transmed
MEDICAL FUND

2025 BENEFITS GUIDE

SATS PENSIONERS – GUARDIAN PLAN

Welcome

to Transmed Medical Fund's 2025 benefits guide. This guide explains the 2025 benefits and services and how to access them. Please read the guide carefully and keep it safe for future reference.

The 2025 benefit and contribution changes come into effect once approved by the Council for Medical Schemes.

This guide does not replace the rules. The registered rules are legally binding, always take precedence and are available on request or on the Transmed website at www.transmed.co.za.

2025 BENEFITS GUIDE

A: OVERVIEW OF 2025 BENEFITS

IMPORTANT INFORMATION

- State hospitals are the designated service providers (DSPs*3).
- Major medical benefits for treatment of PMB*15 and non-PMB conditions in hospital will be covered in full if the treatment is obtained at a State hospital.
- The Transmed private hospital network*6 is the secondary DSP*3. This network is only available for emergency or involuntary admissions for PMB*15 conditions where a State hospital is not accessible.
- A co-payment*8 for the voluntarily use of a non-DSP hospital is applicable to PMB*15 conditions. There is no private hospital benefit for non-PMB conditions.
- The Transmed pharmacy network*2 is the DSP*3 for chronic and HIV/AIDS medication.
- Preferred Provider Negotiators (PPN*9) is contracted to manage optical benefits.
- DENIS*10 is contracted to manage dental benefits.
- Improved Clinical Pathway Services (ICPS*13) network is contracted for selected knee and hip replacements.
- Ophthalmology Management Group Limited (OMG*11) is contracted for cataract surgery.
- Independent Clinical Oncology Network (ICON*7) is the DSP*3 for cancer treatment.
- Pre-authorisation, where necessary, can be obtained 24 hours a day and on weekends and public holidays by calling the care manager on **0800 225 151**.

KEY TO TERMS USED IN THIS BENEFITS GUIDE

*	Transmed rate	The Transmed rate is the fee payable for a benefit year in respect of a specific tariff or service
*1	General day-to-day limit	The day-to-day benefit covers all routine services received out of hospital, other than those covered from insured benefits in terms of an authorisation or other defined benefits or limits
*2	Transmed pharmacy network	A network of pharmacies that Transmed has negotiated a preferred rate with: - Clicks pharmacy group - Dis-Chem pharmacies - MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) - Contracted independent pharmacies
*3	DSP	A designated service provider is contracted by the Fund to provide certain treatment or services to patients at a preferred tariff
*4	Formularies	Formularies applicable to a specific medication benefit: - Chronic medication – comprehensive medication formulary - Acute medication – acute medication formulary - Over-the-counter (OTC) medication – OTC medication formulary
*5	Reference pricing	This is the maximum price that the Fund will pay for a specific class of medication
*6	Transmed private hospital network	A network of private hospitals that Transmed has negotiated a preferred rate with for admissions approved as an emergency or an involuntary admission
*7	ICON	The Independent Clinical Oncology Network is a network of oncologists that is the contracted DSP for oncology (cancer) treatment
*8	Co-payment	A co-payment is a fee that is payable by a member directly to a service provider and is calculated as the difference between the price charged by the member's chosen service provider and the price negotiated with the applicable designated/ preferred service provider
*9	PPN	Preferred Provider Negotiators is contracted to manage optical benefits, including the optical claims processing
*10	DENIS	DENIS is contracted to manage dental benefits, including dental claims processing
*11	OMG	The Ophthalmology Management Group Limited is a network of ophthalmologists that is contracted to provide cataract surgery
*12	UPFS	The uniform patient fee schedule is the tariff structure applicable to State hospital facilities
*13	ICPS	Improved Clinical Pathway Services is a network of orthopaedic surgeons that is contracted for selected knee and hip replacements
*14	Fund exclusions	Services, procedures and consumables that are not covered by Transmed: - Accommodation in old age homes, frail care centres or similar institutions - All costs for operations, medicines, treatment and procedures for cosmetic or for psychological purposes - All costs for operations, medicines, treatment and procedures related to weight reduction - Operations to reverse a sterilisation - Artificial insemination (GIFT or similar procedures) - Patent foods, including baby food - Slimming preparations - Household remedies or preparations and herbal and natural remedies - Aphrodisiacs - Cosmetic soaps, shampoos and other topical applications - Sun screening and sun tanning agents - Cosmetic preparations, medicated or otherwise - Contact lens preparations - Holidays for recuperative purposes - Vitamins and mineral supplements
*15	PMB	Prescribed minimum benefits is a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option

B: EXPLANATION OF THE 2025 BENEFITS

DAY-TO-DAY BENEFITS

Optical and dental services are paid from the respective optical and dental benefits. All other day-to-day services (except for services covered on an authorised PMB[*15] treatment plan) are paid from the general day-to-day limit[*1]. Members may use any registered healthcare or service provider of their choice, except for optical and dental services, which are managed by the contracted providers.

HOSPITALISATION

Private hospitalisation is limited to certain conditions and procedures, where a State hospital cannot provide the service or where the Fund has contracted with a private provider. Such admissions must be pre-authorised in order to confirm the availability of the benefit.

