



transmed  
MEDICAL FUND

# BENEFITS GUIDE

SATS PENSIONERS –  
GUARDIAN PLAN

Welcome to Transmed Medical Fund's 2021 benefits guide. This guide explains the 2021 benefits and services available and how you can access it. Please read it carefully and keep it safe for future reference.



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# 2021

*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](http://www.transmed.co.za).*

# BENEFITS GUIDE

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2021



## A. OVERVIEW OF 2021 BENEFITS

### SUMMARY OF CHANGES FOR 2021

- Contributions were increased by 2%.
- The general, day-to-day benefit was increased by 4%.

### IMPORTANT INFORMATION

- State hospitals are the designated service providers (DSPs<sup>\*3</sup>).
- Major medical benefits for treatment of PMB<sup>\*16</sup> 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<sup>\*6</sup> is the secondary DSP<sup>\*3</sup>. This network is only available for emergency or involuntary admissions for PMB<sup>\*16</sup> conditions where a State hospital is not accessible.
- A co-payment<sup>\*9</sup> for the voluntarily use of non-DSP hospital is applicable to PMB<sup>\*16</sup> conditions. No private hospital benefit for non-PMB conditions.
- The Transmed pharmacy network<sup>\*2</sup> is the DSP<sup>\*3</sup> for chronic and HIV/AIDS medication.
- Preferred Provider Negotiators (PPN<sup>\*10</sup>) is contracted to manage optical benefits.
- DENIS<sup>\*11</sup> is contracted to manage dental benefits.
- Improved Clinical Pathway Services (ICPS<sup>\*14</sup>) network is contracted for selected knee and hip replacements.
- Ophthalmology Management Group Limited (OMG<sup>\*12</sup>) is contracted for cataract surgery.
- Independent Clinical Oncology Network (ICON<sup>\*7</sup>) is the DSP<sup>\*3</sup> 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: <ul style="list-style-type: none"> <li>- Clicks pharmacy group</li> <li>- Dis-Chem pharmacies</li> <li>- MediRite pharmacy group (pharmacies in Shoprite/Checkers stores)</li> <li>- Contracted independent pharmacies</li> </ul>
*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: <ul style="list-style-type: none"> <li>- Chronic medication – comprehensive medication formulary</li> <li>- Acute medication – acute medication formulary</li> <li>- Over-the-counter (OTC) medication – OTC medication formulary</li> </ul>
*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	Transmed oncology pharmacy network	Clicks Direct Medicines (CDM) is the designated service provider for oncology (cancer) medicine
*9	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
*10	PPN	Preferred Provider Negotiators is contracted to manage optical benefits, including the optical claims processing
*11	DENIS	DENIS is contracted to manage dental benefits, including dental claims processing
*12	OMG	The Ophthalmology Management Group Limited is a network of ophthalmologists that is contracted to provide cataract surgery
*13	UPFS	The uniform patient fee schedule is the tariff structure applicable to State hospital facilities
*14	ICPS	Improved Clinical Pathway Services is a network of orthopaedic surgeons that is contracted for selected knee and hip replacements
*15	Fund exclusions	Services, procedures and consumables that are not covered by Transmed: <ul style="list-style-type: none"> <li>- Accommodation in old age homes, frail care centres or similar institutions</li> <li>- All costs for operations, medicines, treatment and procedures for cosmetic or for psychological purposes</li> <li>- All costs for operations, medicines, treatment and procedures related to weight reduction</li> <li>- Operations to reverse a sterilisation</li> <li>- Artificial insemination (GIFT or similar procedures)</li> <li>- Patent foods, including baby food</li> <li>- Slimming preparations</li> <li>- Household remedies or preparations and herbal and natural remedies</li> <li>- Aphrodisiacs</li> <li>- Cosmetic soaps, shampoos and other topical applications</li> <li>- Sun screening and sun tanning agents</li> <li>- Cosmetic preparations, medicated or otherwise</li> <li>- Contact lens preparations</li> <li>- Holidays for recuperative purposes</li> <li>- Vitamins and mineral supplements</li> </ul>
*16	PMBs	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

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## B. EXPLANATION OF THE 2021 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<sup>\*16</sup> treatment plan) are paid from the general day-to-day limit<sup>\*1</sup>. 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<sup>\*16</sup> condition was required and could not reasonably be obtained from a State hospital (DSP<sup>\*3</sup>).

