FEDHEALTH

Maxima Standard

2017

COMPREHENSIVE OPTION RANGE

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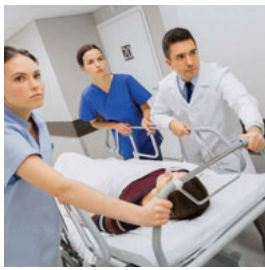

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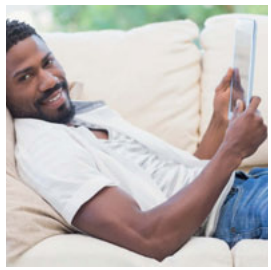

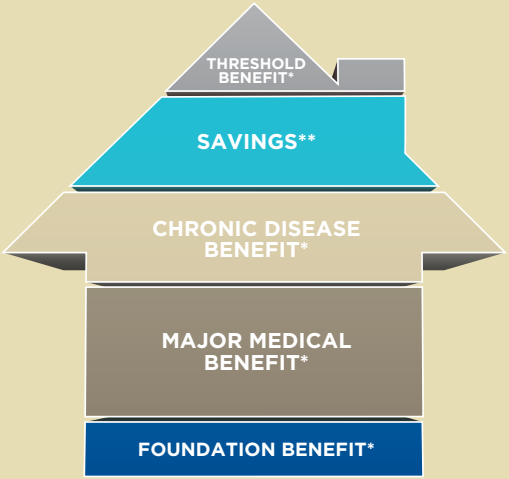

Risk and Savings benefits

Your scheme works by taking your contribution and dividing it into two parts.
The one part goes towards Risk Benefits, the other goes to a Savings Account.

*Risk benefits

For risk benefits, the scheme pools together members' contributions and uses the money to fund a set of benefits, including the Foundation Benefit, Major Medical Benefit, Chronic Disease Benefit and Threshold Benefit.

The scheme has rules for when each of the risk benefits is allowed to pay out. These scheme rules give limits for what the benefit can pay out for particular conditions, treatments and medicines. Because the scheme applies its rules consistently, we can be confident that:

- We treat all members fairly and do not discriminate against any members
- The medical scheme is sustainable and will not run out of money.

**Savings Account

The part of your contribution that is paid to the Savings Account is not pooled with other members' contributions. The money in the Savings Account is your money and it gives you a level of control on your spending. The money that is not used in one year is carried over to the following year and this is called Carry-over Savings. This may be used after your new year's day-to-day benefits have been depleted. Any savings balance not used will be paid out if you leave the scheme.

Examples of what each benefit covers

Each benefit is carefully planned to cover a set of medical expenses for members and their dependants. This table gives a general idea of what may be covered by each benefit. You must read the full member guide to find out what is and is not covered.

Name of benefit	Examples of what may be covered under the benefit	Sections
Foundation Benefit		**Various**
This benefit offers members a host of valuable benefits	Screening benefit Birth & Baby benefit Extended Care benefit	
Major Medical Benefit		**3**
This benefit has no overall yearly limit, but there are limits and restrictions for particular treatments.	Emergency treatment in hospitals or casualty Hospital stays and most treatment in hospital Some treatments and procedures at day clinics and in doctor's rooms Female contraception Some treatment after a hospital visit (30 day benefit) Doctor appointments with network FPs Oncology treatment Threshold Benefit when your day-to-day expenses have added up to your threshold level	
Chronic Disease Benefit		**6**
This benefit has an overall yearly limit and only provides cover if your condition is one of the conditions covered on this option. There may be restrictions for particular medicines and treatment.	Conditions that are covered include the 25 Prescribed Minimum Benefit conditions as well as an additional 14 conditions. The medicine for the treatment of these conditions that meet the criteria as set by the scheme will be covered by this benefit	
Day-to-Day Benefits		**7**
Your day-to-day expenses are covered from: 1. Savings Account 2. Carry-over Savings or self-payment 3. Threshold Benefit	Visits to doctors or specialists Prescribed medicine for illness (for example, the flu) Over-the-counter medicine Other day-to-day medical expenses. Common examples are dentistry, optometry, blood tests and physiotherapy	

Some important words

Here are explanations of some important words used in this booklet:

About healthcare providers

Fedhealth network: The Fedhealth network includes doctors, specialists, pharmacies and facilities that Fedhealth has an agreement with. It is always in your best interest to use a healthcare provider in the network as we have agreed rates with them. Please use the network locator on our website or contact us if you want to find a healthcare provider in the Fedhealth network.

Designated Service Provider: This is a healthcare provider (for example, a doctor, pharmacy or hospital) that members must use in order for them not to incur a co-payment on their treatment.

About medicines and payment for medicines

Medicine Price List: For every originator medicine which has one or more generic alternatives, the scheme has determined a ceiling price (the maximum we will pay) for that group of generic medication. This ceiling price will be high enough to pay in full for at least one of the generic medicines for that particular group of medicine.

Generic medicines: Generic medicines are medicines that are brought to market after patents have expired on originator medicines. They contain the exact same active ingredients, strength and formulation as the originator product. However, they are usually much cheaper than the originator product. Choosing medicine that the scheme covers in full ensures that you will have no out of pocket co-payments. For example, if an originator product has seven generics, the Medicine Price List price will be set – not at the cheapest – but at the cost of one of these generics. When a new generic is introduced for the originator product, the Medicine Price List amount may be recalculated.

Originator: Originator medicines are medicines that have been newly developed and subsequently patented by a pharmaceutical company.

Formulary: This is an approved list of medicine for each of the chronic conditions covered by the scheme. If a formulary applies, we only cover medicine that is listed on the formulary. The Medicine Price List (MPL) also applies to medicines in a formulary.

About limits to what we pay

Fedhealth Rate: These are the rates that the scheme sets every year for each and every medical service, procedure, treatment etc. These rates are adjusted annually by inflation and are used as the basis for all tariff negotiations.

Healthcare professional tariff: This is the reimbursement rate that has been negotiated or set for the payment of professional services and will usually be a multiple of the Fedhealth Rate.

Co-payment: This is an amount that you must pay from your own pocket for a particular treatment or service.

About treatment and payment for treatment

Treatment protocol: A plan for a course of treatment.

360 Care: Let the healing begin (with your FP)

Do you recall there was a time when the family doctor treated Mom, Dad, the kids and Granny as well? He or she got to know the family inside and out, and was aware of all their ailments and allergies. This meant that everyone knew where to turn when they felt poorly – a single medical professional they could trust for expert medical advice.

This is the inspiration behind our 360 Care initiative, in which your family practitioner or FP as we like to call them becomes the coordinator of your care, working directly with you, the member, to ensure that your health needs are met safely, timeously and cost effectively. In a nutshell, this means that your FP, who will have the best understanding of your health status and treatment history, will refer you to the appropriate specialists to deliver the right care at the right time.

We believe that 360 Care improves the quality of healthcare by facilitating access to the appropriate specialist care, and that it prevents unsafe combinations of treatments including medicines. It also prevents unnecessary duplication of costly clinical tests and treatments – which contribute to rising health care costs and increases in members' contributions. Finally, we have introduced electronic health records which allow the healthcare providers treating you to easily access and exchange your medical information.

In addition, your FP will refer you and be able to make an appointment for you with a specialist much quicker than you might be able to do yourself. So, simply visit your Network FP (an unlimited benefit on your option) for a referral to the relevant specialist. Non-network FPs may also be consulted, but these visits will be paid from your Savings and may result in a co-payment from you.

Under 360 Care, you will require a FP referral to visit: cardiologists, dermatologists, gastroenterologists, gynaecologists, neurologists, neurosurgeons, orthopaedic surgeons, otorhinolaryngologists (ENT), paediatric cardiologists, paediatricians, physicians, plastic and reconstructive surgeons, psychiatrists, pulmonologists, rheumatologists, surgeons and urologists. A FP referral is not necessary for: children under the age of two visiting a paediatrician, female members visiting a gynaecologist for their annual check-up, visits to oncologists, ophthalmologists, radiologists (general or specialised) or pathology services.

Trusting your FP to coordinate your specialist care means having a healthcare practitioner with the information at hand to give you and your loved ones the best possible care. Just what your precious family deserves.

Prescribed Minimum Benefits (basic level of cover for a defined set of conditions)

All medical schemes are required by law to cover 270 hospital based conditions and 25 chronic conditions in full without co-payment or deductibles, as well as any emergency treatment and certain out of hospital treatment. This means that all schemes must provide PMB level of care at cost for these conditions.

The Medical Schemes Act 131 of 1998 allows schemes to require members to make use of Designated Service Providers (DSPs) in order for a member to be entitled to funding in full. Schemes may also apply formularies – a list of medicines which should be used to treat PMBs, and managed care protocols – based on evidence-based medicine and cost-effectiveness principles to manage this benefit.

Fedhealth has designated their network specialists, network FPs and three designated pharmacy networks, the Medi-Rite group of pharmacies, Dis-Chem and Pharmacy Direct, as the Designated Service Providers for the provision of PMBs (as well as the State). This means that a member must make use of a Fedhealth network specialist, a network FP or the designated pharmacy networks, in order for the cost to be funded in full. Should the member not use these DSPs for the treatment of a PMB condition, the scheme will reimburse treatment at the non-Fedhealth network rate. Co-payments are applicable to the voluntary use of non-DSPs. It is important to note that qualification as a PMB is not based solely on the diagnosis (condition) but also on the treatment provided (level of care).

