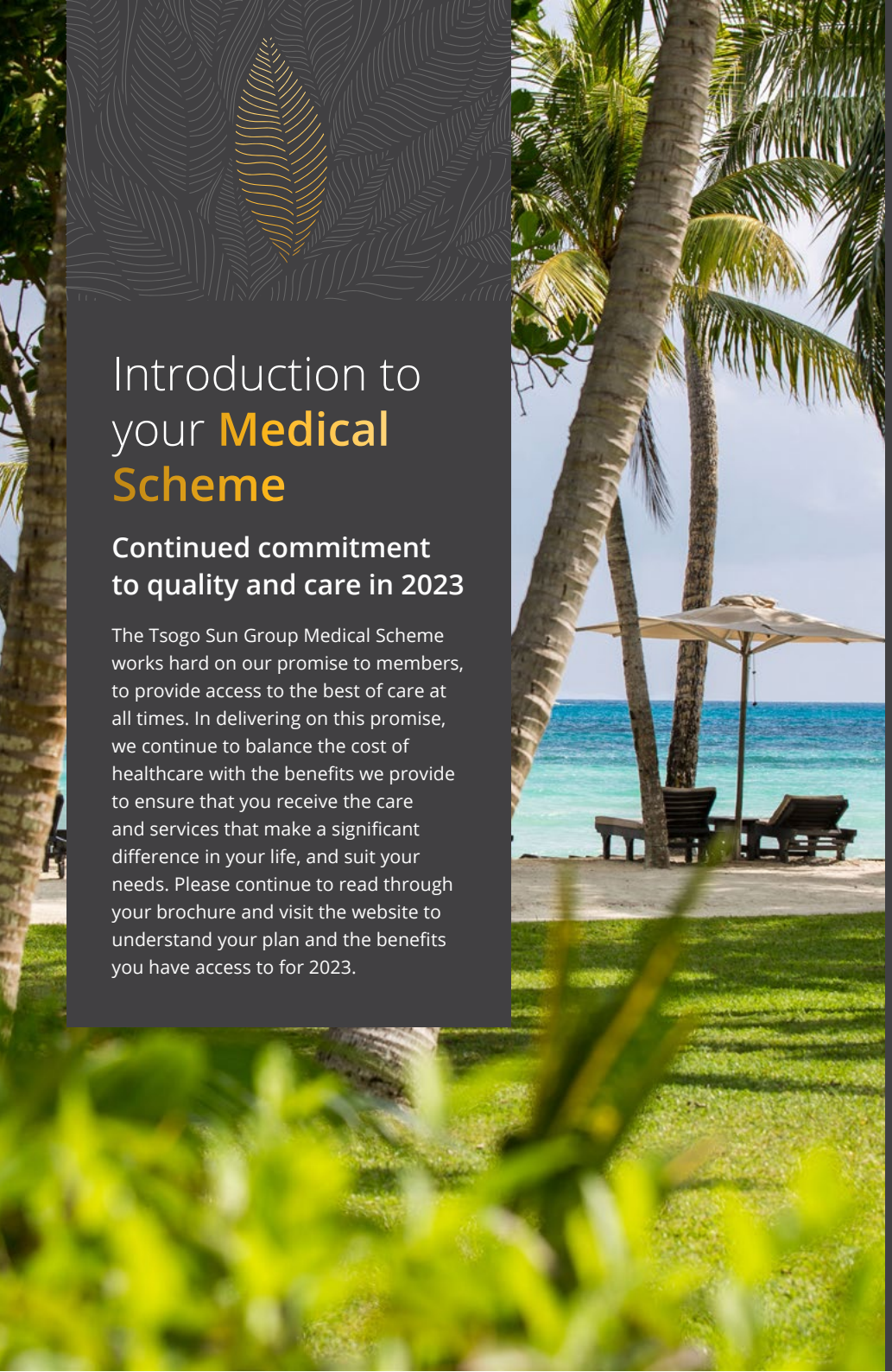
TSOGO SUN
GROUP MEDICAL SCHEME

Administered by
Discovery Health

2023

TSOGO SUN GROUP

Medical Scheme Brochure



Introduction to your **Medical Scheme**

Continued commitment to quality and care in 2023

The Tsogo Sun Group Medical Scheme works hard on our promise to members, to provide access to the best of care at all times. In delivering on this promise, we continue to balance the cost of healthcare with the benefits we provide to ensure that you receive the care and services that make a significant difference in your life, and suit your needs. Please continue to read through your brochure and visit the website to understand your plan and the benefits you have access to for 2023.

HIGHLIGHTS OF CHANGES FOR 2023

The focus for 2023 is to maintain and enhance existing cover, while remaining conservative in the introduction of new benefits where this would have a substantial impact on contribution increases. The changes for 2023 include:

01. Basic Dental Trauma Benefit

We all know of someone who has experienced a traumatic injury to their teeth and / or mouth, needing urgent dental treatment. This benefit covers this kind of sudden and unanticipated injury to the teeth and mouth. The benefit will also cover dental appliances and prostheses and their placement. It doesn't matter whether the care is needed in a hospital or day clinic, the Scheme will pay up to R63 900 per beneficiary per year if the treatment is needed within 30 days of the injury having happened.

02. Enhancements to the existing Trauma Recovery Extender Benefit

The Trauma Recovery Extender Benefit (TREB) already provides cover for certain out-of-hospital costs for a defined list of traumatic events. This means that your other day-to-day benefits are preserved for other needs. This benefit will now be enhanced to provide up to six counseling sessions per beneficiary registered on the membership, who may have been indirectly affected by the event.

03. Procedures In-rooms Benefit

The advancements in medical technologies, procedures and techniques means that more healthcare providers feel comfortable performing certain routine procedures in their rooms, as opposed to scheduling the procedure in a hospital. If your specialist performs a procedure on the approved list (compiled with the guidance of healthcare professionals who perform these procedures), the Scheme will pay for the procedure up to the agreed rate, from the Hospital Benefit.

For yet another year, Classic Saver Plan members will not have an increase in the upfront amount (deductible) that they need to pay to a hospital that is not part of the Scheme's hospital network, for planned admissions. This amount remains unchanged at R8 400.

CONTENTS

WHAT MAKES THE TSOGO SUN GROUP MEDICAL SCHEME

COMPETITIVE

A PLAN OPTION TO MEET EMPLOYEES' NEEDS

We offer you two plans to cater for all your medical needs. The Scheme's actuaries and consultants have independently confirmed the richness of our benefit offering. They also place the Scheme on par with or above most open medical scheme offerings in respect of competitiveness and value for money.

AFFORDABLE AND SUSTAINABLE CONTRIBUTIONS

The Tsogo Sun Group Medical Scheme plans are competitively priced to ensure long-term affordability and value for money.

MEDICAL COVER WHEREVER YOU ARE

The Tsogo Sun Group Medical Scheme plans provide you with cover for emergency medical evacuations in South Africa. If you have an emergency, you can go straight to hospital. If you need medically equipped transport, call Discovery Assist on 0860 999 911.

ACCESS TO ADVANCED MEDICINE AND TECHNOLOGY

Members on the Classic Comprehensive Plan have additional cover for innovative medical technologies and expensive medicine through the Specialised Medicine and Technology Benefit.

CONTROL OVER YOUR DAY-TO-DAY MEDICAL SPENDING

The Medical Savings Account empowers you to make informed choices about how much you spend on your day-to-day healthcare. Any unused funds are carried over to the next year – unlike traditional plans where unused cover is lost.

SCREENING AND PREVENTION BENEFIT

The Tsogo Sun Group Medical Scheme pays for a series of screening tests to ensure you always know your health status and can keep yourself healthy. In addition, the Scheme pays for various types of vaccines to prevent high-risk individuals from contracting illnesses that may result in hospitalisation.

TRAUMA RECOVERY EXTENDER BENEFIT

The Trauma Recovery Extender Benefit provides you with additional day-to-day cover, which follows a specified list of traumatic events. The cover applies for the rest of the year in which the trauma takes place, and for the year after your trauma. This benefit is subject to clinical entry criteria and covers expenses such as GP and specialist visits, private nursing, prescribed medicine, radiology and pathology. These specific day-to-day medical expenses, normally paid from your Medical Savings Account, will be covered under this benefit.

FULL COVER CHOICE FOR HOSPITALISATION, SPECIALISTS IN HOSPITAL, CHRONIC MEDICINE AND GP CONSULTATIONS

By partnering with Discovery Health, we are able to take advantage of their scale and size which has allowed us to enter into agreements with specialists and GPs to ensure certainty of cover and higher levels of reimbursement for healthcare professionals who we pay in full.

THE EXTERNAL MEDICAL ITEMS EXTENDER BENEFIT

This benefit provides access to additional high-end items, in excess of the EMI benefit limit, to high risk members who qualify for extended cover.

