Eastern Cape	Port Elizabeth
Bethlehem Medical Centre Day Theatre	Free State	Bethlehem
CityMed Day Theatre	Free State	Bloemfontein
Cure Day Clinics - Bloemfontein	Free State	Bloemfontein
Welkom Medical Centre	Free State	Welkom
Boksburg Medical and Dental Centre	Gauteng	Boksburg
Constantia Clinic	Gauteng	Florida
Constantia Park Medical and Dental Centre	Gauteng	Garsfontein
Germiston Medical and Dental Centre	Gauteng	Germiston
Silverton Medical and Dental Theatre	Gauteng	Pretoria
The Berg Day Theatre	Gauteng	Bergbron
Protea Day Clinic	Gauteng	Krugersdorp
Advanced Groenkloof Day Hospital	Gauteng	Groenkloof
Medgate Day Hospital	Gauteng	Roodepoort
Advanced Soweto Eye Hospital	Gauteng	Soweto
Birchmed Surgical Centre	Gauteng	Kempton Park
Centre For Gynaecological Endoscopy	Gauteng	Morningside
Centre Of Advanced Medicine	Gauteng	Waverly
Centurion Eye Hospital	Gauteng	Centurion
Cure Day Clinics - Erasmuskloof	Gauteng	Erasmuskloof
Cure Day Clinics - Fourways	Gauteng	Fourways
Medkin Clinic	Gauteng	Pretoria
Cure Day Clinics - Midstream	Gauteng	Midstream
Edenvale Day Clinic	Gauteng	Edenvale
Ekurhuleni SurgiKlin Day Clinic	Gauteng	Kempton Park
Fordsburg Day Clinic	Gauteng	Fordsburg
Johannesburg Eye Hospital	Gauteng	Randburg
Kilnerpark Narkokliniek	Gauteng	Pretoria
Mayo Clinic	Gauteng	Roodepoort
Ocumed Eye And Laser Institute	Gauteng	Vanderbijlpark
Optimed Clinic	Gauteng	Johannesburg

HOSPITAL NAME	PROVINCE	TOWN
Sandhurst Eye Centre	Gauteng	Sandton
Dr Nilesh Dahya Inc	Gauteng	Benoni
Twenty Twenty Eye Surgery Centre	Gauteng	Mulbarton
Visiclin Eye Clinic	Gauteng	Three Rivers
Visiomed Eye And Laser Centre	Gauteng	Randburg
Netcare Rehabilitation Hospital	Gauteng	Auckland Park
Centurion Day Hospital	Gauteng	Centurion
Lakefield Surgical Centre	Gauteng	Benoni
Umhlanga Eye Institute	KwaZulu-Natal	Umhlanga
Bluff Medical and Dental Centre	KwaZulu-Natal	Bluff
Malvern Medical and Dental Centre	KwaZulu-Natal	Malvern
Pinetown Medical and Dental Centre	KwaZulu-Natal	Pinetown
Westridge Surgical	KwaZulu-Natal	West Ridge
Howick Day Clinic	KwaZulu-Natal	Howick
KZN Day Clinic	KwaZulu-Natal	Umhlanga
Lorne Street Anaesthetic Clinic	KwaZulu-Natal	Durban
Durban Eye Hospital	KwaZulu-Natal	Durban
Shelly Beach Day Clinic	KwaZulu-Natal	Shelly Beach
Emalahleni Day Hospital	Mpumalanga	Witbank
Advanced De La Vie Day Hospital	Mpumalanga	Witbank
Highveld Eye Hospital	Mpumalanga	Witbank
Potchefstroom Medical and Dental Centre	North West	Potchefstroom
Rustenburg Private Eye Clinic	North West	Rustenburg
Medi-Harts Day Clinic	Northern Cape	Hartswater
Kimberley Narko Clinic	Northern Cape	Kimberley
Mediclinic Upington	Northern Cape	Upington
Kalahari Eye and Day Theatre	Northern Cape	Upington
Langeberg Medical and Dental Centre	Western Cape	Kraaifontein
Monte Vista Clinic	Western Cape	Monte Vista
Parow Medical and Dental Centre	Western Cape	Parow
Tokai Medical and Dental Centre	Western Cape	Tokai
Advanced Knysna Surgical Centre	Western Cape	Knysna
Advanced Panorama Surgical Centre	Western Cape	Panorama
Advanced Vergelegen Surgical Centre	Western Cape	Somerset West
Advanced Worcester Surgical Clinic	Western Cape	Worcester
Cape Dental Theatres	Western Cape	Wynberg
Cure Day Clinics - Bellville	Western Cape	Parow
Cure Day Clinics - Somerset West	Western Cape	Somerset West
Cure Day Clinics - St Stephen's Paarl	Western Cape	Paarl
Driftwood Clinic	Western Cape	Constantia
George Surgical Centre	Western Cape	George
Kango Clinic (Kannaland Medical Clinic)	Western Cape	Oudtshoorn
The Surgical Institute	Western Cape	Durbanville
Thembani Theatres	Western Cape	Khayelitsha
Vidamed Day Hospital	Western Cape	Mossel Bay
Wesfleur Private Clinic	Western Cape	Atlantis
Advanced Durbanville Surgical Centre	Western Cape	Durbanville
Alchimia Clinic	Western Cape	Gardens
Hermanus Day Hospital	Western Cape	Hermanus

You must have authorisation

You need authorisation before the Core Benefit Bundle will cover any claim, for example, a planned or emergency hospital admission, specialised radiology, selected procedures, 30-day post-hospitalisation benefit or casualty treatment.

Contact us at least 48 hours before the hospital stay or the procedure
You must contact us at least 48 hours before any treatment that is not an emergency or that is planned. You must write down the authorisation number we give to you and take it with you to hospital.

You must get a separate authorisation number for specialised radiology and for treatment covered in the 30 days after the hospital visit. If in doubt, please do contact us to find out if you need an authorisation number.

When you contact us, have this information ready
Are you being admitted as an in-patient or an out-patient to the hospital?
In-patient: if you will be staying overnight.
Out-patient: if you will be admitted and discharged the same day (no overnight stay).

We need the following information to authorise your treatment:

1. Fedhealth membership number
2. Date of birth of patient
3. Reason for admission, ICD10 and applicable tariff codes for the proposed treatment (your doctor must give these to you)
4. Date of admission and the proposed date of the operation or treatment
5. The treating doctor's name and telephone and practice numbers
6. Name of the hospital with telephone and practice numbers
7. For a CT scan, MRI procedure or similar procedure, the name of the radiological practice.

Phone us:

0860 002 153
Monday to Thursday 08h30 – 17h00
Friday 09h00 – 17h00

Email us:

authorisations@fedhealth.co.za

All costs covered from the Core Benefit Bundle need to be pre-authorised by the Authorisation Centre on

0860 002 153

Screening benefit

This benefit covers various screening and preventative programmes that aim to improve your health.