This means that although your condition may be a PMB condition, the scheme would only be obliged to fund it in full if the treatment provided was deemed to be PMB level of care.

You are covered for emergency medical expenses

This table shows that the cost of medical care in emergencies will be paid from the Major Medical Benefit.

To qualify as an emergency, the condition must be unexpected and need immediate treatment. (This means that if there is no immediate treatment, the condition might result in lasting damage to organs, limbs or other body parts, or even in death).

Ambulance Services **call 0860 333 432**	Unlimited cover with Europ Assistance
Treatment in casualty	Claims will be paid from the Major Medical Benefit only if... A member visits the trauma unit of a clinic or hospital and is admitted into hospital immediately for further treatment A member visits the trauma unit of a clinic or hospital for emergency treatment for a fracture, for example. Claims will be paid from the Day-to-Day Benefit if... A member visits the trauma unit of a clinic or hospital for a non-emergency and is not immediately admitted into hospital Please note that if a member visits their FP for an emergency treatment such as stitches and the procedure takes place in the doctor's consulting rooms, this will be paid from day-to-day benefits and not from the Major Medical Benefit A R500 co-payment will apply to all visits to the trauma unit of a clinic or hospital if the member is not admitted to hospital directly.
Trauma counselling	After a traumatic experience, for example, being a victim of crime or being in a car accident, Fedhealth provides emotional and practical support through ICAS. Call ICAS on 0800 212 695.
Emergency medical services: **call 0860 333 432**	You can contact Europ Assistance for a range of emergency services on 0860 333 432. These services include: Emergency road or air response Medical advice in any emergency situation Delivery of medication and blood Patient monitoring Care for stranded minors or frail companions 24-hour Fedhealth Nurse Line.

NB! You must contact us within two working days if it was an emergency

In an emergency you must get an authorisation number from us within two working days after going to hospital. If you do not, you will have to pay a penalty of R1 000.

If you cannot contact the Authorisation Centre yourself, then your doctor or a family member or the hospital can contact us on your behalf.

Contact us within two working days if you needed trauma treatment

If you visit casualty for trauma treatment, you must get an authorisation number from us **within two working days** of the treatment. If you do not, the claim will be paid from the Day-to-Day Benefit.

Going to hospital in an emergency:

AN EXAMPLE	
What the member does	**How the expense is funded**
Kate is involved in a car accident. A bystander calls the number that they see on the Fedhealth sticker on Kate's car. An ambulance is sent by Europ Assistance to transport her to hospital. She receives emergency medical care in casualty and is discharged the same day.	Kate will have to pay the first R500 of the account. The Scheme will pay the balance from the Major Medical Benefit, as long as Kate contacts the scheme within two working days of the emergency treatment.

About limits and co-payments for hospital stays

No overall yearly limit

There is no overall yearly limit for the Major Medical Benefit.

There are limits and restrictions for specific treatments and conditions

Hospital costs are covered unlimited from the Major Medical Benefit. Case management and managed care protocols apply to certain benefits. These protocols have been introduced to ensure best quality treatment at best rates. Consult the Major Medical Benefit tables in this section for detail on these protocols and limits.

For some treatments and procedures, you must pay an amount out of your own pocket. This is called a co-payment. Co-payments apply to the hospital bill and are usually paid upfront to the hospital.

Different cover for different types of hospital treatments

When you go to hospital, there are different accounts from different providers. We cover these accounts differently. Here is a summary. Please read the full section for details.

- The account for hospital costs. Examples of what this would include are: ward fees, theatre fees, supplies, and medicine that was dispensed by the hospital. In most cases, hospital costs will be covered in full by the Major Medical Benefit. However, for some treatments:
  - you might have to pay an amount out of your own pocket, referred to as a co-payment
  - there might be limits to the amount we cover. For example prosthesis.
- The accounts from doctors or specialists. For example, if you had an appendectomy, you would receive a separate account from the specialist who performed the procedure. If the doctor or specialist is in the Fedhealth network, we will cover this in full.
- The separate accounts from other various providers, for example, physiotherapists, X-ray departments. We cover these at different rates. See page 12.

Hospital costs we cover in full

We have agreed rates with hospitals and we will therefore pay the full hospital bill for:
- accommodation in a general ward (you pay the difference if you go to a private ward)
- high care ward and intensive care unit
- theatre fees.

Medicine you receive in hospital

Medicine that you use while you are in hospital	No limit, we pay the full cost, subject to managed care protocols
Medicines that are prescribed in hospital for you to use when you go home (take-out medicines)	Seven days of medicine for each hospital event. We pay the full cost
Specialised medicine (also see page 14)	There is no benefit for specialised medicine on this option

Doctor visits while you're in hospital

While you are in hospital, you are under the care of specialists (such as paediatricians or cardiologists) and other doctors (such as family practitioners). These are covered differently to doctor appointments out of hospital. You must remember that the reimbursement rates below are for the professional fees only.

Specialists who are in the Fedhealth network	We pay professional fees in full
Specialists who are not in the Fedhealth network	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the specialist
Family practitioners who are in the Fedhealth network	We pay professional fees in full
Family practitioners who are not in the Fedhealth network	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the healthcare professional
Dietetics, occupational therapy and speech therapy	Paid from the Day-to-Day Benefit. Does not accumulate to threshold. Paid from threshold up to R10 500 per family per year
Physical therapy (physiotherapy and biokinetics)	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the healthcare professional. Subject to referral by a medical practitioner. Must be pre-authorised and subject to treatment protocols

Before you go to hospital, you should try to make sure that your doctor and specialist are in the Fedhealth network.

Going to hospital for an operation:

AN EXAMPLE

What the member does	How the expense is funded
Alice's son needs to have his tonsils out. Alice made sure that the surgeon and the anaesthetist are in the Fedhealth network. She gathers the required information from her doctor and then phones Fedhealth to get an authorisation number. The child has the operation and leaves the hospital on the same day. Alice receives two invoices by email: - An invoice from the anaesthetist - An invoice from the ear-nose-and-throat (ENT) specialist She sends the accounts to the scheme for payment. The hospital sends its account direct to Fedhealth.	The scheme covers the cost of the anaesthetist and the specialist in full because they are in the Fedhealth network. The scheme covers the hospital account in full. Benefits, limits and managed care protocols apply. Note: if the surgeon and the anaesthetist were not in the Fedhealth network, Alice would pay the difference between 100% of the Fedhealth Rate and the cost directly to the healthcare service provider.

Blood and pathology services while you're in hospital

Blood, blood equivalents and blood products	We cover the full cost
Pathology (blood tests)	We pay 100% of the Fedhealth Rate for professional fees. You must pay the rest direct to the healthcare professional

Maternity benefit

Medical expenses during pregnancy	See Day-to-Day benefits on page 31
Medical expenses related to the delivery	Paid from Major Medical Benefit
Expenses for ward, medicines, materials etc. Includes delivery in hospital, a registered birthing unit or at home Includes the hire of a water bath	We cover the full cost
Gynaecologist and paediatrician	Will be covered in full if in the Fedhealth network. If they are not in the Fedhealth network, they will be covered up to 100% of the Fedhealth Rate
Funding for Doula (labour support during natural childbirth)	R1 200 per delivery
After delivery: Post-natal midwifery benefit	Four consultations per pregnancy at 100% of the Fedhealth Rate

Spinal surgery

There is a R3 700 co-payment on the hospital bill. There is no benefit if the Conservative Back and Neck Rehabilitation Programme has not been completed.

Conservative Back and Neck Rehabilitation Programme

Following headaches, back and neck pain is the most common cause of ill health and incapacity amongst human beings. It often has significant financial and social implications, and is a major source of discomfort.

To ease the pain of eligible members and help them avoid spinal surgery, we have introduced the Conservative Back and Neck Rehabilitation Programme. Qualifying members and beneficiaries will be enrolled in either a physiotherapy programme, or a six-week multidisciplinary programme that involves assessment and treatment by a family practitioner, physiotherapist and biokineticist. This programme is run at DBC Clinics, one of our preferred service providers.

Positive outcomes include improved flexibility, reduced pain and stiffness, and therefore a better quality of life. The programme has also been proven to postpone, limit or assist in avoiding surgery. Where surgery is warranted, it will be permitted within Scheme Rules.

Please note: Should you decline to participate in the programme prior to surgery, there will be NO benefit for spinal surgery. In other words, the Scheme will not pay for the hospital, surgeon, prosthesis or anything related to the procedure. And, if spinal surgery is still necessary following successful completion of the programme, and you do receive

authorisation from the Scheme, you will still have a co-payment of R3 700 on the hospital bill. This does not apply to emergency treatment/PMB.

How can you access the programme? There are a number of ways to access the programme:

- The telephonic helpline on **0860 002 153**
- You could be identified by the Scheme through predictive modelling
- The Scheme might intervene prior to authorising your back and neck surgery
- Managers might refer their employees to be assessed for eligibility
- Referral by your FP or specialist.

