



METROPOLITAN
MEDICAL SCHEME



Member Guide



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I.

Welcome to the Metropolitan Medical Scheme

The Scheme provides cover for you and your dependants for a wide range of medical services, prescribed medication and medical events such as hospitalisation and surgery. These benefits are subject to certain conditions, which will be explained in abbreviated form in this guide.

The guide is designed to answer most of the general questions you may have and provides an overview of the benefits of the Scheme and the major rules governing medical aid scheme membership. Details are also provided on member procedures and contact details relating to claims, pre-authorisation and chronic medication. Please read it carefully and keep it for future reference.

Please note that the scope of the Scheme and all terms and conditions are set out in detail in the rules of the Scheme. This guide does not replace the rules, which are legally binding and always take precedence.

The Metropolitan Medical Scheme is a mutual society that is owned by you, the member, and is governed by the Scheme rules and the Medical Schemes Act, Act 131 of 1998.

II.

The Medical Schemes Act

All medical schemes in South Africa are subject to the Medical Schemes Act, Act 131 of 1998. This Act came into effect in January 2000.

The purpose of the Act "is to ensure that all South Africans are treated fairly in obtaining health insurance in the private sector".

The Act prohibits any unfair discrimination, "either directly or indirectly, against any person based on their age and health status".

A few of the pertinent principles in the Act are:

- community rating, where contributions may only be based on income and/or number of dependants and not based on age, risk, sex or health status;
- Prescribed Minimum Benefits, where all medical schemes are required to provide a range of minimum benefits, as prescribed by the regulations of the Medical Schemes Act; and
- continued membership, where the surviving dependants are allowed to remain as members of the Scheme in the event of a member's death.

III.

The Objectives of a Medical Scheme

The main objective of a medical scheme is to collect sufficient money, in the form of contributions from its members and income from investments, and to assist with the payment of members' medical bills.

It is important to note that medical schemes HELP members pay their medical bills and cannot always provide full cover for all medical bills. The better the range of benefits offered by a scheme and the more members claim, the higher the level of contributions has to be. You are therefore encouraged to manage your medical expenditure prudently.

IV.

Membership

A. Who qualifies to join the Scheme?

The Metropolitan Medical Scheme is a restricted membership scheme and membership is available to employees of Metropolitan Holdings Limited only.

Active employees

As an employee of Metropolitan Holdings Limited, membership of the Scheme is a condition of employment and compulsory for all full-time employees and voluntary for continuation members who qualify for membership, unless you are entitled to benefits as a dependant of a principal member of another registered medical scheme.

In the event of both husband and wife or partners being in the employ of Metropolitan Holdings Limited, the spouse or partner earning the higher income will become the principal member and the other, the dependant.

Retirees

Members have the option to retain membership of the Scheme with their registered dependants if:

- they retire from the service of the employer; or
- their employment is terminated by the employer on account of age, ill health or other disability.

The Scheme will inform you of your right to continue membership and of the contribution payable from the date of your retirement or termination of employment. You will remain a member unless you inform the Board in writing that you want to terminate your membership.



Dependants of deceased members

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

In instances where child dependants have been orphaned, the eldest child will become the principal member, and any younger siblings registered as his/her dependants.

Membership in such cases will end on registration as a member or dependant of another medical scheme.

The Scheme will inform the dependant of his/her right to membership and of the contributions payable, and unless he/she declines membership in writing to the Board, he/she will be admitted as a member of the Scheme.

B. Who qualifies as a dependant?

In terms of the Scheme rules, a dependant is defined as:

- a member's spouse or common-law spouse who is not a member or a registered dependant of another medical scheme;
- the dependent child of a member who is not a member or a registered dependant of a member of another medical scheme;
- a child under the age of 21;
- a child older than 21, up to the age of 25, unmarried and:
 - a full-time student at a recognised tertiary institution; or
 - not self-supporting due to physical or mental incapacity.

Proof of child dependency

These dependants will be considered child dependants until the end of the year in which they turn 25.

Please note that in order for dependants to remain registered as child dependants, supporting documentation is required by the Scheme prior to the end of the month in which the dependant turns 21, and annually thereafter for students.