When can members use a private hospital?
Members can use a private hospital in the following situations:

- In case of a medical emergency or when immediate medical or surgical treatment for a PMB[*15] condition was required and could not reasonably be obtained from a State hospital (DSP[*3]).

  An emergency is defined in terms of the Medical Schemes Act and the rules as the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place a person's life in serious jeopardy.

- In cases where the required service or procedure is covered by the Fund at a State hospital (DSP[*3]), but is not reasonably available at the time or could not be provided without an unreasonable delay. In such cases, members should use hospitals that form part of the Transmed private hospital network[*6] or appointed specialist networks (ICON[*7] and ICPS[*13]) to avoid co-payments[*8].

- If the PMB[*15] service is not available at a State hospital (DSP[*3]), pre-authorisation for admission to a secondary facility will be considered by the care manager, who is available 24 hours a day. The Fund will cover the admission costs in the alternative facility, subject to pre-authorisation, case management and other managed healthcare interventions.

Please call **0800 225 151** to obtain pre-authorisation or for more information and guidance.

When will members be liable for the cost of using a private hospital?
When the service or procedure is not covered by the Fund, the member will be liable for the full account. When the member opts to use a private hospital for a PMB*[15] service or procedure that is available at a State hospital (DSP*[3]), the member will be liable for a co-payment*[8] equal to the difference between the fees charged and the equivalent cost that would have been payable to the State hospital (DSP*[3]).

Co-payment for the voluntary use of a non-DSP facility

Note: The co-payment*[8] for using a private hospital (non-DSP) could be very high. Members are encouraged to contact the care managers, who will gladly guide you to an appropriate hospital that will assist you in keeping your portion of the cost as low as possible.

Example
The following is an **example** of the impact the cost of using a private facility voluntarily can have on members.

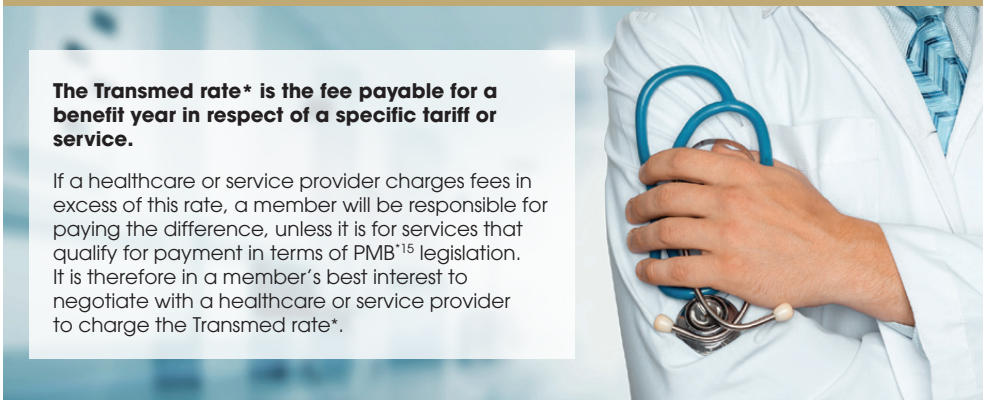
Facility	Total admission cost
State hospitals	R15 000
Transmed private hospital network*[6] facilities	R40 000
Other private hospitals	R50 000

Based on the table above, the impact on the member will be as follows:

- If a member uses a State hospital, the total admission cost of R15 000 will be covered by the Fund.
- If a member voluntarily uses a private hospital for a service or procedure that was available at a State hospital, cover for this type of admission is limited to R15 000 and the member will be liable for payment of any shortfalls directly to the hospital and other providers.
- If a member uses a Transmed private hospital network*[6] facility on a voluntary basis, the member will be liable for a co-payment*[8] equal to the difference between the total admission cost at a State hospital and at a Transmed private hospital network*[6] facility (R40 000 – R15 000 = R25 000).
- If a member uses any other private hospital on a voluntary basis, the member will be liable for a co-payment*[8] equal to the difference between the total admission cost at a State hospital and any other private hospital (R50 000 – R15 000 = R35 000).

*Please note that the above is only an **example** of the calculation of a co-payment*[8] *and is not based on a specific case or an indication of the difference in cost in an actual case.*

C: TRANSMED MEDICAL FUND RATE (TRANSMED RATE)



The Transmed rate* is the fee payable for a benefit year in respect of a specific tariff or service.

If a healthcare or service provider charges fees in excess of this rate, a member will be responsible for paying the difference, unless it is for services that qualify for payment in terms of PMB*[15] legislation. It is therefore in a member's best interest to negotiate with a healthcare or service provider to charge the Transmed rate*.

D: 2025 CONTRIBUTIONS

MONTHLY INCOME	MEMBER	ADULT DEPENDANT **	CHILD DEPENDANT *
R0 - R500	74	68	50
R501 - R1 000	117	109	68
R1 001 - R1 500	158	138	95
R1 501 - R2 000	196	177	117
R2 001 - R2 500	237	213	141
R2 501 - R3 000	273	247	166
R3 001 - R3 500	315	283	188
R3 501 - R4 000	355	319	213
R4 001 - R4 500	393	354	236
R4 501 - R5 000	434	391	260
R5 001 - R5 500	473	426	283
R5 501 - R6 000	511	461	306
R6 001 +	553	497	330

Note the following:

* Child dependant contributions are payable for a maximum of four dependants.

