MEMBER GUIDE 2014

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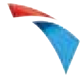

IMPERIAL™
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IMPERIAL GROUP MEDICAL SCHEME

(HEREINAFTER REFERRED TO AS "IMPERIALMED")

This guide contains all the basic information about membership, benefits, contributions and claiming procedures.

Since the guide is very compact, it can unfortunately not cover every aspect of the Scheme. Please discuss any query you may have with the Scheme by phoning the Call Centre or Member Help Line.

Should you have any queries regarding Imperialmed, please refer these to the Client Service Department on 0860 467 374, via fax on 0860 111 788 or via e-mail to imperialmedenquiries@mhg.co.za. Alternatively, please make use of the following address:

IMPERIALMED
PO Box 32759
Braamfontein
2017

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

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UNDERSTANDING YOUR MEDICAL SCHEME

Who is Imperialmed?

Imperialmed is the in-house medical scheme for all permanent employees of Imperial Holdings Limited and its associated and subsidiary companies.

Who is Medi Call?

Medi Call is contracted as Imperialmed's independent scheme manager. Medi Call is an independent, subsidiary company of Imperial Holdings Limited and is therefore well-positioned to represent the members of the Scheme independently from the Administrator, Metropolitan Health. In this regard, Medi Call reports to the Board of Trustees and is responsible for assisting the Board of Trustees in developing clear and sustainable strategies and to ensure that these strategies are implemented.

As part of the scheme management function, Medi Call monitors the effectiveness of all Imperialmed's contractual agreements, such as the third-party administration agreement with the Administrator, the managed care agreement with Metropolitan Health Risk Management and the agreements with designated service providers. In addition, Medi Call specialises in comprehensive client and intermediary services and assists members and employers through the Imperialmed Member Care Line with medical aid related enquiries and the reconciliation of monthly contributions on **0860 105 221**.

Who is Cedar Healthcare Consultants?

As part of the strategy to make the in-house Scheme accessible to more employees of the Imperial Group, the Board of Trustees contracted with Cedar Healthcare Consultants, an independent Healthcare Consulting Company in the Imperial Group, to supply Imperialmed members and employers with consulting services.

In this regard employers are assisted to align medical aid membership policies with the Group policy and employees are consulted with and educated on the benefits offered by Imperialmed. In addition, Cedar Healthcare Consultants facilitates corporate wellness days and assists members in considering appropriate associated products to enhance the benefit structure of the Scheme, i.e. Health Saver to provide for the 15% co-payment on day-to-day expenses, the Gap Cover product to fund shortfalls in the rate specialists are paid during hospitalisation and Multiply, a rewards-based programme offered by Momentum.

Who is Metropolitan Health Corporate (MHC)?

MHC is a third-party service provider appointed by Imperialmed. Its function is to oversee the administration of Imperialmed and to ensure that all your medical queries, claims payments and collection of member contributions are attended to efficiently.

Who is Metropolitan Health Risk Management?

Metropolitan Health Risk Management is part of the MHC group. It provides custom-made, integrated health risk management services such as HIV and AIDS, disease, medicine, hospital and clinical risk management services.

How will this member guide help you?

This member guide has been developed specifically to help you understand your Scheme and the benefits it offers you. It explains all the relevant processes you need to follow before claiming. Please note that any reference to you as the member in this member guide includes your registered dependants.

What are your responsibilities as a member?

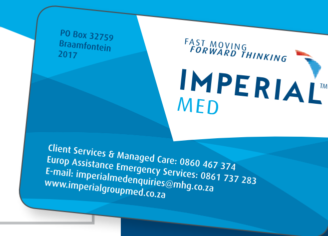
You have to:

- » Understand how Imperialmed works.
- » Keep the Scheme up to date on any changes to your membership details. If you do not notify the Scheme timeously, this may have financial consequences for you as a member.
- » Check all accounts from service providers, as well as your claims statements from the Scheme, to make sure that all your details are correct and that your claims have been processed correctly.
- » Inform the Scheme before you are admitted to hospital, as you require a pre-authorisation number for in-hospital services. If you do not obtain a pre-authorisation number, you may have to make a co-payment of R500.
- » File all your documentation from the Scheme and keep it in a safe place so that you may refer to it at any time.
- » Keep your membership card in a safe place so that no one else can use it.
- » Follow all the procedures set out by the Scheme.
- » Review your circumstances annually to ensure that you are on the correct benefit plan.

Points to remember

- » You need to obtain pre-authorisation from the Scheme at least **three working days prior to the admission date** to hospital or within 24 hours of an emergency admittance for the following events:
  - hospitalisation;
  - admission for mental health and drug or alcohol dependency;
  - confinements (birth of baby);
  - CT, MRI and radio-isotope scans;
  - organ transplants;
  - cancer medication and related treatment; and
  - any other major medical event.
- » For the following benefits, apply for **Scheme approval** in writing, with the relevant doctor's motivation and/or quotation enclosed, as benefits will not be paid unless the Scheme has approved it beforehand:
  - chronic medication;
  - medical and surgical appliances in excess of R1 000;
  - artificial limbs and eyes;
  - maxillo-facial and oral surgery;
  - orthodontic treatment and related surgery;
  - root canals, bridges and crowns;
  - dental surgery; and
  - dental implants.

! Keep your membership card in a safe place so that no one else can use it.



- » The Scheme has various disease risk management programmes available for prescribed minimum benefit conditions. You need to register for these programmes in order to benefit from them.
- » The Scheme covers two types of benefits – day-to-day and major medical benefits.

This member guide has been developed specifically to help you understand your Scheme and the benefits it offers you.

WHAT YOU NEED TO KNOW ABOUT MEMBERSHIP

It is a condition of employment that certain categories of employees of Imperial Holdings Limited who are not registered as dependants on their spouses' medical scheme must join Imperialmed.

» Benefits will only be paid for services deemed medically necessary and if they are obtained from a registered practitioner.
» Your membership will start on your date of employment and may be subject to waiting periods, during which time no benefits will be paid, although contributions must still be paid to the Scheme. **See page 8 for more information on waiting periods.**
» Existing employees who choose to register on their spouses' medical scheme must provide documentary evidence that they have been admitted as dependants in order to terminate their membership of Imperialmed.
» Membership of two medical schemes at the same time is prohibited by law. Therefore employees may not be registered as dependants on their spouses' medical scheme and remain members of Imperialmed.
» Membership is terminated on the last day of employment. **For further details see pages 10 and 11.**

Contributions

Contributions are calculated on the basis of:

» the member's income; and
» the number of a member's dependants.

Contributions are paid for a maximum of three children and late joiner penalties may apply.

Contributions must be paid monthly **in arrears** and must be paid to the Scheme by no later than the third business day of the month following the last business day of the month in which it became due. If it is not paid within 30 days of the due date, the Scheme has the right to give the member notice that if contributions or other debts are not paid within a further 30 days of the notice, his/her membership may be suspended or cancelled.

All contributions in respect of new members are due from the first day of the month during which employment starts, except when the date on which employment starts is the 15th day or later of a month, in which case the contributions will be due from the first day of the following month.

When a member's employment ends on the 15th day or later in a month, contributions for the full month will be due. In cases where employment ends anytime up to and including the 14th day of the month, no contribution will be due for that month, provided that the employer advises the Scheme of the date immediately after it takes place.

IMPERIAL GROUP MEDICAL SCHEME

Definition of dependants

Imperialmed defines dependants as follows:

a) A dependant is a spouse, partner, child, parent or sibling for whom the member is liable for family care and support.

b) If child dependants are orphaned, the oldest of these is registered as a continuation member in terms of the Scheme rules. Any minor sibling, who is registered as a dependant at the time that the child dependant becomes a continuation member, will become a dependant of the continuation member.

Dependants also include:

» **Spouses**
A spouse, to whom the member is married in terms of any law or custom. Only one spouse per principal member is allowed. An affidavit will need to accompany your application.

» **Partner/fiancé/fiancée**
A partner/fiancé/fiancée is a person that the member has a committed and serious relationship with – similar to a marriage – based on mutual dependency and a shared and common household for at least a period of one year, irrespective of the gender of either party. An affidavit will need to accompany your application.

» **Children, grandchildren, stepchildren or adopted children**
Child dependants include:
- a member or spouse's child under the age of 21 who is dependent on the member;
- a child who is incapable of earning an income due to mental or physical disabilities or any similar cause; medical proof will need to accompany your application; and
- a dependant between the ages of 21 and 25 who is a student and not employed full-time.

The maximum age of child dependants, i.e. children, grandchildren, stepchildren or adopted children, on the Scheme is 25, unless they are financially dependent on the member. All dependants over the age of 25 who wish to remain on the Scheme will need to apply annually for continued membership. The Scheme will decide, based on the information that is provided, whether the dependant qualifies for continued membership or not. They will be charged adult dependant contribution rates if the application is accepted.

» **Indigent parents/siblings**
The parent or sibling must be financially dependent on the member, who should be liable for their support. The member must have sufficient income to maintain the parent and proof of indigence will need to accompany your application (this will need to be resubmitted annually). Indigent parents or siblings will be charged adult dependant contribution rates.

NOTE: Waiting periods and exclusions may be imposed on your dependant's membership if you do not register him/her with Imperialmed within 30 days of the date on which he/she becomes eligible for membership, such as in the case of adoption (from the date of adoption) or marriage (from the date of marriage). During such a waiting period no benefits will be paid for the dependants, but contributions must still be paid.

Continuation of membership

Pensioners/retirees
Members of Imperialmed who retire or whose employment is ended by the employer on account of age, ill-health or a disability, may choose to retain their membership.

Widows/widowers and dependants
The dependants of a deceased member, who are registered with the Scheme as his/her dependants at the time of death, are entitled to membership of the Scheme until they become members of another medical scheme.