Kindly refer to the table below for clarity on how often the documentation required by the Scheme must be submitted:

	Documentation required	Frequency
Full-time student	Proof of student registration	Annually
Physical and/or mental incapacity	Medical report	Once off

If the documentation is not submitted, the dependant's registration will be cancelled at the end of the month of his/her next birthday.

Please inform the Scheme within 30 days of any event prior to your dependant's 25th birthday, which will result in him/her no longer satisfying the conditions under which he/she may be classified as a child dependant.

- the parents, brothers or sisters of a member for whom the member is liable for family care and support, who is not in receipt of a regular income greater than the social pension, and who is not a member or registered dependant of a member of a medical scheme;
- other persons who are recognised by the Board as dependants in terms of the Scheme rules.

C. Notice of change in membership details and registration of dependants

You should notify your Human Resources Department and the Scheme within 30 days of:

- a change in marital status;
- the birth of children;
- the adoption of a child (a copy of the final legal documents should accompany your request to register the child as a dependant);
- the exclusion of any of your dependants who no longer qualify as dependants; from this date onwards the dependant will no longer be eligible for benefits;
- any change in your residential and/or postal address (applicable to pensioner members only).

Where appropriate, contributions will be adjusted accordingly in the above cases.

Should a member elect not to register his/her dependants until a later stage, the dependant's membership will be subject to a three-month waiting period before he/she becomes eligible for benefits.

Contributions will be payable during the waiting period.

D. Membership card and certificate of membership

After you have been registered as a member of the Scheme, a membership card will be issued to you.

This card is proof of membership of the Scheme and it remains your sole responsibility to ensure that the card is presented to service providers and that they record the correct membership number and name of the Scheme.

In the event of the membership card being lost or stolen, please contact the Scheme immediately.

Nobody may use your membership card besides you and your registered dependants.

If you allow somebody other than your registered dependants to use it, it will be



treated as an abuse of Scheme benefits, and Scheme privileges could be withheld from you.

When your membership of the Scheme ends, your card should be destroyed. You will be issued with a certificate of membership on request.

V.

Termination of Membership

A. Resignation

You may not resign from the Scheme while you are still employed by Metropolitan Holdings Limited unless you become a dependant of a member of another registered medical scheme.

A member who resigns from the service of Metropolitan Holdings Limited will cease to be a member of the Scheme, and all rights to benefits will end, except for claims in respect of services rendered prior to the date employment ends.

B. Death

C. Failure to pay amounts due to the Scheme

If a member fails to pay amounts due to the Scheme, his/her membership may be terminated.

D. Abuse of privileges, false claims, misrepresentation and non-disclosure of factual information

The Board may exclude from benefits or terminate the membership of any member or registered dependant whom it finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making material misrepresentation or non-disclosure of factual information. In such cases the member may be required to refund any sum paid to him/her by the Scheme, which would not have been paid to him/her but for his/her abuse of privileges.

Where there is reasonable cause for the Board to suspect abuse of benefits and privileges, a member and/or his dependants may, after written notification by the Scheme, be suspended from all scheme benefits for a period not exceeding 60 days to allow investigation of the matter. After this period, the member will be entitled to full benefits unless found guilty, in which case the Board may exclude from benefits or terminate the membership of the member and/or registered dependant.

Where there is reasonable cause for the Board to suspect abuse of benefits and privileges, the Board may terminate the membership of a member or dependant who fails to comply with reasonable Scheme requests that will aid in the investigation.

E. Metropolitan Medical Scheme's zero tolerance to fraud

In an effort to curb the occurrence of fraud at every possible level, the Scheme's initiatives include involvement in combating fraud at a national level under the auspices of the Board of Healthcare Funders (BHF)'s Fraud Management Unit.

To this end members and their service providers can expect to be called on routinely to prove the authenticity of claims paid by the Scheme.

Members are advised to utilise their benefits responsibly, to scrutinise their statements regularly and to report fraud via the Metropolitan Health Group/KPMG hotline number reflected on page 23.