* Child dependants older than 21 who are studying full- or part-time and are financially dependent on the member will pay child dependant contributions until the age of 24 (proof of registration at an accredited institution will be required).

** Dependants older than 21 (or 24 in the case of studying children) who are financially dependent on the member will pay adult dependant contributions.

E1: MAJOR MEDICAL BENEFITS AT PRIVATE FACILITIES

The following services may be obtained in private facilities subject to compliance with certain criteria.

ONCOLOGY (CANCER) TREATMENT

The DSP[*3] for oncology treatment is the Independent Clinical Oncology Network (ICON[*7]) of private oncologists. Should a member consult an oncologist outside this network, a 20% co-payment[*8] will be applicable to all services received from the non-network oncologist. Transmed oncology network is the contracted DSP[*3] for oncology (cancer) medication. Pre-authorisation must be obtained on **0800 225 151**.

Please note that reference pricing[*5] is applicable to oncology (cancer) medication.

CATARACT SURGERY

The Fund has a contract with the Ophthalmology Management Group (OMG*11) Limited to provide cataract surgery. The Fund reimburses the providers with a global fee for this type of surgery. The global fee covers the following:
- the procedure, surgeon and anaesthetist fees, equipment hire and hospital account
- the post-operation consultation within one month of the procedure.

This arrangement does not restrict doctors in terms of where the procedures should be done. The hospitals used depend on the arrangements that the ophthalmologists make with the hospitals of their choice. If a contracted OMG*11 doctor is accessible and the member voluntarily uses a non-DSP, a 20% co-payment*8 will apply on the total hospital and associated provider costs for the cataract surgery.

In addition to cataract surgery, the following services will be covered, subject to pre-authorisation:
- the consultation during which the diagnosis is made and confirmed
- the related tests performed to make the diagnosis, as per the applicable algorithm
- medication administered as part of the procedure, as per the applicable algorithm
- any other indicated services, as per the applicable algorithm.

JOINT REPLACEMENT BENEFIT

The Fund has a contract with Improved Clinical Pathway Services (ICPS*13) to provide selected knee and hip replacements.

The Fund reimburses the providers with a global fee for this type of surgery. The global fee covers the cost of the admission, ICPS*13, orthopaedic surgeon, anaesthetist, prosthesis and physiotherapist.

If an ICPS*13 provider or hospital is available, but the member elects to use a non-ICPS provider or hospital, a co-payment*8 equal to the difference in cost between the total cost incurred in respect of the hospital and all related services, and the cost that would have been payable to the State hospital (DSP*3), will apply.

Please note that this benefit is restricted to selected joint replacements only. Please contact **0800 225 151** for more information and referral guidance to the ICPS*13 providers.

DIALYSIS

Dialysis treatment is subject to case management and clinical protocols. Pre-authorisation is required prior to the treatment. Please contact **0800 225 151**.

E2: MAJOR MEDICAL BENEFITS

CHRONIC MEDICATION

What is a chronic condition?
A chronic condition is a disease that requires life-sustaining medication to be taken continuously for extended periods – normally for longer than three months. Examples of chronic conditions include diabetes, asthma, high blood pressure (hypertension), epilepsy, cardiac failure, high cholesterol (hyperlipidaemia), Parkinson's disease, thyroid dysfunction and rheumatoid arthritis.

What is a chronic medication formulary?
A chronic medication formulary*4 is a list of medication for chronic conditions that is approved by the Fund. The list is compiled to ensure that you receive the most appropriate, cost-effective and safest treatment for your chronic condition.

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E2. MAJOR MEDICAL BENEFITS (CONTINUED)

How can chronic medication be obtained?
In order to obtain your chronic medication, you need to do the following:

- Register on the Fund's chronic medicine management programme if you have not previously registered.
- Complete the member section of the chronic medicine benefit application form, which can be obtained at **www.transmed.co.za** or by contacting the customer service department on **0800 110 268**.
- Ask your healthcare provider to complete the practitioner's section of the form.
- Email the completed application form, together with a copy of the prescription, to the care manager at **chronic@transmed.co.za** or return it to Transmed Medical Fund, PO Box 15079, Vlaeberg 8018.
- If your application is successful you will receive an authorisation letter listing the approved medication.
- Once you have received this letter, take the original prescription to a network pharmacy[*2] to collect the medication. A co-payment[*8] may apply for using a non-DSP pharmacy.
- If you need to change your chronic medication, ask your healthcare provider to email the new prescription, together with the necessary motivation and laboratory reports (where applicable), to **chronic@transmed.co.za**. Your healthcare provider needs to include the patient's name, membership number, the ICD-10 code pertaining to the condition and the practice number on the prescription. Your healthcare provider can also call **0800 122 263** to do the update telephonically.

