

SIZWE MEDICAL FUND

EMPLOYERS MANUAL



Disclaimer:

This Employers Manual is for information purposes only and does not supersede the rules of the Fund. A full set of rules is available on our website: www.sizwe.co.za

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OUR CORE VALUES



CARING

We care for the health of our members and their families.



HERITAGE

We are proud of our heritage that spans over 3 decades with a wealth of expertise in caring for the health of our nation.



COMMUNITY

We are a medical fund for the people by the people and we maintain a strong community focus.



SIMPLICITY

We pride ourselves in designing products which are simple to understand and easy to use. We strive for simplicity in all we do.



RICH BENEFITS

As a community focused medical fund, we offer a range of carefully crafted medical aid products which are simple to understand with generous and unlimited benefits.



WHY SIZWE?

Sizwe Medical Fund stands as one of the top 10 open medical schemes in South Africa, with just under 50 000 members. The Fund is financially sound, with an excellent global credit rating, and provides a wide array of affordable, exceptional products to all South Africans, just as its founders dreamed of.

PRODUCT OFFERING

Sizwe offers a range of products with excellent benefits making it attractive to all South Africans who place value in their health and the health care needs of their families. The traditional range of options works on a fee-for-service basis i.e. a provider bills the medical scheme for the service they have provided. The member is given generous limits for groups of benefits and can use these benefits up to the limit specified in the benefit guide. (Please refer to next page for a list of product offerings)



**SIZWE MEDICAL FUND IS AN OPEN
MEDICAL FUND WITH AFFILIATION TO ALL
THE LABOUR AND UNION MEMBERSHIP**



FINANCIALS

Sizwe is a financially sound scheme and has a solvency ratio well above the 25% requirement by Council for Medical Schemes:

2018	
GCR	AA-
RESERVES ACCUMULATED FUNDS	OVER R1 269 BILLION
SOLVENCY RATIO	53,9%

Why choose Sizwe?:

- Financially sound – healthy solvency and reserves
- Stable fund – over 40 years' experience in caring for the health of the nation
- Rich benefits options – value for money private medical cover
- Top 10 medical fund – big enough to count, small enough to care
- Clear benefit structure – simple to use and understand
- Commitment to the member and the community
- Established relations with both labour and management

EDOs

1. WHAT ARE EDOs?

EDOs are Efficiency Discounted Options

2. WHICH PLANS OFFER EDOs?

WHAT IS THE DIFFERENTIAL FACTOR?

Nothing changes from current plan offering.

The new network options only offer the following:

- Reduced contributions
- Operating within hospital network

3. PRIMARY CARE NETWORK OPTION

The new Primary Care Network option offers reduced contributions, unlimited hospitalisation through a network of private hospitals at the same level of cover. For a full list of network hospitals please visit www.sizwe.co.za

4. AFFORDABLE CARE NETWORK OPTION

The new Affordable Care Network option offers reduced contributions with comprehensive cover with generous chronic and day-to-day benefits through a network of private hospitals. For a full list of network hospitals please visit www.sizwe.co.za

5. WHAT YOU NEED TO KNOW ABOUT EDOs:

- All claims will be paid at 100% Sizwe Rate.
- Members on the EDO options can elect any hospital within the network for scheduled procedures.
- All hospital admissions must be authorised. A co-payment of R1500 will be applied if authorisation was not obtained prior to admission except in an emergency.
- Hospitalisation outside the preferred network will be applied with a co-payment of R12 000 except in an emergency.
- Your membership number will not change with EDO option change.
- The closing date for EDO option selection deadline is at 31st January 2019.
- The EDO option change form can be accessed from Sizwe website at www.sizwe.co.za
- Further enhancements on the provider network will be on-going and will be communicated in due course.

Members are encouraged to go to our website for detailed information on EDOs by visiting the site on www.sizwe.co.za to view the hospital network in your area as well as access all relevant information on these plans. Also, members should consult their Intermediary Partners and/or Brokers for more detailed explanations on EDOs.

OPTION SUMMARY

Sizwe also has preferred providers agreements in place with pharmacies, including Clicks Pharmacies, with which we have negotiated special rates to help members to stretch their chronic, HIV and oncology medicine benefits further in the year (across all option). Should a member choose to use a pharmacy other than those with which we have negotiated special rates for your chronic, HIV and oncology medicines, a co-payment may be charged. All optometry benefits are managed by PPN. A full and up to date list of the hospital network and Preferred Pharmacies is available on our website (www.sizwe.co.za).

HOSPITAL CARE	PRIMARY CARE NETWORK OPTION (NEW)
Hospital Care allows you to manage your day-to-day health care costs through a Medical Savings Account (MSA) at 18%, giving you extensive medical cover, for those looking for peace of mind in case of hospitalisation. Targeted to fit the young, healthy and the adventurous.	The new Primary Care Network option offers reduced contributions, unlimited hospitalisation through a network of private hospitals at the same level of cover. For a full list of network hospitals please visit www.sizwe.co.za
GOMOMO CARE	AFFORDABLE CARE
Gomomo care is our network option. It offers good value for money and the peace of mind linking you with your own selected quality service providers. This option offers rich benefits and unsurpassed day-to-day benefits that meet your healthcare needs.	Our Full Benefit Care option offers comprehensive cover, and generous benefits to cover families and individuals who need access to unlimited hospitalisation at any private hospital. This option also offers additional chronic conditions, specialised dentistry, GP's, specialists, acute medication, preventative care benefits and more rich benefits. This is the only option which offers Top-up cover when in hospital up to 200% of the Sizwe rate.
PRIMARY CARE	AFFORDABLE CARE NETWORK OPTION (NEW)
Primary Care offers good value for money with unlimited hospitalisation at any private hospital. This traditional option has generous day-to-day benefits which cover acute medicines, general practitioners (GPs), specialists, radiologists, pathologists and more to meet the needs of young families with evolving healthcare needs.	Our Full Benefit Care option offers comprehensive cover, and generous benefits to cover families and individuals who need access to unlimited hospitalisation at any private hospital. This option also offers additional chronic conditions, specialised dentistry, GP's, specialists, acute medication, preventative care benefits and more rich benefits. This is the only option which offers Top-up cover when in hospital up to 200% of the Sizwe rate.
FULL BENEFIT CARE	FULL BENEFIT CARE
	Full Benefit Care is an executive plan which offers full cover with generous day-to-day benefits, to families and individuals with established healthcare needs and needing access to unlimited private hospitalisation.



MEMBERSHIP INFORMATION

HOW NEW MEMBERS CAN JOIN SIZWE

To register a new member with the Fund, an Application for Membership form must be fully completed by both the employee and employer and submitted to the scheme.

Employees must be made aware of the possibility of waiting periods and late joiner penalties that may be imposed as per the Rules of the Fund.

All relevant supporting documentation must be attached to the application form before submission to the Fund. A check list of essential documents is included in this booklet.

The application form should be submitted as soon as it has been signed off by the employer and employee, and should not be submitted with the billing statement/payment schedule.

Incomplete application forms and outstanding documentation will result in the delay or rejection of the application. Copies of all Sizwe forms can also be printed from the website (www.sizwe.co.za).

Please note that any member joining during the year will receive pro-rated benefits depending on their joining date.