What is fraud and abuse? Fraud constitutes, amongst others:

- receiving money from your doctor in order for him/her to use your membership number to submit fictitious claims;
- lending your card out to non-registered persons or lending your card out to non-registered persons for cash;
- failing to declare that you have a chronic ailment such as diabetes and later attempting to obtain cover for the associated costs;
- irresponsible use of benefits by visiting numerous practitioners when not necessary and without consulting your own doctor;
- applying for cover for a procedure regarding an undeclared, pre-existing condition within the first 12 months of registration on the Scheme.

What does the Scheme do when it detects fraud?

- All costs are recovered.
- Members' membership of the Scheme may be suspended, while continuing to pay contributions. Alternatively, membership may be terminated.
- Practitioners are reported to the Health Professions Council and may be barred from practising.
- Criminal cases are opened at the South African Police Services and the guilty parties are tried.
- Disciplinary hearings are conducted by the employer and members could face termination of employment if found guilty of serious offences.

Please remember that fraud will not be tolerated. Look after the interests of the Scheme by reporting fraud.



VI.

Interchangeability

Subject to certain terms and conditions, the Scheme may apply the following waiting periods or impose restrictions on members and/or their registered dependants:

- a general waiting period of three months during which no benefits will accrue;
- a condition-specific waiting period of up to 12 months in respect of any condition, including pregnancy, for which medical advice, diagnosis, care and treatment was recommended or obtained within a period of 12 months immediately prior to the member's date of application.

No benefits will accrue during these waiting periods, but contributions must be paid to the Scheme in full.

New members and their dependants will not be subject to these waiting periods, provided they have been members of a previous medical scheme for a continuous period of at least two years, and joined the Scheme within three months of leaving their previous scheme.

Membership certificates or affidavits correlating the above will be necessary for this provision to apply.

New dependants born into the Scheme will not be subject to any waiting periods.

VII.

Benefits

A. Scope of benefits

During a financial year you and your registered dependants will enjoy the benefits as set out in the benefit schedules, subject to limitations and exclusions.

B. Changing from one option to another

Members who want to change to another option may only do so with effect from 1 January of each year.

If you wish to change from one benefit option to another, you should notify the Scheme in writing of your intention to change to another benefit option in the stipulated time.

Your contributions will change in accordance with the contribution table of the benefit option that you have selected.

C. Exclusions

Unless cover is provided as per the Prescribed Minimum Benefits or otherwise pro-

vided for or decided by the Board, expenses in connection with any of the following will not be paid by the Scheme:

- All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant, and for which any other party may be liable, unless the Board is satisfied that there is no reasonable prospect of the member or dependant recovering adequate damages from the other party. Where such a claim, after deliberation, is repudiated by the parties concerned, the member is entitled to such benefits as would have applied under normal conditions, irrespective of the lapse of time.
- Costs arising directly or indirectly from intentional, self-inflicted injury even if the member or dependant was psychologically unstable at the time.
- All costs in respect of injuries arising from speed contests, speed trials and professional sports.
- All costs for operations, medicines, treatment and procedures for cosmetic purposes and any complications arising from such services.
- Holidays for recuperative purposes or treatment or exercise in a gymnasium, whether medically necessary or not.
- Adjustments and repairs to spectacle frames, and the purchase of sunglasses and tinted contact lenses.
- Purchase of:
 - Medicines not registered with the Medicines Control Council (MCC) and proprietary preparations;
 - Applicators, toiletries and beauty preparations;
 - Bandages, cotton wool and other consumable items;
 - Patented foods, including baby foods;
 - Tonics, slimming preparations and drugs as advertised to the public;
 - Household and biochemical remedies;
 - Sunscreen and tanning agents;
 - Medicines other than medicines on written prescriptions of a person legally entitled to prescribe;
 - Devices and material such as dental floss, toothbrushes and toothpaste;
 - Anti-smoking preparations.
- All costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules of the Scheme.
- Charges for appointments that you or your dependants fail to keep.
- Examinations for insurance, employment, law suits, visas or similar purposes.