An emergency is defined in terms of the Medical Scheme's 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<sup>\*3</sup>), 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<sup>\*6</sup> or appointed specialist networks (ICON<sup>\*7</sup> and ICPS<sup>\*14</sup>) to avoid co-payments<sup>\*9</sup>.
- If the PMB<sup>\*16</sup> service is not available at a State hospital (DSP<sup>\*3</sup>), 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<sup>16</sup> service or procedure that is available at a State hospital (DSP<sup>3</sup>), the member will be liable for a co-payment<sup>9</sup> equal to difference between the fees charged and the equivalent cost that would have been payable to the DSP<sup>3</sup> (State hospital).

## CO-PAYMENT FOR THE VOLUNTARY USE OF A NON-DSP FACILITY

**Note:** The co-payment<sup>9</sup> for using a private hospital (non-DSP) could be very high. Members are encouraged to contact the care managers who will gladly guide them 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 <sup>6</sup> 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<sup>6</sup> facility on a voluntary basis, the member will be liable for a co-payment<sup>9</sup> equal to the difference between the total admission cost at a State hospital and at a Transmed private hospital network<sup>6</sup> 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<sup>9</sup> 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<sup>9</sup> and is not based on a specific case or an indication of the difference in cost in an actual case.

## Ⓡ C. THE 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<sup>16</sup> legislation. It is therefore in a member's best interest to negotiate with a healthcare or service provider to charge the Transmed rate\*.



## D. 2021 CONTRIBUTIONS

MONTHLY INCOME	R0 - R500	R501 - R1 000	R1 001 - R1 500	R1 501 - R2 000	R2 001 - R2 500	R2 501 - R3 000	R3 001 - R3 500
<b>Member</b>	70	109	146	180	219	253	291
<b>Adult dependant**</b>	64	101	126	165	197	227	262
<b>Child dependant*</b>	46	64	87	109	129	154	173

MONTHLY INCOME	R3 501 - R4 000	R4 001 - R4 500	R4 501 - R5 000	R5 001 - R5 500	R5 501 - R6 000	R6 001 +
<b>Member</b>	327	363	401	437	472	511
<b>Adult dependant**</b>	295	326	361	394	425	459
<b>Child dependant*</b>	197	218	240	262	282	306

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<sup>13</sup> for oncology treatment is the Independent Clinical Oncology Network (ICON<sup>17</sup>) of private oncologists. Should a member consult an oncologist outside this network, a 20% co-payment<sup>9</sup> will be applicable to all services received from the non-network oncologist.

Clicks Direct Medicines pharmacy<sup>18</sup> is the

contracted DSP<sup>13</sup> for oncology (cancer) medication. A co-payment<sup>9</sup> may apply for using a non-DSP pharmacy. Pre-authorisation must be obtained for the services above on **0800 225 151**.

Please note that reference pricing<sup>15</sup> is applicable to oncology (cancer) medication.



## E1. MAJOR MEDICAL BENEFITS AT PRIVATE FACILITIES

(continued)



### CATARACT SURGERY

The Fund has a contract with the Ophthalmology Management Group (OMG<sup>\*12</sup>) 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<sup>\*12</sup> doctor is accessible

and the member voluntarily uses a non-DSP, a 20% co-payment<sup>\*9</sup> 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 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.



### JOINT REPLACEMENT BENEFIT

The Fund has a contract with the Improved Clinical Pathway Services (ICPS<sup>\*14</sup>) 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<sup>\*14</sup>, orthopaedic surgeon, anaesthetist, prosthesis and physiotherapist.

If an ICPS<sup>\*14</sup> provider or hospital is available, but the member elects to use a non-ICPS

provider or hospital, a co-payment<sup>\*9</sup> 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 DSP<sup>3</sup> (State hospital) 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<sup>\*14</sup> 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.

# BENEFITS GUIDE



## E2. MAJOR MEDICAL BENEFITS (continued)



### CHRONIC MEDICATION (continued)

#### WHAT IS A CHRONIC MEDICATION FORMULARY?

A chronic medication formulary 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.

#### 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.
- Fax the completed application form, together with a copy of the prescription, to the care manager at the Fund on **0800 122 236** or return it to Transmed Medical Fund, PO Box 32931, Braamfontein 2017.
- 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<sup>2</sup> to collect the medication. A co-payment<sup>39</sup> may apply for using a non-DSP pharmacy.
- If you need to change your chronic medication, ask your healthcare provider to fax the new prescription, together with the necessary motivation and laboratory reports (where applicable), to **0800 122 236**. 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)

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



TABLE B: PMB DIAGNOSIS AND TREATMENT PAIRS (DTPs)

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

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

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

\*These conditions may in some instances be considered as PMB<sup>16</sup> conditions.