THE FOLLOWING DOCUMENTS ARE REQUIRED WHEN REGISTERING A MEMBER ONTO THE SCHEME:

- Copy of ID - member and all dependants
- Birth certificates of children (where ID is not available)
- Clinic cards for newborn babies (within 30 days of birth to avoid waiting periods)
- Documentary proof in the case of adopted/foster children
- Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting periods)
- Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable)
- Membership certificates with termination dates from previous medical aids, for member and dependants (where applicable)
- Written confirmation that claimant is a member of the Unemployment Insurance Fund (if unemployed)
- Proof of taxable income (ie, pay slip, sars iT34 form, etc)
- Either an original cancelled cheque (for a cheque account) or an original bank statement (for a transmission or savings account) so that claims can be paid directly into your bank account.

Failure to submit the relevant documents will delay the member's application process.

REGISTRATION OF A DEPENDANT

Should a member wish to add a dependant onto his/her medical aid, an Application to Register a Dependant form must be fully completed and submitted with supporting documents to the administrator.

In order to avoid waiting periods and penalties, please ensure that:

- Newborn babies are registered within 30 days of birth
- Spouses are registered within 30 days of marriage
- Adopted children are registered within 30 days of adoption so no underwriting is imposed.

Supporting documentation such as marriage certificates, birth certificates and membership certificates with termination dates from previous medical aids must be attached before submission. If a newborn's surname differs from the principal member, an affidavit is required.

The Fund determines the following as dependants who qualify to belong to the Fund.

CHILD DEPENDANTS

A dependant is considered a child dependant, and will be charged at child dependant rates, until the age of 21 years. Once the dependant reaches the age of 21 years, the dependant automatically upgrades to adult dependant status, proof of full-time study at an accredited institution or an affidavit showing financial dependency is received 30 days prior to date of 25th birthday

Dependants from the age of 21 to the date of turning 25 years must be provided annually by the 31st March with the below supporting documents:

- Proof of registration for full-time study from the accredited learning institution.
- Doctors report confirming the child is mentally or physically disabled.
- Affidavit with regards to financial dependency of the dependant on the main member.

If the child dependant is currently employed, we request proof of income and an original bank statement of the dependant. A member may apply for the registration of his dependants at the time that he applies for membership. A new born baby must be registered within 30 days of birth, similarly if a child is legally adopted.

ADULT DEPENDANTS

A member who marries subsequent to joining the Fund needs to apply for registration of their spouse within 30 days.

In addition, an adult family member may be registered if they are dependant on the member for financial care and support. (Please refer to company policy - where the company policy differs on dependants, the stipulations of the company policy precede).

CHANGE OF DETAILS

A Member Record Amendment form must be completed for the following changes to a member's records:

- Change of Postal Address
- Change of Surname (supporting document required)
- Change of Banking details (proof required)
- Request for Additional Membership Cards
- Deletion/Termination of a Dependant

TERMINATIONS AND TRANSFERS

If a member leaves the company or wants to terminate their membership for any of the reasons outlined below, the Termination and Transfer Advice form must be fully completed by the employer and submitted to the Administrator.

This form is completed when the member:

- Terminates membership of the fund (voluntary)
- Terminates employment
- Is deceased
- Retires
- Transfers from one group/division to another within the company that would affect his income (e.g, from weekly/hourly to monthly)

In the case of a member's voluntary termination the employer and employee are obliged to give a full calendar month's notice of the intention to resign.

CONTINUATION OF MEMBERSHIP (WIDOW/ERS)

The surviving spouse of a deceased principal member must complete a new application form and a Continuation of Membership form within 30 days if he/she intends to continue with membership of the Fund.

Sizwe requires the following documentation to be submitted with the form:

- Proof of Income
- ID Document
- Debit Order Authority (if applicable - proof of banking details ie. cancelled cheque or bank statement required)
- Copy of the death certificate

TRANSFER TO A DIRECT PAYING MEMBER

Should a member wish to apply for continuous membership after retirement or leaving their current employer, they may remain on the Fund as a direct paying member, but in order to avoid waiting periods, this must be done within 90 days.

Sizwe requires the member to complete a Continuation of Membership form for such a request if the transfer is immediate and there is no break in membership.

Contributions for that member will now be payable in advance rather than in arrears, and their DPM (direct paying member) membership is effective from the 1st of the following month with payment due by the 1st of each month.

ANNUAL OPTION CHANGES

Option changes are only allowed once a year. This process normally starts in November or December or as soon as all contributions and benefits have been finalised for the following year.

An option specific brochure containing the information for the new year are mailed to members and employers towards the end of each year so that the member may decide whether they want to change their option.

The option change process closes on a stipulated date between December and February in order for the membership department to implement all the changes and for new membership numbers and cards to be issued. The Fund does not allow option changes during the year.





UNDERWRITING

LATE JOINER PENALTIES

According to the Medical Schemes Act, a scheme can impose late joiner penalties on any person who is older than 35 years and who has either never belonged to a medical scheme or who has had a break in membership of more than three months with any medical scheme before joining Sizwe. Please ensure that employees join the medical scheme within 30 days of employment to avoid being underwritten.

GENERAL WAITING PERIOD

This is a period of three months after joining the Fund during which a member is not entitled to claim any benefits from the Fund. During this period contributions are payable to the Fund by the member.

CONDITION-SPECIFIC WAITING PERIOD

A condition-specific waiting period can last up to 12 months. During this time a beneficiary is not entitled to any benefits for a condition for which medical advice, diagnosis, care or treatment was recommended or received.

NO WAITING PERIODS MAY BE IMPOSED IF:

The transfer of membership is due to:

- Change of employment status.
- An Employer changing or terminating the medical scheme of its employees.
- The unexpired duration of a waiting period imposed by the former medical scheme will be carried over.
- A child who is born during the period of membership and is registered within 30 days of birth.
- A beneficiary who changes from one benefit option to another within the scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied.
- Adopted children are registered within 30 days of adoption.

CATEGORY	3 MONTH GENERAL WAITING PERIOD	12 MONTH CONDITION-SPECIFIC WAITING PERIOD	WAITING PERIOD APPLIED TO PMB
New members who have not belonged to another medical aid for 90 days or more preceding application	YES	YES	NO
Applicants who had previous medical cover for less than 2 years and who are applying within 90 days of terminating the previous scheme	NO	YES	YES
Applicants who had previous medical cover for less than 2 years and who are applying within 90 days of terminating the previous scheme	YES	NO	YES
Change of medical aid due to change of employment - joined within 90 days	NO	NO	NO
Change of option at the beginning of the year	NO	NO	NO
Enrolment window period	NO	NO	NO

Please note that for larger groups joining Sizwe, the waiting periods may be waived depending on the risk that group poses to the scheme. Each group is assessed individually and will be informed of the underwriting decision from the Fund.

BILLING SERVICES

STATEMENTS

Companies are supplied with an automated monthly billing statement which outlines each member's contributions and number of dependants registered.

NON-PAYMENT

Companies

Contributions are paid in arrears and are due by the 3rd day of the month. Failure to pay contributions will result in the company being suspended from the Fund after 30 days, and terminated after 60 days. Notification will be sent out to the payroll officer and a copy to each member.

Direct Paying Members

Contributions are paid in advance. Failure to pay contributions within 30 days leads to suspension from the Fund, and subsequent termination after 60 days.