HELPING YOU

GET THE MOST

OUT OF YOUR COVER

MAKE THE FULL COVER CHOICE

On both Tsogo Sun Group Medical Scheme plans, we offer you the choice to be covered in full for hospitalisation, specialists in hospital, chronic medicine and GP consultations. Look out for the Full Cover Choice stamp in this brochure. It shows you when to use our range of online tools that guide you to full cover. We have payment arrangements with certain specialists and GPs. These specialists and GPs agreed to join the Discovery Health specialist network and GP network which you have access to. We will refer to the networks and payment arrangements throughout the brochure.

FULL COVER CHOICE FOR HOSPITALISATION, SPECIALISTS IN HOSPITAL, CHRONIC MEDICINE AND GP CONSULTATIONS

The Tsogo Sun Group Medical Scheme participates in Discovery Health's network arrangements with specialists and GPs. We offer you access to these networks to ensure you have certainty of cover and higher levels of reimbursements for claims submitted by healthcare professionals. We pay these network providers directly and in full.

MATERNITY AND POST-BIRTH BENEFIT

Members on the Comprehensive plan will have access to comprehensive maternity and post-birth risk benefits. These benefits do not affect members' day-to-day benefits and are funded from the risk benefit at the Scheme Rate. The benefit must be activated by the member.

Benefits during Pregnancy

- Antenatal Consultations: 12 visits to a GP, gynaecologist or midwife
- Ultrasound Scans and Prenatal Screening: Up to 2 ultrasound scans and 1 nuchal translucency test covered. Non-Invasive Prenatal Test (NIPT) or 1 T21 chromosome test covered, if clinical entry criteria for these tests are met.
- Blood Tests: Defined list of tests per pregnancy
- Antenatal Classes or Consultation with a nurse: Up to 5 pre or post natal classes or consultations with a registered nurse. (You can choose how you want to use before and/or after the birth of your baby. E.g. if you use three antenatal classes you will have two post-natal consultations available)
- Private Ward Cover: up to the Scheme rate

Essential registered devices: a 25% co-payment
e.g. breast pumps and smart thermometers

Post-birth Benefits (up to 2 years after birth)

- Antenatal Classes or Consultation with a nurse: 5 pre- or post-natal classes or consultations with a registered nurse. (You can choose how you want to use before and/or after the birth of your baby. E.g. if you use three antenatal classes you will have two post-natal consultations available)
- GP and Specialist Consultations: Up to 2 visits with a GP, paediatrician or ENT for baby
- Six Week Consultation: 1 six-week post-birth consultation with a mid-wife, GP or gynaecologist is covered, should any complication arise in the six weeks post-birth
- Nutrition Assessment: 1 nutrition assessment with a dietician
- Mental Health: 2 mental health consultations with a counsellor or psychologist
- Lactation Consultation: 1 lactation consultation with a registered nurse or lactation specialist

A PREFERRED MEDICINE LIST FOR ACUTE MEDICINE

Full cover for acute medicine extends to include certain cost-effective branded medicine through the introduction of the Preferred Medicine List. The Preferred Medicine List will include both cost-effective branded and generic medicine. We will cover these types of medicine in full when you use a pharmacy in our network. We will cover medicine not on our Preferred Medicine List, both branded and generic, up to 75% of the Scheme Rate once you reach your Annual Threshold (Comprehensive Plan).

This benefit will result in:

- Preservation of your Medical Savings Account.
- Extended cover in the Above Threshold Benefit (Comprehensive Plan).
- Access to a wider range of acute medicine (Comprehensive Plan).

WE PAY NETWORK SPECIALISTS DIRECTLY AND IN FULL

You can benefit by using healthcare professionals participating in a payment arrangement because the Tsogo Sun Group Medical Scheme will cover their approved procedures and consultations in full. Healthcare professionals who participate in the payment arrangements are also designated service providers for Prescribed Minimum Benefits. Remember, we fund claims up to the overall annual limit, except in the case of Prescribed Minimum Benefits where we fund them in full. If you are treated in hospital by a specialist who does not participate in the payment arrangement, the Tsogo Sun Group Medical Scheme will cover up to 200% of the Scheme Rate on both plans. Please log in to the website www.discovery.co.za to find your nearest network specialist.

WE PAY GPs IN OUR NETWORK DIRECTLY AND IN FULL

When you see a GP in the GP Network, we will pay for their consultation in full. This is first paid from your Medical Savings Account.

If a participating GP treats you while in hospital, the GP will be paid in full at the agreed rate. Please log in to the website www.discovery.co.za to find your nearest participating GP.

WHEN YOU NEED TO GO TO THE DOCTOR

Our Medical and Provider Search Tool helps you find a healthcare professional who we have an agreement with. These healthcare professionals have agreed to only charge you the Scheme Rate and we pay them in full.

If you choose to use a healthcare professional who does not have an agreement with the Scheme, you may need to pay a co-payment of the difference between the Scheme Rate and the billed rate, as well as any amount the healthcare provider charges above this rate.

MAJOR JOINTS NETWORK

Members of schemes administered by Discovery Health claim over R1 billion each year for major joint replacements, with high variances in quality of care. To improve the level and consistency of quality, the Tsogo Sun Group Medical Scheme implemented the Major Joints Network – a national network of doctors and hospitals contracted on the quality of outcomes for elective hip and knee replacements.

Members using the Major Joints Network will enjoy guaranteed full cover, while planned admissions outside the network will attract a 20% co-payment on the cost of the episode. This network will not apply to emergency and trauma related surgeries.

CLASSIC SAVER PLAN ACUTE HOSPITAL NETWORK

Choose a hospital in the network for your planned admissions to avoid an upfront deductible payment of **R8 400**. This network will not apply to emergency and trauma related admissions, or if there is no network facility within 50 kilometres of where you live.

ADVANCED TECHNOLOGY AND CONVENIENCE

WHEN YOU'RE AT THE DOCTOR – HEALTHID

HealthID, Discovery Health's application for healthcare professionals, is the first of its kind in South Africa. Many doctors will be able to access your health records with your consent, allowing them to provide you with the best of care. Remember that member confidentiality will be protected at all times and information can only be accessed with your consent.

ONLINE BOOKINGS AND VIRTUAL CONSULTATIONS

You can conveniently use the Discovery app to make real time online bookings and connect with a doctor virtually. These virtual consultations are paid from your available day-to-day benefits except where they form part of the Prescribed Minimum Benefits (PMBs).

DISCOVERY MEDXPRESS

MedXpress is a free, convenient medicine ordering service available to all Scheme members. This service allows you to maximize your benefits and minimize co-payments through support and guidance. We enable easy access to your medicine through the use of partner pharmacies.

The service provides seamless ordering for prescribed medicines via SMS, the Scheme website, and the Discovery mobile app. Over-the-counter medication is not included in the service. You can get your monthly chronic medicine delivered to your door or collect your medicine at a participating pharmacy at no extra cost to you.

SEND US YOUR SCRIPT

Upload your script on the Discovery website or Smartphone App, under the “Order Medicine using MedXpress” tab. Your order will be placed based on your instruction.

01

DELIVERY OR COLLECTION

- We deliver your medicine to your chosen address within three working days for metropolitan areas and five working days for outlying areas.
- If you choose to collect your medicine yourself, it will be ready for collection within three hours, or six hours if there is a delay due to stock availability. Collection times are dependent on the particular pharmacy’s operating hours.
- This service is available Monday – Friday within business hours (08:00 to 17:00). Orders placed after 15:00 on a Friday will only be ready for collection on a Monday morning.
- Hand the pharmacist your original prescription when you collect your medicine for the first time.

02

REPEAT ORDERS

You can reorder your repeat medicine on the website under ‘Order medicine using MedXpress’, through the Discovery app or use the MedXpress SMS reorder service.

03

CHRONIC ILLNESS,

CANCER AND HIV COVER

CHRONIC ILLNESS BENEFIT (CIB)

The Chronic Illness Benefit covers approved medicine from a list of 27 chronic conditions (including HIV and AIDS) called the Chronic Disease List (CDL) conditions. We will pay for your approved chronic medicine in full if it is on our medicine list (formulary). If your approved chronic medicine is not on our medicine list, we will pay your chronic medicine up to a set monthly Chronic Drug Amount (CDA) for each medicine category. You will be responsible to pay any shortfall.

If you use a combination of medicine in the same medicine category, where one medicine is on the medicine list and the other is not, we will pay for the medicines up to the one monthly Chronic Drug Amount for that medicine category.

The Chronic Illness Benefit also covers certain procedures, tests and consultations for the diagnosis and ongoing management of the 27 Chronic Disease List conditions (including HIV and AIDS) in line with Prescribed Minimum Benefits (PMBs), if your condition is approved for cover from the Chronic Illness Benefit.

To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete, when they refer you to the pathologists and/or radiologists for tests.

This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit to ensure that we pay your claims from the correct benefit.

Medicines for chronic conditions not covered by the Chronic Illness Benefit will be paid from the day-to-day benefits, subject to the Scheme rules and available funds.