- Costs for services rendered by:
 - Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
 - Any institution, nursing home or similar institution except a State or provincial hospital not registered in terms of any law.
- Costs for any services, examinations and/or treatments where no real or diagnosed illness exists and treatment is rendered purely for psychological reasons.
- Any treatment relating to:
 - sterility;
 - infertility;
 - obesity;
 - erectile dysfunction; or
 - artificial insemination.
- Costs relating to telephonic consultations.
- Accommodation in old-age homes or similar institutions.
- Any and all costs incurred at headache clinics.
- Sclerotherapy treatment unless a vascular surgeon is responsible for the treatment where it forms part of the surgical removal of varicose veins.
- Claims for newborn grandchildren.

D. Limitations of benefits

The maximum benefits to which you and your dependants are entitled to in any financial year will be limited as set out in the benefit schedules.

Members who are registered during the course of a financial year are entitled to the benefits set out in the benefit schedules, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

Unless otherwise decided by the Board, benefits in respect of medicines obtained on prescription are limited to one month's supply and the purchase of contact lenses are limited to six months' supply for every prescription or repeat prescription.

In the case of protracted illness, the Board will have the right to insist on the member or dependant consulting a particular specialist the Board may nominate in consultation with the attending practitioner. If the specialist's treatment is not acted upon, no further benefits will be allowed for that particular illness.

The Scheme's health risk managers are mandated by the Scheme to ensure the application of these rules and adherence to the benefit levels, subject to the promotion of best practice protocols and supported by evidence-based guidelines that are cost-effective, but does not compromise quality of care.

E. Prescribed Minimum Benefits

The Minister of Health has revised the section on Prescribed Minimum Benefits (PMB) in the Regulations of the Medical Schemes Act to provide for the treatment of the following 25 most common chronic conditions:

Addison's disease	Epilepsy
Asthma	Glaucoma
Bipolar mood disorder	Haemophilia
Bronchiectasis	Hyperlipidaemia
Cardiac failure	Hypertension
Cardiomyopathy disease	Hypothyroidism
Chronic renal disease	Multiple sclerosis
Coronary artery disease	Parkinson's disease
Chronic obstructive pulmonary disorder	Rheumatoid arthritis
Crohn's disease	Schizophrenia
Diaabetes insipidus	Systemic lupus erythematosus
Diabetes mellitus types 1 and 2	Ulcerative colitis
Dysrhythmias	

The Scheme has chosen the State hospital system as its Designated Service Provider for the treatment of PMB conditions. Diagnosis, medical management and medication for any of the PMB conditions will be paid without restrictions if the service is rendered in a State hospital.

VIII. Contributions and Other Amounts Due to the Scheme

A. Payment of contributions

Contributions are paid monthly in arrears.

Contributions are calculated on the basis of your income and the number of adult and child dependants you have.

Please refer to the contribution table to calculate the total contributions payable.



B. Liability

The liability of your employer is limited to the amount of his/her unpaid contributions, i.e. his/her portion of the monthly contribution subsidy.

Your liability is limited to the amount of your unpaid contributions, i.e. your portion of the contribution, together with any amount paid by the Scheme on your behalf or on behalf of your dependants, that you have not repaid to the Scheme.

If your membership of the Scheme is terminated, any amount that you owe to the Scheme will be a debt to the Scheme and recoverable by it.

IX.

Claims

A. What is the claims procedure?

Claims must be submitted directly to the Scheme's Administrator. Claim forms are not required.

Please note that it is your responsibility to ensure that claims are received and processed by the Administrator.

You may make use of the internal mailing system or allocated claims collection boxes that are placed in central positions in the various buildings.

Every claim submitted to the Scheme must contain the following particulars:

- the surname and initials of the member;
- the surname, full names and date of birth of the patient; this must correspond with the details reflected on the membership card;
- the name of the Scheme;
- the member's membership number;
- the practice number of the supplier, where applicable;
- the name and practice number of the referring medical practitioner or dentist, if applicable;
- the date on which the service was rendered;
- the nature and cost of this service;
- the code of each item as per the National Health Reference Price List (NHRPL) and in the case of the hospital claims, the Uniform Patient Fee Schedule (UPFS) for public hospitals, or the Agreed Tariff for private hospitals and the corresponding CPT 4 and ICD-10 codes;
- where the account is a photocopy of the original, certification on the photocopy by the supplier by means of a signature or rubber stamp is required; no faxes will be accepted;

- the name, identification code (if applicable), quantity and price of each supply of medicine, requirement and apparatus.