ELECTRONIC PAYMENT SCHEDULES

Payment schedules can be provided electronically by email together with the proof of payment in order to facilitate a speedy reconciliation process. Contributions can be deducted from the company's bank account by debit order. To find out more about this option, please speak to your billing specialist

MEMBERS ON MATERNITY LEAVE

In order to avoid arrears, and subsequent suspension or termination, a member going on maternity leave can choose one of the following options:

- To have double deductions implemented on her earnings a few months prior to going on maternity leave, thereby paying contributions in advance for the months of her maternity leave; or
- Pay the total contribution for the length of her maternity leave in advance the month prior to going on leave; or
- The company continues to pay the contributions on behalf of the member as normal on a monthly basis.
- Members who are pregnant are encouraged to join Sizwe's Baby Programme.





TOP-UP COVER

This benefit is applicable to the Full Benefit option only and applies to the cost of surgical procedures whilst hospitalised. It covers the difference between the Sizwe rate and the rate charged by the practitioner (to a maximum of 200% over the Sizwe rate).

In order to access this benefit, a member must complete a Top Up Cover Application form and submit within four months of having received the treatment in order to receive a refund of the medical costs from the first day of hospitalisation.

PMBs (Prescribed Minimum Benefits) & CHRONIC CONDITIONS

Prescribed Minimum Benefits (PMBs) 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 they have selected. PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- **Any emergency medical condition;**
- **A limited set of 270 medical conditions (Diagnostic Treatment Pairs); and**
- **27 Chronic Conditions.**

What is an emergency? An emergency is defined by the Council for Medical Schemes 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 body organ or part, or would place the person’s life in serious jeopardy”.

Put simply, the following factors must be present before an emergency can be concluded:

- **There must be an onset of a health condition.**
- **This onset must be sudden and unexpected.**
- **The health condition must require immediate treatment (medical or surgical)**
- **If not immediately treated, one of three things would result: serious impairment to a bodily function, serious dysfunction of a body part or organ, or death.**



WHAT ARE DIAGNOSTIC AND TREATMENT PAIRS?

The regulations of the Medical Schemes Act, Annexure A, provide a long list of conditions specified as PMBs. The list is in the form of Diagnostic and Treatment Pairs (DTPs). A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated. The treatment and care of PMB conditions should be based on healthcare that has proven to work best, taking affordability into consideration. Should there be a disagreement about the treatment of a specific case, the standards (also called practice and protocols) in force in the public sector will be applied.

The treatment and care of some of the conditions included in the DTP may include chronic medicines e.g. HIV infection and menopausal management. In these cases, the public sector protocols will also apply to the chronic medication.

A full list of the DTPs is available on the Sizwe website (www.sizwe.co.za).

PMBs & CHRONIC CONDITIONS

ADDISON'S DISEASE	EPILEPSY
ASTHMA	GLAUCOMA
BIPOLAR MOOD DISORDER	HAEMOPHILIA
BRONCHIECTASIS	HIV/AIDS
CARDIAC FAILURE	HYPERLIPIDAEMIA
CARDIOMYOPATHY	HYPERTENSION
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	HYPOTHYROIDISM
CHRONIC RENAL DISEASE	MULTIPLE SCLEROSIS
CORONARY ARTERY DISEASE	PARKINSON'S DISEASE
CROHN'S DISEASE	RHEUMATOID ATHRITIS
DIABETES INSIPIDUS	SCHIZOPHRENIA
DIABETES MELLITUS TYPES 1 & 2	SYSTEMIC LUPUS ERYTHMATOSUS
DYSRHYTHMIAS	ULCERATIVE COLITIS

ADDITIONAL NON-CDL CHRONIC CONDITIONS COVERED ON THE AFFORDABLE AND FULL BENEFIT OPTIONS

ANAEMIA: VITAMIN B12 DEFICIENCY	BENIGN PROSTATIC HYPERTROPHY	IRON DEFICIENCY ANAEMIA
ANTI-PHOSPHOLIPID SYNDROME	ENDOCARDITIS	OSTEO-ARTHRITIS
APLASTIC ANAEMIA	GOUT	STROKE
ALLERGIC RHINITIS	HYPOPARATHYROIDISM	

ADDITIONAL PMBs ON THE AFFORDABLE AND FULL BENEFIT OPTIONS

MAJOR DEPRESSION	HORMONE REPLACEMENT THERAPY
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NON-CDL CHRONIC CONDITIONS COVERED FOR THE FULL BENEFIT CARE PLAN

ALZHEIMER'S DISEASE	ENURESIS/ INCONTINENT	OBSESSIVE COMPULSIVE DISORDER
ANKYLOSING SPONDYLITIS	GASTRO OESOPHAGEAL REFLUX	PAGET'S DISEASE
ATTENTION DEFICIT DISORDER/ HYPERACTIVITY	HYPERTHYROIDISM	PANCREATIC INSUFFICIENCY
CHRONIC URINARY TRACT INFECTION	MIGRAINE	PERIPHERAL VASCULAR DISEASE
CRYOGLOBULINEMIA	MOTOR NEURON DISEASE	PSORIASIS
DELUSIONAL DISORDERS	MYASTHENIA GRAVIS	PITUITARY ADENOMAS
DERMATOMYOSITIS	OSTEOPOROSIS	PULMONARY INTERSTITIAL FIBROSIS



MEDICINES

Sizwe has listed medicine formularies that have been compiled in accordance with evidence-based guidelines. The formulary list is extensive and covers a wide range of appropriate medication. Some medicines are excluded by the Fund and should you choose one of these, you will need to cover the cost.

CHRONIC MEDICINES

Sizwe currently uses Medipost Pharmacy as its chronic medicine Designated Service Provider (DSP) for members of the HIV Programme. Medipost delivers the medication directly to the member's doorstep in 48 hours of placing the order. All other chronic medicines can be obtained from the pharmacy of choice. In some instances, Sechaba has negotiated preferential rates in line with the Single Exit Price and a list of these suppliers is available from Sechaba's Managed Healthcare Division.

The Chronic Medicine Programme allows you to obtain certain chronic medication through a benefit that is separate from your everyday acute benefit. You can join by registering on the programme for this chronic (extended) medicine benefit. To join the programme, phone our chronic department or your nearest Sizwe Medical Fund branch and ask for an application form. With your permission, your GP or specialist can also call in on your Behalf to register you on the programme. After your doctor has examined you and completed the application form, you must send it to the contact details as shown in the benefit guide. It takes three working days to review an application. You will receive a letter by email, post or fax indicating whether your application has been accepted. Ask your doctor for a prescription that matches the authorisation. Use the authorisation letter, together with the matching prescription from your doctor, to get your medicines from your usual supplier such as a pharmacy, or from the pharmacy preferred provider network (full list available at www.sizwe.co.za).

FORMULARIES AND EXCLUSIONS

Funding guidelines and protocols are developed for all exclusions and limitations through scientific research, using state of the art technology and medical database. This enables Sizwe to have funding guidelines, protocols and formularies that are recognised by the industry and legislative bodies as being sound and ensuring that members receive quality, affordable and clinically appropriate healthcare delivery.

GENERIC MEDICINES

Sizwe encourages the use of safe and cost-effective generic medicine where a generic equivalent is available and is seen to be clinically suitable for that illness. Where a member chooses to use a brand name instead of the generic, they are responsible for the difference in price.

HOSPITALISATION

All hospital stays must be pre-authorised three working days before being admitted. In emergencies it is the hospital's responsibility to get authorisation on behalf of the member within 24-hours of admission.

The administrator will issue a confirmation of the rate agreed between the Fund and the hospital. This will avoid the member having to settle the account on discharge.