Oncology (cancer)

Full cover for services through ICON

The Scheme has contracted with Independent Clinical Oncology Network (ICON) for oncology treatment. If you have not reached your limit for the Oncology benefit and if you use an ICON service provider, the Major Medical Benefit will cover your treatment for the following in full up to the benefit limit according to the Scheme's level 1 protocols:

- Oncologist consultations
- Visits, treatment and materials for chemotherapy and radiotherapy
- Approved medication
- Radiology and pathology

ICON is a network of oncologists that includes 75% of all practicing oncologists in South Africa. For information, visit **www.cancernet.co.za** or call **0860 100 572**.

If you do not use an ICON oncologist, then we cover your treatment only up to 100% of the Fedhealth Rate.

If you have reached your limit for the Oncology benefit

Once your benefit limits have been reached we will only cover PMBs. You must make use of the Designated Service Provider, ICON. If you use any other service provider, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.

Limits for specific treatments

Oncology: chemotherapy, radiotherapy, approved medication, related consultations, pathology and general radiology	We pay up to a limit of R400 000
Specialised medicine (eg, biologicals)	There is no benefit for specialised medicine on this option
Brachytherapy materials	R39 900

Oncology Disease Management Programme (ODM)

On diagnosis of cancer, it is important that you register on the Oncology Disease Management Programme (ODM). You or your treating doctor can call them on **0860 100 572** and register. The programme aims to help your doctor to ensure best treatment and support. Changes in your oncology medicine need to be given to ODM as soon as possible. Please fax the changed treatment plan to **021 466 2303** or email **cancerinfo@fedhealth.co.za**.

Specialised radiology (for example, MRI or CT scans)

We cover specialised radiology (for example MRI or CT scans) up to 100% of the Fedhealth Rate, whether you have it in or out of hospital. You must pay the first R1 900 for non-PMB scans. You must get separate authorisation for a specialised radiological procedure, whether it takes place in or out of hospital.

Other treatments or procedures that you receive in hospital

All limits in this section are per family per year, unless otherwise explained

Appliances, external accessories and orthotics (e.g., compression stockings for DVT)	Paid from the day-to-day benefit. Does not accumulate to threshold. Paid from threshold up to R10 500 per family per year. Sub-limit of R3 910 per beneficiary for foot orthotics
Arthroscopic procedures: other	You pay a co-payment of R2 100 on the hospital bill. (See page 12 for cover for doctors and specialists)
Arthroscopic procedures: Hip and wrist	You pay a co-payment of R2 100 on the hospital bill. (See page 12 for cover for doctors and specialists)
Colonoscopy, Upper GI endoscopy	You pay a co-payment of R2 100 on the hospital bill. (See page 12 for cover for doctors and specialists)
Corneal graft	We pay up to a limit of R18 700 per person registered on the scheme. (See page 12 for cover for doctors and specialists)
Joint replacements	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists) You must use ICPS for hip and knee joint replacements. See page 18 Subject to internal prosthesis benefit limits. See page 18
All open hernia repairs	Unlimited cover. (See page 12 for cover for doctors and specialists)
HIV: Immune deficiency related to HIV infection	Unlimited cover. (See page 12 for cover for doctors and specialists)
Organ transplant including immunosuppression medication	We pay up to a limit of R400 000. (See page 12 for cover for doctors and specialists)
Rhizotomies and facet pain blocks (limited to one of either procedure for each beneficiary each year)	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists)
Balloon sinuplasty	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists)
Laparoscopic hernia repairs (bilateral inguinal, repeated inguinal hernias and nissen/ toupey repairs only)	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists)
Laparoscopic procedures	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists)
Maxillo-facial surgery	Unlimited cover. (See page 12 for cover for doctors and specialists)
Post-hospitalisation benefit	We pay for up to 30 days after discharge at 100% of the Fedhealth Rate. See page 17.
Psychiatric Services: accommodation in a general ward, procedures, ECT, materials and hospital equipment, consultations and visits, medicines and injection material	We pay up to a limit of R22 600. (See page 12 for cover for doctors and specialists)

Renal dialysis (chronic): consultations, visits, all services, materials and medicines associated with the cost of renal dialysis	We pay up to a limit of R400 000 at 100% of the Fedhealth Rate
Specialised radiology (for example, MRI or CT scans), whether the procedure is performed in or out of hospital	Unlimited at 100% of the Fedhealth Rate (as long as you get separate authorisation) You pay a co-payment of R1 900 for non-PMB scans
Spinal surgery	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists). No benefit unless Conservative Back and Neck Rehabilitation Programme has been completed. See page 13. Subject to internal prosthesis benefit limit. See page 18
Terminal care	We pay up to a limit of R27 900 at 100% of the Fedhealth Rate
Wisdom teeth (surgical removal of impacted wisdom teeth)	You pay a co-payment of R3 700 on the hospital bill. (See page 12 for cover for doctors and specialists)

Some treatment and procedures done out of hospital

To save your Day-to-Day Benefit, we pay for various treatments that are not done in hospital from the Major Medical Benefit. This helps members because it means that your Day-to-Day Benefit will last longer each year.

Services like physical rehab and treatment in sub-acute facilities

In many cases, you might be able to be treated in a sub-acute facility rather than a hospital. There is no limit for the cover we give for this and it is paid from the Major Medical Benefit. Treatment is subject to Prescribed Minimum Benefit level of care only and to managed care protocols.

Nursing instead of hospitalisation

If it is possible to use nursing services (including private nurse practitioners and nursing agencies) instead of going to hospital, we will cover the expense from the Major Medical Benefit. Subject to managed care protocols.

Procedures performed in day wards, day clinics and doctor's rooms

The Major Medical Benefit (not Day-to-Day Benefits) covers more than 60 procedures that do not require an overnight stay in hospital and can safely be performed in day wards, day clinics and the doctor's rooms. An example is a tonsillectomy.

Doctor appointments with network FPs

If you use an FP in the Fedhealth network, the appointment is paid out of the Major Medical Benefit and not from your Savings.

Female contraception

In most cases, female contraception, including the contraceptive pill, contraceptive rings and IUD, is covered by the Major Medical Benefit. However, the Major Medical Benefit will not cover:

- Female contraception that is prescribed for reasons other than contraception (for example, for skin problems). Examples of contraceptive pills that we do not cover are Cyprene-35 ED, Diane–35, Tricilest, Ginette and Minerva
- Costs of consultations or other expenses related to the IUD. The Major Medical Benefit covers the cost of the IUD itself, (for example, Mirena) but does not cover any related costs.

Other costs for contraception will usually be covered by the Day-to-Day Benefits.

Some treatment after a hospital visit

Medicine you get while in hospital to take at home

The scheme covers up to seven days of medicine that a doctor prescribes for you in hospital to take home with you (take-out medicine).

To get cover from the Major Medical Benefit, the medicine must both be dispensed by the hospital and be shown on the original hospital account. If you are given a prescription for take-out medicine and take this prescription to a pharmacy, the claim will be paid from your Day-to-Day Benefit (Savings Account) and not from the Major Medical Benefit.

Treatment in the 30 days after your hospital visit (post-hospitalisation benefit)

To protect your Day-to-Day Benefit, the scheme covers certain treatments up to 30 days after discharge from hospital from the Major Medical Benefit. This treatment is subject to protocols. The day that you are discharged counts as the first day of the 30 days of cover.

This benefit covers treatment at 100% of the Fedhealth Rate. It pays for:

- Complications that might arise from hospitalisation
- Physiotherapy, occupational therapy, speech therapy, ultrasounds, general radiology and pathology tests.

The following conditions apply to the 30-day post-hospitalisation benefit:

- Only treatment as a result of a hospital event will be covered. The treatment must be related to the original diagnosis.
- You must get an authorisation number for this benefit in addition to the authorisation number for the hospital admission. If you do not get a separate authorisation number from us, the claim will be paid from the Day-to-Day Benefits and not from the Major Medical Benefit.

Prosthesis benefit table

External prosthesis

We pay for external prostheses up to a limit of R10 500 per family per year at cost. This is paid out of the Major Medical Benefit.

Internal prosthesis

There is a separate benefit for internal prosthesis. The benefit does not include osseo-integrated implants for replacing teeth. Hip and knee bilateral replacements will be allowed for up to double the amount for a single hip and knee replacement.

Internal prosthesis expense	Cover	Limits per family
Aorta stent grafts	100% of cost	R52 651
Detachable platinum coils	100% of cost	R45 670
Cardiac stents	100% of cost	R25 083
Cardiac valves	100% of cost	R25 083
Cardiac pacemakers	100% of cost	R25 083
Intraocular lenses (per lens)	100% of cost	R2 958
Shoulder replacement	100% of cost	R25 083
Elbow replacement	100% of cost	R25 083
Hip replacement (See ICPS below)	100% of cost	R25 083
Knee replacement (See ICPS below)	100% of cost	R25 083
Total ankle replacement Bone lengthening devices Spinal plates and screws Carotid stents Peripheral arterial stent grafts Embolic protection devices Other approved spinal implantable devices	100% of cost 100% of cost 100% of cost 100% of cost 100% of cost 100% of cost 100% of cost	See combined benefit limit for all unlisted internal prosthesis*
* Combined benefit limit for all unlisted internal prosthesis	100% of cost	R22 480

Improved Clinical Pathway Services (ICPS) for non-PMB hip and knee replacements

We're all about the coordination of your care to ensure you recover quicker and more effectively. That's why we have appointed Improved Clinical Pathway Services (ICPS) as the designated service provider (DSP) for hip and knee replacements. A clinical pathway means that a network of relevant healthcare practitioners will oversee every step of your hip or knee replacement journey with your FP, from FP referral to surgery, right through to your full rehabilitation. As the patient, you benefit since this coordinated approach has been proven to result in better health outcomes and patient satisfaction. So, you'll be back on your feet before you know it thanks to a managed process that includes your pre-op assessment, a rapid recovery plan, with pre-operative strengthening, physiological anaesthesia, minimally traumatic surgery, and postoperative physiotherapy.