What is the chronic disease list (CDL)?
(Standard condition list applies)

The CDL includes 26 common chronic conditions and medical schemes have to provide cover for the diagnosis, treatment and care of these conditions.

TABLE A: PMB CDL

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac (heart) dysrhythmias
6. Cardiac (heart) failure
7. Cardiomyopathy disease
8. Chronic obstructive lung disease
9. Chronic renal disease
10. Coronary artery disease
11. Crohn's disease
12. Diabetes insipidus
13. Diabetes mellitus type I
14. Diabetes mellitus type II
15. Epilepsy
16. Glaucoma
17. Haemophilia
18. Hyperlipidaemia (cholesterol)
19. Hypertension
20. Hypothyroidism
21. Multiple sclerosis
22. Parkinson's disease
23. Rheumatoid arthritis
24. Schizophrenia
25. Systemic lupus erythematosus
26. Ulcerative colitis

TABLE B: PMB DIAGNOSIS AND TREATMENT PAIRS (DTPs)

1. Aplastic anaemia
2. Benign prostatic hypertrophy
3. Cardiac arrhythmias
4. Cerebrovascular disorders (stroke)
5. Cushing's disease
6. Delusional disorders
7. Depressive mood disorder
8. Endometriosis
9. Glomerular disease
10. HIV/AIDS
11. Hyperthyroidism
12. Hyperparathyroidism/Hypoparathyroidism
13. Menopausal syndrome
14. Moto neuron disease
15. Muscular dystrophy
16. Pancarditis
17. Paraplegia/Quadriplegia
18. Pemphigus
19. Peripheral artheriosclerotic disease
20. Pituitary adenoma
21. Polycystic ovarian disease (PCOS)
22. Polyarteritis nodosa
23. Pulmonary hypertension
24. Sarcoidosis
25. Thromboangiitis obliterans (TAO)
26. Thrombocytopenia purpura
27. Tuberculosis
28. Valvular heart disease
29. Venous thromboembolism

TABLE C: NON-PMB CONDITIONS – ADDITIONAL CONDITIONS COVERED OUTSIDE THE CDL AND DTP CRITERIA

1. Acne
2. Allergic rhinitis
3. Alzheimer's disease
4. Ankylosing spondylitis
5. Attention deficit hyperkinetic disorders
6. Cystic fibrosis*
7. Dermatopolymyositis
8. Dystonias*
9. Gastro-oesophageal reflux disease
10. Generalised anxiety disorder
11. Huntington's disease
12. Interstitial fibrosis*
13. Ménière's disease
14. Migraine
15. Myasthenia gravis
16. Obsessive-compulsive disorder
17. Osteo-arthritis
18. Osteoporosis
19. Overactive bladder syndrome
20. Paget's disease
21. Panic disorders
22. Peptic ulcer disease
23. Psoriasis
24. Psoriatic arthritis
25. Sjögren's/Sicca syndrome
26. Systemic sclerosis/Scleroderma*
27. Tic disorders*
28. Trigeminal nerve disorders*
29. Urinary tract infection

* *These conditions may in some instances be considered as PMB*[*15] *conditions.*

SUMMARY OF DESIGNATED SERVICE PROVIDERS AND CO-PAYMENTS FOR CHRONIC MEDICATION

Benefit category	Designated service provider (DSP)	Co-payment for voluntary use of a non-DSP pharmacy
CHRONIC MEDICATION	Transmed pharmacy network[*2] • Clicks pharmacy group • Dis-Chem pharmacies • MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) • Contracted independent pharmacies	Pharmacies used outside the Transmed pharmacy network[*2] may result in a co-payment[*8] Reference pricing[*5] is applicable

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F: BREAKDOWN OF BENEFITS

DAY-TO-DAY COVER

BENEFITS	GUARDIAN PLAN
General practitioner (GP) consultations 1	Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit*[1]
Specialist consultations 2	Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit*[1]
Acute and over-the-counter (OTC) medication 3	Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit*[1] Acute and OTC formularies*[4] apply Fund exclusions*[14] apply
Out-of-hospital pathology 4	Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit*[1]
Out-of-hospital radiology 5	Paid at the Transmed rate* **Basic radiology (X-rays)** Subject to the availability of funds in the general day-to-day limit*[1]
Optical benefits 6	Benefit provided through PPN*[9] protocols **NETWORK BENEFIT** Optical benefits are subject to authorisation by PPN*[9] and clinical protocols/ prescribed rules apply