Members should take note of the following when being admitted to hospital:

- If the procedure or length of stay is changed in any way, the hospital must ensure that the hospital utilisation department is informed, otherwise any additional procedures done will not be covered. If the member has been hospitalised in a private ward, they will need to pay on discharge the difference between private and general ward rates.
- Hospital stays are charged from noon to noon. Sizwe will not pay for afternoon discharges if they are not seen as medically necessary. Similarly if the member is being operated on in the afternoon, they should not check in before noon.
- Maternity cases are charged from midnight to midnight. In the case of an uncomplicated labour, the time from admission until midnight of the delivery date is considered one day. Subsequent days are charged from midnight to midnight and Sizwe covers the cost of three days of hospitalisation in this case. In the case of caesarean section, Sizwe members are covered for the day of delivery, and the following three days.
- For dental hospitalisation a co-payment of R1500 applies.



WELLNESS & BENEFIT MANAGEMENT PROGRAMMES

YOUR HEALTH IN CARING HANDS



MANAGEMENT PROGRAMMES

1. CARDIOVASCULAR WELLNESS PROGRAMME

This programme guides members with illnesses of the heart and its vessels to manage their illness through exercise, diet and by following a specific treatment programme.

2. HIV/AIDS MANAGEMENT PROGRAMME

The HIV/AIDS Management Programme, encourages early diagnosis, education, adherence to treatment regimes and ongoing counselling to keep infected members healthy. All dealings with the HIV programme are highly confidential.

For a member to join the programme, they need to:

- Visit their doctor or clinic for testing and counselling.
- Once the results are available, they should call the confidential line to be admitted onto the programme.

3. DISEASE RISK MANAGEMENT PROGRAMME

For registration on the Disease risk management programme including HIV, the National Contact Centre at 086 010 3454 or email welcare@sechabamedical.co.za

4. RESPIRATORY WELLNESS PROGRAMME

This programme helps members to improve their understanding of asthma and educate them on how to avoid asthma triggers and how to manage their disease.

5. DIABETES WELLNESS PROGRAMME

This programme focuses on helping members to manage their condition and administer their medication. Consultants are on hand to advise members on the importance of routine check-ups, daily blood sugar testing, blood pressure control, foot care, diet, exercise and adherence to the treatment plan.

6. MENTAL HEALTH WELLNESS PROGRAMME

This programme is managed by qualified psychiatric nursing staff and a full time consulting psychiatrist and facilitates a holistic management programme for members.

8. HOSPITAL MANAGEMENT PROGRAMME

This programme assists members to ensure that they are receiving the most appropriate treatment for their condition within their benefits. A case manager is assigned to the member's case once hospital pre-authorisation has been received.

9. CHRONIC MEDICATION WELLNESS PROGRAMME

This programme allows members to access certain chronic medication through a separate benefit from the acute benefit. To join the programme, the member must call Sizwe for an application form, and after the doctor has examined the member and completed the form, it must be submitted to CHAMPS. It takes three working days to review an application, after which the member will receive a letter as to whether their application has been accepted.

10. DENTAL MANAGEMENT PROGRAMME

The Dental Benefit Management Programme, managed by Dental Information Systems (Denis), is designed so that Sizwe Medical Fund members have access to treatment that ensures good general oral health all year round. Call Denis for pre-authorisation on all specialised dentistry such as crowns, orthodontics and hospitalisation. If you require specialised dental treatment, you must obtain preauthorisation from Denis at least two days in advance. Additionally, if your dental treatment requires that you go to hospital, you must also obtain pre-authorisation from Denis. Dental queries and authorisations: Call contact centre on 0860 109 556 Fax: 0866 770 336 or via email: sizweenq@denis.co.za

Your dental benefits are outlined in the benefit table in the comparative guide to determine when pre-authorisation is required.

11. SIZWE BABY PROGRAMME

This programme offers Sizwe moms access to comprehensive support, both during and after the birth of their children. Registration is required within 24 weeks of falling pregnant. Kindly email to us at sizwebaby@healthichoice.com

12. OPTICAL BENEFITS

PPN is your service provider for Optical benefits confirmation and claims. For Optical benefits, queries and authorisations contact PPN contact centre at 086 110 3529 or via email at info@ppn.co.za or via their website www.ppn.co.za

13. ONCOLOGY RISK MANAGEMENT PROGRAMME

To enroll the member on the programme, a history or pathology report confirming the cancer (diagnosis) is required. Only malignant cancer will be covered from the Oncology Benefit. The Oncology risk management programme allows registration through a benefit that is separate from Disease Risk Management Program. Requests for registration and treatment should be forwarded to oncology@sechabamedical.co.za



SIZWE BABY

This programme offers Sizwe moms access to comprehensive support, both during and after the birth of their children. Registration is required within 24 weeks of falling pregnant. Kindly email to us at sizwebaby@healthchoices.com

PROFESSIONAL SUPPORT

The Sizwe Baby Maternity Care Programme lists exactly what benefits female members have access to, as well as how often they should book doctors' appointments. This plan also clearly details healthcare practitioners in terms of what is covered, should members enquire. Sizwe Baby offers unlimited pre- and post-natal telephonic support via a dedicated help line. This support extends to cover issues such as miscarriages and pregnancy terminations. Personal, outbound calls are regularly made by experienced midwives. The purpose of these is to have a one-to-one connection with Sizwe members, and to assist with risk identification and pertinent pregnancy information. Should the need arise, the midwife will refer the member to professionals such as chronic disease experts, psychologists and more.

REGULAR COMMUNICATION

All Sizwe moms-to-be will be given a copy of the Sizwe Baby Maternity Manual filled with parenting tips, practical hints and sound advice on the important issues facing pregnant moms and parents of new-borns. An informative newsletter will be issued per pregnancy trimester, highlighting changes to be experienced by mom and baby in that trimester. A regular Sizwe Baby Electronic Mailer will be sent by Sizwe to relevant healthcare practitioners on the Sizwe network.

RESOURCES, GIFTS, DISCOUNTS

The Sizwe Baby Website is a vital online tool providing information on all baby and maternity matters. The website is smartphone- and tablet friendly, and those members who do not have online access will be able to view the information via the midwife in the Sizwe Baby Care Centre. Sizwe members will be given access to the Sizwe Online Shopping Mall during their pregnancy and after the birth of their babies. This mall will offer exclusive discounts and special offers on baby and maternity goods. Our Sizwe Maternity Bag is a high-quality, durable gift to Sizwe moms to-be. This beautiful gift is presented in the member's final trimester, and includes a delightful branded babygro, a magazine, toiletries and a pack of new-born diapers.

WELLNESS PROGRAMME

The programme encourages members to commit to regular health and wellness screening tests, offered at Wellness Days at regular intervals throughout the year.

WELLNESS DAYS

For our Sizwe Corporate Clients' convenience, Wellness Days are held on their premises, to address specific pertinent health issues such as hypertension, diabetes and more. Informative, theme-specific talks will be held, and leaflets and giveaways will be disseminated to all Sizwe Medical Fund members participating in the day's activities.

SCREENING TESTS

Free health screening tests will be offered on wellness days. These will include blood pressure measurements, blood glucose tests and so on.



ZEST PROGRAMME

Zest Rewards is the exclusive loyalty program for all Sizwe Medical Fund Members. With Zest Rewards, you have a basket of unique assistance services that you can use every day and save money.