Screening test	Beneficiaries registered on the scheme who qualify for the benefit	Limit of screening tests
Women's Health		
Cervical cancer screening (Pap smear)	Women, 21 to 65 years old	1 every 3 years
Men's Health		
Prostate Specific Antigen (PSA)	Men, 45 to 69 years old	1 every year
Children's Health – see table on the right for the immunisation benefit		
Cardiac Health		
Cholesterol screening (full lipogram)	Everyone 20 years old and older	1 every 5 years
Over 50s		
Pneumococcal vaccination	Everyone older than 65	1 per lifetime
Bone densitometry	Women older than 65 and Men older than 70	1 every 2 years
Colorectal cancer screening (faecal occult blood test)	Everyone; 50 to 75 years old	1 every year
General		
Breast cancer screening with mammography	Everyone older than 45	1 every 3 years
Flu vaccination	Everyone	1 every year
HIV finger prick test by contracted wellness network provider	Everyone	1 every year
Health risk assessments		
Wellness screening (BMI, blood pressure, finger prick cholesterol and glucose tests)	Everyone	1 every year
Preventative screening by contracted wellness network provider (waist-to-hip ratio, body fat %, flexibility, posture and fitness)	Everyone	1 every year

Active Disease Risk Management programmes

The Scheme offers the following programmes to help you address certain health issues:

Programme	Beneficiaries registered on the scheme who qualify for the benefit
Conservative Back and Neck Rehabilitation Programme	Qualifying members
Diabetes Management Programme	Qualifying members
Emerging Risk Beneficiary Management Programme	Qualifying members
High Risk Beneficiary Management Programme	Qualifying members
Mental Health Management Programme	Qualifying members
Smoking Cessation Programme	Everyone
Weight Management Programme	Qualifying members

Immunisation benefit for children

Age of child	Vaccine
At birth	Tuberculosis (Bacilles Calmette Guerin) **OPV (0)** Oral Polio Vaccine
6 Weeks	**OPV (1)** Oral Polio Vaccine **RV (1) Rotavirus Vaccine** **DTaP-IPV//Hib (1)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Hep B (1)** Hepatitis B Vaccine **PCV_7 (1)** Pneumococcal Conjugated Vaccine
10 Weeks	**DTaP-IPV//Hib (2)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Hep B (2)** Hepatitis B Vaccine
14 Weeks	**RV (2) Rotavirus Vaccine** (should not be administered after 24 weeks) **DTaP-IPV//Hib (3)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Hep B (3)** Hepatitis B Vaccine **PCV_7 (2)** Pneumococcal Conjugated Vaccine
9 Months	**Measles Vaccine (1)** **PCV_7 (3)** Pneumococcal Conjugated Vaccine
18 Months	**DTaP-IPV//Hib (4)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Measles Vaccine (2)**
6 Years	**Td Vaccine** Tetanus and reduced strength of diphtheria Vaccine
12 Years	**Td Vaccine** Tetanus and reduced strength of diphtheria Vaccine

What is chronic medicine?

The Chronic Disease Benefit covers chronic medicine. Chronic medicine is medicine that is taken for a persistent or otherwise long-lasting condition. Examples of conditions that require ongoing medicine are hypertension, diabetes and asthma. This option covers chronic medicine for 51 chronic conditions.

Limits

The overall limit is R7 100 per year per beneficiary, up to a limit of R13 100 per year for each family.

To claim under this benefit

Your condition:

- Must be in the list of chronic conditions (given below); and
- Must meet a set of defined criteria to qualify for the benefit (referred to as clinical entry criteria).

In other words, just because you have one of the conditions on the list below, does not mean that we will cover the expenses out of the Chronic Disease Benefit. The condition must also meet a set of defined criteria. If you need information on the criteria, please contact us.

List of chronic conditions

This benefit covers medicine and treatment for a set of 51 chronic conditions as well as HIV/Aids. These are given in List 1 below and List 2 on page 30.

List 1: Conditions that are on the Chronic Disease List (CDL)

See section 1, 'Prescribed Minimum Benefits (basic level of cover for a defined set of conditions)' for an explanation of Prescribed Minimum Benefits.

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Renal Disease	Hypothyroidism
COPD/ Emphysema/ Chronic Bronchitis	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus type 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

If your condition is on List 1 (CDL)

If you have not reached your limit for the Chronic Disease Benefit:

Medicines that we cover (formulary)	If the condition qualifies for the benefit, we cover medicines on the comprehensive formulary only, and only up to the ceiling price given in the Medicine Price List. If you use a medicine not on this list, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.
Service providers you should use	If the condition qualifies for the benefit, you can use any service provider. The Scheme pays up to an agreed rate for dispensing fees. You will pay the difference if the pharmacy charges more. MediRite, Dis-Chem, Clicks and Pharmacy Direct do not charge more than the agreed rate.

If you have reached your limit for the Chronic Disease Benefit:

Medicines that we cover (formulary)	If the condition qualifies for the benefit, we cover medicines on the comprehensive formulary only, and only up to the ceiling price given in the Medicine Price List. If you use a medicine not on this list, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.
Service providers you should use	If the condition qualifies for the benefit, you can use any service provider. The Scheme pays up to an agreed rate for dispensing fees. You will pay the difference if the pharmacy charges more. MediRite, Dis-Chem, Clicks and Pharmacy Direct do not charge more than the agreed rate.

List 2: Additional chronic conditions covered on your option

Angina	Narcolepsy
Ankylosing Spondylitis	Obsessive Compulsive Disorder
Anorexia Nervosa	Panic Disorder
Attention Deficit Disorder (in children only up to age of 18)	Paraplegia/ Quadriplegia (associated medicine)
Barrett's Oesophagus	Polyarteritis Nodosa
Bulimia Nervosa	Post-Traumatic Stress Syndrome
Conn's Syndrome	Pulmonary Interstitial Fibrosis
Cushing's Syndrome	Scleroderma
Deep Vein Thrombosis	Thromboangitis Obliterans
Depression	Thrombocytopaenic Purpura
Dermatomyositis	Tourette's Syndrome
Gastro-Oesophageal Reflux Disease	Valvular Heart Disease
Generalised Anxiety Disorder	Zollinger-Ellison Syndrome

If your condition is on List 2 (Additional Chronic Conditions)

If you have not yet reached your limit for the Chronic Disease Benefit

Medicines that we cover (formulary)	If the condition qualifies for the benefit, we cover medicines on the comprehensive formulary only, and only up to the ceiling price given in the Medicine Price List. If you use a medicine not on this list, you must pay 40% of the cost from your own pocket.
Service providers you should use	If the condition qualifies for the benefit, you can use any service provider. The Scheme pays up to an agreed rate for dispensing fees. You will pay the difference if the pharmacy charges more. MediRite, Dis-Chem, Clicks and Pharmacy Direct do not charge more than the agreed rate.

There is no benefit at all for the additional chronic conditions once your chronic benefit is used up.