Where an account relates to a service supplied in respect of orthodontic treatment, a document containing the following further information must accompany the claim:

- the code of each item as per the National Health Reference Price List (NHRPL), or the corresponding CPT 4 and ICD-10 codes for the treatment;
- a treatment plan indicating the following:
 - the total amount that the orthodontist is going to charge for the treatment;
 - the expected duration of the treatment;
 - the initial amount payable by the member; and
 - the monthly amount which the member must pay.

Please consult with the Scheme before receiving costly medical treatment that could result in unexpected expenses for your own account.

B. What is the claiming period?

Claims should be submitted as soon as possible. All claims must be submitted by the last day of the fourth month following the month in which the service was rendered. Claims that are received after this claiming period will not be paid by the Scheme and you will be responsible for settling the claim.

C. Accounts for treatment in respect of injuries

A statement setting out particulars of the circumstances in which the injury was sustained should support accounts for treatment of injuries. Accounts that are submitted without the supporting documentation cannot be processed and will cause delays in the payment of benefits.

D. Rejected accounts

Where the Scheme is of the opinion that a claim was incorrect or unacceptable for payment, the Scheme will notify the member or service provider accordingly within 30 days of receipt of the claim. The Scheme will state the reasons why the claim is incorrect or unacceptable.

The member or service provider must return the corrected claim within 60 days of the date on which it was returned for correction.

E. When are claims paid?

All valid claims are paid in the middle and at the end of the month. Claims statements setting out how the accounts were processed and paid, are posted or e-mailed to you.



Reimbursement is made either via cheque, which is attached to the claims statement, or via direct deposit into your banking account, if requested.

We would like to encourage you to make use of the direct deposit method of reimbursement, as it is safer and more efficient. If you prefer this method of payment, please notify the Scheme in writing, and provide the following information:

- name of account holder;
- name of banking institution;
- branch name and branch code;
- account number; and
- type of account.

F. Checking of processed claims

When you receive your claims statement, please check that:

- the Scheme has processed all your claims;
- all the claims shown are for services provided to you and/or your registered dependants; and
- the amount paid to you or the service provider is reflected correctly.

Please notify the Scheme of your e-mail address. In doing so, you will receive an e-mail message as soon as a claim is processed. This e-mail message will reflect all the information required to conduct the necessary checks. This facility does not replace the claims statement, but enables you to follow the processing of your claims before transactions are finalised.

Should you note any discrepancies or have any queries about your claims statement or the e-mail notification, please contact the Client Service Department immediately.

G. Online services via the Scheme's website

You have 24-hour Internet access to your personal medical scheme information, including claims processed, benefit schedules and membership details at the Scheme's website at www.metromed.co.za.

Online access to your personal information can be performed in a PIN-protected environment. You can apply for a PIN on the website. This is a valuable tool that can also be used to monitor the processing of your claims and to obtain further information about the Scheme at a time that is convenient for you.

H. Rates charged by service providers

When service providers charge the applicable National Health Reference Price List (NHRPL) tariff, Scheme benefits are paid on your behalf up to the applicable benefit limit.

Members are responsible for settling the difference between the fees charged by service providers and the Scheme Rate in cases where service providers charge in excess of these rates.

Accounts that have been settled by you will be reimbursed to you by the Scheme in accordance with the applicable Scheme benefit. Please submit a receipt to the Scheme as proof of payment, or clearly indicate on the account when it was paid.

X.

Chronic Medication

A. What is chronic medication?

Chronic medication is medication that is taken on an ongoing basis:

- for a life-threatening condition or chronic illness, e.g. diabetes;
- to relieve symptoms of an ongoing condition which, if not treated, could seriously harm your health.