Join the program that offers you more!

Complete an application form via your Broker or sign up online at www.zestrewards.co.za.
Email: join@zestrewards.co.za
SMS "ZEST" to 49212

Our practical assistance includes Debt Assist, Legal Assist and Emergency Home Assist services for our members and their families. Zest Rewards Program is committed to providing real value to its members every day.

WHY ZEST?

Drive current member loyalty
Keep Sizwe members healthy and active
Offer attractive benefits for new members

ASSISTANCE SERVICES

HOME EMERGENCY ASSIST:

All Emergency Home Assist including electrical, plumbing and locksmiths services including call out fees and labour for 1st hour free of charge to the client.

DEBT ASSIST

Credit report review/Debt counselling/Mediation services/ Voluntary debt review/ Administration order assist and reduction of monthly payments in terms of the NCR regulations.

BAIL PROTECT

Maximum amount of bail per incident is R3 000. An attorney will get to Police station within 4 hours.

LEGAL ASSIST

Legal Aid Assistance with qualified lawyers for all members including perusal of documents and advice and consultations. Limited to 30 minutes per consultation.

WILLS AND TRUST

Assist with drafting, safekeeping of wills, Interpretation of wills and assistance in finalising a will and estate administration.

SOS ASSIST

GPS location based service for emergency notifications to programmed numbers, Hospitals, chemists and doctors including a TrackMe Service.

GYM MEMBERSHIP

Zest Members Qualify For Discounted Gym Membership Fees At Planet Fitness & Affiliated Gyms with over 250 branches nationwide



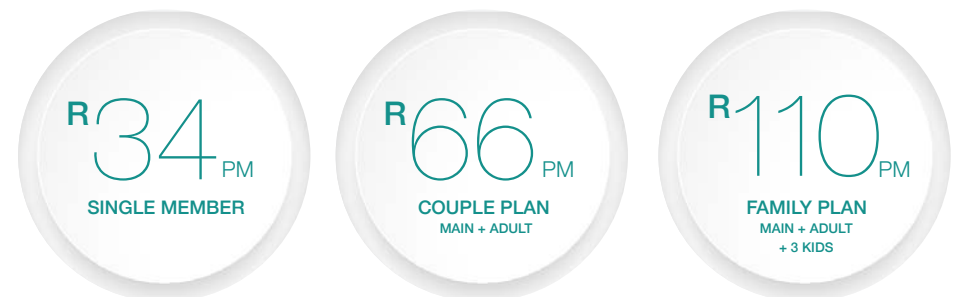
DISCOUNT PARTNERS

Nationwide Discounts retail partners including Shoprite Checkers



MONTHLY FEE

Exclusive to Sizwe Medical Fund members at a low low price. Additional members R20 per person



EMERGENCIES

Through Europ Assistance SA, Sizwe provides members with a 24-hour emergency and ambulance service. Transfer to hospital is by road ambulance unless air transport is essential for survival. This service includes patient monitoring and the delivery of emergency medicines and/or blood to the treating medical facility, as well care for minor or frail companions who, if stranded in an emergency, will be taken to a place of safety. Through Europ Assistance SA, Sizwe members have access to a professional advice line that includes emergency medical advice, an audio health library, access to vital knowledge, information on specific medicines, a poison hotline and health counselling 24-hours a day, 365 days a year.

For 24 Hour Ambulance Services and Medical Advice, contact EUROP Assistance SA, Medical Emergencies at contact centre number at 0860 117 799

FRAUD

Sizwe takes a hard line on fraud and therefore has a specific fraud unit that investigates all suspected fraudulent claims. To this end, Sizwe also belongs to the Board of Healthcare Funders (BHF) national fraud task team which gathers information regarding fraudulent members or providers across all medical schemes

