MEMBER GUIDE 2017

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 should a dispute arise.

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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, MMI 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 MMI Health 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.

Who is MMI Health?

MMI Health 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.

It also 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 **48 hours prior to the admission date** to hospital or within 48 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;
  - maxillofacial and oral surgery;
  - orthodontic treatment and related surgery;
  - root canals, bridges and crowns;
  - dental surgery; and
  - dental implants.
- 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.

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

WHAT YOU NEED TO KNOW ABOUT MEMBERSHIP

» 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**.

» 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. This is in line with the Group Membership Policy that has been approved and implemented by the Group Executive Committee. The Group Medical Aid Membership Policy is available on the Imperialmed website at www.imperialgroupmed.co.za.

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 of working members are 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.

Contributions for pensioner and continuation members must be paid monthly in advance and must be paid to the Scheme by no later than the first day of the month in which it becomes due. The Scheme has the right to suspend a member's membership should contributions not be paid by the due date. Two notices will be given to the member at his/her domicilium citandi et executandi. His/her membership will be terminated 14 days after the second notice. The member's postal or residential address on his/her application will be deemed to be the domicilium citandi et executandi.

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 between the 1st and up to the 14th day of the month, no contribution will be due for that month. The employer must advise the Scheme of the date immediately after it takes place. The benefits of Imperialmed end on the same day that employment ends.

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/common-law spouses

A spouse, to whom the member is married in terms of any law or custom. Only one spouse per principal member is allowed. A marriage certificate, or in the case of a customary marriage, an affidavit, needs 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, 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;
- a dependant between the ages of 21 and 25 who is a student and not employed full time; and
- grandchildren – only if the parent of the grandchild is a dependant of Imperialmed as well, or if the grandchild has been placed in the care and custody of the member, spouse or partner by virtue of a court order or legal adoption. Legal documents need to accompany your application.

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. Members with dependants over the age of 25 who wish to keep their dependants 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. However, the Scheme pays for Prescribed Minimum Benefits (PMBs), including emergencies, as defined by PMB legislation.

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.

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.

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.

CREDITABLE COVERAGE is any period during which a late joiner was:

a) a member or a dependant of a medical scheme, but excluding any period of coverage as a child dependant under the age of 21;

b) a member or a dependant of an entity doing the business of a medical scheme, which at the time of his/her membership of such entity was exempt from the provisions of the Act;

c) a uniformed employee of the South African National Defence Force; or

d) a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21.

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.

Changes in membership

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

- 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 day-to-day 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 register on the Imperialmed Budget Plan will be calculated on a pro rata basis for members joining form 1 February to 30 June of each year, but those joining from 1 July to 31 December of each year will have access to six months' benefits.

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 49 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.

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.

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

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
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	Member family limit calculated as follows: **R2 640** per member **R1 980** per adult dependant **R1 650** per child dependant (maximum of three children)
b)	**All procedures** (including those listed in 1(a) of Major Medical Expenses) 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	
c)	**Circumcision** – done in doctor's rooms	100% of Medical Scheme Rate	Major Medical Expenses **R1 000** per beneficiary per annum
d)	**PMB Care Plan Services** Consultations as authorised on care plan	100% of Cost	Major Medical Expenses 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)**		
a)	**Radiology (X-rays) and Pathology** Including Bone Density Scans	85% of Medical Scheme Rate	Member family limit calculated as follows: **R3 400** per member **R3 400** per adult dependant **R590** per child dependant (maximum of three children)

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	**ANNUAL LIMITS FOR 2017**
1. General Practitioners (GPs) and Specialists – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary)	
85% of Medical Scheme Rate These benefits are covered on the MMI Health Network and Specialists only on referral by a GP	Member family limit calculated as follows: **R900** per member **R670** per adult dependant **R550** per child dependant (maximum of three children) Benefits applicable to the nomination of two GPs per dependant Two out-of-network GP visits allowed
100% of Medical Scheme Rate	To be done by a nominated Network GP
100% of Medical Scheme Rate	Major Medical Expenses **R1 000** per beneficiary per annum at a nominated Network GP
100% of Cost	Major Medical Expenses 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
2. Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary)	
85% of Medical Scheme Rate	Member family limit calculated as follows: **R1 130** per member **R1 130** per adult dependant **R200** per child dependant (maximum of three children)

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

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
2.	**Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary) (continued)**		
b)	Mammograms, Pap Smears and Prostate-Specific Antigen (PSA) Tests	100% of Medical Scheme Rate	Subject to the above Radiology and Pathology day-to-day benefit limits
c)	**PMB care plan Radiology and Pathology services as authorised on care plan** Including Cardiac Ultrasounds	100% of Cost	Major Medical Expenses 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**		
a)	**Preventative dentistry** » Scaling and/or polishing and fluoride treatment » Fissure sealing	100% of Medical Scheme Rate 100% of Medical Scheme Rate	Two per beneficiary per annum Once-off for permanent molars in persons under 24 years
b)	**Basic dentistry** » Oral examination » Diagnostics (X-rays, etc.) » Restorations (fillings) » Non-surgical extractions » Root canal treatment	85% of Medical Scheme Rate	**R3 400** per beneficiary per annum
c)	**Advanced/Specialised dentistry** » Inlays, onlays, veneers, crowns and bridges » Study models » Dentures » Dental implants, placements, exposure and related procedures such as jaw ridge, sinus lifts, augmentations, etc. » Orthodontic retainers, space maintainers and biteplates » Periodontal (gum) treatment » Wisdom teeth	85% of Medical Scheme Rate	**R10 200** per family per annum

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
2. Diagnostic Services – out of hospital (annual limits are calculated as a family benefit and can be used by any beneficiary) (continued)	
100% of Medical Scheme Rate	Subject to the above Radiology and Pathology day-to-day benefit limits
100% of Cost	Major Medical Expenses 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	
No benefit No benefit	No benefit No benefit
85% of Medical Scheme Rate	**R2 260** per family per annum
No benefit	No benefit