Please note: Since ICPS is the Fedhealth DSP for hip and knee replacements, you will have no benefit if you decline to use them for hip or knee replacements. In other words, the Scheme will NOT pay for the hospital, surgeon, prosthesis, or anything related to the procedure.

Please ensure that you use an ICPS surgeon by visiting **www.icpservices.co.za** or by calling **0860 002 153**.

You must have our authorisation

You need authorisation before the Major Medical Benefit will cover any claim, for example, a planned or emergency hospital admission, specialised radiology, selected procedures, 30-day post-hospitalisation benefit or casualty treatment.

Contact us at least 48 hours before the hospital stay or the procedure
You must contact us at least 48 hours before any treatment that is not an emergency or that is planned. You must write down the authorisation number we give to you and take it with you to hospital.

You must get a separate authorisation number for specialised radiology and for treatment covered in the 30 days after the hospital visit. If in doubt, please do contact us to find out if you need an authorisation number.

When you contact us, have this information ready
We need the following information to authorise your treatment:

1. Fedhealth membership number
2. Date of birth of patient
3. Reason for admission, ICD10 and applicable tariff codes for the proposed treatment (your doctor must give these to you)
4. Date of admission and the proposed date of the operation or treatment
5. The treating doctor's name and telephone and practice numbers
6. Name of the hospital with telephone and practice numbers
7. For a CT scan, MRI procedure or similar procedure, the name of the radiological practice.

Phone us:

0860 002 153
Monday to Thursday 08h30 – 19h00
Friday 09h00 – 19h00

Email us:

authorisations@fedhealth.co.za

All costs covered from the Major Medical Benefit need to be pre-authorised by the Authorisation Centre on

0860 002 153

Screening benefit

This benefit covers various screening and preventative programmes that aim to improve your health.

Screening test	People registered on the scheme who qualify for the benefit	Limit of screening tests
Women's Health		
Breast cancer screening with mammography	Women, 50 to 74 years old	1 every 3 years
Cervical cancer screening. However, we cover liquid based Cytology up to the rate for a standard Pap smear. Before you have a Pap smear, you should check if we will cover it in full or not. If you have a liquid-based cytology, you will have to pay in an amount from your own pocket.	Women, 21 to 65 years old	1 every 3 years
Children's Health – see table on the right for the immunisation benefit		
Cardiac Health		
Cholesterol screening (full lipogram)	Everyone 20 years old and older	1 every 5 years
General		
Flu vaccination	Everyone	1 every year
HIV test by contracted wellness network provider	Everyone	1 every year
Health risk assessments		
Wellness screening (BMI, blood pressure, finger prick cholesterol and glucose tests)	Everyone	1 every year
Preventative screening by contracted wellness network provider (waist-to-hip ratio, body fat %, flexibility, posture and fitness)	Everyone	1 every year

Immunisation benefit for children

Age of child	Vaccine
At birth	Tuberculosis (Bacilles Calmette Guerin) **OPV (0)** Oral Polio Vaccine
6 Weeks	**OPV (1)** Oral Polio Vaccine **RV (1) Rotavirus Vaccine** **DTaP-IPV//Hib (1)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Hep B (1)** Hepatitis B Vaccine **PCV_7 (1)** Pneumococcal Conjugated Vaccine
10 Weeks	**DTaP-IPV//Hib (2)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Hep B (2)** Hepatitis B Vaccine
14 Weeks	**RV (2) Rotavirus Vaccine** (should not be administered after 24 weeks) **DTaP-IPV//Hib (3)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Hep B (3)** Hepatitis B Vaccine **PCV_7 (2)** Pneumococcal Conjugated Vaccine
9 Months	**Measles Vaccine (1)** **PCV_7 (3)** Pneumococcal Conjugated Vaccine
18 Months	**DTaP-IPV//Hib (4)** Diphtheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined **Measles Vaccine (2)**
6 Years	**Td Vaccine** Tetanus and reduced strength of diphtheria Vaccine
12 Years	**Td Vaccine** Tetanus and reduced strength of diphtheria Vaccine

What is chronic medicine?

The Chronic Disease Benefit covers chronic medicine. Chronic medicine is medicine that is taken for a persistent or otherwise long-lasting condition. Examples of conditions that require ongoing medicine are hypertension, diabetes and asthma. This option covers chronic medicine for 39 chronic conditions.

Limits

The overall limit is R5 120 per year per beneficiary, up to a limit of R10 200 per year for each family.

To claim under this benefit

Your condition:

- must be in the List of chronic conditions (given below); and
- must meet a set of defined criteria to qualify for the benefit (referred to as clinical entry criteria).

In other words, just because you have one of the conditions on the List below, does not mean that we will cover the expenses out of the Chronic Disease Benefit. The condition must also meet a set of defined criteria. If you need information on the criteria, please contact us.

List of chronic conditions

This benefit covers medicine and treatment for a set of 39 chronic conditions as well as HIV/ Aids. These are given in List 1 below and List 2 on page 24.

List 1: Conditions that are Prescribed Minimum Benefit conditions

See section 1, 'Prescribed Minimum Benefits (basic level of cover for a defined set of conditions) for an explanation of Prescribed Minimum Benefits.

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	Hyperlipidaemia
Cardiac Failure	Hypertension
Cardiomyopathy	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
COPD/ Emphysema/ Chronic Bronchitis	Parkinson's Disease
Coronary Artery Disease	Rheumatoid Arthritis
Crohn's Disease	Schizophrenia
Diabetes Insipidus	Systemic Lupus Erythematosus
Diabetes Mellitus type 1 & 2	Ulcerative Colitis
Dysrhythmias	

If your condition is on List 1 (Prescribed Minimum Benefits)

If you have not reached your limit for the Chronic Disease Benefit:

Medicines that we cover (formulary)	If the condition qualifies for the benefit, we cover medicines on the restrictive formulary only, and only up to the ceiling price given in the Medicine Price List. If you use a medicine not on this list, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.
Service providers you should use	If the condition qualifies for the benefit, you must use the Designated Service Providers, Medi-Rite, Dis-Chem and Pharmacy Direct. If you use any other service provider, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.

If you have reached your limit for the Chronic Disease Benefit:

Medicines that we cover (formulary)	If the condition qualifies for the benefit, we cover medicines on the restrictive formulary only, and only up to the ceiling price given in the Medicine Price List. If you use a medicine not on this list, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.
Service providers you should use	If the condition qualifies for the benefit, you must use the Designated Service Providers, Medi-Rite, Dis-Chem and Pharmacy Direct. If you use any other service provider, you must pay 40% of the cost from your own pocket. You cannot get the 40% back from your Day-to-Day Benefits.

List 2: Additional chronic conditions covered on your option

Ankylosing Spondylitis	Narcolepsy
Anorexia Nervosa	Obsessive Compulsive Disorder
Attention Deficit Disorder (in children only up to age of 18)	Panic Disorder
Bulimia Nervosa	Paraplegia/ Quadriplegia (associated medicine)
Depression	Post-Traumatic Stress Syndrome
Dermatomyositis	Scleroderma
Generalised Anxiety Disorder	Tourette's Syndrome

If your condition is on List 2 (Additional Chronic Conditions)

If you have not yet reached your limit for the Chronic Disease Benefit

Medicines that we cover (formulary)	If the condition qualifies for the benefit, we cover medicines on the restrictive formulary only, and only up to the ceiling price given in the Medicine Price List. If you use a medicine not on this list, you must pay 40% of the cost from your own pocket.
Service providers you should use	If the condition qualifies for the benefit, you must use the Designated Service Providers, Medi-Rite, Dis-Chem and Pharmacy Direct. If you use any other service provider, you must pay 40% of the cost from your own pocket.

There is no benefit at all for the additional chronic conditions once your chronic benefit is used up.