DAY-TO-DAY COVER

BENEFITS	GUARDIAN PLAN
Optical benefits (continued) 6	Beneficiaries can claim every 24 months **Examination** Limited to 1 consultation to the value of R890, including refraction, glaucoma and visual field screening and artificial intelligence for the detection of diabetic retinopathy **Frames/Spectacles/Lenses** R1 150 towards frame and/or lens enhancements, together with 1 pair of clear, single-vision lenses to the value of R215 or clear, bifocal lenses to the value of R460 or clear, multifocal lenses to the value of R810 **OR** **Contact lenses** Limited to R1 505 **NON-NETWORK BENEFIT** Members will be liable for a co-payment*[8] for out-of-network services **Examination** Limited to 1 consultation to the value of R400 **Frames/Spectacles/Lenses** R920 towards frame and/or lens enhancements, together with 1 pair of clear, single-vision lenses to the value of R215 or clear, bifocal lenses to the value of R460 or clear, multifocal lenses to the value of R810 **OR** **Contact lenses** Limited to R1 505 Please call PPN*[9] on **0861 103 529**
Basic dentistry 7 	Benefit provided through DENIS*[10] Subject to protocols and limitations No annual limit and only stated codes covered Paid at the Transmed rate* **Root canal** Limited to 1 per family per year Please call DENIS*[10] on **0860 104 941**
Specialised dentistry 8 	Benefit provided through DENIS*[10] Subject to protocols and limitations Limited to R4 893 per family per year Paid at the Transmed rate* **Crowns** Limited to 1 per family every 2 years for beneficiaries 16 years and older

DAY-TO-DAY COVER (CONTINUED)

BENEFITS	GUARDIAN PLAN
Specialised dentistry (continued) 8	**Dentures** Limited to 1 set per jaw every 4 years for beneficiaries older than 21 Limited to 1 set of chrome cobalt-frame dentures every 5 years for beneficiaries 21 years and older **Pre-authorisation required** Please call DENIS*10 on **0860 104 941**
Dentures 9	Benefit provided through DENIS*10 R1 239 stand-alone benefit per family for beneficiaries older than 21 Amounts in excess of this limit are payable from the available funds in the specialised dentistry limit of R4 893 per family per year Paid at the Transmed rate* **Pre-authorisation required** Please call DENIS*10 on **0860 104 941**
General day-to-day limit*1 10	Paid at the Transmed rate* Includes: • GP and specialist consultations • Acute and over-the-counter (OTC) medication • Routine pathology and radiology All other day-to-day benefits not specifically mentioned above M0 R5 040 M+ R8 850

CHRONIC MEDICATION

Benefits 11	The Transmed pharmacy network*2 is the DSP*3 Comprehensive formulary*4 applies Reference pricing*5 applies
Pharmacies 12	The Transmed pharmacy network*2 consists of: • Clicks pharmacy group • Dis-Chem pharmacies • MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) • Contracted independent pharmacies Members may be liable for a co-payment*8 if a pharmacy outside the Transmed pharmacy network*2 is used

MAJOR MEDICAL COVER

BENEFITS	GUARDIAN PLAN
State hospital admissions 13 	The DSP*3 is State hospitals Paid at the Transmed rate* 100% cover at a State hospital, subject to the UPFS*12 for PMB*15 and non-PMB admissions
Private hospital admissions 14 	Only PMB*15 conditions for major medical events and selected knee and hip replacements through ICPS*13 No benefit for non-PMB conditions If a State hospital is not accessible in terms of the set criteria for PMB*15 treatment, authorisation will be considered for admission to a hospital on the Transmed private hospital network*6 as the secondary DSP*3 and payable at the Transmed rate* The co-payment*8 for the voluntary use of a non-DSP will be the amount equal to the difference between the total cost incurred in respect of the hospital services, including all related medical services, and the cost that would have been payable to the State hospital (DSP*3) or secondary DSP*3 – whichever is applicable **Pre-authorisation required** Please call **0800 225 151**
In-hospital services (Including GP and specialist services, pathology and radiology) 15 	100% cover for PMB*15 and non-PMB admissions at a State hospital Subject to the UPFS*12 Paid at the Transmed rate* **Advanced radiology (MRI and CT scans)** Subject to case management and clinical protocols **Pre-authorisation required** Please call **0800 225 151**
In-hospital dentistry 16 	Benefit provided through DENIS*10 Subject to protocols and limitations Only PMB*15 conditions and certain surgical procedures (fistula closure) Paid at the Transmed rate* The fee for the hospitalisation and anaesthetist is paid from the major medical benefit Dental treatment/procedures are subject to the availability of funds in the specialised dentistry limit of R4 893 per family per year **Pre-authorisation required** Please call **0800 225 151**

MAJOR MEDICAL COVER (CONTINUED)

BENEFITS	GUARDIAN PLAN
Internal prostheses 17 	Only PMB*15 conditions and selected knee and hip replacements – refer to page 7 Subject to individual prosthesis limits – refer to Annexure A on page 18 Medical motivation may be required **Pre-authorisation required** Please call **0800 225 151**
Orthopaedic, surgical and medical appliances 18 	Subject to individual appliance limits – refer to Annexure B on page 19 Medical motivation may be required **Pre-authorisation required** Please call **0800 225 151**
Organ transplants 19 	Subject to case management and clinical protocols Harvesting cost of organs (both live and cadavers) is subject to PMB*15 legislation **International donors** The cost of an international donor search and harvesting shall be limited to R225 000 (irrespective of the rand/dollar/euro exchange rate) In all cases, special approval is required from the Principal Officer or his delegate before an international donor search can be funded and a confirmation of the non-availability of a suitable local donor is required The recipient must be a Transmed member **Pre-authorisation required** Please call **0800 225 151**
Ambulance services 20 	Transfer protocols apply Paid at the Transmed rate* **Pre-authorisation required** Please call **0800 115 750**
Emergency visits in hospital casualties 21 	Paid at the Transmed rate* if life-treatening **Authorisation is required within 1 working day of the emergency treatment** If no authorisation is obtained, services will be paid from general day-to-day*1 benefits, subject to the availability of funds Please call **0800 225 151**
Dialysis 22 	The DSP*3 is State hospitals 100% cover at a State hospital, subject to the UPFS*12