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

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
3.	**Dentistry (continued)**		
d)	**Dental implants** Includes the cost of the implants only – the anaesthetist and hospital fees are covered as part of Major Medical Expenses The treating dental specialist fee subject to the Advanced/ Specialised Dentistry limit above	100% of Medical Scheme Rate	**R13 190** per beneficiary Pre-authorisation required
e)	**Orthodontic treatment**	100% of Medical Scheme Rate	**R6 790** 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)**		
a)	**Acute medicines** Acute medicines and injection material, including flu vaccines	100% of Generic Reference Price after deduction of **R30** levy per script	Member family limit calculated as follows: **R5 840** per member **R3 670** per adult dependant **R1 100** per child dependant (maximum of three children)
b)	**Over-the-counter (OTC) medication**, also known as pharmacy-advised therapy (PAT), refers to medicines supplied by a registered pharmacist without a doctor's prescription	100% of Generic Reference Price, up to a maximum of **R185** per event	**R1 070** per family per annum Subject to Acute Medication limit Subject to an over-the-counter formulary
c)	**Childhood vaccines**	Refer to the Wellness Benefit **(page 48)**	

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
3. Dentistry (continued)	
No benefit	No benefit
No benefit	No benefit
4. Prescribed Medicine (annual limits are calculated as a family benefit and can be used by any beneficiary)	
100% of Generic Reference Price after deduction of a **R30** levy per script	Member family limit calculated as follows: **R1 950** per member **R1 230** per adult dependant **R370** per child dependant (maximum of three children)
No benefit	No benefit
No benefit	No benefit

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

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
5.	**Medical Auxiliaries – out of hospital**	85% of Medical Scheme Rate	R7 120 per family per annum for the listed disciplines
	Only for the following disciplines: • Podiatry • Orthoptic treatment • Audiometry/audiology • Occupational therapy • Therapeutic dietician • Remedial and speech therapy • Clinical technology • Chiropody • Social work • Biokinetics • Chiropractor • Homeopaths		
6.	**Physiotherapy – out of hospital**	85% of Medical Scheme Rate	**R4 500** per family per annum
7.	**Mental Health – out of hospital**		
	Includes Psychologist and Psychiatrist	85% of Medical Scheme Rate	**R4 260** per beneficiary per annum
8.	**Optical Services**		
a)	Eye test	85% of Medical Scheme Rate	One test per beneficiary per annum from Major Medical Expenses
b)	Spectacles (lenses, replacements, repairs and adjustments), contact lenses and fitting of contact lenses	85% of Cost	**Overall Optical limit of R2 470** per beneficiary per annum
c)	Frames	85% of Cost	**R780** per beneficiary per annum; included in the Overall Optical limit above
d)	Sunglasses	No benefit	No benefit

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
5. 85% of Medical Scheme Rate	R1 700 per family per annum for the disciplines listed **below**
	Only for the following disciplines: • Clinical psychology • Psychiatry • Physiotherapy
6. 85% of Medical Scheme Rate	**Included in the Medical Auxiliaries limit above (item 5)**
7. Mental Health – out of hospital	
85% of Medical Scheme Rate	**Included in the Medical Auxiliaries limit above (item 5)**
8. Optical Services	
85% of Medical Scheme Rate	One test per beneficiary per annum from Major Medical Expenses
85% of Cost	**Overall Optical limit of R1 120** per beneficiary per annum
85% of Cost	**R230** per beneficiary per annum; included in the Overall Optical limit above
No benefit	No benefit

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
	BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
All Major Medical Expenses are subject to pre-authorisation			
1.	**Hospitalisation – Private and Provincial**		
a)	A deductible of **R620** applies if the following procedures are done in hospital: » Scopes • Arthroscopies • Gastro-intestinal endoscopies – Gastroscopies – Colonoscopies – Sigmoidoscopies » Urological scopes and cystoscopies » Gynaecological scopes » Biopsies » Minor dermatological procedures » Dental procedures Refer to dental benefit for more details on in-hospital dentistry **(page 40 and 41, point 19)**	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 Subject to pre-authorisation
b)	Circumcision	100% of Medical Scheme Rate	Major Medical Expenses **R2 000** per beneficiary per annum Subject to pre-authorisation
c)	Accommodation in general ward, recovery room, intensive care unit or high care ward	100% of Medical Scheme Rate	Major Medical Expenses
d)	Theatre fees	100% of Medical Scheme Rate	Major Medical Expenses
e)	Medicines used in hospital/ theatre	100% of Medicine Price	Major Medical Expenses

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	**ANNUAL LIMITS FOR 2017**
1. Hospitalisation – Private and Provincial	
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 Subject to pre-authorisation
100% of Medical Scheme Rate	Major Medical Expenses **R2 000** per beneficiary per annum Subject to pre-authorisation
100% of Medical Scheme Rate	Major Medical Expenses
100% of Medical Scheme Rate	Major Medical Expenses
100% of Medicine Price	Major Medical Expenses