Having a chronic condition:

AN EXAMPLE	
What the member does	**How the expense is funded**
Lily has asthma and her doctor prescribes medicine that she must take regularly. She decides to apply online on **www.fedhealth.co.za** rather than on the phone. Her doctor gives her the details that the online application asks for. Chronic Medicine Management (CMM) at Fedhealth tell her that the application is accepted because her asthma meets the clinical criteria. Lily then gets the Medicine access card in the post as well as by email. She can take it to any pharmacy together with her script to buy her medicine. Since the Scheme pays up to an agreed rate for dispensing fees, Lily will pay the difference if the pharmacy she uses charges more. MediRite, Dis-Chem, Clicks and Pharmacy Direct do not charge more than the agreed rate. If Lily wants to make use of Pharmacy Direct, a courier pharmacy, she can register with them and have her chronic medication delivered to an agreed address. When Lily is buying her medicine, the pharmacist tells her that the prescribed medicine will not be covered in full but that there is a generic medicine that would be covered in full. She decides to change to the generic so that the full cost of the medicine is covered. Because asthma is on the CDL, she will receive treatment guidelines with her letter from CMM. These will tell her about which other expenses are covered by risk benefits (the scheme).	Lily has not reached the limit for the Chronic Disease Benefit, so the cost of the medicine is covered in full, as long as the prescribed medicine is on the comprehensive formulary and the costs fall within the ceiling price given on the Medicine Price List. If Lily uses medicine that is not on the comprehensive formulary, then Lily would have to pay 40% of the cost from her own pocket. If Lily had reached the limit for the Chronic Disease Benefit, because asthma is a Prescribed Minimum Benefit condition, we would cover medicines that are on the comprehensive formulary. This means that there might be some medicines that we do not cover at all. If Lily uses medicines that are not on the comprehensive formulary, then Lily would have to pay 40% of the cost from her own pocket. We would only cover the medicine up to the ceiling price given on the Medicine Price List. Lily can get her medicine from any pharmacy. Since the Scheme pays up to an agreed rate for dispensing fees, Lily will pay the difference if the pharmacy she uses charges more. MediRite, Dis-Chem, Clicks and Pharmacy Direct do not charge more than the agreed rate. If Lily had a condition that is not a Prescribed Minimum Benefit, there would be no cover after the Chronic Disease Benefit has reached the limit.

Cover for treatment for HIV/Aids

There is unlimited cover for HIV/Aids treatment and preventative medicine.

To qualify for this benefit, you must be registered on the scheme's HIV/Aids disease management programme, Aid for Aids (AfA). You have access to the HIV/Aids medicine benefit only when you are registered.

AfA is a comprehensive HIV disease management programme with access to:

- anti-retrovirals and related medicines
- post-exposure preventative medicine
- preventative medicine for mother-to-child transmission
- post-exposure preventative medicine after rape.

The programme gives ongoing patient support and monitors the disease and response to therapy. To join AfA, call them in confidence on **0860 100 646**. Your doctor may also call AfA on your behalf.

How to apply for the Chronic Disease Benefit

STEP 1: Collect the information needed to apply
You will need the following information to apply. If you need help gathering this information, please contact us.
- Membership number
- Dependant code
- ICD10 code of your chronic condition
- Drug name, strength and quantity
- Prescribing doctor's practice number
- Diagnostic test results, e.g. Total Cholesterol, LDL, HDL, glucose tests, thyroid (depending on your condition).

STEP 2: Apply
You have a choice of how to apply:
Apply by telephone: You can call Chronic Medicine Management (CMM) between 08h30 and 17h00, Monday to Thursday and 09h00 to 17h00 on Fridays. Phone **0860 002 153**.
Apply on the Fedhealth Family Room: Go to **www.fedhealth.co.za**. You can apply for the chronic disease benefit in the Fedhealth Family Room. Simply click on Health > Request Chronic Pre-authorisation, and complete the form.
Ask your doctor or pharmacist to apply on your behalf. They can do an online application or contact our Provider Call Centre on 0861 112 666.

STEP 3: We will give you a response right away
We will reply to your application right away. If we need more information, we will let you, your doctor or your pharmacist know exactly what information to give to us.

If we do not approve the application, we will give you the reasons why, and you will have the opportunity to ask us to review our decision.

STEP 4: You get your medicine access card
If we approve your application, we will give you a medicine access card. Your medicine access card will record the medical condition for which we have approved treatment.

We will give you treatment guidelines

The scheme has set up treatment guidelines if you have applied for conditions on List 1 to ensure that you have access to appropriate treatment for your condition. You will receive details of the treatment guidelines with your letter from CMM.

If there is a co-payment on your medicine

If you find that the medicine your doctor has prescribed for you has a co-payment, because it costs more than the ceiling price given in the Medicine Price List, you can ask your pharmacist to help you to change it to a generic medicine that the scheme covers in full. If the medicine has a co-payment because it is not in the formulary then you should discuss a possible alternative with your prescribing doctor.

We will approve a chronic condition, not individual chronic medications

Thanks to a streamlined, simplified approval process for chronic medication called Disease Authorisation, you can apply for approval of a chronic condition, as opposed to a single chronic medication.

This means that the Scheme will approve an entire list of medication for your specific condition (known as a basket of medicine). So, if your doctor should ever change your medication, you will most likely already be approved for it – provided it's in the basket. You will be able to view the approved medication for your condition in the Fedhealth Family Room. Simply click on Health > My authorisations > Select a dependant > Track authorisation type > Submit. On a more practical level it means that when you need to change or add a new medicine for your condition, you can do this quickly and easily at your pharmacy with a new prescription, without having to contact Fedhealth at all.

If you would like to check what medicine is available to you in your condition's basket, you can call Chronic Medicine Management (CMM) between 08h30 and 17h00, Monday to Thursday and 09h00 to 17h00 on Fridays. Phone **0860 002 153**.

Chronic medication delivered to your door

To give you the added convenience of having your chronic medication delivered directly to you (home, work, temporary address or nearest Post Office), you can use our preferred provider, Pharmacy Direct, for free-of-charge courier services.

Pharmacy Direct has a proven track record of friendly professional service and on time deliveries. For more information, visit **www.pharmacydirect.co.za** or get in touch by calling **0860 027 800**, Mondays to Fridays from 07h30 to 17h00. Remember to include your Fedhealth membership number on all communication!

Paying for day-to-day expenses (Day-to-Day Benefits)

The scheme gives an overall limit for the amount of cover you and your family have for day-to-day medical expenses. Examples of day-to-day medical expenses are:

- Visits to doctors or specialists
- Short-term courses of medicine (for example, antibiotics for the flu)
- Optometry (glasses)
- Visits to the dentist.

These day-to-day expenses may be paid out of two different benefits under the overall Day-to-Day Benefit. The way the benefits work will affect the limits that are given in the table on page 40, so make sure you read this whole section.

The basics of the two benefits for day-to-day medical expenses

The limits of all the benefits below depend on the size of your family. Please refer to the rates table on page 50.

The Savings Account pays for day-to-day expenses first (from the beginning of the year) and pays expenses up to the actual cost. In some cases, if you have money available in your Savings Account, you can use this to pay co-payments. However, a co-payment for a Prescribed Minimum Benefit condition cannot be paid from your Savings Account.
The Savings Account works differently to other benefits in that you carry any remaining amount over to the next year. There are also implications if you leave the scheme – see page 51.

The Threshold Benefit is intended to cover medical expenses if you still have day-to-day medical expenses even after your Savings Account is used up.

You must pay while you are in the self-payment gap

There might be a gap between when the Savings Account runs out and the Threshold Benefit kicks in. During this gap (referred to as a self-payment gap), you will have to pay for all day-to-day medical expenses out of your own pocket.

The gap occurs because the Threshold Benefit kicks in only when all your day-to-day expenses have added up to the threshold level at the Fedhealth Rate. When you are in the self-payment gap, you must still continue to submit all your claims. Even though we won't be able to refund them, they will still add up towards your threshold level.