MAJOR MEDICAL COVER

BENEFITS	GUARDIAN PLAN
Dialysis (continued) 22	Paid at the Transmed rate* If a State hospital is not accessible in terms of the set criteria, authorisation can be obtained for admission to a hospital on the Transmed private hospital network*6 as secondary DSP*3 or approved dialysis centres **Pre-authorisation required** Please call **0800 225 151**
Oncology (cancer) treatment 23 	The Independent Clinical Oncology Network (ICON*7) of private oncologists and State hospitals are DSPs*3 Paid at the Transmed rate* Benefits are restricted to tier 1 of the South African Oncology Consortium (SAOC) guidelines Limited to 1 PET scan per beneficiary per year A 20% co-payment*8 applies for using a provider other than an ICON*7 service provider or the State Oncology (cancer) medication to be obtained through the Transmed oncology network and is subject to evidence-based clinical protocols Reference pricing*5 applies to oncology (cancer) medication **Pre-authorisation required** Please call **0800 225 151**
HIV/AIDS benefit 24 	Members are encouraged to register on the HIV YourLife programme Obtain medicine from a Transmed pharmacy network*2 or courier pharmacy, as selected during enrolment Members may be liable for a co-payment*8 if a pharmacy outside the Transmed pharmacy network*2 is used Reference pricing*5 applies **Pre-authorisation required** Please call **0860 109 793** (all calls are handled confidentially)
Cataract surgery 25	The Ophthalmology Management Group (OMG*11) network and State hospitals are DSPs*3 Paid at the Transmed rate* A 20% co-payment*8 on the total hospital and associated provider costs applies for using a provider other than an OMG*11 provider or the State In addition to cataract surgery, the following services will be covered, subject to pre-authorisation: • the consultation during which the diagnosis is made and confirmed

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MAJOR MEDICAL COVER (CONTINUED)

BENEFITS	GUARDIAN PLAN
Cataract surgery (continued) 25	• the relevant tests performed to make the diagnosis, as per the applicable algorithm • medication administered as part of the procedure, as per the applicable algorithm • any other indicated services, as per the applicable algorithm **Pre-authorisation required** Please call **0800 225 151**
Terminal care benefit 26	Subject to pre-authorisation (home assessment if indicated) Once-off limit of R25 000 per beneficiary (this is an additional benefit and the financial limit is not applicable to any services rendered that qualify for payment in terms of the PMB*15 legislation) Only applicable for treatment provided in an accredited facility (hospice/ sub-acute/homecare by a registered nurse) **Pre-authorisation required** Please call **0800 225 151**
Prescribed minimum benefits (PMBs) 27	**Hospitalisation** 100% cover at a State hospital, subject to the UPFS*12 If a State hospital is not accessible in terms of the set criteria, authorisation can be obtained for admission to a hospital on the Transmed private hospital network*6 as the secondary DSP*3 and payable at the Transmed rate* The co-payment*8 for the voluntary use of a non-DSP will be the amount equal to the difference between the total cost incurred in respect of the hospital services, including all related medical services, and the cost that would have been payable to the State hospital (DSP*3) If the PMB*15 service was not accessible in a State hospital, but available at a Transmed private hospital network*6 hospital, and the member voluntarily uses a non-network private hospital, the co-payment*8 will be the amount equal to the difference between the total cost incurred in respect of the hospital services, including all related medical services, and the cost that would have been payable to the State hospital (DSP*3)

MAJOR MEDICAL COVER

BENEFITS	GUARDIAN PLAN
Prescribed minimum benefits (PMBs) (continued) 27	**Treatment plan services** Paid at the Transmed rate* or at cost Subject to the approved treatment plan services Supplier of own choice may be used for PMB*15 CDL conditions **Chronic medication – the Transmed pharmacy network*2 consists of:** • Clicks pharmacy group • Dis-Chem pharmacies • MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) • Contracted independent pharmacies Members may be liable for a co-payment*8 if a pharmacy outside the Transmed pharmacy network*2 is used

ADDITIONAL BENEFIT

Health advisor 28 	Free access to Hello Doctor, a mobile phone-based service that gives you access to doctors 24 hours a day, 7 days a week You can get expert health advice from qualified South African medical doctors through your phone, tablet or computer, at absolutely no cost to you! Just download the app, request a call and the doctor will phone you back within an hour Refer to page 21 for more information

PREVENTATIVE CARE BENEFITS

Flu vaccinations 29 	Available to all beneficiaries The Transmed pharmacy network*2 is the DSP*3 Paid at the Transmed rate* Subject to the flu vaccination formulary*4 One vaccination per beneficiary per year
Pneumococcal vaccination 30 	Available to high-risk beneficiaries with respiratory complications Subject to an approved treatment plan The Transmed pharmacy network*2 is the DSP*3 Paid at the Transmed rate* Subject to the applicable formulary*4