You must apply for chronic cover by completing a Chronic Illness Benefit application form with your doctor and submit it for review. You can get the latest application form on the website at www.discovery.co.za or call **0860 100 421** to receive one.

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that you need to meet.

If necessary, your doctor may have to give additional information or copies of certain documents to the Scheme to finalise your application.

Remember: If you leave out any information or do not provide the medical test results or documents needed with the application, cover will only start from the date we receive the outstanding documents or information.

YOU NEED TO LET US KNOW WHEN YOUR TREATMENT PLAN CHANGES

You do not not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your approved chronic condition. However, you do need to let us know when your doctor makes these changes to your treatment so that we can update your chronic authorisation.

You can email the prescription for changes to your treatment plan for an approved chronic condition to CIB_APP_FORMS@discovery.co.za or fax it to 011 539 700. Alternatively, your doctor can submit changes to your treatment plan through HealthID, provided that you have given consent to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

Should you be diagnosed with a **new chronic condition**, a new Chronic Illness Benefit application form would need to be completed.

CHRONIC DISEASE LIST (CDL) CONDITIONS THAT FORM PART OF THE PRESCRIBED MINIMUM BENEFITS ON BOTH PLANS

The cover for chronic medicine is subject to the Scheme medicine list (formulary) or monthly Chronic Drug Amount (CDA).

Addison's disease	Chronic renal disease	Epilepsy	Multiple sclerosis
Asthma	Coronary artery disease	Glaucoma	Parkinson's disease
Bipolar mood disorder	Crohn's disease	Haemophilia	Rheumatoid arthritis
Bronchiectasis	Diabetes insipidus	HIV and AIDS*	Schizophrenia
Cardiac failure	Diabetes mellitus type 1	Hyperlipidaemia	Systemic lupus erythematosis
Cardiomyopathy	Diabetes mellitus type 2	Hypertension	Ulcerative colitis
Chronic obstructive pulmonary disease (COPD)	Dysrhythmias	Hypothyroidism	

* Managed through the HIV*Care* Programme

ADDITIONAL DISEASE LIST (ADL) CONDITIONS WE COVER ON THE CLASSIC COMPREHENSIVE PLAN

There is no medicine list (formulary) for these conditions. We pay for approved medicine for these conditions up to the monthly Chronic Drug Amount.

Ankylosing spondylitis	Huntington's disease	Obsessive compulsive disorder	Pulmonary interstitial fibrosis
Behcet's disease	Ischaemic heart disease	Osteoporosis	Sjogren's syndrome
Connective tissue disorder (mixed)	Major depression	Paget's disease	Systemic sclerosis
Cystic fibrosis	Motor neurone disease	Panic disorder	Tourette's syndrome
Delusional disorder	Muscular dystrophy and other inherited myopathies	Polyarteritis nodosa	Wegener's granulomatosis
Dermatopolymyositis	Myasthenia gravis	Post-traumatic stress disorder	
Generalised anxiety disorder	Narcolepsy	Psoriatic arthritis	

THE SPECIALISED MEDICINE AND TECHNOLOGY BENEFIT

This benefit covers a specific list of new and advanced medicines and medical technologies. This benefit has a limit of R200 000 per beneficiary per year and you need authorisation to qualify for this benefit. You may need to pay a co-payment of up to 20% on certain medicine.

DISEASE

MANAGEMENT

PROGRAMMES

ONCOLOGY PROGRAMME

The Oncology Programme follows the South African Oncology Consortium guidelines to ensure you have access to the most appropriate level of treatment for the particular stage of your disease. We pay most claims related to treating cancer from the Oncology Benefit, although we pay some from the day-to-day benefits. Refer to the Oncology Benefit brochure on www.discovery.co.za for more information.

Depending on your health plan, the Oncology Programme covers the first R200 000 or R400 000 of your approved cancer treatment over a 12-month cycle in full up to the Scheme Rate. Once your treatment costs go over this amount, the Scheme will pay 80% of the Scheme Rate for all further treatments and you will need to pay the balance yourself. This amount could be more than 20% if your treatment costs are higher than the Scheme Rate.

Bone marrow transplant costs do not accumulate to the 12-month rolling limit for cancer treatment.

The Scheme covers you for bone marrow donor searches and transplant, subject to protocols. Your cover is subject to review and approval. To register on this programme call **0860 100 421.**

DIABETES CARE PROGRAMME

The Diabetes Care Programme is designed to offer our diabetic members optimal care from the best service providers in a coordinated network, to ensure the best outcomes and quality of life for our members. To access the programme, you need to be registered on the Chronic Illness Benefit with either type 1 or type 2 Diabetes. A GP in the Premier Plus GP network can enroll you onto the programme.

The Diabetes Care Programme is based on clinical and lifestyle guidelines. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. In addition to the standard treatment basket of procedures and consultations available to members with Diabetes who are registered on the Chronic Illness Benefit, members who join the Diabetes Care Programme will have access to an additional dietician and one biokineticist consultation per year.

To access this benefit, please complete a Chronic Illness Benefit application form and send it to Discovery Health for review. Once registered on the Chronic Illness Benefit, your Premier Plus GP can register you on the Scheme's Disease Management Programme.

CARDIO CARE PROGRAMME

The Cardio Care Programme is designed to offer our members approved for certain heart-related conditions the optimal care from the best service providers in a coordinated network, to ensure the best outcomes and quality of life for our members. To access the programme, you need to be 18 years or older and registered on the Chronic Illness Benefit with hypertension, hyperlipidaemia and/or ischaemic heart disease. A GP in the Premier Plus GP network can enroll you onto the programme. The Cardio Care Programme is based on clinical and lifestyle guidelines. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. You and your GP can track your progress on a personalised dashboard. This will help you to identify the steps you should take to manage your condition and remain healthy over time.
For more information, please visit the website at www.discovery.co.za > TSGMS> Manage your plan> Find a document

HIVCARE PROGRAMME

The HIV*Care* Programme provides comprehensive disease management for members living with HIV and AIDS. Members registered on this programme can be assured of utmost confidentiality. You will have access to unlimited hospitalisation and antiretroviral treatment on the formulary, or the Chronic Drug Amount (CDA) for non-formulary antiretroviral treatment.. Members who are not registered are limited to PMB protocols.

To register on this programme call **0860 100 421.**

GLUCOSE MONITORS

The Scheme funds approved glucose monitoring devices and test strips for members registered on the Chronic Illness Benefit for the treatment of Diabetes.

In addition, members with Type 1 Diabetes have access to funding for sensors for the Freestyle Libre (Abbot), MediLink and Enlite (Medtronic) and Dexcom G6 (Ethitec) devices, which are paid up to the following limits when prescribed by a network provider:

Classic Comprehensive Plan:
Adults: R1 170 per person per month
Children (under 18): R1 560 per person per month

Classic Saver Plan:
Adults: R780 per person per month
Children (under 18): R1 560 per person per month

Should the sensors be obtained from a non-network provider, funding will be from the available day-to-day benefits.

SPINAL CARE PROGRAMME

The **Conservative Care** element of this Programme is available to members who are determined to be at increased risk of spinal surgery. Access to the benefit requires referral from a spinal surgeon and includes access to:

- A network of physiotherapists trained in managing back pain, supported by a panel of specialist surgeons.
- Up to six face-to-face consultations with an appropriately registered allied healthcare professional, of which two may be virtual consultations, where appropriate.

The **Spinal Surgery Network** provides full cover for approved spinal surgery admissions. The network consists of hospitals, surgeons, anaesthetists and allied healthcare professionals that are contracted to the network based on clinical outcomes.

LONG COVID-19 RECOVERY PROGRAMME

Long COVID-19 disease is diagnosed when symptoms of acute COVID-19 disease persist beyond 21 days after a confirmatory test. The COVID-19 Recovery Programme has been developed for members diagnosed with Long COVID-19 disease. The benefit is stratified according to clinical need, based on the severity of the acute illness.

Benefit duration is up to a maximum of six months, subject to PMB requirements. The treating doctor must request access to the benefit, based on the member's clinical needs.

ADVANCED ILLNESS BENEFIT

The Advanced Illness Benefit provides funding for the care of patients with end-of-life stage diseases. Cover includes, but is not limited to, the following out-of-hospital services:

GP or Specialist consultations, home based care, Hospice nursing care, general nursing care, oxygen, pain management, wound care, counseling, pathology and medicine (per defined baskets), and appropriate feeds. Your palliative care provider needs to register you on this programme.

ADVANCED ILLNESS MEMBER SUPPORT PROGRAMME

The Advanced Illness Member Support Programme provides benefits for you and your family when you are facing the impacts of a disease in the long term. This programme will help you and your family to assess and understand end-of-life care needs, as well as help you to navigate the benefits available to you.