Waiting periods

How soon after joining the Scheme can you claim if you have a waiting period?

The criteria for and application of waiting periods apply to new members and dependants individually and are as follows:

A **condition-specific waiting period** is a period during which a beneficiary is not entitled to claim benefits for a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. The waiting period is applied for 12 months.

A **general waiting period** is a period during which a beneficiary is not entitled to claim any benefits for a three-month period.

No waiting periods will apply if application for membership is:

- as a result of a change of employment – you need to join Imperialmed within 90 days of joining the company;
- within 30 days of your transfer to an associated company or subsidiary of Imperial Holdings Ltd., where it is a condition of employment that you become a member;
- within 30 days of a specified period of secondment; or
- if you had a break in membership with a medical scheme for a period of 90 days because you lived or worked outside the borders of South Africa.

Waiting periods may apply

If you don't fall into the above categories and apply for membership after 90 days of being employed, a condition-specific waiting period may apply:

- if you have had a break in membership for a period of 90 days or more; or
- if you have had a break in membership for a period of less than 90 days and enjoyed previous membership of up to 24 months before applying for membership of Imperialmed. (Please note: Any unexpired waiting periods pending will continue to apply.)

If you choose to apply for membership after 90 days of having joined the company and have had previous medical scheme membership of up to 24 months, a 12-month condition-specific waiting period may be imposed on your membership. If you have had previous membership of more than 24 months, a three-month general waiting period will be imposed. You will have no coverage for this time, except for prescribed minimum benefits.

Late Joiner Penalties

Contribution penalties will be applied in respect of adult dependants over the age of 35 years, according to the rates below.

- Age over 35 years: **1 to 4 years** at 0.05 multiplied by the relevant contribution
- Age over 35 years: **5 to 14 years** at 0.25 multiplied by the relevant contribution
- Age over 35 years: **15 to 24 years** at 0.50 multiplied by the relevant contribution
- Age over 35 years: **25 or more years** at 0.75 multiplied by the relevant contribution

Seconded employees

A member and his/her dependants will not forfeit any benefits or interest in the Scheme on the grounds of having been seconded for service, in or outside the borders of the Republic of South Africa, but will continue to be a member of the Scheme.

Membership of the following entities will be recognised when determining whether waiting periods should be imposed:

- if you were a uniformed employee of the South African National Defence Force or a dependant of such an employee, who received medical benefits from the South African National Defence Force; or
- if you have been a beneficiary of the Permanent Force Medical Continuation Fund.

Changes in membership

If your membership details change for any of the following reasons, your **Payroll Department** must be notified 30 days in **advance**:

- cancellation of dependants;
- change of address or banking details, for claims refunds or debit order deductions;
- your child becomes independent/self-supporting; or
- your child is registered as a dependant of a member of another medical scheme.

If your membership details change for any of the following reasons, your **Payroll Department** must be notified within 30 days:

- registration of dependants;
- change in marital status;

- birth or adoption of a child; or
- death.

Cancellation of membership

Your membership of the Scheme ends:

- on the day your employment with the employer ends;
- upon death;
- in the event of non-payment of contributions;
- in the event of non-payment of shortfalls;
- in the event of abuse of privileges;
- in the event of fraud;
- in the event of non-disclosure of material information;
- in the event of submission of false claims; and
- in the event of misrepresentation.

Termination of membership

Upon resignation or termination of employment with Imperial Holdings Limited and its associated and subsidiary companies, the member and his/her dependants will not be entitled to claim benefits from the Scheme for services rendered after the date on which employment ended. Any claims incurred before the date on which employment ended will be processed subject to the Scheme rules and the member's available benefit limits.

NOTE: The Scheme has no responsibility or liability in respect of a member who does not comply with the requirements of the Scheme. If a member fails to apply for registration of a newborn child within the 30-day period, but applies for the registration of the child within six months of the birth, the Scheme will register the child from the first day of the month following the date on which the member applied. Benefits will accrue from the date of registration.

If any of the above applies, you will need to complete a Change in Membership Details form, which is obtainable from your Payroll Department. A copy of the applicable legal documentation, e.g. birth certificate or death certificate, must accompany your Change in Membership Details form.

Failure to advise the Scheme of a change in membership details may result in waiting periods being imposed. Furthermore, if claims are being paid in respect of a dependant or member and the Scheme is notified too late of the cancellation of the member or dependant's membership, the member will be liable for all costs in respect of benefits paid by the Scheme after the cancellation date.

PLEASE TAKE SPECIAL NOTE OF THE FOLLOWING:

- You will only be covered by the Scheme until the date your employment ended and not until the end of that month or for an extended period.
- Any services rendered after the date your employment ended are for your account.
- Please inform the Scheme in advance of your new postal address and of any changes in banking details to ensure that you receive any benefits that are due to you.

UNDERSTANDING YOUR BENEFITS

Benefit plans

Imperialmed has two benefit plans, namely the Imperialmed Health Plan and the Imperialmed Budget Plan.

Imperialmed Health Plan

This is a traditional plan that provides unlimited private hospital cover at 100% of the Medical Scheme Rate and routine non-prescribed minimum benefits at 85% of the Medical Scheme Rate up to generous annual limits.

Imperialmed Budget Plan

The Budget Plan provides low-cost cover for essential, basic healthcare with unlimited in-hospital cover at 100% of the Medical Scheme Rate, no chronic non-prescribed minimum benefits, a general practitioner network with specialist referrals and day-to-day benefits at 85% of the Medical Scheme Rate, with relatively low annual limits.

Pro rata limitation of benefits

Imperialmed Health Plan

Members who are registered on the Imperialmed Health Plan during the course of a financial year will be entitled to the benefits set out in Annexure B of the rules of the Scheme. The maximum available benefits will be adjusted in proportion to the period of membership, which is calculated from the date of admission to the end of the financial year.

Imperialmed Budget Plan

The annual limits for members who are registered on the Imperialmed Budget Plan from 1 February to 31 July of a year will be calculated on a pro rata basis, but those joining from 1 August to 31 December of a year will have access to the same benefit limits as those joining on 1 July of a year.

Benefit year

The benefit year runs from 1 January to 31 December of any year. All limits quoted in the benefit schedules on pages 14 to 43 of this member guide are effective from 1 January and are valid for the benefit year. Should the Board of Trustees decide to change any of the benefits, we will communicate the changes to you as soon as possible.

Benefit cycle – two-year cycle

A two-year cycle for related benefits will commence on the date on which the member joins the Scheme. The two-year cycle for all members who were already registered on Imperialmed before 1 January 2013 started on 1 January 2013.

Prescribed Minimum Benefits (PMBs)

In terms of the Medical Schemes Act, all schemes must offer their members PMBs for the treatment of certain medical conditions. The medical conditions covered are prescribed by the Minister of Health. The Scheme will pay for the diagnosis, treatment and care of these conditions in full, provided the services are rendered by a designated service provider.

IMPERIAL GROUP MEDICAL SCHEME

DAY-TO-DAY BENEFITS (OUT-OF-HOSPITAL EXPENSES)

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
1.	**General Practitioners (GPs) and Specialists – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary)**			**1. General Practitioners (GPs) and Specialists – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary)**	
a)	**Visits, consultations and treatment by a GP or Specialist**	85% of Medical Scheme Rate These benefits are covered on the Metropolitan Health Risk Management Network and Specialists only on referral by a GP	Member family limit calculated as follows: **R750** per principal member **R550** per adult dependant **R460** per child dependant (maximum of three children) The GP benefits above are subject to the nomination of a GP – each person in the family may nominate two GPs Two out-of-network GP visits allowed	85% of Medical Scheme Rate	Member family limit calculated as follows: **R2 200** per principal member **R1 650** per adult dependant **R1 380** per child dependant (maximum of three children)
b)	**All procedures** (including those listed in 1(a) of Major Medical Benefits) will be paid from the Major Medical Expenses Benefit and not Day-to-Day limits when performed in a doctor's rooms, except for dental procedures, as indicated in 1(a) of Major Medical Benefits	100% of Medical Scheme Rate		100% of Medical Scheme Rate	
C)	**PMB Care Plan Services** Consultations as authorised on Care Plan	100% of Cost	Major Medical Expenses Benefit Subject to Care Plan authorisation Services in excess of the Care Plan will be paid from the GP/Specialist Benefit limit at 85% of Medical Scheme Rate PMB Care Plan consultations only at nominated Network GP	100% of Cost	Major Medical Expenses Benefit Subject to Care Plan authorisation Services in excess of the Care Plan will be paid from the GP/Specialist Benefit limit at 85% of Medical Scheme Rate
2.	**Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary)**			**2. Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary)**	
a)	**Radiology (X-rays) and Pathology** Including Bone Density Scans and Mammograms	85% of Medical Scheme Rate	Member family limit calculated as follows: **R950** per principal member **R950** per adult dependant **R170** per child dependant (maximum of three children)	85% of Medical Scheme Rate	Member family limit calculated as follows: **R2 840** per principal member **R2 840** per adult dependant **R500** per child dependant (maximum of three children)

IMPERIAL GROUP MEDICAL SCHEME

DAY-TO-DAY BENEFITS (OUT-OF-HOSPITAL EXPENSES)