IMPORTANT CONTACT DETAILS

HOSPITAL PRO-AUTHORISATION HOSPITAL BENEFIT MANAGEMENT PROGRAMME

TEL : 0880 101 176

DENTAL BENEFIT MANAGEMENT - DENIS

TEL : 0880 109 556

FAX : 0880 770 336

EMAIL : sizweenq@denis.co.za

OUT OF HOSPITAL DAY-TO-DAY BENEFITS NETWORK PROVIDERS

UITENHAGE : UDIPA

TEL : 041 991 0455

PORT ELIZABETH: ECIPA

TEL : 041 395 4482

ALL OTHER AREAS : ENABLEMED

TEL : 0860 00 24 00

WELLNESS PROGRAMME – HELPLINE FOR ASTHMA, CARDIOVASCULAR DISEASE, DIABETES AND MENTAL HEALTH

TEL : 0860 103 454

FAX : 011 221 5238

EMAIL : wellnessqueries@sizwemedfund.co.za

HIV/AIDS MANAGEMENT PROGRAMME

TEL : 0860 103 454

FAX : 011 221 5235 / 56

EUROP ASSISTANCE SA, MEDICAL EMERGENCIES, 24-HOUR AMBULANCE SERVICES AND MEDICAL ADVICE

TEL : 0860 117 799

SIZWE BABY PROGRAMME

FAX : 011 221 5218

EMAIL : sizwebaby@healthchoices.com

TIP-OFFS ANONYMOUS FRAUD LINE

TEL : 0800 204 702

FAX : 0800 007 788

EMAIL : sizwemedical@tip-offs.com

CHRONIC MEDICATION PROGRAMME

TEL : 0860 103 455 /
011 353 0030

FAX : 011 353 0352
/ 0076

EMAIL : chronic@sizwe.co.za

UITENHAGE : UDIPA

FAX : 041 991 1915

EMAIL : admin@udipa.co.za

PORT ELIZABETH: ECIPA

FAX : 086 680 8855

EMAIL : pbm@providence.co.za

ALL OTHER AREAS : ENABLEMED

FAX : 086 666 0228

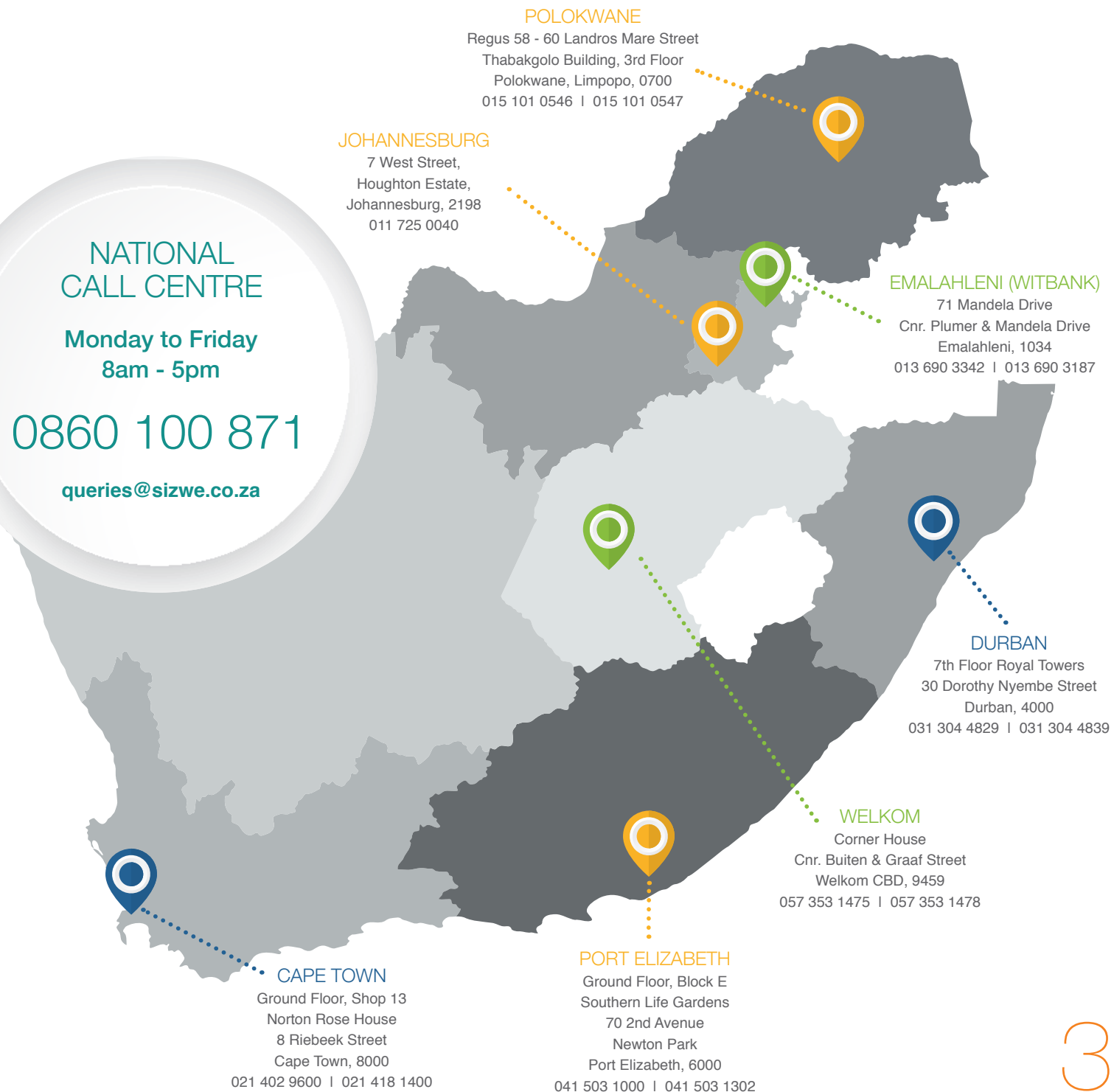
EMAIL : chronic@enablemed.com

**NATIONAL
CALL CENTRE**

**Monday to Friday
8am - 5pm**

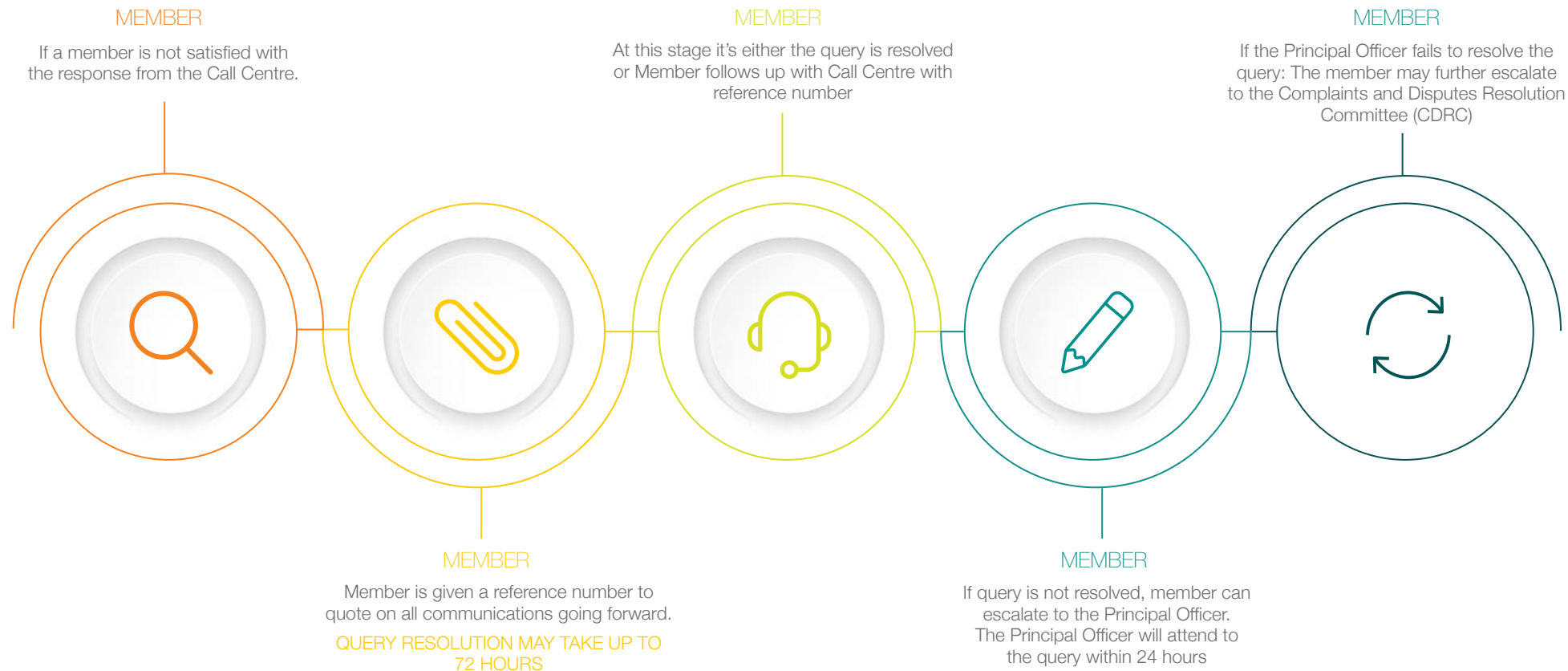
0860 100 871

queries@sizwe.co.za



COMPLAINTS ESCALATION PROCESS

At Sizwe Medical Fund, we continuously strive to ensure that our service and communication to you, our valued member is of the highest standard. Occasionally errors do occur and there could be times when you are not satisfied with the service you receive. Please feel free to lodge any queries or complaints and we will attempt to resolve these as quickly and effectively as possible. In our added efforts to improving our communication with you our valued member, the scheme has enhanced the query and escalation process.



Should your query not be resolved, then you have the options outlined to further assist you. Note that the steps above require a reference number that you would be given to you on your initial query. Ensure that you have utilised one of the contact methods above before embarking on the escalation process. Email your query with a reference number to escalations@sizwemedfund.co.za.

IF YOUR QUERY HAS NOT BEEN ATTENDED TO, THEN THE MATTER CAN BE ESCALATED FURTHER TO THE COMPLAINTS AND DISPUTES RESOLUTION COMMITTEE (CDRC), ALL THE ABOVE ACTIONS MUST BE TAKEN BEFORE ESCALATION. CDRC ESCALATIONS TO BE SENT TO PRINCIPAL.OFFICER@SIZWEMEDFUND.CO.ZA

LIST OF LIMITATION OF BENEFITS AND BENEFITS EXCLUSIONS

1. LIMITATION OF BENEFITS AND BENEFIT EXCLUSIONS

The scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, the scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

The following limitations will apply on all benefit options:

- 1.1 The maximum benefits to which a member and his dependants shall be entitled in any financial year shall be limited set out in Annexure B
- 1.2 All new members admitted during the course of a financial year shall be entitled to the benefits set out in Annexure B with the maximum benefits being adjusted in proportion to the period of membership from the admission date to the last day of such financial year.
- 1.3 In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or a dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending practitioner.
- 1.4 Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.
- 1.5 Where the Fund has Designated Service Providers in place, the benefits will be limited in accordance to the rules specified in Annexure B for each of the registered options.