SCREENING AND

PREVENTION

BENEFIT

The Screening Benefit covers preventive screening tests at a Scheme network provider. The Screening Benefit pays for certain tests that can provide early warning signs of serious illnesses. It includes the following tests: blood glucose, blood pressure, cholesterol and body mass index. We cover one set of screenings per person per year up to the Scheme rate. In addition it also covers mammograms, Pap smears, HIV screening tests and one Prostate-Specific Antigen (PSA) blood test for adult males. These tests are paid up to the Scheme Rate when referred and performed by an appropriately registered healthcare professional. Related consultations and costs will be paid from the Medical Savings Account or the Above Threshold Benefit. The Scheme covers one mammogram per member every two years and one Pap smear per member every three years. We also cover all members and their dependants for a seasonal flu vaccine.

If a member meets our clinical entry criteria, they will get access to the following additional tests:

- Colorectal cancer screening test
- Breast MRI or mammogram and once-off BRCA testing for breast screening.
- Pap smear for cervical screening.

CHILDREN'S VACCINATIONS

Members with children aged 24 months and younger are encouraged to vaccinate their children against a host of childhood illnesses. These vaccines can be costly and as a result, the Scheme will fund the prescribed list of childhood vaccines for children aged 24 months and younger.

CHILD HEALTH ASSESSMENT

Paediatricians in the Discovery Health Premier Rate A and Rate B network and GPs in the Discovery Health GP network perform educational and preventive Child Health Assessments. Take your child to have one of these assessments once a year and we will pay for the consultation.

Note: The vaccine benefits cover the cost of the vaccine only and not the consultation fee.

CHILDREN'S SCREENING BENEFIT

Age appropriate tests including, but not limited to, growth assessment, blood pressure and health tracking for children between the ages of two years and 18 years will be paid up to a maximum of 100% of the Scheme Rate. This will be one test per year for each qualifying child, which must be performed at a network pharmacy or provider.

PNEUMOCOCCAL VACCINATION

Certain high risk individuals such as individuals over the age of 65 and individuals with certain respiratory conditions, may suffer from pneumonia several times during the year and may even be admitted to hospital several times to treat the pneumonia. We want to prevent this and will pay for these eligible members to receive the pneumococcal vaccine. The vaccine will not be paid from your day-to-day benefits.

SCREENING FOR ADULTS

This covers certain tests such as blood glucose, blood pressure, cholesterol, body mass index and HIV screening at one of our wellness providers. We also cover a mammogram every two years, a Pap smear once every three years, prostate screening (PSA test) each year and bowel cancer screening tests every two years for members between 45 and 75 years.

ADDITIONAL TESTS

Clinical entry criteria may apply to these tests:

- Defined diabetes and cholesterol screening tests
- Breast MRI or mammogram and once-off BRCA testing for breast screening
- Colonoscopy for bowel cancer screening
- Pap smear for cervical screening.
- Seasonal flu vaccine for members who are pregnant, 65 years or older or registered for certain chronic conditions.

Prescribed minimum benefits (PMBs) and designated service providers (DSPs)

WHAT ARE PMBs?

Prescribed Minimum Benefits are prescribed by law as a minimum benefit package that each medical scheme member is entitled to. The Council for Medical Scheme's regulations state that medical schemes need to provide cover for certain conditions at designated service providers; even when scheme exclusions, or certain waiting periods apply, or when the member has reached their limit for a benefit. A designated service provider is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with, to provide treatment or services at a contracted rate.

WHAT WE COVER AS A PRESCRIBED MINIMUM BENEFIT

The Prescribed Minimum Benefits make provision for the cover of the diagnosis, treatment and ongoing care of:

- 271 diagnoses and their associated treatment
- 27 chronic conditions and emergency conditions.

HOW WE PAY PMB CLAIMS

Your cover depends on whether you choose to use Tsogo Sun Group Medical Scheme's designated service providers (DSPs):

Tsogo Sun Group Medical Scheme has selected hospital networks and other service providers as our designated service providers (DSPs). We also have contracts with specific state facilities that are also part of our DSPs. The latest list of hospitals and other service providers is available on www.discovery.co.za

If you choose to use Tsogo Sun Group Medical Scheme's DSPs, we pay your medical expenses in full, from your Hospital Benefit. If you choose not to use a DSP, we pay for medical expenses incurred while you are admitted to hospital for health professionals (doctors) at up to 80% of the Scheme Rate.

PLEASE NOTE

If you are involuntarily admitted to a hospital which is not part of the DSP, you will be transferred to a relevant network hospital as soon as a bed becomes available, or as soon as you are stable enough to be transferred. However, if you decline to move to a relevant network hospital, medical expenses incurred during your admission will be paid up to a maximum of 80% of the Scheme Rate.

This will be calculated from the date that you opted to stay in a hospital that is not part of the Tsogo Sun Group Medical Scheme's DSPs.

THE TSOGO SUN GROUP MEDICAL SCHEME'S LIST OF DESIGNATED SERVICE PROVIDERS (DSPs)

PROVIDER TYPE	DESIGNATED SERVICE PROVIDER
Hospital	Classic Comprehensive Plan: All hospitals with whom we have a contract
	Classic Saver Plan: The Scheme's Acute Hospital Network
	Prescribed Minimum Benefit admissions on both plans, excluding emergencies: The Scheme's Acute Hospital Network
HIV and AIDS medicine	HIV network pharmacies or MedXpress
Drug and alcohol rehabilitation	SANCA, Nishtara Lodge and Ramot
Renal dialysis	Any dialysis provider with whom we have a contract
General Practitioners	Discovery Health GP Network
Specialists	Discovery Health Premier A and B Network
Home oxygen	VitalAire, Oxygen & General, Ecomed, Sleepnet
Emergency services	Discovery 911
Terminal care	Hospice
Wound care	Any wound care provider with whom we have a contract
Diabetes	Contracted Disease Management Programme
Pathology	PathCare (Dr. Dietrich, Voight, Mia & partners), Lancet (Dr. AC Mauff & partners), Ampath (Dr. Du Buisson & partners) and Vermaak

ACCESS TO

WORLD-CLASS

MEDICAL COVER

TRAUMA RECOVERY EXTENDER BENEFIT

The Trauma Recovery Extender Benefit provides members on both the Classic Comprehensive and Classic Saver plans with additional day-to-day cover following a specified list of traumatic events. The cover applies for the rest of the year in which the trauma takes place, and for the year after your trauma. The Trauma Recovery Extender Benefit will pay for ongoing intensive day-to-day care for emergencies related to:

- Crime-related trauma
- Near drowning
- Poisoning
- Severe anaphylactic reaction
- Paraplegia
- Quadriplegia
- Severe burns
- Head injuries (external and internal)

This benefit is subject to clinical entry criteria and covers expenses such as GP and specialist visits, private nursing, prescribed medicine, radiology and pathology.

These day-to-day medical expenses, normally paid from your Medical Savings Account, will be covered under this benefit, except for optometry, dentistry and over-the-counter medicines. Family members registered on the membership have access to 6 counselling sessions, from the day of the traumatic incident for the remainder of that year to the end of the following calendar year.

Once members register for the benefit following the trauma event, all claims linked to the event will be funded from the Trauma Recovery Extender Benefit (not your Medical Savings Account) according to the rules of your chosen Plan. This is a limited benefit and there may be co-payments that you have to pay, depending on the medical condition and the type of medicine or treatment that is used. You need to apply for authorisation to qualify for the benefit.

INTERNATIONAL SECOND OPINION SERVICES

Through your specialist you have access to second opinion services from Cleveland Clinic for life-threatening and life-changing conditions. We cover 50% of the cost of the second opinion service.

Classic Comprehensive Plan Cover

The Classic Comprehensive Plan offers the highest level of coverage of the Tsogo Sun Group Medical Scheme Plans. This Plan offers comprehensive in-hospital cover, chronic illness benefits and a wide range of benefits to cover out-of-hospital expenses.

2023 CLASSIC COMPREHENSIVE PLAN MONTHLY CONTRIBUTION

TOTAL CONTRIBUTION (INCLUDING MEDICAL SAVINGS ACCOUNT)

Income band	Main member	Spouse or adult dependant	Child*
R0 – R5 770	R3 360	R2 184	R556
R5 771 – R11 660	R4 324	R2 804	R788
R11 661 – R29 260	R4 700	R3 052	R876
R29 261+	R4 848	R3 144	R952

A contribution calculator is provided for your use on Sunlink (Hotels) and the internal HR websites (Gaming). Please use this calculator to calculate your contribution for your own unique family size.

* Maximum of three children will be charged for.

** For more information on Premier Rate and GP network please refer to the relevant page in this brochure.

HOSPITAL BENEFIT

- The Hospital Benefit covers hospitalisation in a general ward and related in-hospital accounts if you are admitted to hospital and Tsogo Sun Group Medical Scheme has approved the treatment.
- The Hospital Benefit covers the payment of hospital accounts in full if you are in a general ward and related in-hospital accounts (for example, specialists and anaesthetists) up to the contracted rate where applicable, or up to 200% of the Scheme Rate.
- You also have access to specialists participating in the Premier Rate payment arrangement** ensuring you have no co-payment when you consult these specialists.
- Classic Comprehensive members have access to the maternity and post-birth benefit. The maternity benefit includes antenatal consultations and classes, ultrasound scans and prenatal screenings, blood tests, private ward cover and cover for essential registered devices. The post-birth benefit includes GP and specialist visits, a six week post-birth consultation, a nutrition assessment, a lactation consultation and up to two mental health consultations.