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
2.	**Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary) (continued)**			**2. Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary) (continued)**	
b)	**PMB Care Plan Radiology and Pathology services as authorised on Care Plan** Including Cardiac Ultrasounds	100% of Cost	Major Medical Expenses Benefit Subject to Care Plan authorisation Services in excess of the Care Plan will be paid from Radiology and Pathology Benefit limit at 85% of Medical Scheme Rate	100% of Cost	Major Medical Expenses Benefit Subject to Care Plan authorisation Services in excess of the Care Plan will be paid from Radiology and Pathology Benefit limit at 85% of Medical Scheme Rate
3.	**Dentistry**			**3. Dentistry**	
a)	**Preventative dentistry** » Scaling and/or polishing and fluoride treatment » Fissure sealing	No benefit No benefit	No benefit No benefit	100% of Medical Scheme Rate 100% of Medical Scheme Rate	Two per beneficiary per annum Once-off for permanent molars in persons under 18 years
b)	**Basic dentistry** » Oral examination » Diagnostics (X-rays, etc.) » Restorations (fillings) » Extractions » Root canal treatment	85% of Medical Scheme Rate	**R2 000** per family per annum	85% of Medical Scheme Rate	**R3 000** per beneficiary per annum
c)	**Advanced/Specialised dentistry** » Inlays, onlays, veneers, crowns and bridges » Study models » Dentures » Procedures related to placement of dental implants » Orthodontic retainers, space maintainers and biteplates » Periodontal (gum) treatment	No benefit	No benefit	85% of Medical Scheme Rate	Member family limit calculated as follows: **R4 290** per principal member **R2 070** per adult dependant **R900** per child dependant (maximum of three children) Pre-authorisation required

IMPERIAL GROUP MEDICAL SCHEME

DAY-TO-DAY BENEFITS (OUT-OF-HOSPITAL EXPENSES)

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
3. Dentistry (continued)				**3. Dentistry (continued)**	
d)	**Dental implants** Includes the cost of the implants only – the anaesthetist and hospital fees are covered as part of the Major Medical Expenses limit The treating dental specialist fee subject to the Advanced/ Specialised Dentistry limits above	No benefit	No benefit	100% of Medical Scheme Rate	**R11 660** per beneficiary Pre-authorisation required
e)	**Orthodontic treatment**	No benefit	No benefit	100% of Medical Scheme Rate	**R6 000** per beneficiary per annum Pre-authorisation required
4. Prescribed Medicine (annual limits are calculated as a family benefit and can be used by any beneficiary)				**4. Prescribed Medicine (annual limits are calculated as a family benefit and can be used by any beneficiary)**	
a)	**Acute medicines** Acute medicines and injection material	100% of Generic Reference Price after deduction of a **R25** levy	Member family limit calculated as follows: **R1 620** per principal member **R1 020** per adult dependant **R310** per child dependant (maximum of three children)	100% of Generic Reference Price after deduction of a **R25** levy	Member family limit calculated as follows: **R4 865** per principal member **R3 055** per adult dependant **R920** per child dependant (maximum of three children)
b)	**Pharmacist-advised Therapy (PAT)** refers to medicines supplied by a registered pharmacist without a doctor's prescription	No benefit	No benefit	100% of Generic Reference Price, up to a maximum of **R175** per prescription	**R1 000** per family per annum Subject to Acute Medication limit
c)	**Childhood Vaccines**	No benefit	No benefit		Refer to the Wellness Benefit (page 42)

IMPERIAL GROUP MEDICAL SCHEME

DAY-TO-DAY BENEFITS (OUT-OF-HOSPITAL EXPENSES)

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
5.	**Medical Auxiliaries – out of hospital**			**5. Medical Auxiliaries – out of hospital**	
		85% of Medical Scheme Rate	R1 500 per family per annum a) Clinical psychology b) Psychiatry c) Physiotherapy	85% of Medical Scheme Rate	R6 295 per family per annum for all services from 5(a) to 5(g) a) Podiatry b) Orthoptic Treatment c) Audiometry/Audiology d) Occupational Therapy e) Therapeutic Dietician f) Other registered Medical Auxiliaries: Remedial and speech therapy, clinical technology, chiropody, acupuncture, social work, biokinetics, kinesiology, ayurvedics and reflexology g) Consultations, treatment and radiological examinations by chiropractors and osteopaths
6.	**Physiotherapy – out of hospital**	85% of Medical Scheme Rate	Included in Medical Auxiliaries	85% of Medical Scheme Rate	**R3 980** per family per annum
7.	**Mental Health – out of hospital**			**7. Mental Health – out of hospital**	
	Includes Psychologist and Psychiatrist	85% of Medical Scheme Rate	Included in Medical Auxiliaries	85% of Medical Scheme Rate	**R4 000** per beneficiary per annum
8.	**Optical Services**			**8. Optical Services**	
a)	Eye test	85% of Medical Scheme Rate	One test per beneficiary per annum from Major Medical Expenses Benefit	85% of Medical Scheme Rate	One test per beneficiary per annum from Major Medical Expenses Benefit
b)	Spectacles, lenses (replace, repair and adjust), contact lenses and fitting of contact lenses	85% of Cost	**R1 000** per beneficiary over a two-year cycle	85% of Cost	**R3 000** per beneficiary over a two-year cycle
c)	Frames	85% of Cost	**R210** per beneficiary over a two-year cycle; subject to the Overall Optical limit of R1 000	85% of Cost	**R700** per beneficiary over a two-year cycle; subject to the Overall Optical limit of R3 000
d)	Sunglasses	No benefit	No benefit	No benefit	No benefit

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
All Major Medical Expenses are subject to pre-authorisation				**All Major Medical Expenses are subject to pre-authorisation**	
1.	**Hospitalisation – Private and Provincial**			**1. Hospitalisation – Private and Provincial**	
a)	A deductible of **R500** applies if the following procedures are done in hospital or day clinics: » Scopes • Arthroscopies • Gastro-intestinal endoscopies – Gastroscopies – Colonoscopies – Sigmoidoscopies » Urological scopes and cystoscopies » Gynaecological scopes » Minor dermatological procedures » Dental procedures Refer to dental benefit for more details on in-hospital dentistry (page 34, point 18)	100% of Medical Scheme Rate A deductible will not apply if done in doctor's rooms; services in rooms will be paid at 100% of Medical Scheme Rate, **except for dental procedures**, which are still paid as Day-to-Day dental benefits	Major Medical Expenses Benefit Subject to pre-authorisation	100% of Medical Scheme Rate A deductible will not apply if done in doctor's rooms; services in rooms will be paid at 100% of Medical Scheme Rate, **except for dental procedures**, which are still paid as Day-to-Day dental benefits	Major Medical Expenses Benefit Subject to pre-authorisation
b)	Accommodation in general ward, recovery room, intensive care unit or high care ward	100% of Medical Scheme Rate	Major Medical Expenses Benefit	100% of Medical Scheme Rate	Major Medical Expenses Benefit
c)	Theatre fees	100% of Medical Scheme Rate	Major Medical Expenses Benefit	100% of Medical Scheme Rate	Major Medical Expenses Benefit
d)	Medicines used in hospital/ theatre	100% of Medicine Price	Major Medical Expenses Benefit	100% of Medicine Price	Major Medical Expenses Benefit
2.	**General Practitioners (GPs) and Specialists – in hospital**			**2. General Practitioners (GPs) and Specialists – in hospital**	
a)	Visits and consultations	100% of Medical Scheme Rate	Major Medical Expenses Benefit	100% of Medical Scheme Rate	Major Medical Expenses Benefit
b)	Surgical procedures and anaesthetics	100% of Medical Scheme Rate	Major Medical Expenses Benefit	100% of Medical Scheme Rate	Major Medical Expenses Benefit

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
3.	**Diagnostic Services – pre-authorisation required for certain services**			**3. Diagnostic Services – pre-authorisation required for certain services**	
a)	Radiology (X-rays) and pathology (in hospital)	100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation	100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation
b)	MRI, CT and radio-isotope scans (in and out of hospital)	100% of Medical Scheme Rate	One scan (MRI, CT or radio-isotope) per beneficiary per annum Subject to pre-authorisation	100% of Medical Scheme Rate	**R14 600** per beneficiary per annum Subject to pre-authorisation
c)	Ultrasound scans (in and out of hospital)	100% of Medical Scheme Rate	**R1 370** per beneficiary per annum Subject to pre-authorisation	100% of Medical Scheme Rate	**R4 350** per beneficiary per annum Subject to pre-authorisation
d)	PET scans (in and out of hospital)	No benefit	No benefit	100% of Medical Scheme Rate	**R22 540** per beneficiary per annum Subject to pre-authorisation
e)	Sleep studies, diagnostic polysomnograms (in and out of hospital)	No benefit	No benefit	100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation
4.	**To-take-out (TTO) Medicine**			**4. To-take-out (TTO) Medicine**	
	Medicines dispensed on discharge from hospital will be covered under the Major Medical Expenses Benefit	100% of Medicine Price	Major Medical Expenses Benefit; subject to **R370** per beneficiary per admission	100% of Medicine Price	Major Medical Expenses Benefit; subject to **R370** per beneficiary per admission
5.	**Out-patient Services**			**5. Out-patient Services**	
a)	**Private hospital**	» Consultation paid at 85% from the GP/Specialist Day-to-Day Benefit limit » Procedure and related materials paid at 100% from Major Medical Expenses Benefit	Major Medical Expenses Benefit	» Consultation paid at 85% from the GP/Specialist Day-to-Day Benefit limit » Procedure and related materials paid at 100% from Major Medical Expenses Benefit	Major Medical Expenses Benefit
b)	**Provincial hospital**	» Consultation paid at 100% from the GP/Specialist Day-to-Day Benefit limit	Major Medical Expenses Benefit	» Consultation paid at 100% from the GP/Specialist Day-to-Day Benefit limit	Major Medical Expenses Benefit