The list of conditions that qualify under the chronic medication benefit is:

- Allergic rhinitis (strict protocols applied)
- Attention deficit hyperactivity disorder (strict protocols applied)
- Alzheimer's disease
- Angina
- Arrhythmias
- Asthma
- Benign prostatic hypertrophy
- Cardiac failure and cardiomyopathy
- Chronic obstructive airways disease
- Chronic recurring peptic ulcer (allowed if non-responsive to triple therapy)
- Chronic renal failure
- Coronary artery disease
- Crohn's disease
- Cystic fibrosis
- Deep vein thrombosis
- Depression/dysthymia
- Diabetes insipidus
- Diabetes mellitus (types 1 and 2)



- Dry eye syndrome
- Eczema
- Enuresis/incontinence
- Epilepsy
- Gastro-oesophageal reflux
- Glaucoma
- Gout
- Gouty arthritis
- Hyperlipidaemia
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Meniere's disease
- Menopause
- Migraine (cluster and vascular are other headaches included in this category) (allowed with protocol)
- Multiple sclerosis
- Myasthenia gravis
- Narcolepsy and cataplexy
- Osteo-arthritis
- Osteoporosis
- Parkinson's disease
- Peripheral vascular disease
- Psoriasis
- Psychosis/schizophrenia
- Rheumatoid arthritis
- Systemic lupus erythematosus
- Ulcerative colitis.

If you or your dependants require medicine for the treatment of these conditions, you have to apply to the Medicine Risk Management (MRM) programme. Your application must be approved before you can claim from the chronic medication benefit.

B. The application process

- Request an application form for the programme from the Client Service Department or download the application form from the Scheme's website at www.metromed.co.za.

- Complete the applicant's section of the form.
- Ask your doctor to complete the practitioner's section of the form.
- Check that the application form is correctly completed and accompanied by test results or specialist reports, as indicated on the application form (an incomplete form will delay the processing of your application).
- Send the application form and the requested information to the Scheme's address, clearly marked for the attention of the MRM programme.

C. The authorisation process

On receipt of your application form, the MRM team will assess and process it.

If your application for chronic medication is successful, an authorisation letter will be mailed to you. The period of authorisation for each medication item will be indicated in the letter.

If you intend to purchase your chronic medication from your pharmacy, you need to do the following:

- Ensure that your doctor writes a separate prescription listing only your approved chronic medication, i.e. separate from any acute medication items.
- Present your copy of the authorisation letter, together with the doctor's prescription, to your pharmacist.
- The pharmacist will submit the claim to the Scheme as chronic medication and will be reimbursed directly.
- If you pay cash for your chronic medication, please submit the receipt, together with a copy of the doctor's prescription and the invoice, to the Scheme for reimbursement.

D. Unauthorised or rejected medication

You will be informed of any medication item not approved by MRM. A reason for the rejection will be provided.

In certain instances, MRM might require results of special tests or reports from specialists.

Please obtain this information and forward it to MRM as soon as possible to prevent further delays. Applications will only be reconsidered on receipt of the supporting information.

If your doctor believes that certain medicines or conditions that were rejected should be reconsidered for approval as chronic, please request him/her to motivate this in a detailed clinical report.



E. Changes to authorised medication

If your doctor wishes to add or delete certain medication items, or to change the dosage, strength, form or quantity of your approved medication, MRM requires that your doctor complete a new application form.

XI.

Qualsa's Disease Risk Management Programme

The Scheme has contracted Qualsa to administer its diabetes and maternity management programmes through Qualsa's Disease Risk Management Programme.

The programme's motto is, "Health through education and awareness".

Diabetes programme

Members who are diabetic, or who have dependants who are diabetic, are encouraged to apply for the chronic medication benefit by following the process on page 18.

The main aim of the programme is to assist members in understanding the disease and its treatment, and to manage their healthcare costs in an effective manner.

Oncology Risk Management Programme

The programme's comprehensive approach is geared towards developing effective strategies in caring for cancer patients.

All oncology therapy requires pre-authorization from Qualsa. Patients can contact Qualsa telephonically. The case manager will request a treatment plan from your specialist. Authorisation will be granted based on the medical necessity and clinical appropriateness of the proposed treatment.