DAY-TO-DAY BENEFITS

- The day-to-day benefits fund out-of-hospital medical expenses such as general practitioners and dentists. These expenses are funded firstly from the Medical Savings Account and thereafter from the Above Threshold Benefit, subject to available funds and limits.
- Healthcare claims at or below the Scheme Rate are paid directly to the provider. If the provider charges more than the Scheme Rate, the claim will be paid to you and you will need to settle the account with the provider.

MEDICAL SAVINGS ACCOUNT (MSA)

- Your day-to-day medical expenses are first funded through the Medical Savings Account. This is an amount set at approximately 25% of your annual contribution for the year.
- Any remaining funds for the year are carried over to the following year.
- You can make use of the GP network** for consultations.

MONTHLY MEDICAL SAVINGS ACCOUNT CONTRIBUTION

Income band	Main member	Spouse or adult dependant	Child*
R0 – R5 770	R840	R546	R139
R5 771 – R11 660	R1 081	R701	R197
R11 661 – R29 260	R1 175	R763	R219
R29 261+	R1 212	R786	R238

ANNUAL MEDICAL SAVINGS ACCOUNT ALLOCATION

Main member	Spouse or adult dependant	Child*
R10 080	R6 552	R1 668
R12 972	R8 412	R2 364
R14 100	R9 156	R2 628
R14 544	R9 432	R2 856

* Maximum of three children will be charged for.

** For more information on Premier Rate and GP network, please refer to the relevant page in this brochure.

SELF-PAYMENT GAP (SPG)

There will be a gap between the time the Medical Savings Account is depleted and reaching the Annual Threshold. During this time you will have to pay all claims. However, medical expenses during this time will still accumulate to the Annual Threshold at the Scheme Rate (subject to certain criteria) as long as the accounts are submitted to the Scheme.

SELF-PAYMENT GAP

Income band	Main member	Spouse or adult dependant	Child
R0 – R5 770	R5 900	R6 948	R3 202
R5 771 – R11 660	R3 008	R5 088	R2 506
R11 661 – R29 260	R1 880	R4 344	R2 242
R29 261+	R1 436	R4 068	R2 014

ABOVE THRESHOLD BENEFIT (ATB)

- The Above Threshold Benefit provides extra cover once your day-to-day expenses, claimed at the Scheme Rate, have accumulated to a fixed Rand amount called the Annual Threshold.
- Once you have reached your Annual Threshold, the Scheme will pay claims from the Above Threshold Benefit at a maximum of the Scheme Rate, subject to some specific category sub-limits (for example, prescribed medicine).
- Claims are paid from the Above Threshold Benefit, up to the set Annual Threshold limit.

ANNUAL THRESHOLD AMOUNTS FOR 2023

Main member	Spouse or adult dependant	Child*
R15 980	R13 500	R4 870

* Maximum of three children will be used to calculate the Annual Threshold value.

ABOVE THRESHOLD LIMITS FOR 2023

Main member	Spouse or adult dependant	Child*
R15 940	R11 930	R5 580

* Maximum of three children will be used to calculate the Above Threshold Limits.

Classic Saver Plan Cover

This plan is for members who need a lower level of day-to-day benefits while still having access to a high level of in-hospital benefits.

2023 CLASSIC SAVER PLAN MONTHLY CONTRIBUTION

TOTAL CONTRIBUTION (INCLUDING MEDICAL SAVINGS ACCOUNT)

Income band	Main member	Spouse or adult dependant	Child*
R0 – R7 350	R1 612	R1 040	R244
R7 351 – R11 660	R2 028	R1 320	R336
R11 661 – R29 260	R2 388	R1 548	R436
R29 261+	R2 464	R1 600	R492

A contribution calculator is provided for your use on Sunlink (Hotels) and the internal HR websites (Gaming). Please use this calculator to calculate your contribution for your own unique family size.

* Maximum of three children will be charged for.

** For more information on Premier Rate and GP network, please refer to the relevant page in this brochure.

HOSPITAL BENEFIT

- The Hospital Benefit covers hospitalisation in a general ward and related in-hospital accounts if you are admitted to hospital and Tsogo Sun Group Medical Scheme has approved the treatment.
- The Hospital Benefit covers the payment of hospital accounts in full if you are in a general ward and related in-hospital accounts (for example, specialists and anaesthetists) up to 200% of the Scheme Rate.
- You also have access to specialists participating in the Premier Rate payment arrangement** ensuring you have no co-payment when you consult these specialists.

DAY-TO-DAY BENEFITS

The day-to-day benefit funds out-of-hospital medical expenses such as general practitioners and dentists. These expenses are funded from the Medical Savings Account subject to available funds.

Healthcare claims at or below the Scheme Rate are paid directly to the provider. If the provider charges more than the Scheme Rate, the claim will be paid to you and you will then need to settle the account with the provider.

MEDICAL SAVINGS ACCOUNT (MSA)

- Your day-to-day medical expenses are funded through the Medical Savings Account. This is an amount set at approximately 25% of your annual contribution.
- Any remaining funds are carried over to the following year.
- You can make use of the GP network** for consultations.

MONTHLY MEDICAL SAVINGS ACCOUNT CONTRIBUTION

Income band	Main member	Spouse or adult dependant	Child*
R0 – R7 350	R403	R260	R61
R7 351 – R11 660	R507	R330	R84
R11 661– R29 260	R597	R387	R109
R29 261+	R616	R400	R123

ANNUAL MEDICAL SAVINGS ACCOUNT ALLOCATION

Main member	Spouse or adult dependant	Child*
R4 836	R3 120	R732
R6 084	R3 960	R1 008
R7 164	R4 644	R1 308
R7 392	R4 800	R1 476

* Maximum of three children will be charged for.

** For more information on Premier Rate and GP network, please refer to the relevant page in this brochure.

The Tsogo Sun Group **Medical Scheme Benefit Table**

Benefit summary for the Classic Comprehensive Plan and the Classic Saver Plan in 2023

No overall hospital limit applies on these plans, however, certain sub-limits apply. Related accounts will be paid at up to 200% of the Scheme Rate for both plans. Some healthcare services have limits. Here is a summary:

HOSPITAL BENEFIT	CLASSIC COMPREHENSIVE	CLASSIC SAVER
	THE LIMIT ON THIS BENEFIT	THE LIMIT ON THIS BENEFIT
HIV and AIDS related illnesses	Unlimited if registered on the HIV and AIDS management programme. If not registered on the HIV and AIDS management programme, subject to PMB protocols.	
Cochlear implants, implantable defibrillators and auditory brain implants	R256 910 per person per benefit	
Internal nerve stimulators	R184 320 per person	
Mental health disorders	Up to a maximum of 200% of the Scheme Rate for related accounts	
	Up to a maximum of 100% of the Scheme Rate for hospital account in a network facility. Up to a maximum of 80% of the Scheme Rate for the hospital account if a non-network facility is used. 21 days for admissions or up to 15 out-of-hospital consultations for each person for major affective disorders, anorexia and bulimia and up to 12 out-of-hospital consultations for acute stress disorder accompanied by recent significant trauma. 21 days for all other mental health admissions.	
	Relapse Prevention Programme*: 2 psychiatric visits 6 counselling sessions Care coordination services ** Offered in addition to existing mental health benefits and the Prescribed Minimum Benefits*	
	Enhanced out-patient care: Members with Major Depression or Episodic Depression within the last 12 months are eligible for enrolment. Programme duration is 12 months upon receipt of a clinical motivation and results of a PHQ-9 assessment. Enrolment must be done by a Premier Plus GP and a network psychologist must be used.	
Alcohol and drug rehabilitation	Up to a maximum of 200% of the Scheme rate for related accounts	
	21 days per person, PMB protocols apply	
Major maxillo-facial procedures (severe infections, jaw joint replacements, cancer and trauma related surgery, cleft and palate repairs)	No overall limit	
Terminal care benefit	PMB services will be paid by the Scheme on an unlimited basis	
Advanced Illness Benefit for patients needing end-of life and palliative care: Defined list of out of hospital benefits	100% of the Scheme Rate. Subject to registration by the treating physician. Cover subject to authorisation, approved treatment guidelines and managed care criteria.	
Advanced Illness Member Support Programme	100% of Scheme Rate for a defined basket of care.	
Hip joint, knee joint and shoulder joint prosthesis	R47 890 per shoulder joint prosthesis (R95 780 for both shoulder joints) and R47 890 per hip and knee joint prosthesis (R95 780 for both hip or knee joints) per person per annum if non-network provider used. Unlimited if network provider is used	
Dialysis	Unlimited. Paid at Scheme Rate	
Spinal Benefit This benefit includes cover for cervical spinal fusion, cervical artificial disk replacement, lumbar spine fusion, lumbar artificial disk replacement, interspinous devices. Clinical protocols apply.	R29 270 for the first level for the prothesis and/or devices, R58 540 for two or more levels for the prothesis and/or devices. Maximum of one procedure each year Unlimited if the member uses the preferred/network provider. Clinical protocols apply	
Circumcisions Male circumcision for the following reasons: Foreskin trauma, Phimosis, Paraphimosis, Balanoposthitis (balanitis), Circumcision due to birth injury, Congenital hydronephrosis and vesicoureteric reflux, previous failed circumcision, Recurrent urinary tract infections in children	Paid from the hospital benefit if performed in the doctor's rooms. If a circumcision is performed for other reasons, for example, religious, cultural, non-medical, the costs will be paid from the available funding in your day-to-day benefits.	
Maternity benefits Antenatal consultations Antenatal classes Ultrasound scans and prenatal screening Blood tests Private ward Essential registered devices	Paid from the hospital benefit subject to certain limits: Antenatal consultations with a GP, midwife or gynaecologist are limited to 12 visits. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of 2 Ultrasound scans and one nuchal translucency test is covered. One NIPT or T21 chromosome test is covered if clinical entry criteria is met. Blood tests are limited to a defined basket. Private ward cover is limited to Scheme rate. Cover on essential external medical devices obtained from a registered healthcare provider up to a limit of R5 350, with a co-payment of 25% per device.	All pre and post-natal healthcare services paid from available funds in the Medical Savings Account (MSA), unless they qualify as Prescribed Minimum Benefits (PMB). Once MSA depleted, the following services are paid from the hospital benefit, subject to certain limits: Antenatal consultations: 8 visits. Two x 2D scans.
Post-birth benefits GP and specialist visits Post natal consultations Six week post-birth consultation Nutrition assessment Mental health consultation Lactation consultation	Paid from the hospital benefit subject to certain limits: Consultations with a GP, paediatrician or an ENT is limited to 2 visits for your baby. Pre or post natal classes are limited to 5 consultations with a registered nurse. A limit of one six-week post-birth consultation with a GP, midwife or gynaecologist is covered if a complication arises in the first six weeks after the birth. A limit of one nutrition assessment with a dietician is covered. Mental health consultations with a counsellor or psychologist is limited to 2 visits. A limit of one lactation consultation with a nurse or lactation specialist is covered.	No benefit

	DAY-TO-DAY BENEFITS (PAID FROM MSA/ATB)	HOW THE CLAIM WILL BE REIMBURSED AND ACCUMULATE TO THE ANNUAL THRESHOLD**	CLASSIC COMPREHENSIVE	CLASSIC SAVER
			THE LIMIT ON THIS BENEFIT	THE LIMIT ON THIS BENEFIT
PROFESSIONAL SERVICES	Specialists and GPs	100% of the Scheme Rate	Paid from MSA/ATB Subject to Annual ATB limit	Limited to funds in the MSA
	Antenatal classes	100% of the Scheme Rate	R2 090 per pregnancy Paid from MSA/ATB	Limited to funds in the MSA
	Virtual paediatrician consultations	Up to a maximum of 100% of the Scheme Rate for children under the age of 10. Any amount paid from Health Care Cover does not accumulate to threshold.	Subject to Annual ATB limit	Limited to funds in the MSA
	Non-PMBs trauma services obtained from a casualty unit	Up to a maximum of 100% of the Scheme Rate for children under the age of 10. Any amount paid from Health Care Cover will not accumulate to threshold.	Limited to funds available in MSA Subject to Annual ATB limit	Limited to funds available in MSA
	Allied, Therapeutic and Psychology Benefit* * *acousticians, chiropractors, counsellors, dietitians, homeopaths, nurses, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, biokineticist, speech and hearing therapists*	Allied and Therapeutic Healthcare Services*	Limited to funds in MSA/ATB Annual sub-limits apply: Single Member R20 150 Member + 1 : R27 290 Member + 2 : R33 370 Member + 3 : R38 580 Limits are pro-rated when beneficiary joins after 1 January of the benefit year	Limited to funds in the MSA
	Allied, Therapeutic and Psychology Extender Benefit	Clinical Entry Criteria applies Upon application	Upon application. If granted, subject to limited ATB once approved.	No benefit
	Radiology	100% of the Scheme Rate	Paid from MSA/ATB Subject to Annual ATB limit	Limited to funds in the MSA
MEDICINE	Pathology	100% of the Scheme Rate	Paid from MSA/ATB Subject to Annual ATB limit	Limited to funds in the MSA
	Point-of-care device testing		Point-of-care device testing covered from Chronic Illness Benefit for members registered on the programme, when your doctor uses the defined integration solution to submit claims for tests using these devices	
	Over-the-counter medication, including prescribed schedule 0, 1 and 2 medicine and lifestyle-enhancing products	100% of the Scheme Medication Rate and does not accumulate to Annual Threshold	Limited to funds in the MSA Not paid from ATB	Limited to funds in the MSA
	Prescribed medicine*	Up to a maximum of 100% of the Scheme Rate for medicine on the Preferred Medicine List Up to a maximum of 75% of the Scheme Rate for medicine that is not on the Preferred Medicine List	Single Member R34 530 Member + 1 : R40 630 Member + 2 : R47 200 Member + 3 : R53 810 Paid from MSA/ATB	Limited to funds in the MSA
APPLIANCES AND EQUIPMENT	External medical items	100% of the Scheme Rate	R67 520 per family Paid from MSA/ATB	Limited to funds in the MSA
	Hearing aids	100% of the Scheme Rate	R29 660 per family (separate limit to EMI). Paid from MSA/ATB	Limited to funds in the MSA
	Optical* (spectacles, frames, contact lenses and refractive eye surgery, for example excimer laser)	100% of the Scheme Rate	R7 120 per person Paid from MSA/ATB. If a network optician is used, a 20% discount may be enjoyed by the member for frames and lenses	Limited to funds in the MSA If a network optician is used, a 20% discount may be enjoyed by the member for frames and lenses
	Optometry consultations	100% of the Scheme Rate	Paid from MSA/ATB Subject to Annual ATB limit	Limited to funds in the MSA
	Mobility and breathing devices for conditions such as: Hemiplegia, paraplegia, quadriplegia, Cerebral Palsy, Parkinson's disease, Multiple Sclerosis, respiratory disorders, Extrapulmonary, pleural or parenchymal respiratory diseases, connective tissue disorders, neonatal congenital defects, Muscular Dystrophy and Chronic Obstructive Pulmonary Disease	Up to a maximum of 100% of the Scheme Rate Subject to authorisation and the condition meeting the Scheme's entry criteria	Unlimited	

* Prescribed Medicine, dentistry, mental health, optical benefits and other benefits with limits are pro-rated according to the number of months left in the calendar year when the member joins the Scheme.

** Where the claimed amount is less than the Scheme Rate, we will pay and accumulate the claimed amount.

	DAY-TO-DAY BENEFITS (PAID FROM MSA/ATB)	HOW THE CLAIM WILL BE REIMBURSED AND ACCUMULATE TO THE ANNUAL THRESHOLD**	CLASSIC COMPREHENSIVE	CLASSIC SAVER
			THE LIMIT ON THIS BENEFIT	THE LIMIT ON THIS BENEFIT
DENTISTRY	Dentistry* (this includes in-hospital and out-of-hospital dentistry, and applies to hospital and related accounts)	100% of the Scheme Rate	**Treatment in-hospital** If admitted to a hospital or day-case facility: A deductible upfront payment of R7 630 (hospital) or R4 920 (day-case facilities) is payable per admission The balance of the hospital/day-case facility account will be paid by the Scheme up to 100% of the Scheme Rate. If aged 12 years and younger: a deductible upfront payment of R2 950 (hospital) or R1 350 (day-case facility) is payable by you. Dentist, Anaesthetist and related accounts are paid by the Scheme up to 100% of the Scheme Rate	
			Treatment out-of-hospital Paid from the MSA/ATB **Limits (in- and out-of-hospital)** Dental devices, appliances, prosthesis and orthodontics (surgical/non-surgical) are limited to R33 590 per beneficiary per year. Paid from MSA/ATB	**Treatment out-of-hospital** Limited to funds in the MSA **Limits (in- and out-of-hospital)** Dental devices, appliances, prosthesis and orthodontics (surgical/non-surgical) are limited to funds in the MSA
PREVENTIVE SCREENING	Seasonal flu vaccine	100% of the Scheme Rate	Limited to one per beneficiary per year Paid from the Hospital Benefit	
	Health Check (includes blood glucose, cholesterol, blood pressure and BMI check)	100% of the Scheme Rate	Limited to one group of tests per beneficiary per annum	
	Mammograms	100% of the Scheme Rate	Limited to one per beneficiary every two years Paid from the Hospital Benefit If additional mammograms are required during the course of the year, they will be funded from available day-to-day benefits but if a member meets our clinical entry criteria, they will get access to additional mammogram tests	
	Pap smears	100% of Scheme Rate	Limited to one per beneficiary every three years Paid from the Hospital Benefit If additional Pap smears are required during the course of the year, they will be funded from available day-to-day benefits but if a member meets our clinical entry criteria, they will get access to additional Pap smears	
	Prostate Specific Antigen Check	100% of Scheme Rate	Limited to one per beneficiary per year Paid from the Hospital Benefit If additional prostate checks are required during the course of the year, they will be funded from available day-to-day benefits	
	Children's vaccinations	100% of the Scheme Rate for medicine	Limited to vaccines as prescribed by the Department of Health for children aged 24 months and younger Paid from the Hospital Benefit	
	Child Health Assessment	100% of the Scheme Rate Performed by a Network provider	Applies to children over the age of two and under the age of 18 Limited to one health assessment per year Paid from the Hospital Benefit	

Consultations for screening and vaccinations are paid from the available day-to-day benefits.