Examples of expenses that will increase the self-payment gap

The following expenses will increase your self-payment gap:

- Using alternative healthcare (eg, homeopathy) or having medicines prescribed from alternative healthcare providers
- Claiming for services that are charged above the Fedhealth Rate, for example if you go to doctors or specialists that are not in the Fedhealth network
- Claiming for medicines that are more expensive than the ceiling price given in the Medicine Price List
- Claiming for more than the yearly limits, for example, for advanced dentistry and optical limits
- Claiming for over-the-counter medicines
- Using pharmacies that are not in the Fedhealth network
- Claiming for any Additional Medical Service eg, speech therapy
- Claiming for appliances, external accessories and orthotics eg, hearing aids.

When the Threshold Benefit kicks in, existing limits apply

Once you have reached the required threshold level, your day-to-day expenses will be paid from the Threshold Benefit. Many of your day-to-day expenses will be covered unlimited, but any existing limits will still apply. For example, if a family spends R11 000 on optometry, a maximum of R10 190 will add up towards their threshold level because the limit for optometry is R10 190 per family. Once this family is in the Threshold Benefit, they will have no more cover for optometry from the Threshold Benefit as their limit will have been reached.
Also the Threshold Benefit pays only up to the Fedhealth Rate and there is a 10% co-payment on all claims paid from the Threshold Benefit. You have to pay any difference from your own pocket.

Cover for doctors, specialists and medicines

GPs in the Fedhealth network

If you use a GP (General Practitioner) in the Fedhealth network, your consultation is firstly paid from Savings. When your Savings runs out, GP consultations are paid out of the Core Benefit Bundle. This covers the consultation only. To find a GP in the Fedhealth network, go to our website or call **0860 002 153**.

Even if you're in the self-payment gap, Fedhealth gives unlimited cover for GP consultations, as long as you use a GP who is in the Fedhealth network. This means that you always have unlimited cover for GPs, as long as you use a GP in the Fedhealth network.

Please note that a maximum of two mental health GP consultations per beneficiary per year will be covered from Risk. (Combined limit with out-of-network GPs).

GPs not in the Fedhealth network

If you do not use a GP in the Fedhealth network, the consultation will be paid from Savings. These consultations will not add up to the threshold level. When in the Threshold Benefit, these consultations are paid at 100% of the Fedhealth Rate. Please note that a maximum of two mental health GP consultations per beneficiary per year will be covered from Savings and Threshold. (Combined limit with network GPs).

Specialists in the Fedhealth network

Specialists in the Fedhealth network have agreed to a set rate for consultations. If you have day-to-day benefits available, the consultation will be paid out of these benefits at this rate. It will also add up towards the threshold level at this rate.
If you are in the self-payment gap, you will have to pay for the consultation from your own pocket but also only at the set rate.
When you reach the threshold level and the Threshold Benefit kicks in, we cover visits to specialists in the Fedhealth network in full. Before you consult a specialist, please see your GP to obtain a referral. If referral is not obtained there will be a 10% co-payment on specialist claims paid from the Risk benefit.

Specialists not in the Fedhealth network

If you do not use a specialist in the Fedhealth network, the consultation will be paid from your Savings Account up to cost.

These consultations will not add up to the threshold level. When in the Threshold Benefit, the consultations are also paid at the Fedhealth Rate. Before you consult a specialist, please see your GP to obtain a referral. If referral is not obtained there will be a 10% co-payment on specialist claims paid from the Risk benefit.

Prescribed medicine

There is a limit for prescribed medicine. For example, the individual limit is R7 100. If you have already spent R5 000 according to the ceiling prices given in the Medicine Price List when you reach the threshold level, then you will only have R2 100 available to spend from the Threshold Benefit for prescribed medicine. When you are in the Threshold Benefit, you get cover for prescribed medicine only at the ceiling price of the Medicine Price List. You are responsible for paying the difference.

Dispensing fees for prescribed medicine

Pharmacies charge a dispensing fee for each prescribed medicine that they sell. The scheme has agreed special rates for dispensing fees with pharmacies in the Fedhealth network. If you use a pharmacy in the Fedhealth network, we will cover the agreed dispensing fee in full from your day-to-day benefits.
To find a pharmacy in the Fedhealth network, go to the website or call **0860 002 153**.

If you buy from a pharmacy not in the Fedhealth network, then you might have to pay the difference between the agreed dispensing fee and the dispensing fee that the pharmacy charges.

Over-the-counter medicine

Medicines with a schedule of 0, 1 or 2 can be bought from the pharmacy without a prescription from your doctor. The cost will be paid out of your Savings Account only and the amount will not add up towards your threshold level.

The Threshold Benefit does not cover over-the-counter medicine.

Female contraception

In most cases, female contraception is covered by the Core Benefit Bundle – see page 18.
However, contraceptive pills are paid from your Savings Account if they are prescribed for reasons other than contraception (for example, for skin problems). Examples of contraceptive pills that we do not cover under the Core Benefit Bundle include Cyprene-35 ED, Diane–35, Tricilest, Ginette and Minerva.

The consultation and the cost of procedures for IUDs are paid from your Savings Account. Only the cost of the IUD itself is paid from Core Benefit Bundle. We cover the cost of an IUD every second year.

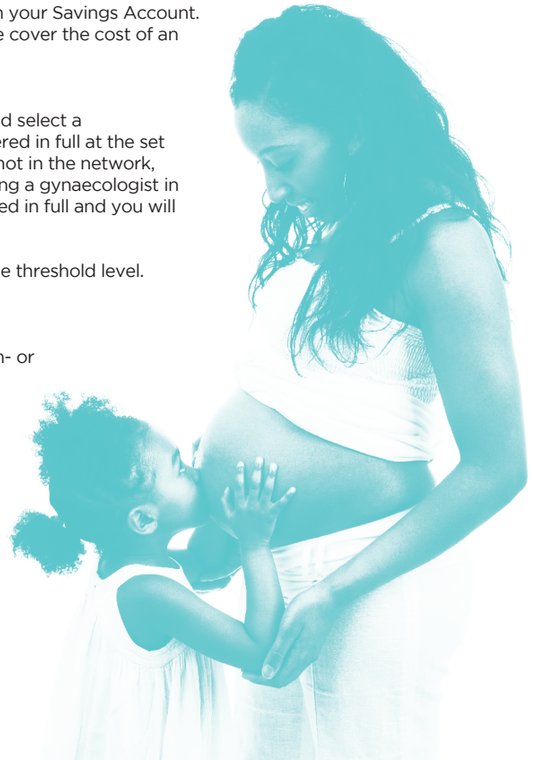
Pregnancy

Pregnancy costs are covered from the Savings Account. You should select a gynaecologist in the Fedhealth network. Consultations will be covered in full at the set rate and will add up to the threshold level in full. If the specialist is not in the network, then only the Fedhealth Rate will add up to the threshold level. Using a gynaecologist in the Fedhealth network will ensure that in-hospital claims are covered in full and you will not have to pay any co-payments.

A total of two 2D ultrasound scans per pregnancy will add up to the threshold level.