MAJOR MEDICAL EXPENSES

	BENEFIT DESCRIPTION	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	IMPERIALMED HEALTH PLAN ANNUAL LIMITS FOR 2017
2.	**Post-operational physiotherapy**		
	Physiotherapy after hip, knee and shoulder replacement surgery and spinal surgery only	100% of Medical Scheme Rate	Major Medical Expenses 6 weeks' treatment, as per clinical protocols Pre-authorisation required
3.	**General Practitioners (GPs) and Specialists – in hospital**		
a)	Visits and consultations	100% of Medical Scheme Rate	Major Medical Expenses
b)	Surgical procedures and anaesthetics	100% of Medical Scheme Rate	Major Medical Expenses
4.	**Diagnostic Services – pre-authorisation required for certain services**		
a)	Radiology (X-rays) and pathology (in hospital)	100% of Medical Scheme Rate	Major Medical Expenses
b)	MRI, CT and radio-isotope scans (in and out of hospital)	100% of Medical Scheme Rate	**R15 490** per beneficiary per annum Subject to pre-authorisation
c)	Ultrasound scans (in and out of hospital)	100% of Medical Scheme Rate	**R4 620** per beneficiary per annum
d)	PET scans (in and out of hospital)	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)	100% of Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation
5.	**To-take-out (TTO) Medicine**		
	Medicines dispensed on discharge from hospital will be covered under the Major Medical Expenses	100% of Medicine Price	Major Medical Expenses, subject to **R390** per beneficiary per admission

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	**ANNUAL LIMITS FOR 2017**
2. Post-operational physiotherapy	
100% of Medical Scheme Rate	Major Medical Expenses 6 weeks' treatment, as per clinical protocols Pre-authorisation required
3. General Practitioners (GPs) and Specialists – in hospital	
100% of Medical Scheme Rate	Major Medical Expenses
100% of Medical Scheme Rate	Major Medical Expenses
4. Diagnostic Services – pre-authorisation required for certain services	
100% of Medical Scheme Rate	Major Medical Expenses
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	**R1 450** per beneficiary per annum
No benefit	No benefit
No benefit	No benefit
5. To-take-out (TTO) Medicine	
100% of Medicine Price	Major Medical Expense, subject to **R390** per beneficiary per admission

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
6.	**Out-patient Services**		
	Private and provincial hospitals	If ICD-10 code is for an emergency, the cost of the consultation, facility, procedure, related materials and medication is to be paid at 100% of Major Medical Expenses If ICD-10 code is **not** for an emergency, all applicable services to be paid at 85% from the applicable day-to-day benefit limits	Major Medical Expenses
7.	**Blood Transfusions**	100% of Cost	Major Medical Expenses
8.	**Nursing Services, Sub-acute Care and Hospice Services, including medicines, dressings, ointments, etc.**	100% of Medical Scheme Rate or Cost, whichever is the lesser	Major Medical Expenses Subject to pre-authorisation
9.	**Ambulance Services**	100% of Cost	**R7 850** per beneficiary per annum Subject to approval and pre-authorisation by preferred provider, Europ Assistance Emergency air ambulance not subject to the above limit, subject to Scheme approval

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
6. Out-patient Services	
If ICD-10 code is for an emergency, the cost of the consultation, facility, procedure, related materials and medication is to be paid at 100% of Major Medical Expenses If ICD-10 code is **not** for an emergency, all applicable services to be paid at 85% from the applicable day-to-day benefit limits	Major Medical Expenses
7. 100% of Cost	Major Medical Expenses, subject to PMBs
8. No benefit	No benefit
9. 100% of Cost	**R3 180** per beneficiary per annum Subject to approval by preferred provider and Scheme

MAJOR MEDICAL EXPENSES

	BENEFIT DESCRIPTION	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
10.	**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 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 **R24 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 **R6 000** » **Hernia mesh – umbilical repair** subject to a limit of **R10 500**

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
10. Internal Prostheses	
100% of Cost	Limited to **R31 830** per family per annum for prostheses

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
	BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
10.	**Internal Prostheses (continued)**		
			» **Total hip replacement** subject to a limit of **R45 160** per hip, including cement and antibiotics » **Total knee replacement** subject to a limit of **R43 960** per knee, including cement and antibiotics » **Total shoulder replacement** subject to a limit of **R39 640** per shoulder, including cement and antibiotics » **Spinal instrumentation** subject to a limit of **R30 450** » **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 **R30 340** » **Intraocular lenses** limited to **R7 500** per lens » **Any other prostheses** will be subject to a limit of **R40 150**
11.	**Renal Dialysis**		
	(Inclusive of all related costs) Benefit is subject to the submission of a treatment plan by the treating Specialist to the Care Manager and approval of the treatment plan before treatment starts	Subject to 100% of the Negotiated Rate	Major Medical Expenses Subject to pre-authorisation

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
10. Internal Prostheses (continued)	
11. Renal Dialysis	
Subject to 100% of the Negotiated Rate and PMBs	Major Medical Expenses Subject to pre-authorisation

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
12. Organ Transplants			
a)	Hospital accommodation and surgically-related services and procedures	PMBs covered in full at 100% of Negotiated Rate Non-PMBs covered at Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation
b)	Heart, kidney and liver – Including organ search (nationally only), harvesting and transportation The benefit covers the donor if the recipient is an Imperialmed member	100% of Cost	Subject to pre-authorisation Unlimited
c)	Corneal transplant – Including organ search (nationally only)	100% of Cost	Major Medical Expenses Subject to pre-authorisation **R15 000** per beneficiary per event
d)	Other organs – Including organ search (nationally only), harvesting and transportation The benefit covers the cost of the donor if the recipient is an Imperialmed member	100% of Medical Scheme Rate	Subject to pre-authorisation Limited to **R18 550** for organs from a cadaver or limited to **R89 000** for live donor organs per beneficiary per annum
e)	Anti-rejection drugs	100% of Medicine Price	Major Medical Expenses Subject to pre-authorisation

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
12. Organ Transplants	
PMBs covered in full at 100% of Negotiated Rate Non-PMBs covered at Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation
100% of Cost	Subject to pre-authorisation Unlimited
100% of Cost	Major Medical Expenses Subject to pre-authorisation **R15 000** per beneficiary per event
100% of Medical Scheme Rate	Subject to pre-authorisation Limited to **R6 580** for organs from a cadaver or limited to **R31 830** for live donor organs per beneficiary per annum
100% of Medicine Price	Major Medical Expenses Subject to pre-authorisation