2. BENEFITS EXCLUDED ON ALL BENEFIT OPTIONS, SUBJECT TO PMBs

EXCLUSIONS (all options)

Unless otherwise decided by the Board, the Fund shall not be liable in respect of expenses incurred in connection with any of the following:

- 2.1 The surgical treatment for obesity;
- 2.2 The surgical treatment of infertility unless it is classified as a PMB;
- 2.3 Operations, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease;
- 2.4 Surgical treatment of keloids, unless such keloids are a result of a complication from a PMB condition resulting in functional impairment;
- 2.5 Cosmetic surgery;
- 2.6 Frail care;
- 2.7 Breast reconstructive surgery for Primary Care unless it is classified as a PMB;
- 2.8 Injuries arising from speed contests and speed trials unless it is classified as a PMB;
- 2.9 Such costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules, unless otherwise agreed by the Board;
- 2.10 The purchase of medicines not included in a prescription from a person legally entitled to prescribe, unless otherwise provided for in Annexure B;

2. BENEFITS EXCLUDED ON ALL BENEFIT OPTIONS, SUBJECT TO PMBs

2.11 Unless otherwise provided for in Annexure B, services rendered by:

2.11.1 Any other person not registered with the Health Professions Council of South Africa or with the Chiropractors Homeopaths and Allied Health Services Professions Council of South Africa;

2.11.2 Any person not registered with the South African Nursing Council as a nurse; or

2.11.3 Any person not registered with the South African Dental Technicians Council as a dental technician;

2.11.4 Any place, nursing or similar institution, except a State or provincial hospital, not registered in terms of the applicable legislation as a private hospital, unattached theatre or day clinic and any institution not licensed in terms of the Mental Health Act, 1973, provided that if a member incurs a cost for services rendered outside the Republic of South Africa for which, as per the discretion of the Board a benefit would have been payable if such service had been rendered within the Republic of South Africa such benefit shall be entitled to be granted in accordance with the provisions or Rule 16.5; and

2.11.4 Medical Scientist

- Psychometry and Registered Counselling
- Industrial and Research Psychologist.

2.12 Other exclusions

- Anabolic steroids;
- Anti-diarrhoeal micro-organism;
- Anti-malarials for prophylactic use;
- Aphrodisiacs;
- Contact lens preparations;
- Cosmetic preparations, medicated or otherwise;
- Diagnostic monitors and appliances,
- Essential fatty acid preparations and combinations;

- Household remedies or preparations of the type generally promoted to the public to increase consumption;
- Household type bandages and dressings;
- Immune sera and immunoglobulins;
- Medicines used specifically to promote fertility unless classified as a PMB;
- Medicines used specifically to treat alcoholism and addiction, subject to PMBs;
- Minerals (single and combined);
- Musculo-skeletal topical agents;
- Nutritional supplements, including baby foods, and formulas unless it is specially authorised as part of a scheme approved treatment protocol;
- Preparations used specifically to treat and or prevent obesity;
- Preparations to treat smoking dependency;
- Sanitary products (nappies, sanitary pads etc.);
- Items appearing on the Scheme's non-covered items list for hospitals;
- Section 21 products;
- Soaps, shampoos and other applications (medical or non-medicated);
- Stimulant laxatives;
- Surgical appliances and devices for use out of hospital;
- Syringes and needles for use out of hospital (except for use by diabetics and if classified as a PMB);
- Tonics and stimulants;
- Topical acne facial wash preparations;
- Topical sun screening, sun tanning and after sun agents;
- Travel vaccines;
- Treatment not proven safe and effective, such as natural remedies, herbs, and treatment prescribed by non-licensed practitioners etc.;
- Treatment prescribed for indicated use (off label);
- Vaccines, oral and parenteral (except childhood and flu vaccines);
- Vitamins, multivitamins and combinations;
- Voluntary withdrawn products and treatment that might be harmful or unsafe; and
- Acupuncture and Chinese Medicine
 - o Naturopath
 - o Osteopathy.

2.12.1 Holidays for recuperative purposes

- 2.12.2 Travelling expenses incurred by a member Traveling expenses claimed by medical or dental practitioners will be provided for in line with Rule P of the NHRPL
- 2.12.3 Charges for appointments cancelled or which a member or dependant or a member fails to keep.
- 2.12.4 The use of gold in dentures or the cost of gold as an alternative to non-precious metal in crowns, inlays and bridges, and metal frame on full dentures.
- 2.12.5 The payment of interest on arrear accounts.

3. DENTAL EXCLUSIONS

3.1 Oral Hygiene/Prevention

- 3.1.1 Oral hygiene instruction
- 3.1.2 Oral hygiene evaluation
- 3.1.3 Professionally applied fluoride for beneficiaries 13 years and older
- 3.1.4 Dental bleaching
- 3.1.5 Nutritional and tobacco counselling
- 3.1.6 Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments
- 3.1.7 Fissure sealants on patients 16 years and older

3.2 Fillings/Restorations

- 3.2.1 Fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis.
- 3.2.2 Resin bonding for restorations charged as a separate procedure to the restoration.
- 3.2.3 Polishing of restorations
- 3.2.4 Gold foil restorations
- 3.2.5 Ozone therapy

3.3 Root Canal Therapy and Extractions

- 3.3.1 Root canal therapy on primary (milk) teeth
- 3.3.2 Direct and indirect pulp capping procedures
- 3.3.3 Root canal therapy on wisdom teeth (third molars).

3.4 Plastic Dentures/Snoring appliances/Mouth-guards

- 3.4.1 Diagnostic dentures and the associated laboratory costs
- 3.4.2 Snoring appliances and the associated laboratory costs
- 3.4.3 Provisional dentures and associated laboratory costs.
- 3.4.4 The clinical fee of dental repairs, denture tooth replacements and the addition of a soft base to new dentures (The laboratory fee will be covered at the Scheme Dental Tariff where managed care protocols apply.)
- 3.4.5 The laboratory cost associated with mouth guards (The clinical fee will be covered at the Scheme Dental Tariff where managed care protocols apply.)
- 3.4.6 High impact acrylic
- 3.4.7 Cost of gold, precious metal, semi-precious metal and platinum foil
- 3.4.8 Laboratory delivery fees

3.5 Partial Metal Frame Dentures

- 3.5.1 Metal base to full dentures, including the laboratory cost.
- 3.5.2 High impact acrylic
- 3.5.3 Cost of gold, precious metal, semi-precious metal and platinum foil
- 3.5.4 Laboratory delivery fees

3.6 Crown and Bridge

- Crown and crown retainers on wisdom teeth (3rd molars)
- Pontics on 2nd molars
- Crown and bridge procedures for cosmetic reasons and the associated laboratory costs
- Crown and bridge procedures where there is no extensive tooth structure loss and associated laboratory costs
- Occlusal rehabilitations and the associated laboratory costs
- Provisional crowns and the associated laboratory costs
- Porcelain veneers and inlays/onlays and the associated laboratory costs
- Emergency crowns that are not placed for immediate protection in tooth injury, and the associated laboratory costs.
- Cost of gold, precious metal, semi-precious metal and platinum foil
- Laboratory delivery fees

3.7 Implants

- 3.7.1 Implants on wisdom teeth (3rd molars).
- 3.7.2 Dolder bars and associated abutments on implants including the associated laboratory costs.
- 3.7.3 Laboratory delivery fees.