Specialised radiology (for example, MRI or CT scans)

We cover specialised radiology (for example MRI or CT scans) up to 100% of the Fedhealth Rate, whether you have it in- or out-of-hospital. You must pay the first R2 200 for non-PMB scans.
You must get separate authorisation for a specialised radiological procedure, whether it takes place in- or out-of-hospital.



Over-the-counter medicine:

AN EXAMPLE	
What the member does	**How the expense is funded**
Andy feels unwell and decides to follow his pharmacist's recommendation to take an over-the-counter flu medicine. He chooses a pharmacy within the Fedhealth network.	Whether the expense is covered depends on his benefits: If Andy has enough money in his Savings Account to cover the medicine, he will not have to pay anything from his own pocket. If Andy does not have enough money in his Savings Account, he will have to pay the pharmacy himself. The cost of over-the-counter medicine does not add up to the threshold level.

Visiting a doctor (General Practitioner):

AN EXAMPLE	
What the member does	**How the expense is funded**
Mary has flu and wants to see her doctor, Dr Chris. She goes onto **www.fedhealth.co.za** to confirm if Dr Chris is on the Fedhealth network. She finds out that he is. She has a consultation with the doctor and he prescribes a course of antibiotics for her. Mary then goes to the pharmacy to buy the medicine that was prescribed for her. She makes sure that she asks for a generic version of the antibiotics and she makes sure that she goes to a pharmacy in the Fedhealth network.	The consultation Because Dr Chris is in the Fedhealth network, Fedhealth has agreed a set rate for the consultation. This is how the consultation will be funded: If Mary has money in the Savings account, it will fund the consultation in full. The full amount adds up to the threshold level. If Mary's Savings Account is used up, the consultation is paid out of risk benefits (Core Benefit Bundle). The prescribed medicine Mary had not reached the limit for prescribed medicine and had asked for a generic of the medicine which fell within the ceiling price on the Medicine Price List. So: If she has money in the Savings Account, it will pay the expense and the full amount adds up to the threshold level. (If Mary had chosen a medicine that cost more than the ceiling price on the Medicine Price List, the difference would not add up to the threshold level)

GP non-network:

AN EXAMPLE	
What the member does	**How the expense is funded**
David has flu and wants to see his doctor, Dr Mary. He goes onto **www.fedhealth.co.za** to confirm if Dr Mary is on the Fedhealth network. He finds out that she is not. He has a consultation with the doctor and she prescribes a course of antibiotics for him. David then goes to the pharmacy to buy the medicine that was prescribed for him. He makes sure that he asks for a generic version of the antibiotics and he makes sure that he goes to a pharmacy in the Fedhealth network.	The consultation Because Dr Mary is not in the Fedhealth network, this is how the consultation will be funded: If David has funds available in his Savings Account, the consultation is covered in full. However, the cost of non-network GP consultations does not add up to the threshold level. The prescribed medicine David had not reached the limit for prescribed medicine and had asked for a generic of the medicine which fell within the ceiling price on the Medicine Price List. So: If he has money in the Savings Account, it will pay the expense and the full amount adds up to the threshold level. (If David had chosen a medicine that cost more than the ceiling price on the Medicine Price List, the difference would not add up to the threshold level).

Going to see a specialist:

AN EXAMPLE	
What the member does	**How the expense is funded**
John's family doctor has referred him to a specialist because of an ongoing sore throat. He has a consultation with the specialist.	If the specialist is in the Fedhealth network This is how the consultation will be funded: If John has money available in his Savings Account, the consultation is covered in full at the set rate and adds up to the threshold level in full. If the specialist is not in the Fedhealth network This is how the consultation will be funded: If John has money available in his Savings Account, the consultation is covered in full. However, the cost of non-network specialist consultations does not add up to the threshold level.

All cover in day-to-day benefits

In the table below, certain expenses are subject to limits. These limits apply to the accumulation of claims to the threshold level as well as the refund of claims from the Threshold Benefit. For example, if a family spends R11 000 on optometry, a maximum of R10 190 will add up towards their threshold level because the limit for optometry is R10 190 per family. Once this family is in the Threshold Benefit, they will have no more cover for optometry from the Threshold Benefit as their limit will have been reached. Also the Threshold Benefit pays only up to the Fedhealth Rate and there is a 10% co-payment on all claims paid from the Risk Benefit except consultations with network GPs. Network specialist consultations will now also attract a co-payment of 10% if no GP referral is obtained. You have to pay any difference from your own pocket.

Day-to-day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Additional medical services: Audiology, dietetics, genetic counselling, hearing aid acoustics, occupational therapy, orthoptics, podiatry, private nursing*, psychologists, speech therapy, social workers	Limit of R17 400 per family per year for the total of all additional medical services in and out-of-hospital	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit
Alternative healthcare: Acupuncture, homeopathy, naturopathy, osteopathy and phytotherapy (including medicines prescribed by alternative healthcare professionals)	No limit	At cost	Does not add up to threshold level	Not covered
Antenatal scans	Two 2D antenatal scans per person per year	At cost	Adds up at Fedhealth Rate to the maximum of the limit	Covered at Fedhealth Rate up to the limit
Appliances, external accessories and orthotics: Hearing aids, wheelchairs etc.	Limit of R15 500 per family per year. Sub-limit of R4 340 per person for foot orthotics in and out-of-hospital	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit

* Private nursing that falls outside the Alternatives to Hospitalisation Benefit

Day-to-day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Biokinetics, chiropractics	The Additional Medical Services limit of R17 400 per family per year applies (combined limit)	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit
Dentistry (Advanced): Inlays, crowns, bridges, mounted study models, metal base partial dentures, osseo-integrated implants, orthognathic surgery, oral surgery, orthodontic treatment, periodontists, prosthodontists and dental technicians	Limit of R7 400 per person per year, up to an overall limit of R22 100 per family per year	At cost	Adds up at Fedhealth Rate to the maximum of the limit	Covered at Fedhealth Rate up to the limit
Dentistry (Basic)	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Female contraception	See Female contraception paid out of Core Benefit Bundle (page 18) and Female contraception paid out of Day-to-Day Benefits (page 37).			
General Practitioners: *Please note only two mental health consultations per beneficiary will be paid from the Core Benefit Bundle				
Fedhealth Network GPs	No limit – you are always covered even in the self-payment gap. (This is because when the savings is used up, the expenses will be covered by the Core Benefit Bundle)	At cost (set rate)	Adds up at set rate	Covered from Core Benefit Bundle
Non-Fedhealth Network GPs	No limit	At cost	Does not add up to threshold level	Covered at Fedhealth Rate

Day-to-day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Optometry: Frames, single vision, bifocal, multifocal or special lenses, lens add-ons, contact lenses, Readers and optometric examinations	Limit of R3 340 per person per year, up to an overall limit of R10 190 per family per year	At cost	Adds up at Fedhealth Rate to the maximum of the limit	Covered at Fedhealth Rate up to the limit
Over-the-counter medication	Paid out only from Savings (not from Threshold Benefit)	At cost	Does not add up to threshold level	Not covered
Pathology	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Physiotherapy	The Additional Medical Services limit of R17 400 per family per year applies (combined limit)	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit
Prescribed medication	Limit of R7 100 per person per year, up to an overall limit of R13 100 per family per year	At cost	Adds up at the MPL to the maximum of the limit	Covered up to MPL up to the limit
Radiology (General)	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Radiology (Specialised)	Paid from the Core Benefit Bundle if pre-authorised up to 100% of the Fedhealth Rate, whether you have it in- or out-of-hospital. You must pay the first R2 200 for non-PMB scans.			