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
13. HIV and AIDS			
a)	All consultations, pathology and medicine related to diagnoses and treatment of the disease	Normal percentage benefits for applicable services payable 100% of Cost, unlimited Medicine subject to Generic Reference Price	Major Medical Expenses 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 for babies 18 months and younger where the diagnosis relates to HIV testing
b)	**Human papillomavirus (HPV) vaccines** Only for HIV-positive females who are registered on the HIV YourLife Programme	100% of Cost	Gardasil or Cervarix injection
14. 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 Subject to pre-authorisation Major Medical Expenses Subject to pre-authorisation

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
13. HIV and AIDS	
Normal percentage benefits for applicable services payable 100% of Cost, unlimited	Major Medical Expenses Subject to pre-authorisation and clinical guidelines and protocols
Medicine subject to Generic Reference Price	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 for babies 18 months and younger where the diagnosis relates to HIV testing
100% of Cost	Gardasil or Cervarix injection
14. Maternity Benefits	
100% of Cost	Major Medical Expenses Subject to pre-authorisation
100% of Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
14. 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	100% of Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation Four post-natal consultations with a midwife per event
c) Benefits listed below are subject to enrolment on Maternity Programme			
c1)	**Antenatal classes** – only registered midwives	100% of Cost, as per authorised, registered Maternity Programme	Major Medical Expenses **R1 060** per beneficiary per annum
c2)	**Ultrasound scans (pregnancy)**	100% of Cost, as per authorised, registered Maternity Programme	Major Medical Expenses 2 two-dimensional scans per pregnancy
c3)	**Antenatal vitamins** during pregnancy	100% of Medicine Price as per authorised, registered Maternity Programme	Major Medical Expenses **R85** per month
c4)	**Gynaecologist consultations** during pregnancy – as per care plan	100% of Cost, as per authorised, registered Maternity Programme	Major Medical Expenses
Note: If not registered on the Maternity Programme above, benefits c1, c2, c3 and c4 are to be paid from day-to-day benefit			

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
14. Maternity Benefits (continued)	
100% of Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation Four post-natal consultations with a midwife per event
c) Benefits listed below are subject to enrolment on Maternity Programme	
100% of Cost, as per authorised, registered Maternity Programme	Major Medical Expenses
100% of Cost, as per authorised, registered Maternity Programme	Major Medical Expenses
100% of Medicine Price, as per authorised, registered Maternity Programme	Major Medical Expenses
100% of Cost, as per authorised, registered Maternity Programme	Major Medical Expenses
Note: If not registered on the Maternity Programme above, benefits c1, c2, c3 and c4 are to be paid from day-to-day benefit	

MAJOR MEDICAL EXPENSES

	IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
15. 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 Medical Scheme Rate	**R70 000** per beneficiary per annum Subject to pre-authorisation
16. Psychiatric Institutions and Substance and Alcohol Abuse	100% of Medical Scheme Rate	Maximum of **21 days** per beneficiary per annum Subject to pre-authorisation
17. Stoma Care Products	100% of Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation
18. Cochlear Implants		
All requests are subject to approval by the Clinical Advisory Committee	100% of Cost	**R250 000** per beneficiary per annum Subject to pre-authorisation

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
15. Rehabilitation	
100% of Cost	Subject to clinical protocols PMBs only
16. 100% of Medical Scheme rate	Maximum of **21 days** per beneficiary per annum Subject to pre-authorisation
17. 100% of Medical Scheme Rate	Major Medical Expenses Subject to pre-authorisation
18. Cochlear Implants	
No benefit	No benefit

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
BENEFIT DESCRIPTION		% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
19. 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. • Wisdom teeth	**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 Subject to pre-authorisation Subject to pre-authorisation
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	**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 Subject to pre-authorisation **R10 000** per beneficiary per annum, applies to surgeon's fee

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
19. Dentistry	
Hospital and anaesthetist's fee 100% of Medical Scheme Rate for hospitalisation, operating theatre, sedationist and anaesthetist's fee	Major Medical Expenses Subject to pre-authorisation
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	Subject to pre-authorisation
No benefit	No benefit

MAJOR MEDICAL EXPENSES

		IMPERIALMED HEALTH PLAN	
	BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
19.	**Dentistry (continued)**		
c)	**Maxillofacial 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 Subject to pre-authorisation
20.	**Excimer Laser, Radial Keratotomy, Holmium Procedures, LASIK, Phakic lenses and intra-stromal rings (surgically-related services and procedures)**		
	In line with clinical protocols	Normal percentage benefits for applicable services payable Anaesthetist and hospital costs to be paid from Major Medical Expenses	**R5 620** per beneficiary per annum Pre-authorisation required
21.	**Breast Reduction, Mammoplasty and other cosmetic surgery if deemed clinically appropriate**		
	Prior approval by Medical Advisor	100% of Medical Scheme Rate	Annual limit subject to pre-authorisation and approval from Medical Advisor

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
19. Dentistry (continued)	
100% of Medical Scheme Rate for surgical procedures and related hospitalisation	Major Medical Expenses Subject to pre-authorisation
20. Excimer Laser, Radial Keratotomy, Holmium Procedures, LASIK, Phakic lenses and intra-stromal rings (surgically-related services and procedures)	
No benefit	No benefit
21. Breast Reduction, Mammoplasty and other cosmetic surgery if deemed clinically appropriate	
No benefit	No benefit