SUMMARY OF DESIGNATED SERVICE PROVIDERS (DSPs) AND CO-PAYMENTS FOR CHRONIC AND ONCOLOGY MEDICATION

BENEFIT CATEGORY	DESIGNATED SERVICE PROVIDER (DSP)	CO-PAYMENT FOR VOLUNTARY USE OF A NON-DSP PHARMACY
CHRONIC MEDICATION	Transmed pharmacy network <sup>2</sup> <ul style="list-style-type: none"> <li>Clicks pharmacy group</li> <li>Dis-Chem pharmacies</li> <li>MediRite pharmacy group (pharmacies in Shoprite/Checkers stores)</li> <li>Contracted independent pharmacies</li> </ul>	Pharmacies used outside the Transmed pharmacy network <sup>2</sup> may result in a co-payment <sup>9</sup>  Reference pricing <sup>5</sup> is applicable
ONCOLOGY (CANCER) MEDICATION	Clicks Direct Medicines (CDM) pharmacy <sup>8</sup>	Pharmacies used outside the Transmed oncology network <sup>8</sup> may result in a co-payment <sup>9</sup>  Reference pricing <sup>5</sup> is applicable

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## F. BREAKDOWN OF BENEFITS

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**General  
practitioner (GP)  
consultations**

Paid at the Transmed rate\*  
Subject to the availability of funds in the general day-to-day limit\*<sup>1</sup>

2



**Specialist  
consultations**

Paid at the Transmed rate\*  
Subject to the availability of funds in the general day-to-day limit\*<sup>1</sup>

3



**Acute and over-  
the-counter (OTC)  
medication**

Paid at the Transmed rate\*  
Subject to the availability of funds in the general day-to-day limit\*<sup>1</sup>  
Acute and OTC formularies\*<sup>4</sup> apply  
Fund exclusions\*<sup>15</sup> apply

4



**Out-of- hospital  
pathology**

Paid at the Transmed rate\*  
Subject to the availability of funds in the general day-to-day limit\*<sup>1</sup>

5



**Out-of-hospital  
radiology**

Paid at the Transmed rate\*  
**Basic radiology (X-rays)**  
Subject to the availability of funds in the general day-to-day limit\*<sup>1</sup>

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**Optical benefits**

Benefit provided through PPN<sup>\*10</sup> protocols

**NETWORK BENEFIT**

Optical benefits are subject to authorisation by PPN<sup>\*10</sup> and clinical protocols/prescribed rules apply

Beneficiaries can claim every 24 months

**Examination**

Limited to 1 consultation to the value of R700, including refraction, glaucoma and visual field screening

**Frames/Spectacles/Lenses**

R950 towards frame and/or lens enhancements, together with 1 pair of clear, single-vision lenses to the value of R210 or clear, bifocal lenses to the value of R445 or clear; multifocal lenses to the value of R770

**OR**

**Contact lenses**

Limited to R1 325

**NON-NETWORK BENEFIT**

Members will be liable for a co-payment<sup>\*9</sup> for out-of-network services

**Examination**

Limited to 1 consultation to the value of R350

**Frames/Spectacles/Lenses**

R760 towards frame and/or lens enhancements, together with 1 pair of clear, single-vision lenses to the value of R210 or clear, bifocal lenses to the value of R445 or clear; multifocal lenses to the value of R770

**OR**

**Contact lenses**

Limited to R1 325

Please call PPN<sup>\*10</sup> on **0861 103 529**

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**Basic dentistry**

Provided through DENIS<sup>\*11</sup>

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<sup>\*11</sup> on **0860 104 941**

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## DAY-TO-DAY COVER

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#### Specialised dentistry

Provided through DENIS<sup>11</sup>  
Subject to protocols and limitations  
Limited to R4 110 per family per year

Paid at the Transmed rate\*

#### Crowns

Limited to 1 per family every 2 years for beneficiaries 16 years and older

#### 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<sup>11</sup> on **0860 104 941**

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#### Dentures

R1 040 stand-alone benefit per family for beneficiaries older than 21

Amounts in excess of this limit is payable from the specialised dentistry limit of R4 110 per family per year

Paid at the Transmed rate\*

#### Pre-authorisation required

Please call DENIS<sup>11</sup> on **0860 104 941**

10



#### General day-to-day limit<sup>\*1</sup>

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 R4 270

M+ R7 500

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## CHRONIC MEDICATION

### BENEFITS

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#### Benefits

The Transmed pharmacy network<sup>\*2</sup> is the DSP<sup>\*3</sup>  
Comprehensive formulary<sup>\*4</sup> applies  
Reference pricing<sup>\*5</sup> applies