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
5.	**Out-patient Services (continued)**			**5. Out-patient Services (continued)**	
b)	**Provincial hospital (continued)**	» Procedure and related materials paid at 100% from Major Medical Expenses Benefit		» Procedure and related materials paid at 100% from Major Medical Expenses Benefit	
6.	**Blood Transfusions**	100% of Cost	Major Medical Expenses Benefit; subject to PMBs	100% of Cost	Major Medical Expenses Benefit
7.	**Nursing Services, Sub-acute Care and Hospice Services, including medicines, dressings, ointments, etc.**	No benefit	No benefit	100% of Medical Scheme Rate or Cost, whichever is the lesser	Major Medical Expenses Benefit Subject to pre-authorisation
8.	**Ambulance Services**	100% of Cost	**R2 300** per beneficiary per annum Subject to approval by preferred provider	100% of Cost	**R7 400** per beneficiary per annum Subject to approval by preferred provider Emergency air ambulance not subject to the above limit, subject to Scheme approval
9.	**Internal Prostheses**			**9. Internal Prostheses**	
	Including all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices	100% of Cost	Limited to **R30 000** per family per annum for prostheses	100% of Cost Sub-limits subject to PMBs	**All Internal Prostheses are per beneficiary per annum** » **Cardiac stents** (including carrier) subject to a limit of **R22 000** per stent and a maximum of three stents » **Cardiac stents** – drug eluting, subject to a limit of **R19 000** per stent and a maximum of three stents » **Cardiac pacemakers** subject to a limit of **R52 500** » **Cardiac valves** subject to a limit of **R31 000** per valve, limited to two valves » **Cardiac pacemakers** with defibrillator subject to a limit of **R90 000** » **Aortic stents** subject to a limit of **R89 800** per stent (including the delivery system), limited to one stent » **Carotid stents** limited to **R14 950** » **Detachable platinum coils** limited to **R37 200** » **Embolic protection devices** limited to **R37 100** » **Peripheral arterial stent grafts** limited to **R30 750** » **EVAR** (Endovascular repair)/Anaconda subject to a limit of **R60 000** » **Hernia mesh** – subject to a limit of **R5 000** » **Hernia mesh** – umbilical repair subject to a limit of **R10 500** » **Total hip replacement** subject to a limit of **R40 150** per hip, including cement and antibiotics

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
9.	**Internal Prostheses (continued)**			**9. Internal Prostheses (continued)**	
					» **Total knee replacement** subject to a limit of **R41 470** per knee, including cement and antibiotics » **Total shoulder replacement** subject to a limit of **R37 400** per shoulder, including cement and antibiotics » **Spinal instrumentation** subject to a limit of **R28 700** » **Other approved spinal implantable devices** and intervertebral discs limited to **R37 200** » **Bone lengthening devices** limited to **R33 400** » **Neuro-stimulation/abalation devices** for Parkinson's disease limited to **R33 900** » **Vagal stimulator** for intractable epilepsy limited to **R28 600** » **Intraocular lenses** limited to **R4 000** per lens » **Any other prostheses** will be subject to a limit of **R40 150**
10.	**Renal Dialysis**			**10. Renal Dialysis**	
	(Inclusive of all related costs) Benefit is subject to the submission of a treatment plan by the treating Specialist to the Case Manager and approval of the treatment plan before treatment starts	Subject to 100% of the Negotiated Rate and PMBs	Major Medical Expenses Benefit Subject to pre-authorisation	Subject to 100% of the Negotiated Rate	Major Medical Expenses Benefit Subject to pre-authorisation
11.	**Organ Transplants**			**11. Organ Transplants**	
a)	**Hospital accommodation and surgically related services and procedures**	PMBs covered in full at 100% of Negotiated Rate	Major Medical Expenses Benefit Subject to pre-authorisation	PMBs covered in full at 100% of Negotiated Rate	Major Medical Expenses Benefit Subject to pre-authorisation
b)	**Donor** Including organ search, harvesting and transportation; the benefit covers the cost of the donor if the recipient is an Imperialmed member	100% of Cost	Limited to **R6 200** for a cadaver or limited to **R30 000** for live donors per beneficiary per annum Subject to pre-authorisation	100% of Cost	Limited to **R18 550** for a cadaver or limited to **R89 000** for live donors per beneficiary per annum Subject to pre-authorisation
c)	**Anti-rejection drugs**	100% of Medicine Price to be obtained from a DSP pharmacy	Major Medical Expenses Benefit Subject to pre-authorisation	100% of Medicine Price to be obtained from a DSP pharmacy	Major Medical Expenses Benefit Subject to pre-authorisation

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
12. HIV and AIDS				**12. HIV and AIDS**	
a)	All consultations, pathology and medicine related to diagnoses and treatment of the disease	100% of Cost, unlimited Medicine subject to Generic Reference Price and to be obtained from a DSP 25% co-payment applies if obtained from a non-DSP DSPs include Clicks, Dis-Chem and Scriptpharm	Major Medical Expenses Benefit Subject to pre-authorisation and clinical guidelines and protocols HIV resistance tests provided only if pre-authorised by a relevant Case Manager on the HIV YourLife Programme Polymerase chain reaction funded from Major Medical Expenses Benefit for babies 18 months and younger where the diagnosis relates to HIV testing	100% of Cost, unlimited Medicine subject to Generic Reference Price and to be obtained from a DSP 25% co-payment applies if obtained from a non-DSP DSPs include Clicks, Dis-Chem and Scriptpharm	Major Medical Expenses Benefit Subject to pre-authorisation and clinical guidelines and protocols HIV resistance tests provided only if pre-authorised by a relevant Case Manager on the HIV YourLife Programme Polymerase chain reaction funded from Major Medical Expenses Benefit for babies 18 months and younger where the diagnosis relates to HIV testing
b)	**Human papillomavirus (HPV) vaccines** Only for HIV-positive female who are registered on the HIV YourLife Programme	100% of Cost	Gardasil or Cervarix injection	100% of Cost	Gardasil or Cervarix injection
13. Maternity Benefits				**13. Maternity Benefits**	
a)	**Labour and ward accommodation** Normal delivery limited to three days Elective Caesarean delivery limited to four days Additional days are subject to submission of a motivation by the attending doctor and approval by the Case Manager	100% of Cost 100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation Major Medical Expenses Benefit Subject to pre-authorisation	100% of Cost 100% of Medical Scheme rate	Major Medical Expenses Benefit Subject to pre-authorisation Major Medical Expenses Benefit Subject to pre-authorisation

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
13. Maternity Benefits (continued)				**13. Maternity Benefits (continued)**	
b)	**Midwife** Delivery by a midwife, confinement in a registered birthing unit or home delivery, including birth attendant and birth bath Midwife must be registered with the Board of Healthcare Funders and Nursing Council If a gynaecologist is not used, benefit covers pre- and post-confinement costs	No benefit	No benefit	100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation Four post-natal consultations with a midwife per event
Benefits listed below are subject to enrolment on Maternity Programme				**Benefits listed below are subject to enrolment on Maternity Programme**	
c)	**Antenatal classes** – only registered midwives	100% of Medical Scheme Rate	As per the Maternity Care Plan	100% of Medical Scheme Rate	**R1 000** per beneficiary per annum
d)	**Ultrasound scans (pregnancy)**	100% of Medical Scheme Rate	As per the Maternity Care Plan	100% of Medical Scheme Rate	2 two-dimensional scans per pregnancy
e)	**Antenatal vitamins** during pregnancy	100% of Generic Reference Price	As per the Maternity Care Plan	100% of Generic Reference Price	**R75** per month
f)	**Gynaecologist consultations** during pregnancy – as per Care Plan	100% of Medical Scheme Rate	As per the Maternity Care Plan	100% of Medical Scheme Rate	Major Medical Expenses Benefit
14. Rehabilitation				**14. Rehabilitation**	
	The benefit covers beneficiaries who are acutely disabled as a result of strokes, spinal cord injuries or brain injuries The condition must be non-progressive All associated accounts will be paid subject to this limit	100% of Cost	Subject to clinical protocols PMBs only	100% of Medical Scheme Rate	**R65 000** per beneficiary per annum Subject to pre-authorisation
15. Psychiatric Institutions and Substance and Alcohol Abuse		100% of Medical Scheme Rate	Maximum of **21 days** per beneficiary per annum Subject to pre-authorisation	100% of Medical Scheme Rate	Maximum of **21 days** per beneficiary per annum Subject to pre-authorisation

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
16. Stoma Care Products		100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation	100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation
17. Cochlear Implants				**17. Cochlear Implants**	
	All requests are subject to approval by the Clinical Advisory Committee	No benefit	No benefit	100% of Cost	**R250 000** per beneficiary per annum Subject to pre-authorisation
18. Dentistry				**18. Dentistry**	
a)	**Dental alveolar surgery** Surgical procedures involving the teeth and supporting jawbone ridges, such as: » Basic dental procedures in children under the age of eight » Surgical dental procedures in exceptional clinical scenarios in children older than eight and adults • Surgical removal of multiple/impacted teeth or roots • Apicectomies • Tooth exposures • Corticotomies • Surgical preparation of mouth for dentures, etc.	**Hospital and anaesthetist's fee** 100% of Medical Scheme Rate for hospitalisation, operating theatre, sedationist and anaesthetist's fee **Dental procedures** Note that the associated dental procedures will still be funded at 85% of the Medical Scheme Rate from the respective Dental Benefit categories, as indicated under Day-to-Day Benefits	Major Medical Expenses Benefit Subject to pre-authorisation Major Medical Expenses Benefit Subject to pre-authorisation	**Hospital and anaesthetist's fee** 100% of Medical Scheme Rate for hospitalisation, operating theatre, sedationist and anaesthetist's fee **Dental procedures** Note that the associated dental procedures will still be funded at 85% of the Medical Scheme Rate from the respective Dental Benefit categories, as indicated under Day-to-Day Benefits	Major Medical Expenses Benefit Subject to pre-authorisation Major Medical Expenses Benefit Subject to pre-authorisation