Day-to-day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Specialists excluding Psychiatrists				
Fedhealth Network Specialists Network GP referral required for consultations (including PMB conditions) to be paid from Risk benefit	No limit	Up to set rate	Adds up at set rate	Covered at set rate (Fedhealth network specialists will only charge the set rate). 10% co-payment if GP referral not obtained
Non-Fedhealth Network Specialists Network GP referral required for consultations (including PMB conditions) to be paid from Risk benefit	No limit	At cost	Does not add up to threshold level	Covered at Fedhealth Rate. 10% co-payment if GP referral not obtained
Specialists: Psychiatrists				
Fedhealth Network Psychiatrists Network GP referral required for consultations (including PMB conditions) to be paid from Risk benefit	The Additional Medical Services limit of R17 400 per family per year applies (combined limit)	Up to set rate	Does not add up to threshold level	Covered at set rate up to the limit (Fedhealth network specialists will only charge the set rate). 10% co-payment if GP referral not obtained
Non-Fedhealth Network Psychiatrists Network GP referral required for consultations (including PMB conditions) to be paid from Risk benefit	The Additional Medical Services limit of R17 400 per family per year applies (combined limit)	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit. 10% co-payment if GP referral not obtained

How to claim

If the healthcare professional or the hospital claims on your behalf
Your healthcare professional usually sends your claim to us on your behalf. **In this case, you do not need to claim as well**.
If your healthcare professional tells you that they have not been paid, you can check your claims status on the Fedhealth Family Room or contact us on **0860 002 153**.

If you need a refund because you paid the medical expense
If your healthcare professional does not claim on your behalf, or if you have already paid, you must send us the:
- Proof of payment
- The claim (the account). Make sure the account shows:
  - Your membership number
  - **The ICD10 and procedure codes**
  - The practice number.

If we approve the claim according to the scheme rules, Fedhealth will refund you directly into your bank account.
You must make sure that we have your correct bank details. To update your bank details, call us on **0860 002 153** or **email member@fedhealth.co.za**

You must claim within four months of the date of the treatment
The scheme will only consider claims that we receive within four months of the treatment date. We process claims that we receive after four months only to show on tax certificates. We will not pay any claims that we receive after four months.

Send your claims to:

You can submit claims on the Fedhealth Family Room.
Go to Quick actions > Submit a claim.

You can email, fax or post the claims to us.
Email: **claims@fedhealth.co.za**
Fax number: **011 671 3842**

Postal address:
Private Bag X3045
Randburg
2125

If you have been in a car accident

If you were injured in a car accident, you may have to go through certain procedures with the Road Accident Fund before the scheme will pay any claims.

Please contact the MVA/ Third Party Recovery Department at Fedhealth for more information:

Telephone number: 0800 117 222

About your scheme and membership

Principal members and registered dependants are covered by the scheme.

Members

The principal member can add or remove dependants. In this section, we use 'you' for the principal member.

Dependants

Who can be registered as a dependant

You can register the following people as dependants:

- Your spouse or partner
- Your children
- Other family members if, according to the scheme rules, they rely on you for financial care and support and have been approved by the Scheme.

Before you add a dependant, if a company pays your medical aid contribution, you should check how much of the contribution your company will pay.

Criteria for children

Fedhealth will charge the child rate for your child dependants until they turn 27. However, the child needs to be either:

- A full-time student, who is living at home or in a residential situation at a tertiary education institution; or
- Living at home, unmarried, and not receiving a regular income greater than the maximum social pension.

Adding a newborn baby

You must register babies within 30 days after they are born. Third generation babies (your adult child dependant's baby) will not be covered from date of birth and will be subject to normal underwriting. If a company pays your medical aid contribution, you must tell the salary department that you are going to add a newborn as a dependant. Fedhealth does not charge for the baby for the month in which the baby is born.

You must give us these documents for registering dependants

To register a dependant, you must fill in a Member Record Amendment Form. For the following types of dependants, we need this information:

Type of dependant	Extra document we may need
A newborn baby	A copy of the baby's birth certificate or notification of birth from the hospital The baby's ID number when they are registered
A biological or adopted child over the age of 21 years	Proof of registration from a full time tertiary institution for the current year if a full time student, or an affidavit for the dependant confirming residency, employment, income and marital status
An adopted child	Proof of legal adoption
A foster child	Legal proof that the child is a foster child
A brother or sister, grandchild, nephew or niece, third generation baby	An affidavit confirming residency, employment, income and marital status of child and both parents
A parent or grandparent of the principal member	An affidavit confirming residency, employment, income and marital status
A spouse or partner	Marriage certificate, if available

Membership cards

We will send two membership cards for families with one or more dependants. Please contact us if you want more membership cards for your dependants.

Membership e-card

As part of Fedhealth's drive to support a paperless environment, we've introduced membership e-cards which you can use instead of a physical card. Your e-card is available in the Fedhealth Family Room online member portal, or you can access it from the FedChat app. Simply share it with your healthcare service provider via email or SMS.

Removing a dependant from your membership

To remove a dependant, you must fill in a Member Record Amendment Form. If a company pays your medical aid, your HR Department must stamp the form and send it to the scheme.

How we communicate with you

We email and SMS your claim status

Fedhealth will email and SMS a claim status to you. This shows the claims that we have received and processed.

Make sure we have your correct email address and cell number

Please ensure that Fedhealth has your correct cell phone number and email address by calling the **Fedhealth Customer Contact Centre on 0860 002 153**.

You can find your claim and benefit information on our website

Fedhealth website

Visit the Fedhealth website at **fedhealth.co.za** to access our interesting **Living Fedhealthy blog** brimming with must-reads, as well as all our product brochures, option selection forms and related documents.

Fedhealth Family Room

The Family Room **(accessed via fedhealth.co.za)** allows you to: obtain hospital pre-authorisation; apply for chronic medication; submit claims; locate network pharmacies, GPs and Specialists using the locator tool; update personal information; conduct benefit enquiries; track claim submissions and claims due to you; join communities based on your interests; earn rewards; and read all the latest Scheme news.

The site also features **LiveChat** - this is an innovative feature that allows you to raise any important medical aid questions you may have on the site during office hours. Skilled consultants attend to your queries in a personal, one-on-one capacity, without the need for phone calls. You are also able to **obtain hospital and chronic disease authorisations** on the site using **LiveChat**.

You can message Fedhealth free of charge with the FedChat Mobile App

FedChat is available as a free download to Apple, Windows, Blackberry and Android users. This dedicated Instant Messenger channel offers you the convenience of being able to communicate with Fedhealth service consultants during office hours, without the cost of a phone call or SMS, as FedChat uses the same data you use for email and Internet browsing.