Having a chronic condition:

AN EXAMPLE

What the member does	How the expense is funded
Lily has asthma and her doctor prescribes medicine that she must take regularly. She decides to apply online on **www.fedhealth.co.za** rather than on the phone. Her doctor gives her the details that the online application asks for. Chronic Medicine Management (CMM) at Fedhealth tell her that the application is accepted because her asthma meets the clinical criteria. Lily then gets the Medicine Access Card in the post as well as by email and takes it to the pharmacy together with her script to buy the medicine. The pharmacy is a Medi-Rite pharmacy. Lily could also use a Dis-Chem pharmacy. Alternatively, if Lily wants to make use of Pharmacy Direct, a courier pharmacy, she can register with them and have her chronic medication delivered to an agreed address. When Lily is buying her medicine, the pharmacist tells her that the prescribed medicine will not be covered in full but that there is a generic medicine that would be covered in full. She decides to change to the generic so that the full cost of the medicine is covered. Because asthma is a Prescribed Minimum Benefit condition, she will receive treatment guidelines with her letter from CMM. These will tell her about which other expenses are covered by risk benefits (the scheme).	Lily has not reached the limit for the Chronic Disease Benefit, so the cost of the medicine is covered in full, as long as the prescribed medicine is on the restrictive formulary and the costs fall within the ceiling price given on the Medicine Price List. If Lily uses medicine that is not on the restrictive formulary, then Lily would have to pay 40% of the cost from her own pocket. If Lily had reached the limit for the Chronic Disease Benefit, because asthma is a Prescribed Minimum Benefit condition, we would cover medicines that are on the restrictive formulary. This means that there might be some medicines that we do not cover at all. If Lily uses medicines that are not on the restrictive formulary, then Lily would have to pay 40% of the cost from her own pocket. We would only cover the medicine up to the ceiling price given on the Medicine Price List. This is subject to Lily getting the medicine from one of the scheme's Designated Service Providers, Medi-Rite, Dis-Chem or Pharmacy Direct. If Lily uses any other service provider, then Lily would have to pay 40% of the cost from her own pocket. She cannot get the 40% back from her Day-to-Day benefits. If Lily had a condition that is not a Prescribed Minimum Benefit, there would be no cover after the Chronic Disease Benefit has reached the limit.

Cover for treatment for HIV/Aids

There is unlimited cover for HIV/Aids treatment and preventative medicine.

To qualify for this benefit, you must be registered on the scheme's HIV/Aids disease management programme, Aid for Aids (AfA). You have access to the HIV/Aids medicine benefit only when you are registered.

AfA is a comprehensive HIV disease management programme with access to:

- anti-retrovirals and related medicines
- post-exposure preventative medicine
- preventative medicine for mother-to-child transmission
- post-exposure preventative medicine after rape.

The programme gives ongoing patient support and monitors the disease and response to therapy. To join AfA, call them in confidence on **0860 100 646**. Your doctor may also call AfA on your behalf.

How to apply for the Chronic Disease Benefit

STEP 1: Collect the information needed to apply
You will need the following information to apply. If you need help gathering this information, please contact us.
- Membership number
- Dependant code
- ICD10 code
- Drug name, strength and quantity
- Prescribing doctor's practice number
- Diagnostic test results, e.g. Total Cholesterol, LDL, HDL, glucose tests, thyroid (depending on your condition).

STEP 2: Apply
You have a choice of how to apply:
Apply by telephone: You can call Chronic Medicine Management (CMM) between 08h30 and 19h00, Monday to Thursday and 09h00 to 19h00 on Fridays. Phone **0860 002 153**.
Apply on our website: Go to **www.fedhealth.co.za**. You will need to register on the website before you can apply. Once you have registered, click on "my authorisations" and then select "my chronic application". Select the person that you want to apply for and then click on the "Chronic" authorisation button at the bottom of the page. Then select "New Chronic Application".
Ask your doctor or pharmacist to apply on your behalf. They can do an online application or contact our Provider Call Centre on 0861 112 666.

STEP 3: We will give you a response right away
We will reply to your application right away. If we need more information, we will let you, your doctor or your pharmacist know exactly what information to give to us.

If we do not approve the application, we will give you the reasons why, and you will have the opportunity to ask us to review our decision.

STEP 4: You get your medicine access card
If we approve your application, we will give you a medicine access card. Your medicine access card will record the medical condition that we have approved treatment for.

We will give you treatment guidelines

The scheme has set up treatment guidelines if you have applied for conditions on List 1 to ensure that you have access to appropriate treatment for your condition. You will receive details of the treatment guidelines with your letter from CMM.

If there is a co-payment on your medicine

If you find that the medicine your doctor has prescribed for you has a co-payment, because it costs more than the ceiling price given in the Medicine Price List, you can ask your pharmacist to help you to change it to a generic medicine that the scheme covers in full. If the medicine has a co-payment because it is not in the formulary then you should discuss a possible alternative with your prescribing doctor.

We will approve a chronic condition, not individual chronic medications

Thanks to a streamlined, simplified approval process for chronic medication called Disease Authorisation, you can apply for approval of a chronic condition, as opposed to a single chronic medication.

This means that the Scheme will approve an entire list of medication for your specific condition (known as a basket of medicine). So, if your doctor should ever change your medication, you will most likely already be approved for it – provided it's in the basket. On a more practical level it means that when you need to change or add a new medicine for your condition, you can do this quickly and easily at your pharmacy with a new prescription, without having to contact Fedhealth at all.

If you would like to check what medicine is available to you in your condition's basket, visit **www.fedhealth.co.za** and log in as a member to use our handy Disease Authorisation Medicine Search tool. If you are not registered on the site, click 'Register' and follow the instructions.

Chronic medication delivered to your door

To give you the added convenience of having your chronic medication delivered directly to you (home, work, temporary address or nearest Post Office), you can use our designated service provider (DSP), Pharmacy Direct, for free-of-charge courier services.

Pharmacy Direct has a proven track record of friendly professional service and on time deliveries. For more information, visit **www.pharmacydirect.co.za** or get in touch by calling **0860 027 800**, Mondays to Fridays from 07h30 to 17h00. Remember to include your Fedhealth membership number on all communication!

However, should you prefer, you can visit over 150 Medi-Rite pharmacies in Checkers or Shoprite stores or almost 100 Dis-Chem pharmacies countrywide to collect your medication.

Paying for day-to-day expenses (Day-to-Day Benefits)

The scheme gives an overall limit for the amount of cover you and your family have for day-to-day medical expenses. Examples of day-to-day medical expenses are:

- visits to doctors or specialists
- short-term courses of medicine (for example, antibiotics for the flu)
- optometry (glasses)
- visits to the dentist.

These day-to-day expenses may be paid out of two different benefits under the overall Day-to-Day Benefit. The way the benefits work will affect the limits that are given in the table on page 34, so make sure you read this whole section.

The basics of these two benefits for day-to-day medical expenses

The limits of all the benefits below depend on the size of your family. Please refer to the rates table on page 44.

The Savings Account pays for day-to-day expenses first (from the beginning of the year) and pays expenses up to the actual cost. In some cases, if you have money available in your Savings Account, you can use this to pay co-payments. However, a co-payment for a Prescribed Minimum Benefit cannot be paid from your Savings Account.

The Savings Account works differently to other benefits in that you carry any remaining amount over to the next year. There are also implications if you leave the scheme – see page 45.

The Threshold Benefit is intended to cover medical expenses if you still have day-to-day medical expenses even after your Savings Account is used up.

You must pay while you are in the self-payment gap

There might be a gap between when the Savings Account runs out and the Threshold Benefit kicks in. During this gap (referred to as a self-payment gap), you will have to pay for all day-to-day medical expenses out of your own pocket.

The gap occurs because the Threshold Benefit kicks in only when all your day-to-day expenses have added up to the threshold level at the Fedhealth Rate.

When you are in the self-payment gap, you must still continue to submit all your claims. Even though we won't be able to refund them, they will still add up towards your threshold level.

Examples of expenses that will increase the self-payment gap

The following expenses will increase your self-payment gap:

- Using alternative healthcare (eg, homeopathy) or having medicines prescribed from alternative healthcare providers
- Claiming for services that are charged above the Fedhealth Rate, for example if you go to doctors or specialists that are not in the Fedhealth network
- Claiming for medicines that are more expensive than the ceiling price given in the Medicine Price List
- Claiming for more than the yearly limits, for example, for advanced dentistry and optical limits
- Claiming for over-the-counter medicines
- Using pharmacies that are not in the Fedhealth network
- Claiming for any Additional Medical Service eg, speech therapy
- Claiming for appliances, external accessories and orthotics eg, hearing aids.

When the Threshold Benefit kicks in, existing limits apply

Once you have reached the required threshold level, your day-to-day expenses will be paid from the Threshold Benefit. Many of your day-to-day expenses will be covered unlimited, but any existing limits will still apply. For example, if a family spends R9 500 on optometry, a maximum of R9 170 will add up towards their threshold level because the limit for optometry is R9 170 per family. Once this family is in the Threshold Benefit, they will have no more cover for optometry from the Threshold Benefit as their limit will have been reached.

Also the Threshold Benefit pays only up to the Fedhealth Rate and there is a **20% co-payment** on all claims paid from the Threshold Benefit. You have to pay any difference from your own pocket.

Cover for doctors, specialists and medicines

FPs in the Fedhealth network

If you use an FP (family practitioner) in the Fedhealth network, your consultation is paid out of the Major Medical Benefit and never from your Savings. This covers the consultation only. To find an FP in the Fedhealth network, go to our website, the Fedhealth Member App or call **0860 002 153**.

Even if you're in the self-payment gap, Fedhealth gives unlimited cover for FP consultations, as long as you use an FP who is in the Fedhealth network.

This means that you always have unlimited cover for FPs, as long as you use an FP in the Fedhealth network.

FPs not in the Fedhealth network

If you do not use an FP in the Fedhealth network, the consultation will be paid from Savings and will add up to the threshold level at 100% of the Fedhealth Rate. When in the Threshold Benefit, these consultations are paid at 100% of the Fedhealth Rate.