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

		IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
18. Dentistry (continued)				**18. Dentistry (continued)**	
b)	**Orthodontic related surgery** Surgical procedures of: » the jaw, facial bones, mouth and its various internal and surrounding structures, where required as part of an orthodontic treatment plan to improve the orthodontic malocclusion and related functional discrepancies; and/or » to complement the non-surgical portion of the orthodontic treatment plan	No benefit	No benefit	**Hospital and anaesthetist's fee** 100% of Medical Scheme Rate for hospitalisation, operating theatre and anaesthetist's fee **Surgical fee** 100% of Medical Scheme Rate	Major Medical Expenses Benefit Subject to pre-authorisation **R10 000** per beneficiary per annum
c)	**Maxillo-facial surgery** » Oral/facial trauma, such as fractured jaw or facial bones for which hospitalisation is required » Oral cancer and similar aggressive oral pathologies » Cleft lip/palate repair » Salivary gland pathology » Serious life-threatening infection of dental origin » Internal temperomandibular joint (jaw-joint) pathology	100% of Medical Scheme Rate for surgical procedures and related hospitalisation	Major Medical Expenses Benefit Subject to pre-authorisation	100% of Medical Scheme Rate for surgical procedures and related hospitalisation	Major Medical Expenses Benefit Subject to pre-authorisation
19. Excimer Laser, Radial Keratotomy, Holmium Procedures, LASIK, Phakic lenses and intra-stromal rings (surgically related services and procedures)				**19. Excimer Laser, Radial Keratotomy, Holmium Procedures, LASIK, Phakic lenses and intra-stromal rings (surgically related services and procedures)**	
	Subject to South African Optometric Association guidelines	No benefit	No benefit	Anaesthetist and hospital costs to be paid from Major Medical Expenses Benefit	**R5 300** per beneficiary per annum

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

	IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
20. Breast Reduction, Mammoplasty and other cosmetic surgery if deemed medically essential			**20. Breast Reduction, Mammoplasty and other cosmetic surgery if deemed medically essential**	
Prior approval by Medical Advisor	No benefit	No benefit	100% of Medical Scheme Rate	Subject to pre-authorisation
21. Prosthetic Limbs and Eyes			**21. Prosthetic Limbs and Eyes**	
The submission of a quotation prior to purchase is required	100% of Cost	Subject to the **R30 000** Internal Prostheses limit	100% of Cost	All prostheses are **per beneficiary** and subject to pre-authorisation » **Prosthetic leg** subject to a limit of **R61 800** per leg » **Prosthetic arm** subject to a limit of **R61 800** per arm » **Prosthetic eye** subject to a limit of **R21 300** per eye Above limits are available every two to five years, as per clinical protocol
22. Infertility			**22. Infertility**	
Benefit limited to the treatment guidelines applied by State hospitals	100% of Cost	PMBs only	100% of Cost	PMBs only
23. Oncology			**23. Oncology**	
Subject to a treatment plan and enrolment on the Oncology Programme	100% of Medical Scheme Rate Subject to PMBs	Overall Oncology limit **R86 700** per beneficiary per annum Subject to pre-authorisation	100% of Medical Scheme Rate Subject to PMBs	Overall Oncology limit **R260 000** per beneficiary per annum Subject to pre-authorisation
Brachytherapy materials (including seeds and disposables) and equipment	100% of Medical Scheme Rate	Limited to **R11 300** per beneficiary per annum and included in the Overall Oncology limit Subject to pre-authorisation	100% of Medical Scheme Rate	Limited to **R33 920** per beneficiary per annum and included in the Overall Oncology limit Subject to pre-authorisation
Pathology, X-rays, MRI, CT and radio-isotope scans	100% of Medical Scheme Rate	Limited to **R7 000** per beneficiary per annum; **not** subject to the Overall Oncology limit Subject to pre-authorisation	100% of Medical Scheme Rate	Limit of **R21 000** per beneficiary per annum; **not** subject to the Overall Oncology limit Subject to pre-authorisation
24. Services Rendered Abroad by a foreign supplier			**24. Services Rendered Abroad by a foreign supplier**	
No benefit for beneficiaries travelling outside the borders of the Republic of South Africa for more than 90 consecutive days	No benefit	No benefit	Services subject to benefits provided in this guide and equal to South African currency	**R1 000 000** per beneficiary per annum

IMPERIAL GROUP MEDICAL SCHEME

MAJOR MEDICAL EXPENSES

	IMPERIALMED BUDGET PLAN		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2014
25. Home Oxygen cylinders, concentrators and ventilation expenses	100% of Cost	PMBs only	100% of Cost	**R12 830** per beneficiary per annum Pre-authorisation required PMBs unlimited
26. External Medical Appliances			**26. External Medical Appliances**	
Permanent or temporary devices that are not surgically implanted and are seen to improve the function of a diseased organ, e.g. wheelchair, crutches, CPAP machine, Baumanometer and all orthopaedic braces Incontinence diapers, which are required as part of a chronic condition, are included	100% of Cost	**R3 000** per beneficiary per annum Motivation and pre-authorisation required for devices and appliances above **R1 000**	100% of Cost	**R11 000** per beneficiary per annum Motivation and pre-authorisation required for devices and appliances above **R1 000**
27. Hearing Aids			**27. Hearing Aids**	
Subject to an audiology report and pre-authorisation	No benefit	No benefit	100% of Cost	**R13 150** per beneficiary per ear over a two-year cycle
28. Prescribed Medicines			**28. Prescribed Medicines**	
Chronic medicine: Prescribed for a PMB and/or additional chronic condition	100% of Generic Reference Price, according to the Scheme's formulary To be obtained from a DSP 25% co-payment applies if obtained from a non-DSP DSPs include Clicks, Dis-Chem and Scriptpharm	Unlimited – PMBs only	100% of Generic Reference Price To be obtained from a DSP 25% co-payment applies if obtained from a non-DSP DSPs include Clicks, Dis-Chem and Scriptpharm	**R20 500** per beneficiary per annum Once limit is depleted, authorised PMB medication will still be paid.

IMPERIAL GROUP MEDICAL SCHEME

WELLNESS BENEFITS

BENEFIT DESCRIPTION		IMPERIALMED BUDGET PLAN % BENEFIT PAYABLE	IMPERIALMED BUDGET PLAN ANNUAL LIMITS FOR 2014	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	IMPERIALMED HEALTH PLAN ANNUAL LIMITS FOR 2014
1.	**Screening tests**				
a)	This benefit will be accessible via the Scheme's DSPs – Scriptpharm, Dis-Chem and Clicks Directmedicines	100% of Negotiated Rate at one of the DSPs	One visit per beneficiary per annum	100% of Negotiated Rate at one of the DSPs	One visit per beneficiary per annum
b)	**HIV test** This benefit will be accessible via the Scheme's DSPs – Scriptpharm, Dis-Chem and Clicks Directmedicines	100% of Negotiated Rate at one of the DSPs	One test per beneficiary per annum	100% of Negotiated Rate at one of the DSPs	One test per beneficiary per annum
c)	**Childhood Vaccine Benefit**	No benefit	No benefit	100% of SEP	According to the Scheme's formulary from birth to the age of 18 months Vaccines outside the formulary will be paid from the Acute Medicine limit; see table below

CHILDHOOD VACCINES ONLY COVERED ON THE IMPERIALMED HEALTH PLAN

REQUIRED AGE	VACCINE
Birth	Bacilles Calmette Guerin (TB) Vaccine
	Oral Polio Vaccine
6 Weeks	Oral Polio Vaccine
	Rotavirus Vaccine
	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae Type B
	Hepatitis B
	Pneumococcal Conjugate Vaccine
10 Weeks	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae Type B
	Hepatitis B

REQUIRED AGE	VACCINE
14 Weeks	Rotavirus Vaccine
	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae Type B
	Hepatitis B
	Pneumococcal Conjugate Vaccine
9 Months	Measles
	Pneumococcal Conjugate Vaccine
18 Months	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae Type B
	Measles

PLEASE NOTE

Please note that it is a requirement that the ages be adhered to for the specific injections. If the specific injection is obtained after the age mentioned in the left-hand column (subject to a leeway of four weeks) it will not be paid for by the Scheme.

PRESCRIBED MINIMUM BENEFITS (PMBs)

BENEFIT DESCRIPTION	IMPERIALMED BUDGET PLAN % BENEFIT PAYABLE	IMPERIALMED BUDGET PLAN ANNUAL LIMITS FOR 2014	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	IMPERIALMED HEALTH PLAN ANNUAL LIMITS FOR 2014
Any service that falls under the State's PMBs	100% of Cost	Unlimited	100% of Cost	Unlimited

DESIGNATED SERVICE PROVIDERS (DSPs)

Imperialmed's contracted DSPs have been supplying chronic medicine to our members from 2011 to minimise the risk of sharp increases in dispensing fees that came about as a result of legislative changes. Members can still choose to receive their chronic medication from any pharmacy, but will be liable for a 25% co-payment if their chronic medicine is received from a non-DSP pharmacy.

The following three providers are contracted as DSPs for chronic medication in 2014 and the agreed dispensing fee for each provider is shown in the table below:

Provider	Dispensing fee for medicine at retail pharmacy below R100	Dispensing fee for medicine at retail pharmacy above R100	Dispensing fee for medicine below R100 when making use of courier services	Dispensing fee for medicine above R100 when making use of courier services	Wellness screening tests
Clicks	28%	R28	26%	R26	R132
Scriptpharm	28%	R28	20%	R20	R110
Dis-Chem	27%	R27	20%	R20	R110

SOME IMPORTANT DEFINITIONS TO UNDERSTAND

Scheme Rate refers to the rate at which health services are reimbursed by the Scheme, which will be determined by the Scheme from time to time.

Generic Reference Price refers to the Metropolitan Health Reference Price (MetRef). It is a cost-control mechanism whereby the Scheme bases its medicine benefits on the cost of generic medicines rather than brand-name medicines.

Medicine Price refers to the Single Exit Price, plus a dispensing fee. Please be aware of this in order to ensure you are not charged additional costs on medicine.

