



FOR **ALL OUR** PEOPLE



transmed
MEDICAL FUND

2026 BENEFITS GUIDE

SATS PENSIONERS – GUARDIAN PLAN

Welcome to Transmed Medical Fund's 2026 benefits guide.

This guide explains the 2026 benefits and services and how to access them. Please read the guide carefully and keep it safe for future reference.

The 2026 benefit and contribution changes come into effect once approved by the Council for Medical Schemes.

This guide does not replace the rules. The registered rules are legally binding, always take precedence and are available on request or on the Transmed website at www.transmed.co.za.



A: OVERVIEW OF 2026 BENEFITS

Important information

- State hospitals are the designated service providers (DSPs³).
- Major medical benefits for treatment of PMB¹⁵ and non-PMB conditions in hospital will be covered in full if the treatment is obtained at a State hospital.
- The Transmed private hospital network⁶ is the secondary DSP³. This network is only available for emergency or involuntary admissions for PMB¹⁵ conditions where a State hospital is not accessible.
- A co-payment⁸ for the voluntarily use of a non-DSP hospital is applicable to PMB¹⁵ conditions. There is no private hospital benefit for non-PMB conditions.
- The Transmed pharmacy network² is the DSP³ for chronic and HIV/AIDS medication.
- Preferred Provider Negotiators (PPN⁹) is contracted to manage optical benefits.
- DENIS¹⁰ is contracted to manage dental benefits.
- Improved Clinical Pathway Services (ICPS¹³) network is contracted for selected knee and hip replacements.
- Ophthalmology Management Group Limited (OMG¹¹) is contracted for cataract surgery.
- Independent Clinical Oncology Network (ICON⁷) is the DSP³ for cancer treatment.
- Pre-authorisation, where necessary, can be obtained 24 hours a day and on weekends and public holidays by calling the care manager on **0800 225 151**.

KEY TO TERMS USED IN THIS BENEFITS GUIDE

*	Transmed rate	The Transmed rate is the fee payable for a benefit year in respect of a specific tariff or service
*1	General day-to-day limit	The day-to-day benefit covers all routine services received out of hospital, other than those covered from insured benefits in terms of an authorisation or other defined benefits or limits
*2	Transmed pharmacy network	A network of pharmacies that Transmed has negotiated a preferred rate with: <ul style="list-style-type: none"> • Clicks pharmacy group • Dis-Chem pharmacies • MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) • Contracted independent pharmacies
*3	DSP	A designated service provider is contracted by the Fund to provide certain treatment or services to patients at a preferred tariff
*4	Formularies	Formularies applicable to a specific medication benefit: <ul style="list-style-type: none"> • Chronic medication – comprehensive medication formulary • Acute medication – acute medication formulary • Over-the-counter (OTC) medication – OTC medication formulary
*5	Reference pricing	This is the maximum price that the Fund will pay for a specific class of medication
*6	Transmed private hospital network	A network of private hospitals that Transmed has negotiated a preferred rate with for admissions approved as an emergency or an involuntary admission
*7	ICON	The Independent Clinical Oncology Network is a network of oncologists that is the contracted DSP for oncology (cancer) treatment
*8	Co-payment	A co-payment is a fee that is payable by a member directly to a service provider and is calculated as the difference between the price charged by the member's chosen service provider and the price negotiated with the applicable designated/preferred service provider
*9	PPN	Preferred Provider Negotiators is contracted to manage optical benefits, including the optical claims processing
*10	DENIS	DENIS is contracted to manage dental benefits, including dental claims processing
*11	OMG	The Ophthalmology Management Group Limited is a network of ophthalmologists that is contracted to provide cataract surgery
*12	UPFS	The uniform patient fee schedule is the tariff structure applicable to State hospital facilities
*13	ICPS	Improved Clinical Pathway Services is a network of orthopaedic surgeons that is contracted for selected knee and hip replacements
*14	Fund exclusions	Services, procedures and consumables that are not covered by Transmed: <ul style="list-style-type: none"> • Accommodation in old age homes, frail care centres or similar institutions • All costs for operations, medicines, treatment and procedures for cosmetic or for psychological purposes • All costs for operations, medicines, treatment and procedures related to weight reduction • Operations to reverse a sterilisation • Artificial insemination (GIFT or similar procedures) • Patent foods, including baby food • Slimming preparations • Household remedies or preparations and herbal and natural remedies • Aphrodisiacs • Cosmetic soaps, shampoos and other topical applications • Sun screening and sun tanning agents • Cosmetic preparations, medicated or otherwise • Contact lens preparations • Holidays for recuperative purposes • Vitamins and mineral supplements
*15	PMBs	Prescribed minimum benefits are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option