3.7 Orthodontics

- 3.8.1 Orthodontic treatment for cosmetic reasons and associated laboratory costs
- 3.8.2 Orthognathic (jaw correction) surgery, other orthodontic related surgery and any related hospital cost including associated laboratory costs.
- 3.8.3 Orthodontic re-treatment and the associated laboratory costs
- 3.8.4 Cost of invisible retainer material
- 3.8.5 Laboratory delivery fees

3.9 Periodontics

- 3.9.1 Surgical periodontics, which includes gingivectomies, periodontal flap surgery, tissue grafting and hemi-section of a tooth.

- 3.9.2 Perio chip placement

3.10 Maxillo-Facial Surgery and Oral Pathology

- 3.10.1 Orthognathic (jaw correction) surgery and any related hospital cost, and the associated laboratory costs.
- 3.10.2 Bone augmentations
- 3.10.4 Cost of bone regeneration material
- 3.10.5 The auto-transplantation of teeth
- 3.10.6 Sinus lift procedures
- 3.10.7 The closure of an oral-antral opening (item code 8909) when claimed during the same visit with impacted teeth (item codes 8941, 8943 and 8945).

3.11 Hospitalisation (general anaesthetic)

- 3.11.1 Where the reason for admission to hospital is dental fear or anxiety.
- 3.11.2 Multiple hospital admissions.
- 3.11.3 Where the only reason for admission to hospital is to acquire a sterile facility.
- 3.11.4 The cost of dental materials for procedures performed under general anaesthetic.

3.11.5 The hospital and anaesthetist claims for the following procedures will not be covered when performed under general anaesthesia:

- Apicectomies
- Dentectomies
- Frenectomies
- Conservative dental treatment (fillings, extractions and root canal therapy) in hospital for adults
- Professional oral hygiene procedures
- Implantology and associated surgical procedures, and
- Surgical tooth exposure for orthodontic reasons.

3.12 Additional scheme exclusions

3.12.1 Special reports

3.12.2 Dental testimony, including dentolegal fees

3.12.3 Behaviour management

3.12.4 Intramuscular and subcutaneous injections

3.12.5 Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures

3.12.6 Appointments not kept

3.12.7 Treatment plan completed (code 8120)

3.12.8 Electrognathographic recordings, pantographic recordings and other such electronic analyses

3.12.9 Caries susceptibility and microbiological tests

3.12.10 Pulp tests

3.12.11 Cost of mineral trioxide



GLOSSARY

ACUTE MEDICINES:

Medicines for short-term illnesses and medical problems.

ADULT DEPENDANT:

A dependant from the age of 21 who is not a full-time student or financially dependent on their parent, and is in receipt of an income more than the state pension. Adult rate will be charged.

AIDS:

Acquired Immune Deficiency Syndrome.

CHILD DEPENDANT:

A child dependant is considered an adult dependant and will be billed at an adult rate from the age of 21 unless: The child is between the ages of 21 and 24 years, is a full-time student, in which case a letter must be submitted from an accredited learning institution confirming that they are registered as a full-time student. The child is mentally or physically disabled; The child is still financially dependent on the matter, in which case an affidavit is required.

CHRONIC BENEFIT ENTRY CRITERIA:

Diagnostic tests to confirm a chronic illness, e.g. blood tests or ECG reports, etc.

CHRONIC DISEASE LIST:

A list of chronic illnesses that are covered in terms of legislation.

CHRONIC MEDICINES:

Medicines used to manage conditions as listed on the Sizwe chronic conditions list.

CONSERVATIVE DENTISTRY:

Simple dental services, such as fillings, tooth removal (extractions) and teeth cleaning.

CONSULTATION:

A visit to your doctor, surgeon or other service provider to obtain a diagnosis and/ or treatment.

CT AND MRI SCANS:

CT scans, uses X-rays, MRI scans use powerful magnetic fields and radio frequency pulses to produce detailed pictures of organs, soft tissues, bone and other internal body structures.

DAY-TO-DAY BENEFIT:

A combined out of hospital benefit which may be used by any registered family member in respect of GPs, Specialists, Acute medicines, Pathology, Radiology and Physiotherapy.

DENTAL BENEFIT MANAGEMENT PROGRAMME:

A behind-the-scenes cost and quality programme managed by Dental Information Systems (Denis).

DESIGNATED SERVICE PROVIDER:

Providers of medical services with whom Sizwe has negotiated special rates.

FORMULARY:

A list of medicines that will be paid by Sizwe Medical Fund according to the specific chronic illness and option chosen.

GENERIC:

A medicine that has the same ingredients and which works the same as a well-known brand medicine.

HIV:

Human Immunodeficiency Virus.

MEDICAL EMERGENCY:

An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

MMAP:

This refers to the Maximum Medical Aid Price which is the maximum price Sizwe Medical Fund is prepared to pay for specific categories of generic medicine.

NETWORK OPTIONS:

This is an option with the exact same benefits as its main option; however with reduced contributions due to restrictions placed on members to only use certain healthcare providers or provider groups.

GLOSSARY

OCCUPATIONAL THERAPY:

Mental or physical activity designed to help you recover from an injury or a disease.

ONCOLOGY:

Is a branch of medicine that deals with the prevention, diagnosis, and treatment of cancer.

PHARMACY ADVISED THERAPY (PAT):

Medicine recommended by your pharmacist and which falls within the self-medication category.

PRE-AUTHORISATION:

Obtaining permission from Sizwe Medical Fund before receiving treatment.

PREFERRED PROVIDER:

A provider recommended by Sizwe Medical Fund that offers cost-effective treatment to members.

PRESCRIBED MINIMUM BENEFITS (PMBS):

The Registrar of Medical Schemes requires all medical schemes to offer a number of minimum benefits to all its members.

REFERENCE PRICING:

This refers to a medicine cost control mechanism used by schemes and assists schemes to manage the high costs of medicines. Members are given a formulary list of medicines that are paid for by the Scheme. Where a member chooses a medicine off the formulary, the reference price refers to the co-payment between the cost of the formulary medicine and the non-formulary medicine.

REHABILITATION:

Treatment to help you get back to a normal life following injury or disease.

SAOPA RATES:

The tariff charged by the South African Orthoptic and Prosthetic Association.

SIZWE RATES:

The rate negotiated by Sizwe Medical Fund with groups of providers.

SPECIALISED DENTISTRY:

Reconstructive surgery providing, for example, caps, crowns and bridges. This typically requires the services of a dental technician.

TOP-UP COVER:

When in hospital, it is the difference between Sizwe rates and the amount charged by practitioners. Top-up cover pays up to 200% over the Sizwe rate. Top-up cover comes into effect immediately when you are admitted to hospital. Only available on the Full Benefit care option and must be claimed within three months of hospitalisation.

TREATMENT PROTOCOLS:

The rules and processes that are followed for treating a specific condition.

UPFS RATES:

Uniform Patient Fee Schedule - the tariffs charged by public hospitals.



SIZWE
MEDICAL FUND
Your health in caring hands

Disclaimer:

This Employers Manual is for information purposes only and does not supersede the rules of the Fund. A full set of rules is available on our website: www.sizwe.co.za