ANNEXURE A: INTERNAL PROSTHESES

PROSTHESIS	SUB-LIMIT	COMBINED ANNUAL SUB-LIMIT
1. Cardiac stents (per stent) up to a maximum of three	R25 650	R77 000 per beneficiary per year
2. Cardiac valves (per valve)	R37 500	
3. Grafts (per graft)	R28 500	
4. Hernia mesh	R11 000	
5. Partial hip replacement	R30 000	
6. Total hip replacement	R67 760	
7. Hip revision	R50 000	
8. Total knee replacement	R51 150	
9. Knee revision	R45 000	
10. Partial knee replacement	R30 000	
11. Pacemaker and leads	R44 000	
12. Total shoulder replacement	R57 200	
13. Cervical and lumbar disc replacements	R30 000	
14. Spinal fusion (per procedure)	R55 660	
15. Non-specified items	R25 000	
16. Brain stimulator	R180 000	Per beneficiary per year
17. Endovascular aneurysm repair (EVAR), Anaconda and equivalents	R280 000	Per beneficiary per year
18. Pacemaker plus defibrillator	R280 000	Per beneficiary per year
19. Pacemaker (double chamber)	R120 000	Per beneficiary per year
20. Transcatheter aortic valve implantation (TAVI)	R280 000	Per beneficiary per year

Please note: *These prostheses are only reimbursed for* ***PMB'[15] conditions*** *or unless otherwise specified in the guide.*

ANNEXURE B: ORTHOPAEDIC, SURGICAL AND MEDICAL APPLIANCES

APPLIANCES	LIMITS (PER BENEFICIARY)
1. Wheelchairs (subject to clinical criteria) Non-motorised wheelchair **OR** Motorised wheelchair	R9 900 (once every five years)
2. Hand prosthesis	R10 000 (once every two years)
3. Arm prosthesis – below elbow	R26 000 (once every two years)
4. Arm prosthesis – above elbow	R120 000 (once every two years)
5. Above knee prosthesis	R150 000 (once every two years)
6. Below knee prosthesis	R120 000 (once every two years)
7. Silicone sleeve replacements for all artificial limbs	R20 000 (once every year)
8. Back brace following surgical procedures	R25 000 (once per year)
9. Walking aids	R2 660 (once per year)
10. Hearing aids Per ear Hearing aid repairs	Once every three years R9 284 Part of the hearing aid limit

G: HOW TO CLAIM

All accounts must reach the Fund not later than the last day of the fourth month following the month in which the services were rendered. Claims received after this date will not be paid.

Ensure that all accounts contain the following details

- Your membership number
- Your initials and surname
- The patient's name and dependant code as it appears on the principal member's membership card
- The date on which the service was rendered
- The name and practice number of the healthcare provider
- The referring healthcare provider's practice number (on specialist accounts)
- The tariff code(s)
- The required ICD-10 code(s)
- The patient's ID number or date of birth

HOW TO SUBMIT YOUR CLAIM

Email: **claims@transmed.co.za**
Fax: 011 381 2041/42
Post: Transmed Claims Department, PO Box 2269, Bellville 7535

H: EX GRATIA

Ex gratia is an additional financial benefit that members can apply for when they experience financial hardship related to unforeseen medical expenses.

WHAT YOU NEED TO KNOW ABOUT THE APPLICATION PROCESS

- The submission of an ex gratia application is not a guarantee that assistance will be granted.
- The committee won't consider any advance payment of medical treatment.
- Members are requested to provide full details of the financial assistance required. Details such as duration, cost involved and motivation for the necessity of expenses are essential for the committee to consider an application.
- The ex gratia committee meets once a month.
- A reply to your application could take up to 30 days and the decision will be issued in writing.
- The decision of the committee is final and no further correspondence regarding the application will be considered once the decision has been announced.

An application form can be obtained from **www.transmed.co.za** or from the customer service department on **0800 110 268**.

HOW TO SUBMIT YOUR APPLICATION

Email: **exgratia@transmed.co.za**

Post: Ex Gratia Committee
PO Box 2269
Bellville
7535

I: HEALTH ADVISOR – HELLO DOCTOR

TALK TO A DOCTOR ON YOUR PHONE, ANYTIME, ANYWHERE – FOR FREE.

As a Transmed member, you get free access to Hello Doctor, a mobile phone-based service that gives you access to a doctor 24 hours a day, seven days a week. You can get expert health advice from qualified South African medical doctors through your phone, tablet or computer, at absolutely no cost to you! Just download the app, request a call and the doctor will phone you back within an hour.

The following Hello Doctor platforms are available to access this service:

The website: www.hellodoctor.co.za

You can log in to your personal profile on the Hello Doctor website using your access details and request a call back or simply send a text message to a doctor.

The app:

Download the Hello Doctor app by visiting the Apple App or Google Play stores. You can sign in using your access details and request a call back or send a text message to a doctor.

USSD (unstructured supplementary service data):

You can dial *120*1019# from your mobile phone and follow the menu prompts to request a call back from a doctor or send a text message to the number that they provide.