Prescribed Minimum Benefits (PMBs) refer to the minimum benefits that must be provided by a medical scheme in terms of the Medical Schemes Act (no 131 of 1998) and its regulations. Please contact the Call Centre for more information on these benefits.

Board of Healthcare Funders refers to the representative organisation for the majority of medical schemes throughout South Africa.

Designated Service Provider (DSP) is a healthcare provider such as a doctor, pharmacist, hospital, etc., that is a medical scheme's first choice when its members need diagnosis, treatment or care for a Prescribed Minimum Benefit (PMB) condition.

Preferred provider refers to a network of healthcare providers the Scheme has contracted to provide members with healthcare at negotiated rates.

IMPERIAL GROUP MEDICAL SCHEME

MANAGED HEALTHCARE PROGRAMMES

The following managed healthcare programmes are provided by Metropolitan Health Risk Management:

1. Medicine Risk Management Programme (chronic medication and medical management)
2. Prescribed Minimum Benefits Programme
3. Consolidated Disease Management Programme
4. Maternity Programme
5. Hospital Risk Management Programme

Continued overleaf >

1 *Medicine Risk Management Programme (chronic medication and medical management)*

A chronic condition requires ongoing, long-term or continuous medical treatment. The Scheme makes provision for Prescribed Minimum Benefit (PMB) and non-PMB chronic conditions. However, not all chronic conditions are necessarily covered by the Scheme's diseases list.

1.1 The Generic Reference Price

The Generic Reference Price is a cost-control mechanism whereby the Scheme bases its medicine benefits on the cost of generic medicines rather than brand-name medicines. Imperialmed pays all medication as per the Generic Reference Price.

1.2 Chronic medication application and approval process

Telephonic authorisation

» Your doctor should call the Medicine Risk Management Programme on 0860 467 374 with all the relevant details on your application. The request will be processed immediately, while your doctor is on the phone.

» Copies of relevant test results, specialist reports or letters of motivation may be required before authorisation is granted.

Written authorisations

» You or your doctor can call the Client Service Department on 0860 467 374 to request that a Medicine Risk Management application form be posted, e-mailed or faxed to you.

» The form should be correctly completed and accompanied by relevant test results, specialist reports or letters of motivation, as indicated on the application form. This form is also available on the Scheme's website at www.imperialgroupmed.co.za.

» The application, together with the requested information, can be e-mailed to imperialmedmedicine@metropolitanhrm.co.za, faxed to 0860 111 788 or posted to PO Box 32759, Braamfontein 2017.

Updates to existing chronic medication

» If you require new or additional medication for a registered chronic disease, your doctor or pharmacist can contact the Medicine Risk Management Programme telephonically to process the requested change. Please remember that the Scheme may require additional information before approving certain medicines – your doctor will be requested to submit this information.

» Alternatively you can e-mail a copy of your new prescription (with supporting documentation, if required) to the Medicine Risk Management Programme at imperialmedmedicine@metropolitanhrm.co.za, via fax to 0860 111 788 or via post to PO Box 32759, Braamfontein 2017.

» Please note that it takes a maximum of five working days for your application to be processed once we've received it.

Approval process

» Clinical entry criteria will be applied to your application before chronic medication benefits are authorised, as outlined on the application form.
  - Our pharmacists, supported by the medical advisors, will review your application to ensure that cost-effective medication is authorised, which will ensure cost containment without compromising the quality of care.
  - Medicines will be covered if they are listed on the medicine benefit list, are within the Scheme's maximum benefit limit and are received from designated service providers.
  - Chronic medicines will be approved from the date that we receive your full application, fully completed and including all supporting documentation.
  - We will unfortunately not backdate chronic medication authorisations. Please take careful note of the information in this guide and the instructions on the application form.

» Following the outcome of your application, an authorisation letter will be sent to you and an authorisation period indicated for each approved medication item.

» If any medicines have been rejected or additional information to support your application is required, the reasons will be given.

» Please note that it takes a maximum of five working days for your application to be processed.

2 *Prescribed Minimum Benefits Programme*

Once you have been registered on the Prescribed Minimum Benefits Programme for one of the PMB conditions, a care plan will automatically be sent to you. The care plan contains authorised medical services such as consultations and blood and radiological tests related to the management of your conditions.

2.1 PMB disease list

The Scheme provides for unlimited benefits for the treatment of 26 medical conditions that appear on the PMB chronic disease list (CDL).

PMBs – chronic disease list

This is a list of all the PMB conditions covered by the Scheme in terms of legislation governing all medical schemes.

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic renal disease
- Chronic obstructive pulmonary disease (emphysema)
- Coronary artery disease (angina and ischaemic heart disease)
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types I and II
- Dysrythmia
- Epilepsy
- Glaucoma
- Haemophilia
- HIV and AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

PLEASE NOTE:

- Services listed in the care plan are for a full calendar year, unless stated otherwise.
- Services will be prorated for members joining the programme during the year, depending on the months remaining from the date of registration on the programme.
- To ensure that the medical services listed on the care plan are paid correctly, the relevant ICD-10 diagnosis codes must be reflected on your account.
- If the services on the care plan are insufficient to cover your needs, a motivation can be faxed to 0860 222 552, e-mailed to imperialmeddisease@metropolitanhrm.co.za or posted to PO Box 32759, Braamfontein 2017.

3 Consolidated Disease Management Programme

The aim of this programme is to ensure that Imperialmed members receive health information and guidance related to their conditions. Members receive one-on-one contact with the dedicated case manager, who will advise them on the management of their conditions in terms of medication and lifestyle modification, as well as to provide ongoing support. This will improve their understanding of their conditions, thereby ensuring compliance with the treatment. Members are identified for enrolment on the programmes through their chronic medication claims, consultations and related hospital admissions.

a) Cardiovascular, diabetes and respiratory diseases

Members diagnosed with the following conditions are identified, divided into different risk categories and enrolled on the programme:

- coronary artery disease;
- dysrythmia;
- cardiac failure;
- hypertension;
- hyperlipidaemia;
- asthma;
- chronic obstructive pulmonary disease; and
- diabetes mellitus, types I and II.

Identified members receive an enrolment form, which should be completed by the treating medical practitioner. This form will ensure that the case manager has an overall view of the enrolee's conditions and that they are being managed appropriately.

b) Psychiatry management

The programme is aimed at providing support for members suffering from the following conditions:

- depression;
- bipolar mood disorder;
- alcohol and substance abuse;
- post-traumatic stress disorder; and
- schizophrenia.

The programme offers:

Enhanced out-of-hospital benefits are managed via the authorised care plan to ensure better outcomes and care. A psychiatric case manager will provide health information and guidance to improve understanding and to manage the condition. The case manager provides telephonic counselling and can refer you to local support systems.

c) HIV and AIDS management

The purpose of the HIV YourLife Programme is to identify and manage members who might have contracted HIV or are living with AIDS. We also ensure access to quality care and optimal use of the benefits available to manage the disease. Members are followed up for counselling and support based on the stage of the disease they are in and emphasis is placed on compliance and adherence.

Benefits of enrolment on the programme

Joining the programme soon after diagnosis ensures that you can access appropriate medication, support and education and therefore enjoy a healthier and more productive life. You are also assisted in developing life skills that will help in making decisions about your lifestyle. You will receive information and advice on treatment and get counselling and continuous support. This will in turn minimise hospitalisation associated with opportunistic diseases.

Once you're registered on the programme you can access the following services:

- post-exposure prophylaxis (PEP) medication;
- prevention of mother-to-child transmission;
- adult chronic medication and treatment for children;
- too-early-to-treat care;
- prophylaxis for opportunistic infections; and
- care plan for doctor's consultations and investigations.

Anti-retroviral medication approval process

- Treatment will be authorised according to the stage of the disease and, where indicated, will be authorised as per treatment guidelines.
- An authorisation letter will be sent to both the member and doctor explaining the authorised medication and care plan.

Confidentiality

All communication is handled in a confidential manner. Your employer, friends or even the Scheme Board of Trustees will not have access to information about your HIV status. Access to your records will be limited to your

personal case manager and clinical team in the dedicated HIV management unit.

d) Oncology benefit management

The purpose of the programme is to provide a cost-effective and evidence-based oncology benefit to members. Programme enrolment is compulsory for all beneficiaries receiving oncology treatment.

Benefits of enrolment on the programme:

- Access to the Scheme's oncology benefit;
- Cost-effective management of annual oncology benefit;
- Assistance with authorisation for appropriate health services;
- Co-ordination and negotiation of treatment with other treating doctors; and
- Members will receive holistic education, care and support to better manage their condition.

e) Spinal Treatment Programme

Spinal diseases often cause pain and can also limit body movement when bone changes put pressure on the spinal cord or nerves. 85% of acute lower back pain is usually resolved over several weeks with conservative management. Low-grade symptoms may persist and recurrences can occur. Serious disability is rare, even in those who have developed chronic lower back pain.

The aim of the programme is the following:

- To identify and refer serious pathology immediately for relevant and appropriate treatment;
- To treat lower back pain comprehensively and relieve pain within a reasonable period (6 to 12 weeks) in order to prevent the development of chronic back pain and complications;
- To reduce redundant spinal surgery; and
- To restore full functioning of the patient as much as possible.

4 *Maternity Programme*

Expectant mothers can enrol on the programme once their pregnancy has been confirmed. They can either call the programme or complete an enrolment form. Maternity case managers will also invite members to join the programme by sending them a letter of invitation and enrolment form after analysis of the claims data has indicated possible pregnancy.

The programme offers:

- Information and guidance on all aspects of pregnancy, confinement and the post-natal period;
- A comprehensive pregnancy and birth book; and
- A care plan to guide the medical practitioner in the appropriate treatment necessary for the duration of the pregnancy.

5 *Hospital Risk Management Programme*

The aim of this programme is to manage high costs and major medical expenses for the Scheme. Qualified medical personnel assess requests to ensure appropriateness and cost-effectiveness.