The Fedhealth Family Room – the hub of your relationship with Fedhealth

The Fedhealth Family Room is our online member portal that allows you to manage aspects of your Fedhealth membership like submitting claims and obtaining pre-authorisations. The portal also enables you to join a host of communities based on your interests, earn rewards, and stay up to date on the latest Scheme news. Access it via fedhealth.co.za and register to enjoy all the great features.

maxiFED Contributions

maxima EXEC (including Savings)

	Risk	+	Savings	=	TOTAL	Annual Threshold*
Member	4 584		752		**5 336**	13 651
Adult Dependant	3 973		652		**4 625**	10 482
Child Dependant*	1 431		235		**1 666**	3 511

maxima EXEC^{GRID} (including Savings)

	Risk	+	Savings	=	TOTAL	Annual Threshold*
Member	4 080		670		**4 750**	13 651
Adult Dependant	3 536		580		**4 116**	10 482
Child Dependant*	1 273		209		**1 482**	3 511

*Up to a maximum of three children.

Option changes

You can upgrade to a higher option

You can upgrade to a higher option with more comprehensive benefits anytime of the year, but only on diagnosis of a dread disease or in the case of a life-changing event, for example pregnancy.

NB! The option upgrade will only be allowed within 30 days of diagnosis. In general, option changes are only allowed with effect from 1 January every year.

Paying for your medical aid

You must pay by the third of each month

You pay your contributions to Fedhealth each month for the previous month's cover (you pay in arrears). You must pay by the third day of each month. If we do not receive payment by the third day of the month, we will suspend your cover.

Our bank details

Account name : Fedhealth Medical Scheme
Bank : Nedbank
Branch code : 19-84-05
Account number : 1984 563 009

Please use your membership number as reference when making a payment.

Leaving the scheme

Three months of notice to leave

If you want to leave Fedhealth, you must give us three months' notice in writing.

Last contribution
Because you pay at the start of the month for the previous month's cover, your last contribution will be deducted in the month after your last day of membership. We will deduct your last contribution by the third day of the month after your last day of membership.

Amount in Savings Account – if you spent less than you paid in
We pay the balance in your Savings Account to your new medical scheme's savings account five months after you have left Fedhealth. This ensures that we can pay out any outstanding claims. You must provide us with the name of your new scheme as well as your membership number so we can transfer your Savings Account balance. If your new scheme does not have a savings component, then we will pay the balance to you. Please make sure we have your up-to-date banking details to make this refund.

Amount in Savings Account – if you spent more than you paid in
If you leave the scheme and have spent more than the monthly contributions you have paid into the Savings Account, you will have to refund the scheme with the difference. You must make the refund within 10 days after the last day of membership.

Whistle-blowing on fraud

We ask you to help us to combat fraud. If you know of anything that might involve a healthcare professional or a member using the medical scheme inappropriately, please contact us. You do not have to disclose your name.
Fraud Hotline: 0800 112 811

Extra services

These are the extra services you get from Fedhealth. They do not affect any of the scheme benefits.

24-hour Nurse Line on 0860 333 432
The 24-hour Fedhealth Nurse Line is available for:

- Assessing day-to-day symptoms
- Emergency medical advice, including for poisoning
- Health education (for example, you can call if you need an explanation of medical terms, procedures and test results)
- Drug database (complete information on medicines, including when you should not take medicines, etc)
- Stress management
- Teenage support.

MediTaxi
Members on any option who've had hospital authorisations can access the 24/7 MediTaxi medical taxi benefit to take them to follow-up doctor's appointments, if they've undergone an authorised operation or medical treatment that prevents them from driving. MediTaxi provides transport from the member's home to the approved healthcare service provider such as physiotherapists, doctors, specialists or a radiology practice, and includes the return trip.

- Trips are limited to two return trips per member/beneficiary per annum.
- The pick-up or drop-off point must be in Johannesburg, Pretoria, Cape Town and Durban, and the total trip should not exceed 50km.
- The service is available to validated Fedhealth members. Europ Assistance SA will not request any medical information to support validation for the benefit.

Booking the MediTaxi service
When Fedhealth members phone to book a trip, they need to provide their a) membership number, b) date of operation, and c) healthcare provider's details.

- Members need to save the number *130*3272*31# for Emergency Medical Service (EMS), Nurse Line and MediTaxi as a contact on their phones (under Europ Assistance or a name they'll remember for emergencies);
- When they need to book MediTaxi, members need to choose this number and select the service (EMS, Nurse Line or MediTaxi). An SMS will be sent to the Europ Assistance Emergency Contact Centre who'll phone them back within the agreed emergency timelines for each service: EMS – 120 seconds; Nurse Line – 2 hours; and MediTaxi – 2 hours before pick-up.

SOS Call Me
In times of emergency, it's only human to panic, which could make it difficult for Fedhealth members to get in touch with the Europ Assistance Contact Centre when it's critical. A lack of airtime could also prevent members from getting in touch with us.

To resolve this, Europ Assistance has implemented the SOS Call Me service – a user-friendly call-back service that means we will call members back when they need us at no cost to them. All Fedhealth members and their dependants can use this free service.

Members can select three options on the service:
1. Emergency Medical Services (EMS)
2. Nurse Line
3. MediTaxi

How to use the SOS Call Me service:
- Members should save the number *130*3272*31# for EMS, Nurse Line and MediTaxi as a contact on their phone (under Europ Assistance or a name they will remember for emergencies);
- In an emergency, members must choose this number and select the service (EMS, Nurse Line or MediTaxi). An SMS will be sent to the Europ Assistance Emergency Contact Centre who'll phone the member back within the agreed emergency timelines for each service: EMS – 120 seconds; Nurse Line – 2 hours; and MediTaxi – 2 hours before pick-up.

The Fedhealth Baby Programme
Fedhealth offers a FREE top-notch baby programme designed to offer the best advice, support and personalised care during every stage of pregnancy and beyond.

Moms on the programme can look forward to doula support during pregnancy and labour, a Fedhealth Baby bag packed with items like organic goodies and a baby book, various discounts and vouchers, ongoing support and communication, and a baby medical advice line.

Pregnant members and dependants can **call 0861 116 016** or **email info@babyhealth.co.za** for more information and to register.

Paed-IQ
There has been a growing need from parents and caregivers for reliable, appropriate and up to-date information and advice regarding everyday childhood health problems. As such, Fedhealth is introducing the Paed-IQ service to parents and caregivers in 2019.

Paed-IQ aims to:
- Provide young families with children up to the age of 14 years with 24-hour access to paediatric support and advice. This enhances the level of care parents can provide to their children by means of a paediatric telephone triage service, from a database of information on common health conditions in children.
- Reduce emergency paediatric expenditure and unnecessary clinical interactions for members by offering clinical childcare assessment, triage and telephonic guidance.

Paed-IQ also hosts a live Facebook chat where parents and caregivers can talk to a Paed-IQ paediatrician to answer any questions. This is available on Wednesdays between 12:00pm and 14:00pm, and on Fridays from 10:00am to 12:00pm by **calling 0860 444 128**.

Medscheme Client Service Centres

For personal assistance, visit one of the following Medscheme Client Service Centres.