MAJOR MEDICAL EXPENSES

	BENEFIT DESCRIPTION	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
22.	**Prosthetic Limbs and Eyes**		
	The submission of a quotation prior to purchase is required	100% of Cost	All prostheses are **per beneficiary** and subject to pre-authorisation » **Prosthetic leg** subject to a limit of **R65 570** per leg » **Prosthetic arm** subject to a limit of **R65 570** 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
23.	**Infertility**		
	Benefit limited to the treatment guidelines applied by State hospitals	100% of Cost	PMBs only
24.	**Oncology**		
a)	Subject to a treatment plan and enrolment on the Oncology Programme	100% of Medical Scheme Rate Subject to PMBs	Overall Oncology limit of **R275 860** per beneficiary per annum Subject to pre-authorisation
b)	Brachytherapy materials (including seeds and disposables) and equipment	100% of Medical Scheme Rate	Limited to **R35 990** per beneficiary per annum and included in the Overall Oncology limit Subject to pre-authorisation
c)	Pathology, X-rays, MRI, CT and radio-isotope scans	100% of Medical Scheme Rate	Limit of **R27 560** per beneficiary per annum; **not** subject to the Overall Oncology limit Subject to pre-authorisation
d)	Oncology medicine	100% of Generic Reference Price	Subject to above **R275 860** Overall Oncology limit

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
22. Prosthetic Limbs and Eyes	
100% of Cost	Subject to the Internal Prostheses limit of **R31 830** (item 10, page 29)
23. Infertility	
100% of Cost	PMBs only
24. Oncology	
100% of Medical Scheme Rate Subject to PMBs	Overall Oncology limit of **R91 990** per beneficiary per annum Subject to pre-authorisation
100% of Medical Scheme Rate	Limited to **R11 990** per beneficiary per annum and included in the Overall Oncology limit Subject to pre-authorisation
100% of Medical Scheme Rate	Limited to **R8 000** per beneficiary per annum; **not** subject to the Overall Oncology limit Subject to pre-authorisation
100% of Generic Reference Price	Subject to above **R91 990** Overall Oncology limit

MAJOR MEDICAL EXPENSES

	BENEFIT DESCRIPTION	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
25.	**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	Normal percentage benefits for applicable services payable, provided that medicines will be limited to the Medicine Price in South Africa	**R1 000 000** per beneficiary per annum
26.	**Home Oxygen cylinders, concentrators and ventilation expenses**	100% of Cost	**R14 000** per beneficiary per annum, subject to PMBs and pre-authorisation Major Medical Expenses
27.	**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	**R11 000** per beneficiary per annum Motivation and pre-authorisation required for devices and appliances above **R1 000**
28.	**Hearing Aids**		
	Subject to an audiology report and pre-authorisation	100% of Cost	**R15 000** per beneficiary per ear over a three-year cycle
29.	**Prescribed Medicines**		
	Chronic medicine: Prescribed for a PMB and/or additional chronic condition Subject to chronic medicine baskets with core formulary medicines only	100% of Generic Reference Price	**R21 750** per beneficiary per annum Once limit is depleted, authorised PMB medication will still be paid

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
25. Services Rendered Abroad by a foreign supplier	
No benefit	No benefit
26. 100% of Cost	PMBs only Major Medical Expenses
27. External Medical Appliances	
100% of Cost	**R3 500** per beneficiary per annum Motivation and pre-authorisation required for devices and appliances above **R1 000**
28. Hearing Aids	
No benefit	No benefit
29. Prescribed Medicines	
100% of Generic Reference Price	Unlimited – PMBs only

WELLNESS BENEFITS

	BENEFIT DESCRIPTION	IMPERIALMED HEALTH PLAN % BENEFIT PAYABLE	IMPERIALMED HEALTH PLAN ANNUAL LIMITS FOR 2017
1.	**Screening tests**		
a)	Body mass index (BMI) Finger prick glucose test Finger prick cholesterol test Blood pressure test	100% of Medical Scheme Rate	One visit per beneficiary per annum Major Medical Expenses
b)	HIV test Finger prick test	100% of Medical Scheme Rate	One visit per beneficiary per annum Major Medical Expenses
2.	**Vaccines**		
a)	Childhood vaccine benefit	100% of Medical Scheme Rate	According to Scheme formulary from ages birth to 18 months Vaccines outside the formulary will be paid from the Acute Medicine limit – see table overleaf Major Medical Expenses
b)	Flu and pneumococcal vaccines – for patients registered on the following programmes: • oncology; • asthma; • COPD; • cardiac failure; • HIV; and • patients over 65 years	100% of Medical Scheme Rate	One of each injection per enrolee per annum Major Medical Expenses
c)	HPV vaccine for all females	100% of Medical Scheme Rate	One treatment (prescribed dose) in a lifetime from Acute Medicine limit

IMPERIALMED BUDGET PLAN	
% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
1. Screening tests	
100% of Medical Scheme Rate	One visit per beneficiary per annum Major Medical Expenses
100% of Medical Scheme Rate	One visit per beneficiary per annum Major Medical Expenses
2. Vaccines	
No benefit	No benefit
100% of Medical Scheme Rate	One of each injection per enrolee per annum Major Medical Expenses
100% of Medical Scheme Rate	One treatment (prescribed dose) in a lifetime from Acute Medicine limit

Vaccine formulary overleaf →

CHILDHOOD VACCINES ONLY COVERED ON THE IMPERIALMED HEALTH PLAN

REQUIRED AGE	VACCINE
Birth	Bacillus 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 Conjugated Vaccine
10 Weeks	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae Type B
	Hepatitis B
14 Weeks	Rotavirus Vaccine
	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae Type B
	Hepatitis B
	Pneumococcal Conjugated Vaccine
9 Months	Measles
	Pneumococcal Conjugated 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)

	IMPERIALMED HEALTH PLAN		IMPERIALMED BUDGET PLAN	
BENEFIT DESCRIPTION	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017	% BENEFIT PAYABLE	ANNUAL LIMITS FOR 2017
Any service that falls under the State's PMBs	100% of Cost	Unlimited	100% of Cost	Unlimited

SOME IMPORTANT DEFINITIONS TO UNDERSTAND

Medical Scheme Rate (MSR) The rate at which Imperialmed pays for medical products and services, which will be determined by the Scheme from time to time.