Specialists in the Fedhealth network

Specialists in the Fedhealth network have agreed to a set rate for consultations. If you have day-to-day benefits available, the consultation will be paid out of these benefits at this rate. It will also add up towards the threshold level at this rate. If you are in the self-payment gap, you will have to pay for the consultation from your own pocket but also only at the set rate. When you reach the threshold level and the Threshold Benefit kicks in, we cover visits to specialists in the Fedhealth network in full. Before you consult a specialist, please see your Network FP to obtain a referral.

Specialists not in the Fedhealth network

If you do not use a specialist in the Fedhealth network, the consultation will be paid from your Savings Account up to cost.

The expense will add up to the threshold level at the Fedhealth Rate. When in the Threshold Benefit, the consultations are also paid at the Fedhealth Rate. Before you consult a specialist, please see your Network FP to obtain a referral.

Prescribed medicine

There is a limit for prescribed medicine. For example, the individual limit is R5 120. If you have already spent R3 000 according to the ceiling prices given in the Medicine Price List when you reach the threshold level, then you will only have R2 120 available to spend from the Threshold Benefit for prescribed medicine. When you are in the Threshold Benefit, you get cover for prescribed medicine only at the ceiling price of the Medicine Price List. You are responsible for paying the difference.

Dispensing fees for prescribed medicine

Pharmacies charge a dispensing fee for each prescribed medicine that they sell. The scheme has agreed special rates for dispensing fees with pharmacies in the Fedhealth network. If you use a pharmacy in the Fedhealth network, we will cover the agreed dispensing fee in full from your day-to-day benefits.

To find a pharmacy in the Fedhealth network, go to the website, the Fedhealth Member App or call **0860 002 153**.

If you do buy from a pharmacy not in the Fedhealth network, then you might have to pay the difference between the agreed dispensing fee and the dispensing fee that the pharmacy charges.

Over-the-counter medicine

Medicines with a schedule of 0, 1 or 2 can be bought from the pharmacy without a prescription from your doctor. The cost will be paid out of your Savings Account and the amount will not add up towards your threshold level.

The Threshold Benefit does not cover over-the-counter medicine.

Female contraception

In most cases, female contraception is covered by the Major Medical Benefit – see page 16. However, contraceptive pills are paid from your Savings Account if they are prescribed for reasons other than contraception (for example, for skin problems). Examples of contraceptive pills that we do not cover under the Major Medical Benefit include Cyprene-35 ED, Diane–35, Tricilest, Ginette and Minerva.

The consultation and the cost of procedures for IUDs are paid from your Savings Account. Only the cost of the IUD itself is paid from the Major Medical Benefit.

Pregnancy

Pregnancy costs are covered from the Savings Account. You should select a gynaecologist in the Fedhealth network. Consultations will be covered in full at the set rate and will add up to the threshold level in full. If the specialist is not in the network, then only the Fedhealth Rate will add up to the threshold level. Using a gynaecologist in the Fedhealth network will ensure that in-hospital claims are covered in full and you will not have to pay any co-payments.

A total of two 2D ultrasound scans per pregnancy will add up to the threshold level.

Specialised radiology (for example, MRI or CT scans)

We cover specialised radiology (for example MRI or CT scans) up to 100% of the Fedhealth Rate, whether you have it in or out of hospital. You must pay the first R1 900 for non-PMB scans. You must get separate authorisation for a specialised radiological procedure, whether it takes place in or out of hospital.

Over-the-counter medicine:

AN EXAMPLE	
What the member does	How the expense is funded
Andy feels unwell and decides to follow his pharmacist's recommendation to take an over-the-counter flu medicine. He chooses a pharmacy within the Fedhealth network.	Whether the expense is covered depends on his benefits: If Andy has enough money in his Savings Account to cover the medicine, he will not have to pay anything from his own pocket. If Andy does not have enough money in his Savings Account, he will have to pay the pharmacy himself. The cost of over-the-counter medicine does not add up to the threshold level.

Visiting a doctor (Family Practitioner):

AN EXAMPLE	
What the member does	How the expense is funded
Mary has flu and wants to see her doctor, Dr Chris. She goes onto **www.fedhealth.co.za** to confirm if Dr Chris is on the Fedhealth network. She finds out that he is. She has a consultation with the doctor and he prescribes a course of antibiotics for her. Mary then goes to the pharmacy to buy the medicine that was prescribed for her. She makes sure that she asks for a generic version of the antibiotics and she makes sure that she goes to a pharmacy in the Fedhealth network.	**The consultation** Because Dr Chris is in the Fedhealth network, Fedhealth has agreed a set rate for the consultation. This is how the consultation will be funded: The consultation is paid out of risk benefits (Major Medical Benefit). **The prescribed medicine** Mary had not reached the limit for prescribed medicine and had asked for a generic of the medicine which fell within the ceiling price on the Medicine Price List. So: If she has money in the Savings Account, it will pay the expense and the full amount adds up to the threshold level. (If Mary had chosen a medicine that cost more than the ceiling price on the Medicine Price List, the difference would not add up to the threshold level).

FP non-network:

AN EXAMPLE	
What the member does	**How the expense is funded**
David has flu and wants to see his doctor, Dr Mary. He goes onto **www.fedhealth.co.za** to confirm if Dr Mary is on the Fedhealth network. He finds out that she is not. He has a consultation with the doctor and she prescribes a course of antibiotics for him. David then goes to the pharmacy to buy the medicine that was prescribed for him. He makes sure that he asks for a generic version of the antibiotics and he makes sure that he goes to a pharmacy in the Fedhealth network.	**The consultation** Because Dr Mary is not in the Fedhealth network, this is how the consultation will be funded: If David has funds available in his Savings Account, the consultation is covered in full. However, only the Fedhealth Rate adds up to the threshold level. **The prescribed medicine** David had not reached the limit for prescribed medicine and had asked for a generic of the medicine which fell within the ceiling price on the Medicine Price List. So: If he has money in the Savings Account, it will pay the expense and the full amount adds up to the threshold level. (If David had chosen a medicine that cost more than the ceiling price on the Medicine Price List, the difference would not add up to the threshold level).

Going to see a specialist:

AN EXAMPLE	
What the member does	**How the expense is funded**
John's family doctor has referred him to a specialist because of an ongoing sore throat. He has a consultation with the specialist.	**If the specialist is in the Fedhealth network** This is how the consultation will be funded: If John has money available in his Savings Account, the consultation is covered in full at the set rate and adds up to the threshold level in full. **If the specialist is not in the Fedhealth network** This is how the consultation will be funded: If John has money available in his Savings Account, the consultation is covered in full. However, only the Fedhealth Rate adds up to the threshold level.

All cover in day-to-day benefits

In the table below, certain expenses are subject to limits. These limits apply to the accumulation of claims to the threshold level as well as the refund of claims from the Threshold Benefit. For example, if a family spends R9 500 on optometry, a maximum of R9 170 will add up towards their threshold level because the limit for optometry is R9 170 per family. Once this family is in the Threshold Benefit, they will have no more cover for optometry from the Threshold Benefit as their limit will have been reached. Also the Threshold Benefit pays only up to the Fedhealth Rate and there is a **20% co-payment** on all claims paid from the Threshold Benefit except consultations with FPs and specialists in the Fedhealth network. You have to pay any difference from your own pocket.

Day to day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Additional medical services: Audiology, dietetics, genetic counselling, hearing aid acoustics, occupational therapy, orthoptics, podiatry, private nursing*, psychologists, speech therapy, social workers	Limit of R10 500 per family per year for the total of all additional medical services in and out-of-hospital	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit
Alternative healthcare: Acupuncture, homeopathy, naturopathy, osteopathy and phytotherapy (including medicines prescribed by alternative healthcare professionals)	No limit	At cost	Does not add up to threshold level	Not covered
Antenatal scans	Two 2D antenatal scans per person per year	At cost	Adds up at Fedhealth Rate to the maximum of the limit	Covered at Fedhealth Rate up to the limit
Appliances, external accessories and orthotics: Hearing aids, wheelchairs etc	Limit of R10 500 per family per year. Sub-limit of R3 910 per person for foot orthotics in and out-of-hospital	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit

* Private nursing that falls outside the Alternatives to Hospitalisation Benefit

Day to day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Biokinetics, Chiropractics	The Additional Medical Services limit of R10 500 per family per year applies (combined limit)	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit
Dentistry (Advanced): Inlays, crowns, bridges, mounted study models, metal base partial dentures, osseo-integrated implants, orthognathic surgery, oral surgery, orthodontic treatment, periodontists, prosthodontists and dental technicians	Limit of R6 740 per person per year, up to an overall limit of R20 000 per family per year	At cost	Adds up at Fedhealth Rate to the maximum of the limit	Covered at Fedhealth Rate up to the limit
Dentistry (Basic)	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Female contraception	See Female contraception paid out of Major Medical Benefit (page 16) and Female contraception paid out of Day-to-Day Benefits (page 31).			
Family Practitioners				
Fedhealth Network FPs	No limit – you are always covered even in the self-payment gap	Never paid from savings	Does not add up to threshold level	Covered from Major Medical Benefit
Non-Fedhealth Network FPs	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate

Day to day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Optometry: Frames, single vision, bifocal, multifocal or special lenses, lens add-ons, contact lenses, Readers and optometric examinations	Limit of R3 010 per person per year, up to an overall limit of R9 170 per family per year	At cost	Adds up at Fedhealth Rate to the maximum of the limit	Covered at Fedhealth Rate up to the limit
Over-the-counter medication	No limit	At cost	Does not add up to threshold level	Not covered
Pathology	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Physiotherapy	The Additional Medical Services limit of R10 500 per family per year applies (combined limit)	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit
Prescribed medication	Limit of R5 120 per person per year, up to an overall limit of R10 200 per family per year	At cost	Adds up at the MPL to the maximum of the limit	Covered up to MPL up to the limit
Radiology (General)	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Radiology (Specialised)	Paid from the Major Medical benefit if pre-authorised up to 100% of the Fedhealth Rate, whether you have it in or out of hospital. You must pay the first R1 900 for non-PMB scans			

Day to day medical expense	Limits	How the Savings Account covers the expense	How the expense adds up towards the threshold level	How the Threshold Benefit covers the expense
Specialists excluding Psychiatrists				
Fedhealth Network Specialists	No limit	Up to set rate	Adds up at set rate	Covered at set rate (Fedhealth network specialists will only charge the set rate)
Non-Fedhealth Network Specialists	No limit	At cost	Adds up at Fedhealth Rate	Covered at Fedhealth Rate
Specialists: Psychiatrists				
Fedhealth Network Psychiatrists	The Additional Medical Services limit of R10 500 per family per year applies (combined limit)	Up to set rate	Does not add up to threshold level	Covered at set rate up to the limit (Fedhealth network specialists will only charge the set rate)
Non-Fedhealth Network Psychiatrists	The Additional Medical Services limit of R10 500 per family per year applies (combined limit)	At cost	Does not add up to threshold level	Covered at Fedhealth Rate up to the limit

How to claim

If the healthcare professional or the hospital claims on your behalf

Your healthcare professional usually sends your claim to us on your behalf. **In this case, you do not need to claim as well**. If your healthcare professional tells you that they have not been paid, you can check your claims status on the Fedhealth website or contact us on **0860 002 153**.

If you need a refund because you paid the medical expense

If your healthcare professional does not claim on your behalf, or if you have already paid, you must send us the:

- proof of payment
- the claim (the account). Make sure the account shows:
  - your membership number
  - **the ICD10 and procedure codes**
  - the practice number.

If we approve the claim according to the scheme rules, Fedhealth will refund you directly into your bank account. You must make sure that we have your correct bank details. To update your bank details, call us on **0860 002 153 or email member@fedhealth.co.za**

You must claim within four months of the date of the treatment

The scheme will only consider claims that we receive within four months of the treatment date. We process claims that we receive after four months only to show on tax certificates. We will not pay any claims that we receive after four months.

Send your claims to:

You can email, fax or post the claims to us.

Email: **claims@fedhealth.co.za**
Fax number: **011 671 3842**

Postal address:

Private Bag X3045
Randburg
2125

If you have been in a car accident

If you were injured in a car accident, you may have to go through certain procedures with the Road Accident Fund before the scheme will pay any claims.

Please contact the MVA/ Third Party Recovery Department at Fedhealth for more information:

Telephone number : 012 431 9720/ 18
Fax number : 012 425 4266
Postal address : P O Box 11793
Hatfield
0028

Dis-Chem Pharmacies is a Designated Service Provider

from **1 January 2017**

Get your repeat medication at any branch

Because our 104 (and growing) dispensaries are all linked to a nationwide database, you can pick up your repeats at any Dis-Chem branch.

Save with generic medicines

By switching to a generic alternative when available, you can save significantly without reducing the effectiveness of your medication. Ask your Dis-Chem Pharmacist for advice.

Cut costs on chronic medication

We charge preferential dispensing fees on prescription medication prices, and we will help register your medicine as chronic, to maximise your benefits.

Repeat medication management

Ask your Dis-Chem Pharmacist to get our Call Centre to phone or SMS you monthly, with a repeat medication reminder.

Earn Benefit points on purchases and dispensing fees

Earn points to redeem against future purchases, and help care for the community at the same time. Just register your Benefit Card at the dispensary. Points on dispensing fees are for cash purchases only.

Save time with Call & Collect

Too busy to stand in a queue? Just phone your local Dis-Chem Pharmacy, and your prescriptions will be pre-dispensed and ready for you to pick up at the Collection Counter.

FEDHEALTH

Dis-Chem PHARMACIES

Dis-Chem Customer Careline 0860 347 243 during office hours | Careline@dischem.co.za

About your scheme and membership

Principal members and registered dependants are covered by the scheme.

Members

The principal member can add or remove dependants. In this section, we use 'you' for the principal member.

Dependants

Who can be registered as a dependant

Before you add a dependant, if a company pays your medical aid contribution, you should check how much of the contribution your company will pay. You can register the following people as dependants:

- Your spouse or partner
- Your children
- Other family members if, according to the scheme rules, they rely on you for financial care and support.

Criteria for children

Fedhealth will charge the child rate for your child dependants until they turn 27. However, the child needs to be either:

- a full-time student, who is living at home or in a residential situation at a tertiary education institution; or
- living at home, unmarried, and not receiving a regular income greater than the maximum social pension.

Adding a newborn baby

You must register babies within 30 days after they are born. If a company pays your medical aid contribution, you must tell the salary department that you are going to add a newborn as a dependant. Fedhealth does not charge for the baby for the month in which the baby is born.

You must give us these documents for registering dependants

To register a dependant, you must fill in a Member Record Amendment Form. For the following types of dependants, we need this information:

Type of dependant	Extra document we may need
A newborn baby	A copy of the baby's birth certificate or notification of birth from the hospital The baby's ID number when they are registered
A biological or adopted child over the age of 21 years	Proof of registration from a full time tertiary institution for the current year if a full time student, or an affidavit for the dependant confirming residency, employment, income and marital status
An adopted child	Proof of legal adoption
A foster child	Legal proof that the child is a foster child
A brother or sister, grandchild, nephew or niece	An affidavit confirming residency, employment, income and marital status of child and both parents
A parent or grandparent of the principal member	An affidavit confirming residency, employment, income and marital status
A spouse or partner	Marriage certificate, if available

Membership cards

We will send two membership cards for families with one or more dependants. Please contact us if you want more membership cards for your dependants.

Removing a dependant from your membership

To remove a dependant, you must fill in a Member Record Amendment Form. If a company pays your medical aid, your HR Department must stamp the form and send it to the scheme.

How we communicate with you

We email and SMS your claim status
Fedhealth will email and SMS a claim status to you. This shows the claims that we have received and processed.

Make sure we have your correct email address and cell number
Please ensure that Fedhealth has your correct cell phone number and email address by calling the **Fedhealth Customer Contact Centre on 0860 002 153**.

You can find your claim and benefit information on our website
You can view a full update of your benefit and claim status by registering on the Fedhealth website. You will have immediate access to all your personal information. The **Fedhealth website** carefully details all of the Fedhealth options and has a blog section devoted to **Living Fedhealthy**, where you can look forward to informative health and lifestyle content that gets posted.

In the **Member Tools** section of the website, you can obtain hospital pre-authorisation, apply for chronic medication and submit your claims. You can also **locate Network Pharmacies, FPs and Specialists** using the locator tool. All brochure-ware, option selection forms and related documentation is also available as easy-to-access PDF downloads.

Once logged in to your account you're also able to **update your personal information**, conduct benefit enquiries and successfully **track claim submissions and payments due to you**.

The site also features **LiveChat** - this is an innovative feature that allows you to raise any important medical aid questions you may have on the site during office hours. Skilled consultants attend to your queries in a personal, one-on-one capacity, without the need for phone calls. You are also able to **obtain hospital and chronic disease authorisations** on the site using **LiveChat**.

You can access your medical aid on mobile devices with the Fedhealth Member App
The **Fedhealth Member App** is available free to Apple and Android users and offers the following functions:

- A view of your available benefits - showing in-hospital and day-to-day benefit availability
- **Claims Checker** shows your claims history, status of recent claims and provides a claims search facility
- An electronic version of your **Fedhealth membership card**
- Access to **documents** – like membership certificates, tax certificates and statements that can be viewed and emailed
- The ability to **locate FPs, Pharmacies and Specialists** on the Fedhealth Partner Network with interactive maps
- **My Authorisations** lets you view existing hospital and chronic medication authorisations by dependant for the previous and next 90 days, as well as those in the process of authorisation
- **Contact cards** for emergencies, hospital authorisations, customer care and ICE-aid (In Case Of Emergency)
- **ICE** can also be viewed without you being logged-in, with the option to add 3 editable emergency contacts.

You can message Fedhealth free of charge with the FedChat Mobile App

FedChat is available as a free download to Apple, Windows, Blackberry and Android users. This dedicated Instant Messenger channel offers you the convenience of being able to communicate with Fedhealth service consultants during office hours, without the cost of a phone call or SMS, as FedChat uses the same data you use for email and Internet browsing.

We email you the monthly Fedhealthy newsletter

Our digital newsletter Fedhealthy is customised according to members' unique profiles. It contains the latest Scheme news, as well as lifestyle and parenting articles we believe you might find interesting. There's even sections to help members prevent or manage certain lifestyle or chronic diseases.