* Prescribed Medicine, dentistry, mental health, optical benefits and other benefits with limits are pro-rated according to the number of months left in the calendar year when the member joins the Scheme.

** Where the claimed amount is less than the Scheme Rate, we will pay and accumulate the claimed amount.

	DAY-TO-DAY BENEFITS (PAID FROM MSA/ATB)	HOW THE CLAIM WILL BE REIMBURSED AND ACCUMULATE TO THE ANNUAL THRESHOLD**	CLASSIC COMPREHENSIVE	CLASSIC SAVER
			THE LIMIT ON THIS BENEFIT	THE LIMIT ON THIS BENEFIT
PREVENTIVE SCREENING (CONT.)	Children's Screening Benefit: Group of age appropriate tests including, but not limited to, growth assessment or milestones only up to age eight, blood pressure and health tracking	Up to a maximum of 100% of the Scheme Rate	For children between the ages of two and 18 years One test for each qualifying beneficiary per year Subject to services performed at a DSP pharmacy or provider only	
	Additional cover for Mammogram, breast MRI, BRCA testing and repeat Pap Smear	Up to a maximum of 100% of the Scheme Rate for test code Subject to meeting the Scheme's clinical entry criteria Note: Consultation paid from MSA or ATB. Where the consultation relates to a PMB the consultation will be paid from Health Care Cover	Unlimited Once off BRCA testing	
	Colorectal screening for bowel cancer	Up to a maximum of 100% of the Scheme Rate at a network provider	One fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years	
CHRONIC ILLNESS BENEFIT	Diabetes Management for members registered on the Scheme's Disease Management Programme	Up to 100% of the Scheme Rate for services covered in the Scheme's basket of care if referred by the Scheme's DSP	Basket of care as set by the Scheme	
INVESTIGATIONS	MRI and CT scans (must be referred by a specialist) In-hospital visits are covered at 100% of the Scheme Rate if related to an authorised event	100% of the Scheme Rate	**In-hospital** Covered at 100% of the Scheme Rate if related to an authorised event **Out-of-hospital** First R3 770 of MRI and CT scan code will be paid from the MSA/ATB. The balance of the MRI and CT scan code will be paid from the Hospital Benefit. Also applies to MRI or CT scans done when the member is admitted to hospital for conservative back treatment. Authorisation is required for in-hospital and out-of-hospital events	**In-hospital** Covered at 100% of the Scheme Rate if related to an authorised event **Out-of-hospital** First R3 770 of MRI and CT scan code will be paid from the MSA. The balance of the MRI and CT scan code will be paid from the Hospital Benefit. Also applies to MRI and CT scans done when the member is admitted to hospital for conservative back treatment. Authorisation is required for in-hospital and out-of-hospital events
	Pregnancy scans	100% of the Scheme Rate	Two scans per pregnancy (3D and 4D Scans covered as per 2D Scans)	Two scans per pregnancy (3D and 4D Scans covered as per 2D Scans) Limited to funds in the MSA
	Gastroscopy, colonoscopy, proctoscopy, sigmoidoscopy, oesophagoscopy and anoscopy	100% of the Scheme Rate	**In-hospital** First R4 910 of the hospital account is paid from MSA/ATB for single procedures and R5 740 for multiple procedures Balance of hospital and related accounts are paid by the Scheme up to the Scheme Rate Subject to preauthorisation **Out-of-hospital** If performed out-of-hospital, no co-payments apply All accounts (hospital and related) are paid by the Scheme up to the Scheme Rate Subject to preauthorisation Paid from MSA/ATB	**In-hospital** First R5 580 of the hospital account is paid from MSA for single procedures and R6 970 for multiple procedures Balance of hospital and related accounts are paid by the Scheme up to the Scheme Rate Subject to preauthorisation **Out-of-hospital** If performed out-of-hospital, no co-payments apply All accounts (hospital and related) paid by the Scheme up to the Scheme Rate Subject to preauthorisation Limited to funds in the MSA

* Prescribed medicine, dentistry, mental health, optical benefits and other benefits with limits are pro-rated according to the number of months left in the calendar year when the member joins the Scheme.

** Where the claimed amount is less than the Scheme Rate, we will pay and accumulate the claimed amount.

KEY

INFORMATION

CONTACT DETAILS

Service centre: 0860 100 421

Emergency: 0860 999 911 for Discovery 911

For health plan queries: service@discovery.co.za

Oncology and HIVCare programmes: 0860 100 421

Diabetes Programme: 0860 100 421

If you even slightly suspect someone of committing fraud, report all information directly to the Discovery fraud department: forensics@discovery.co.za

Or you may remain anonymous using these contact details:

Toll-free phone: 0800 004 500

SMS 43477 and include the description of the alleged fraud

Toll-free fax: 0800 00 77 88 Email: discovery@tip-offs.com

Post: Freepost DN298, Umhlanga Rocks 4320

How to **claim**

IMPORTANT TIPS WHEN CLAIMING

- When sending claims, please make sure the following details are clear:
  - Your membership number.
  - The service date.
  - Your doctor's details and practice number.
  - The amounts charged.
  - The relevant consultation, procedure or NAPPI code and diagnostic (ICD-10) codes.
  - The name and birth date of the dependant for whom the service was done.
  - If paid, attach your receipt or make sure the claim says 'paid'.
  - Check with your healthcare provider if they have sent your claims to us to avoid duplicates.
  - Send your claims within four months, otherwise we will consider them expired and not pay them.
  - Remember to always keep copies of your claims for your records.

To see the status of your claim, you can go to www.discovery.co.za

Important notes:

01. *Healthcare practices must be appropriately registered with the Board of Healthcare Funders (BHF) and must have a valid practice number in order for claims to be considered.*
02. *The Scheme Rate is set by the Scheme for reimbursement or it is the rate agreed between the Scheme and the provider.*

Discovery Health has been tasked to negotiate certain rates on behalf of the Scheme.

EMAIL

You can scan and email your claim to claims@discovery.co.za

01

POST

You can post your claims to the following address: Tsogo Sun Group Medical Scheme – Claims P O Box 652509 Benmore 2010.

02

SMARTPHONE APP

You can submit a claim on your device to scan or add a photo of your claim. You can also upload a PDF of the claim.

03

General **exclusions**

SCHEME RATE

This is the amount of money the Scheme pays for a specific type of medical procedure, treatment or consultation. There are, however, certain healthcare professionals with whom the Scheme has negotiated rates. The negotiated tariff replaces the Scheme Rate in those instances.

MEMBER DEBT

You are given your Medical Savings Account upfront each year but you contribute towards this every month when you pay your contributions (annual allocation divided by 12). You may spend your whole Medical Savings Account early in the year or you may save it. If you resign from your employer and you are no longer eligible to remain on the Tsogo Sun Group Medical Scheme as a member, you will need to be withdrawn and move onto an open-market medical scheme.

If you have spent more of your Medical Savings Account than what you have contributed, the amount that you have overspent will be due back to the Tsogo Sun Group Medical Scheme. We call this member debt. You may also create member debt by taking off one or more of your dependants during the year.

Remember that your Medical Savings Account allocation is based on family size so by reducing your family size you reduce your Medical Savings Account allocation. In the event that you have spent more than what you have contributed, this difference will be due back to the Tsogo Sun Group Medical Scheme.

The Tsogo Sun Group Medical Scheme takes member debt very seriously as it places a burden on the rest of the Scheme. A Member Debt Administrator will be in contact with you if debt is owed to the Tsogo Sun Group Medical Scheme. It is important to note that member debt will be deducted from your salary by your employer's payroll and will be paid over to the Tsogo Sun Group Medical Scheme to settle the debt that is owed.