IMPERIAL GROUP MEDICAL SCHEME

If the criteria are met, pre-authorisation is granted. This provides an opportunity to assess, monitor and coordinate each request from admission to discharge and subsequent account submission.

The following services should be pre-authorised:

- Hospital admission or admission to a day clinic;
- Specialised radiology;
- Home nursing;
- Step-down/sub-acute care;
- Alternative therapies;
- Oxygen and Stoma products;
- Psychiatric treatment;
- Cancer treatment; and
- Home oxygen.

The authorisation process

- Pre-authorisation should be requested 48 hours before the service is rendered and within 48 hours of an emergency admission.
- All initial requests for admission will be screened for medical necessity and appropriateness using clinical guidelines and best practice principles.
- A case manager will inform the member of what to expect, his/her available benefits, the applicable Scheme rules and any other concerns.
- Based on the information provided, a request for pre-authorisation can be approved, pended or declined. In each instance feedback will be provided.
- If the request is approved, an authorisation number is granted and written confirmation is sent to the service provider.

The following details are required for pre-authorisation:

- your membership number;
- the ID number of the main member;
- name or date of birth of the patient (for verification purposes);
- name of hospital;
- name or practice number of the admitting doctor;
- reason for admittance to hospital, including ICD-10 codes; and
- date of admission.

If pre-authorisation is not obtained

You may be liable for a co-payment of R500 should you fail to obtain pre-authorisation. Accounts may also be rejected.

CONTACT THE CASE MANAGER BY MAKING USE OF ONE OF THE FOLLOWING FOR ANY OF THE MANAGEMENT PROGRAMMES:

- **Tel: 0860 467 374**
- **E-mail: imperialmedtreatment@metropolitanhrm.co.za**
- **Fax: 0860 111 788**
- **Post: PO Box 32759, Braamfontein 2017**

HOW TO JOIN THE HIV YourLife PROGRAMME

Contact the programme via:

- **a dedicated, confidential helpline on 0861 888 300**
- **fax 0861 888 301**
- **e-mail mail@hivyourlife.co.za**

MEDICAL EMERGENCY AND AMBULANCE SERVICES

In the case of an emergency, you have access to the medical emergency services offered by **Europ Assistance South Africa**. All emergency services case managers and nursing staff are housed in one call centre in Constantia Kloof in Johannesburg.

Two dynamic services offered by **Europ Assistance South Africa** to Imperialmed members are the **Personal Health Advisor** and **Emergency Medical Services**. Both these services are available on one easy-to-remember number:

0861 RESCUE (0861 737 283)

What benefits are included?

- Emergency medical transportation
- 24-hour telephonic medical advice and emergency assistance hotline
- Escorted return of minors
- Arrangements for compassionate visit by a family member
- Inter-hospital transfers
- Return of mortal remains

What to do in an emergency

Dial 0861 RESCUE. You will be given two options: press 1 for emergency services or 2 for the Personal Health Advisor. When an agent answers the call, you are requested to give your name, surname and Imperialmed membership number. If, in the case of an emergency, you do not have your membership number on hand, your name and surname will do.

The **Personal Health Advisor** is a 24-hour health advisory service manned by professional, experienced nurses. The facility offers a comprehensive database of symptom assessment, which allows safe and appropriate advice to be given regarding the management and treatment of illnesses and conditions. The service is offered for both incoming and outgoing calls and in most official South African languages.

Personal Health Advisor

This service includes:

- the Audio Health Library, which lists a range of symptoms and ailments;
- emergency medical advice, which provides appropriate first aid advice to the caller;
- assessment of day-to-day symptoms;
- drug database, which lists different drugs and medication, contra-indications, dosage and whether there are dietary specifications;
- procedures to be followed immediately after poisoning, as well as long-term treatment;
- health counselling for chronic conditions and diseases/conditions, such as cancer, HIV and AIDS, diabetes and asthma, where the patient can receive a better understanding of the disease and the specific treatment given; this counselling helps the patient and those around them cope with the problem;
- addiction counselling to assist the caller with coping skills or to refer them to appropriate medical care clinics;
- stress management, where counselling, advice and relaxation techniques are discussed with the callers;
- trauma debriefing by the Personal Health Advisor nurses, who handle the debriefing of any sort of trauma on a daily basis; and
- assistance for rape survivors during which initial counselling is immediately available to the survivor; after the assessment and counselling, the survivors of rape are directed to the closest medical centre.

Emergency medical services

This is a 24-hour a day, immediate response service to the scene of the medical emergency, where advanced life-saving resuscitation is provided, if needed. A medical emergency is a life-threatening situation such as a heart attack, drowning, snakebite or bodily injury, such as a gunshot wound or motor accident injury. If you experience a medical emergency and are unable to get to a hospital, you will be stabilised before transportation to the closest, most appropriate medical facility.

Please be aware that, unless in situations beyond your control – for example if you are unconscious or unable to talk – you must phone Europ Assistance first for emergency medical assistance. This not only ensures that the best quality service is provided, but also that the claim is channelled correctly. If you are unable to communicate and another person calls for emergency assistance on your behalf, the claim will be treated appropriately, but Europ Assistance must be made aware of the situation as soon as possible.

EXCLUSIONS AND LIMITATIONS

Expenses incurred in connection with any of the following will not be paid by the Scheme, unless otherwise authorised by the Board of Trustees:

Limitation of benefits

The Scheme will not cover costs of whatever nature incurred for the treatment of sickness conditions or injuries sustained by a member or a dependant for which another party may be liable. If the Scheme covers any costs incurred by the beneficiary that arises from the actions or omissions of another party, the beneficiary will:

a) be liable for repayment to the Scheme all amounts paid by the Scheme and recovered by or on behalf of the beneficiary from the party responsible for compensating the beneficiary, free of any legal costs or deductions that may have been incurred in the recovery of such amount;
b) disclose to the Scheme or, alternatively, instruct his/her legal representative to disclose to the Scheme, the full extent of any compensation awarded in respect of past and future medical expenses;
c) sign all documentation, as may be required by the Scheme, to obtain copies of all information not in the Scheme's possession, that relates to the beneficiary's medical accounts and records from the relevant practitioners and/or medical institutions;
d) either personally or through his/her legal representative keep the Scheme informed – whether called upon by the Scheme to do so or not – as to the ongoing progress of his/her claim;

e) when requested by the Scheme, whether prior to or subsequent to the Scheme effecting any payments, as referred to above, provide the Scheme with a written undertaking signed by both the member and his/her legal representative so as to give full effect to what is contained in paragraphs a) to d) above;
f) indemnify the Scheme against all amounts paid by the Scheme in terms of the information contained in paragraph a) above; this indemnity is to be in the form required by the Scheme and to be furnished to the Scheme within three months of the start of treatment; and
g) be entitled to benefits or a portion of the benefits in respect of which his/her claim was unsuccessful as would have applied should no claim have been possible from inception, irrespective of the lapse in time, should a beneficiary's claim (referred to in the information contained in paragraph a) above) against the party liable for his/her injuries not be successful, or alternatively, only partially successful.

Exclusions

- Expenses incurred by a member or dependants of a member in the case of or arising out of wilful self-injury, professional sport, speed contests and speed trials, except for prescribed minimum benefits.
- Laparoscopic surgery for the removal of an appendix, except in the event of an emergency procedure.
- Labial frenectomy in respect of beneficiaries under the age of twelve.
- Dental procedures or devices that are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.
- General anaesthetics, conscious sedation and hospitalisation for dental work, except in the case of patients under the age of eight or bony impactions of the third molars.
- Periodontic plastic procedures for cosmetic reasons.
- All general anaesthetics and conscious sedation in the practitioner's rooms, unless pre-authorised.
- Tooth bleaching, linual (invisible) orthodontic braces and gum guards for sports purposes.
- The purchase of medicines prescribed by a person not legally entitled to prescribe medicine.
- Robotic-assisted surgery.
- Investigations, operations or treatment for cosmetic purposes, obesity, artificial insemination, impotence and erectile dysfunction or treatment and medication of an experimental nature. A medical or surgical procedure, treatment, cause of treatment, equipment, drug or medicine, will be regarded as experimental:
  a) if it is not widely accepted and known to be safe, effective and appropriate for the treatment of illness or injury by a consensus of professional medical specialists, which are recognised as such by the South African medical community;

b) if it is under study, investigation, in a test period or part of or in a clinical research state;
c) where no definite outcome results, following at least a five-year trial period, are available; or
d) if it is more expensive than that which is generally available and does not significantly change the outcome of the procedure, treatment or taking of medicine or drugs; provided that, should a member prefer to have the more expensive treatment, the Scheme will pay the reasonable and customary fees associated with the treatment that is generally available.

» Holidays for recuperative purposes.
» Purchase of patent medicine and proprietary preparations, applicators, toiletries and beauty preparations, bandages, cotton wool and similar aids, patented foods, including baby foods, contraceptives and apparatus to prevent pregnancy, tonics, slimming preparations and drugs, as advertised to the public and household and biochemical remedies.
» Purchase of vitamins or vitamin supplements not approved by the Scheme.
» Purchase of sunglasses.
» Tinted or coloured plano lenses and other "cosmetic effect" contact lenses (other than prosthetic lenses) and contact lens accessories and solutions.
» Optical devices that are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.
» Purchase of exercise equipment.
» Purchase of any drug or medicine not registered by the Medicines Control Council or a similar authority.
» Purchase of any medicines not registered for that specific condition.
» All costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules of the Scheme.
» Examinations for insurance, employment, visas, pilot and driver's licences or examinations for enrolment in university and college.
» Any travelling or conveyance except by ambulance or ambulance aircraft.
» The costs of appointments that are cancelled or not kept by members.
» Costs for services rendered by:
  a) persons not registered in terms of any law, for example the South African Medical and Dental Council, the Chiropractors, Homeopaths and Allied Health Service Professions Council of South Africa or the South African Nursing Council; and
  b) any institution, except a State or provincial hospital, not registered in terms of any law.
» Services that are regarded as not medically necessary. A treatment, procedure, supply, medicine, hospital or specialised centre stay (or part of a hospital or specialised centre stay) will be regarded as medically necessary if:
  a) it is appropriate and essential to the diagnosis and treatment of illness or injury of the member;
  b) does not exceed, in scope, duration or intensity of the level of care that is needed to provide a safe, adequate and appropriate diagnosis or treatment;

  c) it has been prescribed by a doctor;
  d) it is consistent with the widely-accepted professional standards of the medical practice in South Africa and in respect of overseas cover, the United States of America; and
  e) in the case of inpatient care, it cannot be provided safely on an outpatient basis.