The **Generic Reference Price** is a cost-control mechanism through which the Scheme bases its medicine benefits on the cost of generic medicines rather than brand-name medicines. Imperialmed pays all medication according to the Generic Reference Price.

Therapeutic Reference Pricing (MMIRP) refers to the use of chronic condition basket authorisations. Instead of one medication item being authorised, the chronic condition basket contains a variety of approved medication options to treat chronic conditions, giving the benefit of greater flexibility in managing a patient's chronic condition.

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 the Scheme has contracted with that should be used when its members need diagnosis, treatment or care for a specific condition; co-payments will be applied should a non-DSP be used.

The **Imperialmed Specialist Network** The Scheme continues to develop the most appropriate model to implement a specialist network to contribute to sustainable contribution increases; members could be liable for co-payments if a non-network specialist is used.

Major Medical Expenses (MME) are medical expenses for in-hospital treatment and certain out-of-hospital expenses, for example for oncology, dialysis and Prescribed Minimum Benefits (PMBs). (See benefit structure.)

MANAGED HEALTHCARE

Imperialmed's managed healthcare strategy consists of the following three components:

1. Pharmacy benefit management
2. Management of high-risk beneficiaries
3. Hospital risk management

Continued overleaf >

1 *Pharmacy benefit management*

Since chronic conditions may be regarded as life-threatening and require ongoing intervention, we manage these through chronic care management. Imperialmed covers medication for prescribed minimum benefit (PMB) and non-PMB chronic conditions on the Imperialmed Health Plan and medication for only PMB chronic conditions on the Imperialmed Budget Plan. Should your doctor diagnose you or one of your dependants with a medical condition for which you need chronic medication, you need to apply for the medication to be registered as chronic medication with the Scheme.

The process to obtain authorisation for your chronic medication is as follows:

- Your doctor can apply by contacting Imperialmed's Medicine Risk Management (MRM) Team on 0860 467 374 with all the relevant details of your application. The request can be processed immediately – while your doctor is on the phone – unless additional information is required, such as test results or a letter of motivation.
- You can apply in writing by completing an MRM application form. Both you and your treating doctor need to complete this application form and the form must be accompanied by the relevant test results, specialist reports and letters of motivation. The application form is available at www.imperialgroupmed.co.za or from the call centre on 0860 467 374. The completed form can be faxed to 0860 111 788 or emailed to imperialmedtreatment@metropolitanhrm.co.za.
- Updates to your existing chronic medication can be done through the same two processes explained above. Please note that it takes a maximum of five (5) working days for your application to be processed once we've received it.
- Clinical entry criteria, as outlined on the application form, will be applied to your application before chronic medication benefits are authorised. MRM's 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 on the quality of care.
- Medicines will be covered if they are listed on the Scheme's medicine formulary (list of prescribed medicines) and are within the Scheme's maximum benefit limit. Chronic medicines will be approved from the date that we receive your full application – fully completed and including all supporting documentation. 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 if 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.

Imperialmed applies protocols and formularies within therapeutic reference pricing to all medication that is covered. This includes chronic, acute, and over-the-counter (OTC)/pharmacy-advised-therapy (PAT) medication. Should you choose to make use of the original, brand-name product or a more expensive generic equivalent, there will be a co-payment that you will be responsible for making.

Please note that a chronic medication prescription for schedule 3 to 5 medication can be issued for six months. Remember to renew your prescription every six months. Prescriptions for schedule 6 and 7 medication cannot be repeated and a new prescription needs to be obtained and provided to your pharmacy every month so they can dispense your medication.

2 *Management of high-risk beneficiaries*

The Managed Care provider, MMI Health, will identify all high-risk beneficiaries with one or more chronic conditions and allocate a lifestyle coach to each. The purpose of the coach is to:

- monitor the beneficiary following hospitalisation to identify beneficiaries that require further management early;
- check claims to determine the appropriateness of treatment and compliance with treatment plans;
- develop individualised treatment plans in conjunction with the treating doctor;
- monitor compliance of the required chronic condition's treatment by the beneficiary and obtain authorisation for further treatment, if required; and
- remain in regular contact with the beneficiary.

3 *Hospital risk management*

The aim of hospital risk management is to manage major medical expenses. Qualified medical personnel assess requests for hospitalisation to ensure appropriateness and cost-effectiveness. If all the relevant criteria are met, pre-authorisation is granted.

This provides an opportunity to assess, monitor and coordinate each request from admission to discharge. The following services should be pre-authorised:

- hospital admissions or admissions to a day clinic;
- specialised radiology;
- home nursing;
- step-down or sub-acute care;
- alternative therapy;
- oxygen and Stoma products;
- psychiatric treatment;
- cancer treatment; and
- home oxygen.