GENERAL EXCLUSIONS

Claims will not be paid if they are, according to the Scheme, caused directly or indirectly by the following:

01. Healthcare services of a cosmetic nature, for example, otoplasty for bat-ears.
02. Healthcare services relating to portwine stains and blepharoplasty (eyelid surgery).
03. Healthcare services relating to breast reductions/enlargements and gynaecomastia.
04. Healthcare services relating to obesity.
05. Healthcare services relating to frail care.
06. Healthcare services relating to infertility.
07. Healthcare services relating to wilfully self-inflicted illness or injury.
08. Healthcare services relating to alcohol, drug or solvent abuse except where PMB.
09. Healthcare services relating to injuries sustained during participation in a wilful and material violation of the law.
10. Healthcare services relating to injuries sustained during a wilful participation in war, terrorist activity, riot, civil commotion, rebellion or insurrection.
11. Experimental, unproven or unregistered treatment or practices.
12. Healthcare services related to any waiting periods, if applicable.
13. Healthcare services relating to any complication that may arise from any exclusion.
14. Healthcare services relating to any travel to a country at war.
15. Any costs for which a third party is legally responsible.

The Company's subsidy for medical scheme contributions appears in the Company's HR manual. All cover is subject to medical necessity.

This brochure is merely a summary of the Scheme's key benefits and features for 2023, pending approval from the Council for Medical Schemes. Full details will be found in the Scheme Rules.

This brochure gives you a brief outline of the benefits Tsogo Sun Group Medical Scheme offers. This does not replace the Scheme rules. The registered Scheme rules are legally binding and always take precedence.

Fair collection notice

YOUR PERSONAL INFORMATION:
HOW DOES DISCOVERY OBTAIN, USE, DISCLOSE AND PROCESS IT

We understand that your personal information is important to you and that you may be anxious about disclosing it. Your privacy and the security around your information is just as important to us and therefore we want to make sure you understand how we will process your information. We will always strive to keep your personal information and that of your dependants confidential, whether you supplied it to us directly or whether we have collected it from other sources.

We take this commitment to look after your information seriously and we have implemented a number of processes to make sure it's used in the right way. That is why, if you think we have used your personal information in a way that goes against the law, you can speak to us about it and we promise to look into the matter.

The accuracy of your personal information is also important to us and you can always ask us for details about the information we have on record for you. If you think that we have outdated information, you can ask us to update or correct it.

Apart from you giving us your personal information and those of your dependants, there are other sources from which we may also get information i.e. doctors or other healthcare providers. These sources are bound by their own promise to look after your information and make sure it is used in the right way.

THESE ARE SOME OF THE WAYS WE WILL USE YOUR PERSONAL INFORMATION

To service your membership, Discovery Health and Tsogo Sun Group Medical Scheme will use your information in different ways. These include:

- Underwriting or risk assessments.
- Considering a claim for medical expenses.
- Administration of your medical scheme membership.
- Providing managed care services to you or any dependants on your membership.
- Providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependants on your health plan.

Discovery Health may include some of your information in any academic research. Local and international contracted research and survey providers may also use your information. This will always be on an anonymous basis, which means that data about you that is relevant to the research is used but it is not linked to your name or membership. If we want to share your information, for any other reason, we will only do so with your permission.

SOME OF THE OTHER SOURCES THAT WE WILL SHARE YOUR PERSONAL INFORMATION WITH

As a member of an employer group we may get or share information relating to your membership with your employer. This will be limited to information that is relevant to your application or information that is required for the ongoing servicing of your membership, but will not include any health information unless you have given us permission to do so. We may also share your personal information with credit bureaus or the credit provider's industry association, including personal information about any judgement or default history.

We may also share your personal information with other third parties, including healthcare professionals if a clinical assessment is needed. Depending on the circumstances this may also be shared with providers outside of the borders of South Africa.

Discovery will use your contact information to notify you of developments on products you already have with us. If you don't want to receive this kind of communication from us, you can ask us to stop this communication.

We may also share your personal information with other businesses in the Discovery Group if you or your dependants already have a relationship with them or if you have applied for a product or benefit. We will only share information that is needed for the administration of your (or your dependant's) products or benefits. So, for example, if you have a Vitality membership, and you need to obtain Vitality points for a mammogram, Tsogo Sun Group Medical Scheme will share the fact that you had a mammogram done on a specific date.

If you have a financial adviser they may also ask us to share your (or your dependants') personal information with them. We will only share information that enables them to provide you with sound advice, such as your plan type and your contact details. We will not share any information about your medical conditions (or that of your dependants) unless you have given us your permission to do so.

Glossary of terms

TERM	ACRONYM	WHAT
Above Threshold Benefit	ATB	When members' cumulative expenses equal the Annual Threshold amount, the member enters the Above Threshold Benefit. Once the member enters the Above Threshold Benefit, the Scheme covers the cost of certain day-to-day medical expenses
Body mass index	BMI	Formula used to determine whether a person is within an acceptable weight range for his or her body. To calculate BMI divide weight in kilograms by height in centimetres squared. A healthy BMI is between 18 and 25
Benefit entry criteria	CEC	Specific medical standards a member's doctor must attest they meet for the member's condition to be covered from the Chronic Illness Benefit and receive sustainable funding for cost-effective treatment
Co-payment	N/A	This can be funded from your Medical Savings Account, subject to funds available in your Medical Savings Account
Cost	N/A	When choosing to have your claims paid at cost price, the full amount claimed by the provider will be paid from your Medical Savings Account. Certain providers may charge more than the Scheme Rate
Deductible	N/A	This is an amount payable upfront at the point of service. A deductible cannot be paid from your MSA
Designated service provider	DSP	The doctors, specialists, hospitals and pharmacies that the medical scheme has negotiated preferential rates with in offering their benefits for Prescribed Minimum Benefit conditions
Direct Payment Arrangement	DPA	Discovery Health on behalf of Tsogo Sun Group Medical Scheme implemented payment arrangements in an effort to reduce payment frustration for members and healthcare professionals. Participating doctors agree to charge a set rate, as determined by Discovery Health on behalf of Tsogo Sun Group Medical Scheme. This rate is based on what is affordable to the Scheme as well as appropriate for healthcare professionals
Emergency medical services	EMS	Ambulance services
External medical Items	EMI	Medical items used on the exterior of the body such as prosthetic limbs, wheelchairs, crutches, and so on
In-Hospital	IH	Refers to all related, approved costs etc. during procedures (emergency or elected) which occur during a hospital stay
Medical Savings Account	MSA	The Medical Savings Account covers the cost of day-to-day expenses such as visits to GPs and dentists, as well as the cost of medication subject to the availability of funds in the Medical Savings Account. The full annual amount is available on 1 January every year, any leftover savings are carried over to the following year
Out-of-hospital	OH	Refers to any procedures, claims or benefits which occur without an overnight hospital stay. Also known as 'day-to-day'
Over-the-counter	OTC	Medicine Schedule 0 – 2
Preferred provider	N/A	A provider chosen by a medical scheme to provide specific services for its members. These services may be furnished at discounted rates. Members must visit these providers to enjoy specific cover
Scheme Rate	N/A	This is the rate that the Scheme sets for reimbursing claims
Scheme Rate for medicine	SMR	This is the single exit price for medicines plus the relevant dispensing fee
Self-payment Gap	SPG	The Self-payment Gap happens when members on the Tsogo Sun Group Medical Scheme (Classic Comprehensive members only) run out of funds in their Medical Savings Accounts before reaching the Annual Threshold. When a Self-payment Gap is in force, the member is personally responsible for the payment of all day-to-day medical expenses
Single Exit Price	SEP	The Single Exit Price dictates the selling price of medicine at all pharmacies and healthcare providers
To-take-out medicine	TTO	Medicine for seven days, given to you before you are discharged from hospital

Complaints and disputes

What to do when you have a query or complaint that remains unresolved

The Medical Schemes Act 131 of 1998 (the Act) states that members who are aggrieved with the conduct of a medical scheme or want to dispute a decision taken by their medical scheme have the right to contact the Council for Medical Schemes (CMS) for a dispute resolution.

The Act also sets out the complaints procedure that must be followed.

Members must first try to resolve the matter with their medical scheme and only contact CMS if they are still in disagreement with the medical scheme.

The Scheme's Dispute Resolution Process requires that you contact the administrator, Discovery Health, through the contact centre on **0860 100 421** and lodge the complaint or dispute.

If the matter remains unresolved or the feedback received is not to your satisfaction, the matter can be escalated in writing to the Principal Officer at the Scheme's registered address.

Members who thereafter are still in dispute with their Scheme can contact the Council for Medical Schemes.

The contact details for the Council of Medical Schemes are as follows:

- Physical address: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
- Postal address: Private Bag X34, Hatfield 0028
- Phone number: 0861 123 267
- Fax number: 012 431 7644
- Email: complaints@medicalschemes.co.za

TSOGO SUN
GROUP MEDICAL SCHEME

Administered by
Discovery Health

Call Centre 0860 100 421 | service@discovery.co.za | www.discovery.co.za

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