B: EXPLANATION OF THE 2026 BENEFITS

Day-to-day benefits

Optical and dental services are paid from the respective optical and dental benefits. All other day-to-day services (except for services covered on an authorised PMB¹⁵ treatment plan) are paid from the general day-to-day limit¹. Members may use any registered healthcare or service provider of their choice, except for optical and dental services, which are managed by the contracted providers.

Hospitalisation

Private hospitalisation is limited to certain conditions and procedures, where a State hospital cannot provide the service or where the Fund has contracted with a private provider. Such admissions must be pre-authorized in order to confirm the availability of the benefit.

When can members use a private hospital?

Members can use a private hospital in the following situations:

- In case of a medical emergency or when immediate medical or surgical treatment for a PMB¹⁵ condition was required and could not reasonably be obtained from a State hospital (DSP³).

An emergency is defined in terms of the Medical Schemes Act and the rules as the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place a person's life in serious jeopardy.

- In cases where the required service or procedure is covered by the Fund at a State hospital (DSP³), but is not reasonably available at the time or could not be provided without an unreasonable delay. In such cases, members should use hospitals that form part of the Transmed private hospital network⁶ or appointed specialist networks (ICON⁷ and ICPS¹³) to avoid co-payments⁸.
- If the PMB¹⁵ service is not available at a State hospital (DSP³), pre-authorization for admission to a secondary facility will be considered by the care manager, who is available 24 hours a day. The Fund will cover the admission costs in the alternative facility, subject to pre-authorization, case management and other managed healthcare interventions.

Please call **0800 225 151** to obtain pre-authorization or for more information and guidance.

When will members be liable for the cost of using a private hospital?

When the service or procedure is not covered by the Fund, the member will be liable for the full account. When the member opts to use a private hospital for a PMB¹⁵ service or procedure that is available at a State hospital (DSP³), the member will be liable for a co-payment⁸ equal to the difference between the fees charged and the equivalent cost that would have been payable to the State hospital (DSP³).

Co-payment for the voluntary use of a non-DSP facility

Note: The co-payment⁸ for using a private hospital (non-DSP) could be very high. Members are encouraged to contact the care managers, who will gladly guide you to an appropriate hospital that will assist you in keeping your portion of the cost as low as possible.

Example

The following is an **example** of the impact the cost of using a private facility voluntarily can have on members.

Facility	Total admission cost
State hospitals	R15 000
Transmed private hospital network ⁶ facilities	R40 000
Other private hospitals	R50 000

Based on the table above, the impact on the member will be as follows:

- If a member uses a State hospital, the total admission cost of R15 000 will be covered by the Fund.
- If a member voluntarily uses a private hospital for a service or procedure that was available at a State hospital, cover for this type of admission is limited to R15 000 and the member will be liable for payment of any shortfalls directly to the hospital and other providers.
- If a member uses a Transmed private hospital network⁶ facility on a voluntary basis, the member will be liable for a co-payment⁸ equal to the difference between the total admission cost at a State hospital and at a Transmed private hospital network⁶ facility (R40 000 - R15 000 = R25 000).
- If a member uses any other private hospital on a voluntary basis, the member will be liable for a co-payment⁸ equal to the difference between the total admission cost at a State hospital and any other private hospital (R50 000 - R15 000 = R35 000).

*Please note that the above is only an **example** of the calculation of a co-payment⁸ and is not based on a specific case or an indication of the difference in cost in an actual case.*

C: TRANSMED MEDICAL FUND RATE (TRANSMED RATE)

The Transmed rate* is the fee payable for a benefit year in respect of a specific tariff or service.

If a healthcare or service provider charges fees in excess of this rate, a member will be responsible for paying the difference, unless it is for services that qualify for payment in terms of PMB¹⁵ legislation. It is therefore in a member's best interest to negotiate with a healthcare or service provider to charge the Transmed rate*.