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#### Pharmacies

The Transmed pharmacy network<sup>\*2</sup> 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<sup>\*9</sup> if a pharmacy outside the Transmed pharmacy network<sup>\*2</sup> is used

## MAJOR MEDICAL COVER

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#### State hospital admissions

The DSP<sup>\*3</sup> is State hospitals

Paid at the Transmed rate<sup>\*</sup>

100% cover at a State hospital, subject to the UPFS<sup>\*13</sup> for PMB<sup>\*16</sup> and non-PMB admissions

14

P



#### Private hospital admissions

Only PMB<sup>\*16</sup> conditions for major medical events and selected knee and hip replacements through ICPS<sup>\*14</sup>

No benefit for non-PMB conditions

If a State hospital is not accessible in terms of the set criteria for PMB<sup>\*16</sup> treatment, authorisation will be considered for admission to a hospital on the Transmed private hospital network<sup>\*6</sup> as the secondary DSP<sup>\*3</sup> and payable at the Transmed rate<sup>\*</sup>

The co-payment<sup>\*9</sup> 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 DSP<sup>\*3</sup> (State hospital) or secondary DSP<sup>\*3</sup> – whichever is applicable





#### Pre-authorisation required

Please call **0800 225 151**







# YOUR BENEFITS

## MAJOR MEDICAL COVER

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<p><b>15</b></p>  <p><b>In-hospital services</b> (including GP and specialist services, pathology and radiology)</p>	<p>100% cover for PMB<sup>*16</sup> and non-PMB admissions at a State hospital Subject to the UPFS<sup>*13</sup></p> <p>Paid at the Transmed rate*</p> <p><b>Advanced radiology (MRI and CT scans)</b> Subject to case management and clinical protocols</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>
<p><b>16</b></p>  <p><b>In-hospital dentistry</b></p>	<p>Provided through DENIS<sup>*11</sup> Subject to protocols and limitations Only PMB<sup>*16</sup> conditions and certain surgical procedures (fistula closure)</p> <p>Paid at the Transmed rate*</p> <p>The fee for the hospitalisation and anaesthetist are paid from the major medical benefit</p> <p>Dental treatment/procedures are subject to the availability of funds in the specialised dentistry limit of R4 110 per family per year</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>
<p><b>17</b></p>  <p><b>Internal prostheses</b></p>	<p>Only PMB<sup>*16</sup> conditions and selected knee and hip replacements – refer to page 7</p> <p>Subject to individual prosthesis limits – refer to Annexure A on page 18</p> <p>Medical motivation may be required</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>
<p><b>18</b></p>  <p><b>Orthopaedic, surgical and medical appliances</b></p>	<p>Subject to individual appliance limits – refer to Annexure B on page 19</p> <p>Medical motivation may be required</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>

MAJOR MEDICAL COVER


BENEFITS	GUARDIAN PLAN
<p>19</p>  <p><b>Organ transplants</b></p>	<p>Subject to case management and clinical protocols</p> <p>Harvesting cost of organs (both live and cadavers) is subject to PMB<sup>*16</sup> legislation</p> <p><b>International donors</b> The cost of an international donor search and harvesting shall be limited to R225 000 (irrespective of the rand/dollar/euro exchange rate)</p> <p>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</p> <p>The recipient must be a Transmed member</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>
<p>20</p>  <p><b>Ambulance services</b></p>	<p>Transfer protocols apply</p> <p>Paid at the Transmed rate*</p> <p><b>Pre-authorisation required</b> Please call <b>0800 115 750</b></p>
<p>21</p>  <p><b>Emergency visits in hospital casualties</b></p>	<p>Paid at the Transmed rate* if life-threatening</p> <p><b>Authorisation is required within 1 working day of the emergency treatment</b></p> <p>If no authorisation is obtained, services will be paid from general day-to-day benefits, subject to the availability of funds</p> <p>Please call <b>0800 225 151</b></p>
<p>22</p>  <p><b>Dialysis</b></p>	<p>The DSP<sup>3</sup> is State hospitals 100% cover at a State hospital, subject to the UPFS<sup>*13</sup></p> <p>Paid at the Transmed rate*</p> <p>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<sup>*6</sup> as secondary DSP<sup>*3</sup> or approved dialysis centres</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>