The medical need will be determined by the Scheme, taking into account the above requirements.

The fact that a doctor has prescribed, recommended, approved or provided a treatment, service, supply or confinement will not in itself be regarded as proof that a service is medically necessary.

Where necessary the Board will refer cases to a panel of medical specialists for a final decision. The decision of the Board, following advice from the specialist panel, will be final.

» Otoplasty for beneficiaries 12 years of age or older.
» Breast reduction, except where associated with breast reconstruction following a diagnosis of cancer or the beneficiary is diagnosed with gigantomastia during pregnancy that is accompanied by complications such as ulceration of breast tissue, massive infection, tissue necrosis with slough, significant haemorrhaging or if delivery is not imminent.
» Treatment or surgery of scars, keloids and excision of a tattoo are deemed to be for cosmetic purposes, except in cases of severe burn scars on the face and neck and functional impairment such as contractures. Where necessary the Board will refer cases to a panel of medical specialists for a final decision. The decision of the Board following advice from the specialist panel will be final.
» Any medical and/or surgical procedure related to the Gamete intrafallopian transfer, in-vitro fertilisation, Zygote intrafallopian transfer, pronuclear stage tubal transfer or any other transfer or egg or sperm collection will not be covered by the Scheme. Any other treatment or investigation not covered in respect of code 902M (diagnosis: infertility) will not be covered by the Scheme.

The fact that a doctor has prescribed, recommended, approved or provided a treatment, service, supply or confinement will not in itself be regarded as proof that a service is medically necessary.

CLAIMING MADE EASY

Submission of claims

Please do not fax claims to the Scheme, as these will not be processed. Claims may be e-mailed to the Scheme if the claim is clear enough.

» Please sign all accounts and submit them to Imperialmed, PO Box 32759, Braamfontein 2017.

» All accounts submitted must contain the following information:

1. your membership number;
2. your name and initials;
3. date of service/treatment;
4. nature of treatment/illness;
5. tariff code, where applicable;
6. name of patient (not a nickname) as it appears on your membership card;
7. name and practice number of the service provider, e.g. doctor or pharmacy;
8. name of the Scheme;
9. the amount charged; and
10. ICD-10 diagnosis code.

» Ensure that the services charged on the account are correct.

» If you have already paid an account, write "account paid" clearly on the account and attach the receipt.

» The Scheme cannot process receipts received without detailed accounts.

» Accounts must be submitted to the Scheme within four months of treatment, i.e. before or by the last day of the fourth month after the month in which the service was rendered, after which the claims will be rejected as stale.

» Should the claim be for the treatment of injuries in which a third party, e.g. motor vehicle accident claim or occupational injuries and diseases claim, could be involved, a statement of how the injuries were sustained must accompany the claim.

» Ensure that all service providers have your correct membership number and the correct address to which claims should be sent.

» In case of hospital treatment, write "hospital treatment" on the account with your confirmation number.

Electronic submission of claims

The majority of doctors and other service providers (notably large pathology laboratories) submit claims directly to the Scheme using electronic data interchange (EDI).

This process normally works extremely well and ensures quick, direct payment to the supplier.

However, it does not absolve the member from the ultimate responsibility for ensuring that the account is settled, or for any co-payment that is due. Suppliers who submit claims directly to the Scheme are obliged to send duplicate accounts to members to check whether the services and the amounts charged are in fact correct.

Check your claims statement to verify that the accounts have been paid. It could be inconvenient for members when such an account is discovered to be unpaid after the maximum period for the submission of claims has passed.

Should changes be made to the benefits granted by the Scheme, claims submitted after the changes will be paid according to the rules that existed at the date of the service and not the rules that exist at the date when the claims are submitted or received.

Claiming for medicines dispensed directly by pharmacists (pharmacist-advised therapy)

Imperialmed also offers you a facility to buy schedule 1 and 2 medicines from a registered pharmacist without a doctor's prescription. This is called pharmacist-advised therapy. If you make use of this facility, no levy will be payable.

Use this facility for minor complaints such as coughs and colds to avoid unnecessary visits to your doctor. However, do not neglect to see your doctor if you are really ill – there is no price for good health.

You may claim for medicines that have been dispensed by a pharmacist but have not necessarily been prescribed by a doctor. These claims will be deducted from your acute medicine limit. Your benefits for these claims will be paid at 100% of the generic reference price up to a specified maximum per prescription. See the table of benefits on page 18 for more details.

Please remember that medicines that are purchased at a supermarket will not be accepted for payment.

Pharmacists have a clear understanding of medicines and drugs that may be dispensed under this benefit.

Claiming for medical expenses incurred outside the country

If you are intending to travel abroad, it is wise to take out additional medical cover. Your travel agent will be able to assist you with this.

- If you are injured or become ill while outside South Africa on holiday or business, you may submit the account to the Scheme.
- The benefit due will be paid to you and you will be responsible for settling the account.
- The benefit will be paid according to the equivalent medical scheme rates and will be refunded in South African rands.
- This benefit is subject to an overall annual limit of R1 million per beneficiary per annum. Please note that any medical expenses incurred during an overseas stay exceeding a period of three months will not qualify for benefits.

Motor vehicle accidents (MVAs)

In terms of the rules of the Scheme, (Annexure C, point 2.6, page 101) the Scheme is not liable to pay any costs for the treatment of sickness conditions or injuries sustained by a member or a dependant

where any other party, for example the Road Accident Fund (RAF), may be liable.

MVA claims are identified when specific diagnoses are reflected in accounts, e.g. those related to fractures or soft tissue injuries. Sometimes doctors or hospitals send an injury report with the accounts stating that the member or dependant was involved in a motor vehicle accident. Alternatively, the member or the attorneys could also contact the Scheme via fax or telephone. MVA claims have certain procedures, which must be strictly adhered to:

- If you have been involved in an accident where a third party is liable for payment, please inform the Scheme as soon as possible.
- The attorney and the member must submit a written undertaking that the Scheme will be refunded by the attorney when the claim has been settled by the RAF.
- The Scheme will then assist the member by paying the claims to the service providers, such as the hospitals and doctors concerned.
- All claims will be paid in accordance with the Scheme rules and be subject to the benefits available for the specific treatment.
- Any delay in lodging a claim or in appointing an attorney will delay the payment of claims.
- **Cases that are rejected by the RAF will be covered by the Scheme, subject to the beneficiary's benefit limits. However, a letter will be required from the RAF stating that the claim has been rejected.**

Payment of claims

The Scheme pays all accounts up to the benefit limit only. If your service provider charges more than the benefit limit, or your benefits are exhausted, you will be liable for payment of the difference in price, which must be paid directly to the service provider.

Payments to members and service providers are made twice a month. After the claim has been processed, you and the service provider will receive a claims statement setting out how the claim has been dealt with.

Refunds for settled claims

Payment to members will be made directly into your specified banking account. **Please ensure that the Scheme has your correct banking account details or address at all times.**

SHORTFALLS

A shortfall on an account may arise when the benefit payable by the Scheme is less than the amount charged.

HELPING TO CURB YOUR COSTS

The Scheme is there to provide you with cover when you need it. You can help curb future costs by using your Scheme benefits carefully:

- Always talk to your doctor about whether treatment is necessary.
- Negotiate with your doctor to charge medical scheme rates or obtain the services from a contracted doctor.
- Use day clinics where possible.
- Get a second opinion if surgery or expensive treatments are suggested.
- Check your benefit limits (where applicable) before seeking medical treatment.
- Use generic medicines where possible – it can cost up to 80% less than branded medicines.

CONTACT DETAILS

Telephone numbers, fax numbers and e-mail addresses

Claims enquiries, membership confirmations and registrations
Tel: 0860 467 374
Fax: 0860 111 788
E-mail address: Imperialmedenquiries@mhg.co.za

Hospital Pre-authorisation and Oncology Management Programmes
Tel: 0860 467 374
Fax: 0860 888 113
E-mail: hrmimperialmed@metropolitanhrm.co.za

Medicine Risk Management Programme (chronic medication and medical management)
Tel: 0860 467 374
Fax: 0860 111 788
E-mail: Imperialmedmedicine@metropolitanhrm.co.za

Member Care Line – Medi Call
Toll free: 0860 105 221
Fax: 0866 889 411
E-mail: imperialmed@medicall.co.za

HIV YourLife Programme
Tel: 0861 888 300
Fax: 0860 888 301
Address: HIV YourLife Programme, Imperialmed, PO Box 15468, Vlaeberg 8018
E-mail: mail@hivyourlife.co.za

Europ Assistance emergency services and 24-hour Professional Health Advice Line
Tel: 0861 RESCUE (0861 737 283)

Contribution enquiries
Please contact your company's Payroll/Human Resources Department.

The Administrator's website
www.mhg.co.za

The Scheme's website
www.imperialgroupmed.co.za

Postal address
Imperialmed, PO Box 32759, Braamfontein 2017

KPMG Fraud Hotline:
Tel: 0800 200 564

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