Maternity programme

Members and their dependants who are pregnant will benefit from the maternity management programme by receiving advice on Scheme benefits, as well as gaining access to healthcare information.

HIV & AIDS programme

Qualsa's HIV & AIDS Risk Management assists people living with HIV & AIDS to access quality care and to make optimal use of the benefits available to them. If you think that you might be HIV positive, or have been diagnosed as a person living with HIV & AIDS, this free service will be invaluable to you. Each member registered with the programme will be treated in confidence

Other high-risk diseases

Members and dependants who are hypertensive, have asthma and/or high cholesterol are also encouraged to register with the Disease Risk Management Programme.

Registration process

To register on the Disease Risk Management Programme and to obtain more information about your condition, simply call the telephone number listed on page 23.

A case manager will then register you on the telephone.

XII.

Pre-authorisation for Hospitalisation

The rules of the Scheme require that you obtain authorisation from the Scheme before any of the following:

- admission to hospital;
- any surgery or medical procedure in a normal or day hospital;
- MRI and CT scans;
- confinements; and
- maxillo-facial treatment.

In an emergency, you have one working day in which to obtain authorisation.

If you fail to obtain pre-authorisation, you will be liable for payment of a R500 penalty.

When phoning for pre-authorisation, please ensure that you have the following information at hand:

- your membership number, the name and date of birth of the beneficiary to be admitted or treated;
- the name and practice number of the doctor or medical practitioner who is requesting hospitalisation, surgery, or one of the other defined medical services for which pre-authorisation is required;
- the reason for the admission (diagnosis and surgical procedure);
- the name of the hospital and/or facility the beneficiary is to be admitted to;
- the dates of admission and surgery or treatment; and
- the planned number of days you will stay in hospital.

The Scheme will provide you with an authorisation number that you must provide to the hospital on admission.



XIII.

Quick Guide to Managing Costs

- Practise a healthy lifestyle to prevent unnecessary illness.
- Avoid unnecessary visits to the doctor. Remember: your contributions are directly related to the cost of claims.
- Ask for a quotation. This will enable the Scheme to inform you of your share of the costs relating to long or expensive treatment.
- Visit service providers who charge in accordance with the Scheme Rate. It is to your advantage because you will be responsible for any amounts exceeding these rates.
- Ask your doctor or pharmacist if there are any generic equivalents available when purchasing medication.
- Negotiate a cash discount with your service providers and pay up front.
- Register on the Medicine Risk Management programme if you have a chronic illness.
- Register with Qalsas's Disease Risk Management Programme if you or your dependants are diabetic, pregnant, hypertensive, asthmatic or have high cholesterol.
- Check your claims statement, register a PIN via the Scheme's website and inform the Scheme of your e-mail address. These are tools made available to you to monitor the processing of your claims to ensure that no fraud or errors occur.
- Report fraud to the Metropolitan Health Group/KPMG fraud hotline.

XIV.

Financial Year of the Scheme

The financial year of the Scheme extends from 1 January to 31 December.

Scheme address

(for claims, application forms for chronic medication and general enquiries)

Metropolitan Medical Scheme

PO Box 15716

Vlaeberg

8018

Client Service Department

Telephone: 0861 888 104 or 021 480 4414

Fax: 021 480 4420

E-mail: metromed@mhg.co.za

Website: www.metromed.co.za

Hospital pre-authorisation

Telephone: 0861 888 309 or 021 480 4923

Chronic medication enquiries

Telephone: 0861 888 104 or 021 480 4414

Qualsa Disease Risk Management Programme

Telephone: 0861 888 109 or 021 480 4422

Oncology Risk Management programme telephone: 0861 888 309

HIV & AIDS Programme telephone: 0861 888 300 or 021 480 4804

Metropolitan Health Group/KPMG fraud hotline

Telephone: 0800 200 564

E-mail: audit@mhg.co.za

Human Resources Department

(for enquiries relating to registrations, membership details, subsidies and contributions)

Field and indoor staff telephone: 021 940 5855/6/7 or 021 940 6709

Members residing in the Cape Town area are encouraged to make use of the telephone numbers starting with "021" instead of "0861" as the former are more cost-effective for local callers.