# YOUR BENEFITS


## MAJOR MEDICAL COVER

BENEFITS	GUARDIAN PLAN
<div data-bbox="96 256 135 312">23</div> <div data-bbox="221 304 273 365"></div> <div data-bbox="120 379 353 432">Oncology (cancer) treatment</div>	<p>The Independent Clinical Oncology Network (ICON<sup>17</sup>) of private oncologists and State hospitals are DSPs<sup>3</sup></p> <p>Paid at the Transmed rate*</p> <p>Benefits are restricted to tier 1 of the South African Oncology Consortium (SAOC) guidelines</p> <p>Limited to 1 PET scan per beneficiary per year</p> <p>A 20% co-payment<sup>9</sup> applies for using a provider other than an ICON<sup>17</sup> service provider or the State</p> <p>Oncology (cancer) medication to be obtained through the Transmed oncology pharmacy network<sup>8</sup> and is subject to evidence-based clinical protocols</p> <p>A co-payment<sup>9</sup> may apply for obtaining oncology (cancer) medication from a non-oncology medicine network</p> <p>Reference pricing<sup>5</sup> applies to oncology (cancer) medication</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>
<div data-bbox="96 687 135 743">24</div> <div data-bbox="211 708 263 769"></div> <div data-bbox="160 794 314 847">HIV and AIDS benefit</div>	<p>Members are encouraged to register on the HIVYourLife programme</p> <p>Obtain medicine from a Transmed pharmacy network<sup>2</sup> or courier pharmacy, as selected during enrolment</p> <p>Members may be liable for a co-payment<sup>9</sup> if a pharmacy outside the Transmed pharmacy network<sup>2</sup> is used</p> <p>Reference pricing<sup>5</sup> applies</p> <p><b>Pre-authorisation required</b> Please call <b>0860 109 793</b> (all calls are handled confidentially)</p>
<div data-bbox="96 927 135 983">25</div> <div data-bbox="200 932 274 971"></div> <div data-bbox="135 1008 339 1035">Cataract surgery</div>	<p>The Ophthalmology Management Group (OMG<sup>12</sup>) network and State hospitals are DSPs<sup>3</sup></p> <p>Paid at the Transmed rate*</p> <p>A 20% co-payment<sup>9</sup> on the total hospital and associated provider costs applies for using a provider other than an OMG<sup>12</sup> provider or the State</p> <p>In addition to cataract surgery, the following services will be covered, subject to pre-authorisation:</p> <ul style="list-style-type: none"> <li>• the consultation during which the diagnosis is made and confirmed</li> <li>• the relevant tests performed to make the diagnosis, as per the applicable algorithm</li> <li>• medication administered as part of the procedure, as per the applicable algorithm</li> <li>• any other indicated services, as per the applicable algorithm</li> </ul> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>
<div data-bbox="96 1315 135 1370">26</div> <div data-bbox="206 1335 268 1396"></div> <div data-bbox="153 1414 321 1466">Terminal care benefit</div>	<p>Subject to pre-authorisation (home assessment if indicated)</p> <p>Once-off limit of R15 000 per beneficiary (this is an additional benefit and the financial limit is not applicable to any services rendered which qualify for payment in terms of the PMB<sup>16</sup> legislation)</p> <p>Only applicable for treatment provided in an accredited facility (hospice/sub-acute/homecare by registered nurse)</p> <p><b>Pre-authorisation required</b> Please call <b>0800 225 151</b></p>



**PRESCRIBED MINIMUM BENEFITS**

BENEFITS	GUARDIAN PLAN
<p><b>27</b></p> <p></p> <p><b>Prescribed minimum benefits (PMBs)</b></p>	<p><b>Hospitalisation</b> 100% cover at a State hospital, subject to the UPFS<sup>*13</sup></p> <p>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<sup>*6</sup> as the secondary DSP<sup>*3</sup> and payable at the Transmed rate<sup>*</sup></p> <p>The co-payment<sup>*9</sup> 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 DSP<sup>*3</sup> (State hospital)</p> <p>If the PMB<sup>*16</sup> service was not accessible in a State hospital, but available at a Transmed private hospital network<sup>*6</sup> hospital, and the member voluntarily uses a non-network private hospital, the co-payment<sup>*9</sup> 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 DSP<sup>*3</sup> (State hospital)</p> <p><b>Treatment plan services</b> Paid at cost Subject to the approved treatment plan services Supplier of own choice may be used for PMB<sup>*16</sup> CDL conditions</p> <p><b>Chronic medication – the Transmed pharmacy network<sup>*2</sup> consists of:</b></p> <ul style="list-style-type: none"> <li>• Clicks pharmacy group</li> <li>• Dis-Chem pharmacies</li> <li>• MediRite pharmacy group (pharmacies in Shoprite/Checkers stores)</li> <li>• Contracted independent pharmacies</li> </ul> <p>Members may be liable for a co-payment<sup>*9</sup> if a pharmacy outside the Transmed pharmacy network<sup>*2</sup> is used</p>