Maxima Standard contributions table

CONTRIBUTIONS

Rand amounts paid monthly to the Scheme for cover received as well as annual benefit values

	Risk +	Savings =	TOTAL	Annual Threshold*
Member	2 486	546	3 032	11 200
Adult Dependant	2 118	465	2 583	8 600
Child Dependant	744	163	907	2 880*

HEALTHCARE SPENDING

Examples of healthcare spend available for various family structures, as well as annual threshold levels and self-payment gaps

	Annual Savings	Annual Threshold Level	Annual Self-Payment Gap
M	6 552	11 200	4 648
M + AD	12 132	19 800	7 668
M + AD + CD	14 088	22 680	8 592

* Up to a maximum of three children

M - member AD - adult dependant CD - child dependant

Option changes

You can upgrade to a higher option
You can upgrade to a higher option with more comprehensive benefits anytime of the year, but only on diagnosis of a dread disease or in the case of a life-changing event, for example pregnancy.

NB! The option upgrade will only be allowed within 30 days of diagnosis. In general, option changes are only allowed with effect from 1 January every year.

Paying for your medical aid

You must pay by the third of each month
You pay your contributions to Fedhealth each month for the previous month's cover (you pay in arrears). You must pay by the third day of each month. If we do not receive payment by the third day of the month, we will suspend your cover.

Our bank details
Account name : Fedhealth Medical Scheme
Bank : Nedbank
Branch code : 19-84-05
Account number : 1984 563 009

Please use your membership number as reference when making a payment.

Leaving the scheme

Three months of notice to leave
If you want to leave Fedhealth, you must give us three months' notice in writing.

Last contribution
Because you pay at the start of the month for the previous month's cover, your last contribution will be deducted in the month after your last day of membership. We will deduct your last contribution by the third day of the month after your last day of membership.

Amount in Savings Account – if you spent less than you paid in
We pay the balance in your Savings Account to your new medical scheme's savings account five months after you have left Fedhealth. This ensures that we can pay out any outstanding claims. You must provide us with the name of your new scheme as well as your membership number so we can transfer your Savings Account balance. If your new scheme does not have a savings component, then we will pay the balance to you. Please make sure we have your up-to-date banking details to make this refund.

Amount in Savings Account – if you spent more than you paid in
If you leave the scheme and have spent more than the monthly contributions you have paid into the Savings Account, you will have to refund the scheme with the difference. You must make the refund within 10 days after the last day of membership.

Whistle-blowing on fraud

We ask you to help us to combat fraud. If you know of anything that might involve a healthcare professional or a member using the medical scheme inappropriately, please contact us. You do not have to disclose your name.
Fraud Hotline: 0800 112 811

Extra services

These are the extra services you get from Fedhealth. They do not affect any of the scheme benefits.

24 hour nurse line on 0860 333 432

The 24 hour Fedhealth Nurse Line is available for:

- assessing day-to-day symptoms
- emergency medical advice, including for poisoning
- health education (for example, you can call if you need an explanation of medical terms, procedures and test results)
- drug database (complete information on medicines, including when you should not take medicines, etc)
- stress management
- teenage support.

The Fedhealth Baby Programme

When it comes to baby, only the best will do. As such, Fedhealth offers a top-notch baby programme designed by experts to offer the best advice, support and personalised care during every stage of pregnancy and beyond. Best of all, it's FREE! We offer you:

- A Fedhealth baby bag filled with baby care products, nappies, a Having a Baby handbook and much more.

- Discounts and vouchers for the best baby brands including:
  - 40% off Living & Loving magazine
  - 10% off Preggi Bellies exercise classes
  - 15% off safety products for babies and toddlers from 4aKid
  - From 10 to 25% off Chelino strollers, camp cots and car seats
  - 25% off Baby Kaboosh sleeping bags
  - 25% off Babynastics DVD
  - 20% off Boobi Blankets
  - 25% off Lots 4 Tots baby play mats
  - 20% off Baby Legends HUGSEEZ Baby Wrap Carrier
  - Free immunisation email reminders from Tum2mom.

- Ongoing communication and education in the form of emails and e-letters (to Mom and Dad), health profiling for each trimester, funding for Doula assistance (labour support) during natural birth together with a new birth card, call out on estimated due date to check on member's progress, and follow up on the birth within a week of the due date.

- A Baby Medical Advice Line that's on hand 24 hours a day for any pregnancy concerns, pre- or post-birth.

Any pregnant Fedhealth member or dependant may register for the Fedhealth Baby Programme. Simply call **0861 116 016** or email **info@babyhealth.co.za** to register.

MEDI RITE PHARMACY

WHY USE MEDIRITE PHARMACY?

WE ARE YOUR DESIGNATED SERVICE PROVIDER

CONVENIENCE

Fill your chronic and scheduled prescriptions while you shop at any of our 150 stores nationwide

LOW PRICES

Get the same low prices on your health essentials as you do on your groceries

FREE ADVICE

Get free advice from our friendly pharmacists on your everyday health-related matters

WELLNESS SCREENINGS

- Blood Pressure
- Blood Cholesterol
- Blood Glucose
- BMI

DELIVERY

We offer to send your medication via courier wherever you are in South Africa – call us on our toll-free number 0800 222 617 for more information

CONVENIENTLY LOCATED INSIDE

SHOPRITE & Checkers

Medscheme Client Service Centres

For personal assistance, visit one of the following Medscheme Client Service Centres.

These branches are open Monday to Friday 08h30 – 16h00

Bloemfontein – Shop C7, 1st Floor Middestad Centre, cnr Charles and West Burger Street
Cape Town – Icon Building, Ground Floor, Cnr Lower Long Street & Hans Strijdom Avenue, Cape Town
Durban – Ground Floor, 102 Stephen Dlamini Road, Musgrave, Durban
Port Elizabeth – 1st Floor, Block 6, Greenacres Office Park, 2nd Avenue, Newton Park
Pretoria – Nedbank Plaza, Shop 17, Ground Floor, 361 Stanza Bopape Street, Arcadia
Roodepoort – Ground Floor, Park View Building Number 10, Constantia Office Park, Vlakhaas Avenue, off Hendrik Potgieter Rd, Weltevreden Park X81, Roodepoort
Vereeniging – Ground Floor, 36 Merriman Avenue

Contact us

Fedhealth Customer Contact Centre
Monday to Thursday 08h30 – 19h00
Friday 09h00 – 19h00
Tel: 0860 002 153
email: member@fedhealth.co.za
Web: www.fedhealth.co.za
Postal address: Private Bag X3045, Randburg 2125

Hospital Authorisation Centre
Monday to Thursday 08h30 – 17h00
Friday 09h00 – 17h00
Tel: 0860 002 153
email: authorisations@fedhealth.co.za
Web: www.fedhealth.co.za

Ambulance Services
Europ Assistance
Tel: 0860 333 432

Aid for AIDS
Monday to Friday 08h00 – 17h00
Tel: 0860 100 646
Fax: 0800 600 773
email: afa@afadm.co.za
Web: www.aidforaids.co.za
SMS (call me): 083 410 9078

Chronic Medicine Management
Monday to Thursday 08h30 – 19h00
Friday 09h00 – 19h00
Tel: 0860 002 153
email: cmm@fedhealth.co.za
Postal address: P O Box 38632 Pinelands 7430

Dis-Chem
Care-Line: 0860 347 243
To locate a store go to:
Web: www.dischem.co.za and select Store Locator

Disease Management
Monday to Friday 08h00 – 16h30
Tel: 0860 002 153
email: dm@fedhealth.co.za

Fedhealth Baby
Monday to Friday 08h00 – 17h00
Tel: 0861 116 016
email: info@babyhealth.co.za
Web: www.babyhealth.co.za

Fraud Hotline
Tel: 0800 112 811

Medi-Rite Pharmacy
Tel: 0800 222 617
To locate a store go to:
Web: www.medirite.co.za and select Store Locator

MVA Third Party Recovery Department
Monday to Friday 07h00 – 15h00
Tel: 012 431 9720/ 18
Fax: 012 425 4266
Postal address: MVA Third Party Recovery Department, P O Box 11793, Hatfield, 0028

Oncology Disease Management
Monday to Friday 08h00 – 16h00
Tel: 0860 100 572
Fax: 021 466 2303
email: cancerinfo@fedhealth.co.za
Postal address: P O Box 38632, Pinelands, 7430

Pharmacy Direct
Monday to Friday 07h30 – 17h00
Tel: 0860 027 800
Fax: 0866 114 000/ 1/ 2/ 3/ 4
email: care@pharmacydirect.co.za
Web: www.pharmacydirect.co.za
SMS (call me): 083 690 8934

Trauma Counselling
ICAS
Tel: 0800 212 695

Fedhealth Customer Contact Centre 0860 002 153

Ground Floor, Park View Building Number 10, Constantia Office Park, Vlakhaas Ave,
off Hendrik Potgieter Rd, Weltevreden Park X81, Roodepoort • Private Bag X3045, Randburg 2125

www.fedhealth.co.za

FEDHEALTH

Family takes care of family

Please note: All Fedhealth benefits are subject to registered Scheme Rules, and as such, this document only aims to provide a summary of such benefits. For the full Scheme Rules, please visit fedhealth.co.za or contact the Fedhealth Customer Contact Centre on 0860 002 153 to obtain a copy.