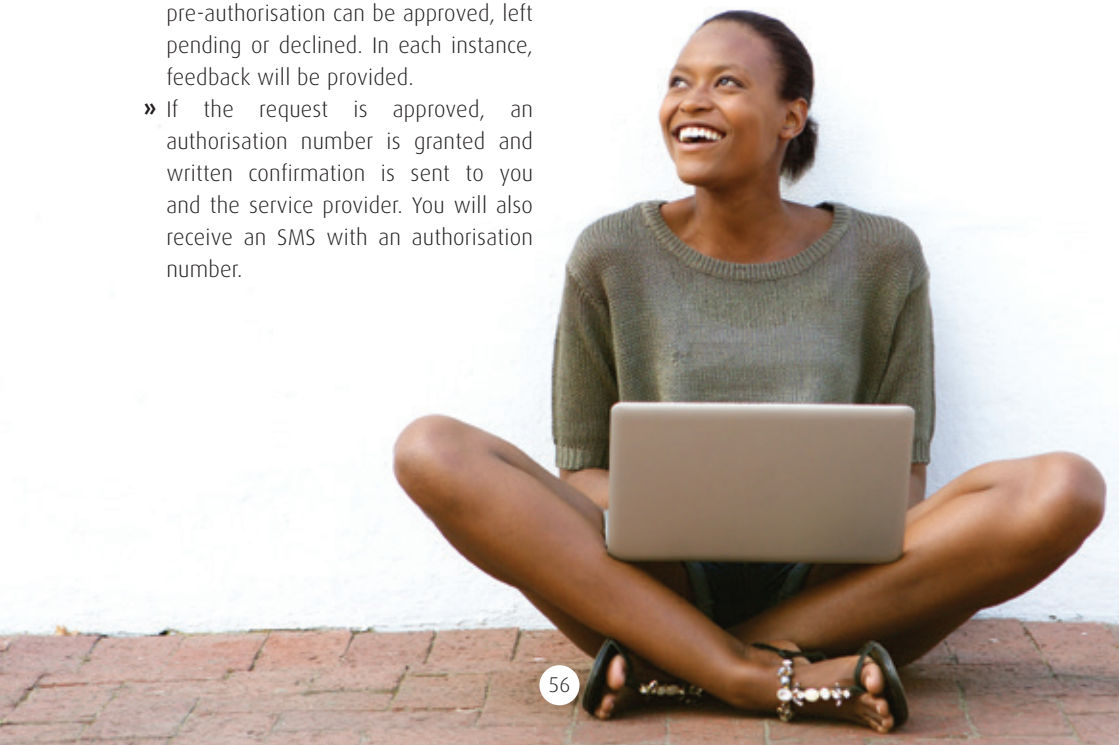
The process for obtaining pre-authorisation for a major medical event is as follows:

- Pre-authorisation should be requested at least 48 hours before the service is rendered or even earlier to ensure all relevant information is submitted that could otherwise delay authorisation. Authorisation should be obtained within 48 hours or on the first working day after 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 you of what to expect, your available benefits, the applicable Scheme rules and any other concerns he or she may have. Based on the information provided, a request for pre-authorisation can be approved, left pending 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 you and the service provider. You will also receive an SMS with an authorisation number.

You need to provide the following details when you call to obtain pre-authorisation:

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

You will be liable for a R500 co-payment if pre-authorisation is not obtained before the admission.



DISEASE MANAGEMENT PROGRAMMES

In addition to the three managed healthcare components outlined in the previous section, the following disease management programmes are in place:

1. Oncology (cancer) programme
2. HIV programme

1 Oncology (cancer) programme

The purpose of the programme is to provide a cost-effective and evidence-based oncology benefit to members. Enrolment on the programme is compulsory for all beneficiaries who receive 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 of treatment with other treating doctors

Members will receive holistic education, care and support to better manage their condition.

CONTACT DETAILS FOR THE ONCOLOGY PROGRAMME:

Tel: 0860 467 374
Email: imperailmedtreatment@metropolitanhrm.co.za
Fax: 0860 111 788
Post: PO Box 32759, Braamfontein 2017

2 *HIV programme*

HIV and AIDS management

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

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 will also be 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;
- prophylaxis for opportunistic infections; and
- a care plan for doctor's consultations and investigations.

Anti-retroviral medication approval process

- Treatment 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's 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 the clinical team in the dedicated HIV management unit.

CONTACT DETAILS FOR THE PROGRAMME:

Tel: 0861 888 300 – this is a dedicated, confidential helpline
Fax: 0861 888 301
Email: 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 him/her 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:

1. Exclusions

The Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Act. Furthermore, where protocol or a formulary drug preferred by the Scheme has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary, as required by regulation 15H and 15I of the Act. The following will not be paid by the Scheme unless otherwise authorised by the Board:

1.1 Optometry

1.1.1 Tinted or coloured plano lenses and other cosmetic effect contact lenses (other than prosthetic lenses), and contact lens accessories and solutions.

1.1.2 Optical devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.

1.2 Breast reduction, except where associated with breast reconstruction following a diagnosis of cancer or if the beneficiary is diagnosed with gigantomastia in pregnancy accompanied by complications such as ulceration of breast tissue, massive infection, tissue necrosis with slough, significant haemorrhage or if delivery is not imminent.

1.3 Treatment 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.

1.4 Any medical and/or surgical procedure related to the Gamate Intrafallopian Transfer, In-Vitro fertilization, 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.

1.5 Donor cost – organ harvesting and donor cost, in case where the donor recipient is not a member of Imperialmed.

1.6 Otoplasty for children 12 years of age or older.

1.7 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.

1.8 Laparoscopic surgery for the removal of an appendix except in the event of an emergency procedure.

1.9 Investigations, operations or treatments for cosmetic purposes, obesity, artificial insemination, impotence and erectile dysfunction or treatment of an experimental nature.

A medical or surgical procedure, treatment, cause of treatment, equipment, drug or medicine will be regarded as experimental:

- 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 that are recognised as such by the South African medical community;
- if it is under study, investigation, in a test period or part of or in a clinical research state;
- where no definite outcome results, following at least a five-year trial period, are available; or
- 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 drug; provided that should a member prefer to have the more expensive treatment, the Scheme shall pay the reasonable and customary fees associated with the treatment generally available.

1.10 Holidays for recuperative purposes.

1.11 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, drugs as advertised to the public and vitamins which are not approved by the Scheme
- household and biochemical remedies
- sunglasses
- exercise equipment
- any drug or medicine not registered by the Medicines Control Council or similar authority
- any medicines not registered for that specific condition.

1.12 All costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules of the Scheme.

1.13 Examinations for insurance, employment, visas, pilot and driving licences or examinations for enrolment to university and college.

1.14 Any member-related travelling or conveyance by whomsoever and of whatsoever nature except as by ambulance or ambulance aircraft.