**ADDITIONAL BENEFIT**

<p><b>28</b></p> <p></p> <p><b>Health advisor</b></p>	<p>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.</p> <p>Refer to page 21 for more information</p>
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**PREVENTATIVE BENEFITS**

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

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## ANNEXURE A: INTERNAL PROSTHESES

PROSTHESES		SUB-LIMITS	COMBINED ANNUAL SUBLIMIT
1.	Pacemaker and leads	R40 000	R74 200 per beneficiary per year
1.1	Pacemaker (double chamber)	R45 000	
2.	Cervical and lumbar disc replacement	R16 000	
3.	Partial hip replacement	R19 000	
4.	Total hip replacement	R54 000	
5.	Hip revision	R43 000	
6.	Total knee replacement	R46 500	
7.	Total shoulder replacement	R49 000	
8.	Total knee revision	R45 000	
9.	Spinal fusion (per procedure)	R46 000	
10.	Cardiac stents (per stent) up to a maximum of 3	R21 200	
11.	Grafts (per graft)	R22 500	
12.	Cardiac valves (per valve)	R30 000	
13.	Hernia mesh (umbilical repair)	R11 000	
13.1	Hernia mesh (other)	R5 500	
14.	Non-specified items	R21 000	Per beneficiary per year
15.	Endovascular aneurysm repair (EVAR), Anaconda and equivalents	R70 000	
16.	Pacemaker plus defibrillator	R100 000	
17.	Brain stimulator	R150 000	

**Please note:** These prostheses are only reimbursed for **PMB<sup>16</sup> conditions** or unless otherwise specified in the guide.



## ANNEXURE B: ORTHOPAEDIC, SURGICAL AND MEDICAL APPLIANCES

APPLIANCES	LIMITS
1. Wheelchairs (subject to clinical criteria) Non-motorised wheelchair OR Motorised wheelchair	R8 000 (once every five years)
2. Hand prosthesis	R10 000 (once every two years)
3. Arm prosthesis	R26 000 (once every two years)
4. Above knee prosthesis	R75 000 (once every two years)
5. Below knee prosthesis	R68 000 (once every two years)
6. Silicone sleeve replacements for all artificial limbs	R9 500 (once every year)
7. Back brace following surgical procedures	R7 700
8. Walking aids	R2 000
9. Hearing aids One hearing aid Set of hearing aids Hearing aid repairs	Once every three years R8 800 R18 300 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](mailto:claims@transmed.co.za)

Fax: 011 381 2041/42

Post:

Transmed claims department

PO Box 32931

Braamfontein

2017

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2021



## 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 at [www.transmed.co.za](http://www.transmed.co.za) or from the customer service department on **0800 110 268**.

### HOW TO SUBMIT YOUR APPLICATION

Email: [exgratia@transmed.co.za](mailto:exgratia@transmed.co.za)

Post:

Ex gratia Committee

Private Bag X50

Braamfontein

2017

## 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](http://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.

#### 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.



## J. MEMBERSHIP (continued)



### 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, e-mail address, fax number, 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 (i.e. nine months for an existing pregnancy).



### LATE-JOINER PENALTIES

Medical schemes can impose late-joiner penalties on individuals 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, crossed cheque 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 services department or by sending an email to:

- Toll free: 0800 110 268
- Email: [enquiries@transmed.co.za](mailto:enquiries@transmed.co.za)

Should you not be satisfied with the response to your enquiry, you can email [complaints@transmed.co.za](mailto: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](mailto: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](mailto:complaints@medicalschemes.co.za)



## K. IMPORTANT CONTACT DETAILS

### 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)	0860 304 060/0861 103 529
Dental services (DENIS)	0860 104 941
Fraud hotline	0800 000 436
HIV YourLife programme	0860 109 793
WhatsApp	0860 005 037



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**transmed**  
MEDICAL FUND

**Postal address:**

Transmed Medical Fund  
PO Box 32931  
Braamfontein, 2017

[www.transmed.co.za](http://www.transmed.co.za)