These branches are open Monday to Friday 08h30 – 16h00

Bloemfontein – Medical Suites 4 and 5, First Floor, Middestad Mall, Corner West Burger and Charles Streets
Cape Town – Icon Building, Ground Floor, Cnr Lower Long Street & Hans Strijdom Avenue, Cape Town
Durban – Ground Floor, 102 Stephen Dlamini Road, Musgrave, Durban
Port Elizabeth – 1st Floor, Block 6, Greenacres Office Park, 2nd Avenue, Newton Park
Pretoria – Nedbank Plaza, Ground Floor, Shop 17, 631 Steve Biko Street, Arcadia
Roodepoort – Shop 21 & 22, Flora Centre, Cnr Ontdekkers and Conrad Roads, Florida North, Roodepoort
Vereeniging – Ground Floor, 36 Merriman Avenue

Contact us

Fedhealth Customer Contact Centre
Monday to Thursday 08h30 – 17h00
Friday 09h00 – 17h00
Tel: 0860 002 153
email: member@fedhealth.co.za
Web: www.fedhealth.co.za
Postal address: Private Bag X3045, Randburg 2125

Hospital Authorisation Centre
Monday to Thursday 08h30 – 17h00
Friday 09h00 – 17h00
Tel: 0860 002 153
email: authorisations@fedhealth.co.za
Web: www.fedhealth.co.za

Ambulance Services
Europ Assistance
Tel: 0860 333 432

Aid for AIDS
Monday to Friday 08h00 – 17h00
Tel: 0860 100 646
Fax: 0800 600 773
email: afa@afadm.co.za
Web: www.aidforaids.co.za
SMS (call me): 083 410 9078

Chronic Medicine Management
Monday to Thursday 08h30 – 17h00
Friday 09h00 – 17h00
Tel: 0860 002 153
email: cmm@fedhealth.co.za
Postal address: P O Box 38632 Pinelands 7430

Disease Management
Monday to Friday 08h00 – 16h30
Tel: 0860 002 153
email: dm@fedhealth.co.za

Emotional Wellbeing Programme
Tel: 087 365 8664

Fedhealth Baby
Monday to Friday 08h00 – 17h00
Tel: 0861 116 016
email: info@babyhealth.co.za
Web: www.babyhealth.co.za

Fedhealth Paed-IQ
Tel: 0860 444 128

Fraud Hotline
Tel: 0800 112 811

MVA Third Party Recovery Department
Monday to Friday 08h00 – 16h00
Tel: 0800 117 222

MediTaxi
Dial *130*3272*31#

Oncology Disease Management
Monday to Friday 08h00 – 16h00
Tel: 0860 100 572
Fax: 021 466 2303
email: cancerinfo@fedhealth.co.za
Postal address: P O Box 38632, Pinelands, 7430

SOS Call Me
Dial *130*3272*31#

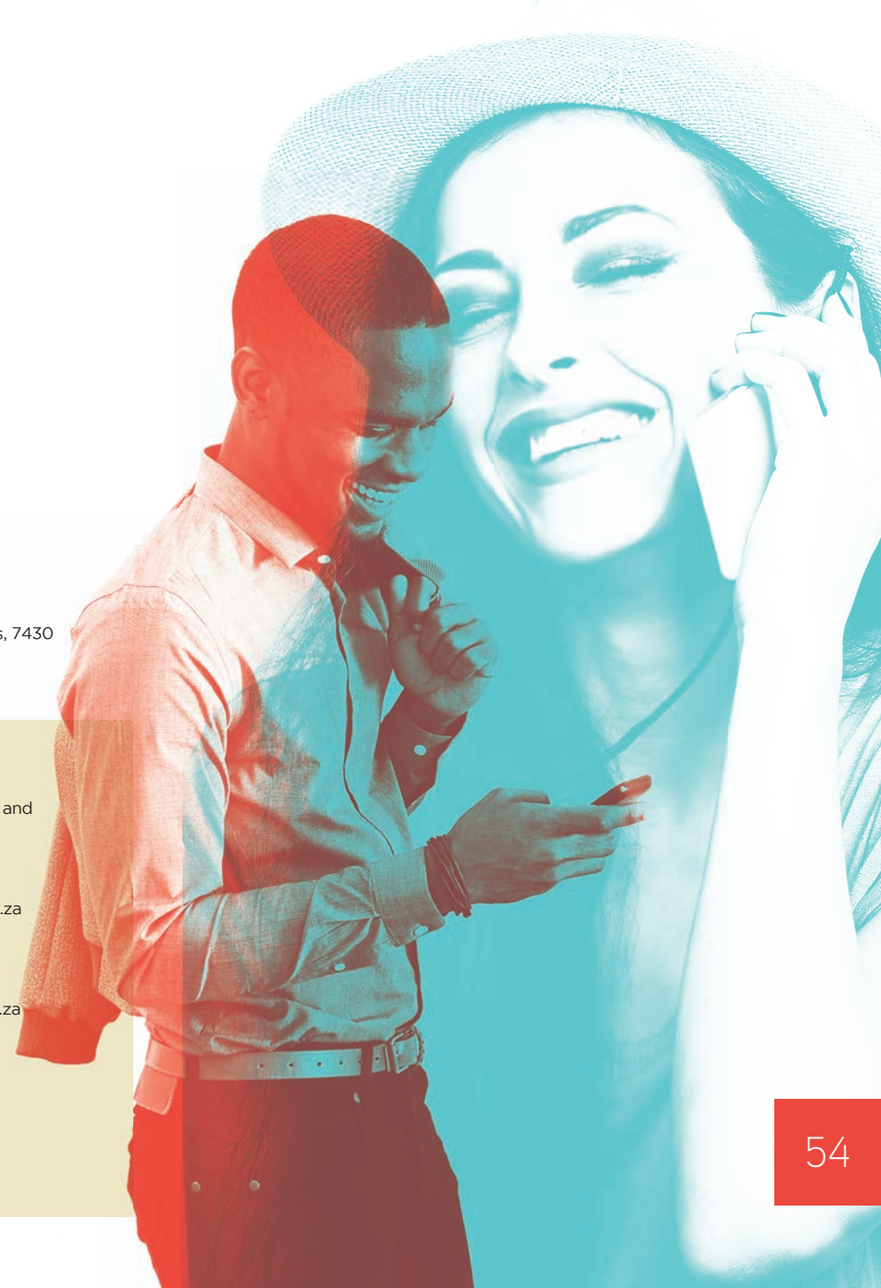
Preferred Provider Pharmacies

Clicks
Tel: 0860 254 257
To locate a store go to: www.clicks.co.za and select Store Locator

Dis-Chem
Care-Line: 0860 347 243
To locate a store go to: www.dischem.co.za and select Store Locator

MediRite Pharmacy
Tel: 0800 222 617
To locate a store go to: www.medirite.co.za and select Store Locator

Pharmacy Direct
Monday to Friday 07h30 – 17h00
Tel: 0860 027 800
Fax: 0866 114 000/ 1/ 2/ 3/ 4
email: care@pharmacydirect.co.za
Web: www.pharmacydirect.co.za
SMS (call me): 083 690 8934



Fedhealth Customer Contact Centre **0860 002 153**
Corner Ontdekkers Road and Conrad Street, Absa Building Block F,
Florida, 1716 • Private Bag X3045, Randburg 2125

www.fedhealth.co.za

We let **you be YOU**

Please note: All Fedhealth benefits are subject to registered Scheme Rules, and as such, this document only aims to provide a summary of such benefits. For the full Scheme Rules, please visit fedhealth.co.za or contact the Fedhealth Customer Contact Centre on 0860 002 153 to obtain a copy.

FEDHEALTH