1.15 Dentistry

1.15.1 Labial frenectomy in respect of beneficiaries under the age of 12 years old.

1.15.2 Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.

1.15.3 General anaesthetic, conscious sedation and hospitalisation for dental work, except in the case of patients under the age of eight years or bony impactions of the third molars.

1.15.4 Periodontic plastic procedures for cosmetic reasons.

1.15.5 Tooth bleaching, lingual (invisible) orthodontic braces and gum guards for sports purposes.

1.16 The purchase of medicines prescribed by a person not legally entitled thereto.

1.17 Robotic assisted surgery.

1.18 Costs of appointments cancelled or not kept by members.

1.19 Costs for services rendered by:

1.19.1 Persons not registered in terms of any law;

1.19.2 Any institution, except a state or provincial hospital, not registered in terms of any law.

1.20 Services which 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; and

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; and

c) it has been prescribed by a doctor; and

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 shall 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 shall 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.

1.21 The following medicines, unless they form part of the public sector protocols and are authorised by the relevant managed healthcare programme:

1.21.1 Any specialised drugs that have not convincingly demonstrated a survival advantage of more than three months in advanced or metastatic solid organ malignant tumours, for example Sorafenib for hepatocellular carcinoma and Bevacizumab for colorectal and metastatic breast cancer.

2. Limitation of benefits

Provided that no limitations shall apply in respect of any service falling within the minimum benefits other than as provided for in Rule 3.1, the following limitations shall apply:

2.1 The maximum benefits to which a member and his/her dependants shall be entitled in any financial year shall be limited as set out in Annexure B.

2.2 Members admitted to the Imperialmed Health Plan during the course of a financial year shall be entitled to the benefits set out in Annexure B with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

2.3 The annual limits for members admitted to the Imperialmed Budget Plan will be allocated on a pro rata basis for members joining from 1 February to 30 June of each year, but those joining from 1 July to 31 December of a year will have access to six months' benefits.

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

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

2.6 In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending practitioner.

2.7 Subject to the general limitations on benefits determined by the Board from time to time, in the event that any other party may be liable for costs incurred for treatment of sickness conditions or injuries sustained by a beneficiary, the Scheme shall cover the appropriate medical costs on behalf of the beneficiary in accordance with the available benefits, after which the Scheme may recover the cost from the appropriate party.

In the event that the Scheme effects payment of any such costs incurred by the beneficiary prior to the beneficiary recovering all or a portion of such costs from another party, then the beneficiary shall:

2.7.1 be liable to repay to the Scheme all amounts or a portion thereof paid by the Scheme and recovered by or on behalf of the beneficiary from the party responsible for compensating such beneficiary, after the deduction of any legal costs or deductions that may have been incurred in the recovery of such amount;

2.7.2 disclose to the Scheme, alternatively, instructs his/her legal representative to disclose to the Scheme, the full extent of any compensation awarded in respect of past and future medical expenses;

2.7.3 sign all documentation as may be required by the Scheme to obtain copies of all such information not in the Scheme's possession, relating to the beneficiary's medical accounts and records from the relevant practitioners and/or medical institutions;

2.7.4 provide the Scheme with such assistance as the Scheme may reasonably require should the Scheme wish to recover any amounts paid on behalf of the member for which a third party may be liable.

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 (PAT) or over-the-counter (OTC) medicine

Imperialmed also offers you a facility to buy schedule 1 and 2 medicines from a registered pharmacist without a doctor's prescription, in accordance with the Imperialmed PAT/OTC formulary. This is called pharmacist-advised therapy or over-the-counter medicine. 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 for a refund.
- 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 2.7, page 107) the Scheme shall cover the appropriate medical 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 on behalf of the beneficiary in

accordance with the benefits available, after which the Scheme may recover the cost from the appropriate party.

MVA claims are identified when specific diagnoses are reflected on 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 brand-name medicines.

CONTACT DETAILS

Telephone numbers, fax numbers and e-mail addresses

CLAIMS ENQUIRIES, MEMBERSHIP CONFIRMATIONS AND REGISTRATIONS
Phone: 0860 467 374
Fax: 0860 111 788
E-mail: imperialmedenquiries@mhg.co.za

MANAGED CARE SERVICES – HOSPITAL PRE-CERTIFICATION AND ONCOLOGY BENEFIT MANAGEMENT PROGRAMME

HOSPITAL PRE-CERTIFICATION
Phone: 0860 467 374
Fax: 0861 888 113
E-mail: hrmimperialmed@metropolitanhrm.co.za

ONCOLOGY
Phone: 0860 467 374
Fax: 0861 222 552
E-mail: imperialmedoncology@metropolitanhrm.co.za

CHRONIC MEDICATION AND MEDICAL MANAGEMENT
Phone: 0860 467 374
Fax: 0860 111 788
E-mail: imperialmedmedicine@metropolitanhrm.co.za

EUROP ASSISTANCE EMERGENCY SERVICES
Phone: 0861 RESCUE (0861 737 283)

MEMBER CARE LINE – MEDI CALL
Toll free: 0860 105 221
Fax: 0866 889 411
E-mail: imperialmed@medicall.co.za

CEDAR HEALTHCARE CONSULTANTS
Phone: 011 547 8624

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

CONTRIBUTIONS
Contact your company's payroll/human resources department

THE ADMINISTRATOR'S WEBSITE
www.mhg.co.za

THE SCHEME'S WEBSITE
www.imperialgroupmed.co.za

MEMBER SUGGESTION E-MAIL BOX
E-mail: imperialmedsuggestions@mhg.co.za

KPMG FRAUD HOTLINE
Phone: 0800 200 564

COUNCIL FOR MEDICAL SCHEMES – COMPLAINTS
Phone: 0861 123 267
Fax: 012 431 0608
E-mail: complaints@medicalschemes.com