J: MEMBERSHIP

The Transmed Medical Fund is a medical scheme that is open to employees and pensioners of the Transnet Group, its subsidiaries and former subsidiaries.

DEPENDANTS

In terms of the Fund's rules, the following persons may be registered as dependants, provided that they are not a member or a registered dependant of a member of any other medical scheme.

Your spouse

This refers to a member's wife, husband, or partner. If you are divorced, your former spouse cannot be registered as a dependant.

Your immediate family/spouse's immediate family

This refers to a parent, brother, or sister in respect of whom the member/spouse is liable for family care and support.

Your children

This refers to a member's natural child, stepchild, a legally adopted child, an illegitimate child, a child in the process of being legally adopted or placed in foster care, a child for whom the member has a duty of support, or a child placed in the custody of the member or his/her spouse or partner.

J. MEMBERSHIP (CONTINUED)

Note the following:

* Child dependant contributions are payable for a maximum of four dependants.
* Child dependants older than 21 who are studying full- or part-time and are financially dependent on the member will pay child dependant contributions until the age of 24 (proof of registration at an accredited institution will be required).
** Dependants older than 21 (or 24 in the case of studying children) who are financially dependent on the member will pay adult dependant contributions.

DEPENDANTS OF DECEASED MEMBERS

The dependants of a deceased member, who are registered with the Fund as dependants at the time of the member's death, will be entitled to membership of the Fund without any new restrictions, limitations or waiting periods.

MEMBERSHIP AMENDMENTS

A member must complete a membership amendment form and submit it to the Fund within 30 days of the change, in the following instances:

- when you register/cancel the membership of dependants
- when a member divorces his/her spouse
- when registered dependants no longer qualify as dependants
- when there are any changes to a member's residential and/or postal address, email address, cell phone number or other telephone numbers and banking details.

TERMINATION OF MEMBERSHIP

Resignation
Members may terminate their membership by giving one calendar month's written notice. This will also terminate the membership of their registered dependants. All rights to benefits will cease except for claims in respect of services rendered prior to resignation.

WAITING PERIODS

The Fund applies a waiting period, which is often referred to as underwriting.

The rules of the Fund stipulate two types of waiting periods to be imposed when a member/dependant joins the Fund:

1. a general waiting period of three months
2. a condition-specific waiting period of 12 months for certain pre-existing conditions (e.g. nine months for an existing pregnancy).

LATE-JOINER PENALTIES

Medical schemes can impose late-joiner penalties on indiviuals who join after the age of 35 and who have never been members of or haven't belonged to a medical scheme for a specified period of time. Depending on the number of years that they have not belonged to a medical scheme, late-joiner penalties will be added to members'monthly contributions. It is calculated as a percentage of the contribution and can range from 5% to 75%. Late-joiner penalties are applied to discourage members from only joining medical schemes when they are older or ill, as this will make medical schemes unaffordable.

UPDATE YOUR BANKING DETAILS

Fraud risk has forced Transmed to stop any refunds to members by cheque. It is therefore of the utmost importance that you ensure your banking details are updated with the Fund. If you have not received a refund in the past year or if your banking details have changed recently, you must ensure that the updated details reach Transmed within 30 days of the change, as stipulated in the Transmed rules. The Fund will not be liable if the member has neglected to follow this rule and money is deposited into an incorrect bank account.

To update your banking details, the following information is required:

- a copy of your ID; and
- a bank account statement or letter from the bank with a bank stamp as confirmation (not older than three months).

Please remember to include your membership number in the communication.

COMPLAINT AND DISPUTE RESOLUTION PROCESS

Transmed takes pride in delivering excellent service and strives to have open communication with its members. Please note that there is a formal complaint and dispute resolution process that can be followed when you are dissatisfied with services rendered by the Fund.

Any enquiry must first be directed to the Administrator of the Fund. This can be done by calling the customer service department toll free on **0800 110 268** or by sending an email to **enquiries@transmed.co.za**. Should you not be satisfied with the response to your enquiry, you can email **complaints@transmed.co.za**.

Should you still not be satisfied with the response to your enquiry, you can direct your complaint to the Fund at **fundmanagement@transmed.co.za**.

If your complaint is still not resolved, you can contact the Regulator, who will evaluate your complaint as an independent entity.

COMPLAINTS DEPARTMENT AT THE COUNCIL FOR MEDICAL SCHEMES

Customer Care: 0861 123 267
Email: **complaints@medicalschemes.co.za**

K: IMPORTANT CONTACT DETAILS

FOR **ALL OUR** PEOPLE

SERVICE	CONTACT NUMBER
Customer service department (general queries)	0800 110 268
Chronic medication application	0800 122 263
Hospital and major medical pre-authorisation	0800 225 151
Ambulance authorisation	0800 115 750
Optical services (PPN)	0861 103 529
Dental services (DENIS)	0860 104 941
Fraud hotline	0800 000 436
HIV YourLife Programme	0860 109 793
WhatsApp	0860 005 037

Postal address
Transmed Medical Fund, PO Box 2269, Bellville 7535

www.transmed.co.za