D: 2026 CONTRIBUTIONS

Monthly income	Member	Adult dependant**	Child dependant*
R0 - R500	75	69	51
R501 - R1 000	119	111	69
R1 001 - R1 500	161	141	97
R1 501 - R2 000	200	181	119
R2 001 - R2 500	242	217	144
R2 501 - R3 000	278	252	169
R3 001 - R3 500	321	289	192
R3 501 - R4 000	362	325	217
R4 001 - R4 500	401	361	241
R4 501 - R5 000	443	399	265
R5 001 - R5 500	482	435	289
R5 501 - R6 000	521	470	312
R6 001 +	564	507	337

Note the following:

- * Child dependant contributions are payable for a maximum of four dependants.
- * Child dependants older than 21 who are studying full- or part-time and are financially dependent on the member will pay child dependant contributions until the age of 24 (proof of registration at an accredited institution will be required).
- ** Dependants older than 21 (or 24 in the case of studying children) who are financially dependent on the member will pay adult dependant contributions.

E1: MAJOR MEDICAL BENEFITS AT PRIVATE FACILITIES

The following services may be obtained in private facilities, subject to compliance with certain criteria.

Oncology (cancer) treatment

The DSP³ for oncology treatment is the Independent Clinical Oncology Network (ICON¹⁷) of private oncologists. Should a member consult an oncologist outside this network, a 20% co-payment⁸

will be applicable to all services received from the non-network oncologist. The Transmed oncology network is the contracted DSP³ for oncology (cancer) medication. Pre-authorisation must be obtained on **0800 225 151**.

Please note that reference pricing⁵ is applicable to oncology (cancer) medication.

Cataract surgery

The Fund has a contract with the Ophthalmology Management Group (OMG¹¹) Limited to provide cataract surgery. The Fund reimburses the providers with a global fee for this type of surgery. The global fee covers the following:

- the procedure, surgeon and anaesthetist's fees, equipment hire and hospital account
- the post-operation consultation within one month of the procedure.

This arrangement does not restrict doctors in terms of where the procedures should be done. The hospitals used depend on the arrangements that the ophthalmologists make with the hospitals of their choice. If a contracted OMG¹¹ doctor is accessible and the member voluntarily uses a non-DSP, a 20% co-payment⁸ will apply on the total hospital and associated provider costs for the cataract surgery.

In addition to cataract surgery, the following services will be covered, subject to pre-authorisation:

- the consultation during which the diagnosis is made and confirmed
- the related tests performed to make the diagnosis, as per the applicable algorithm
- medication administered as part of the procedure, as per the applicable algorithm
- any other indicated services, as per the applicable algorithm.

Joint replacement benefit

The Fund has a contract with Improved Clinical Pathway Services (ICPS¹³) to provide selected knee and hip replacements. The Fund reimburses the providers with a global fee for this type of surgery. The global fee covers the cost of the admission, ICPS¹³, orthopaedic surgeon, anaesthetist, prosthesis and physiotherapist. If an ICPS¹³ provider or hospital is available, but the member elects to use a non-ICPS provider or hospital, a co-payment⁸ equal to the difference in cost between the total cost incurred in respect of the hospital and all related services, and the cost that would have been payable to the State hospital (DSP³), will apply.

Please note that this benefit is restricted to selected joint replacements only. Please contact **0800 225 151** for more information and referral guidance to the ICPS¹³ providers.

Dialysis

Dialysis treatment is subject to case management and clinical protocols. Pre-authorisation is required prior to the treatment. Please contact **0800 225 151**.

E2: MAJOR MEDICAL BENEFITS

Chronic medication

What is a chronic condition?

A chronic condition is a disease that requires life-sustaining medication to be taken continuously for extended periods – normally for longer than three months. Examples of chronic conditions include diabetes, asthma, high blood pressure (hypertension), epilepsy, cardiac failure, high cholesterol (hyperlipidaemia), Parkinson's disease, thyroid dysfunction and rheumatoid arthritis.

What is a chronic medication formulary?

A chronic medication formulary⁴ is a list of medication for chronic conditions that is approved by the Fund. The list is compiled to ensure that you receive the most appropriate, cost-effective and safest treatment for your chronic condition.

E2. MAJOR MEDICAL BENEFITS (CONTINUED)



How can chronic medication be obtained?

In order to obtain your chronic medication, you need to do the following:

- Register on the Fund's chronic medicine management programme if you have not previously registered.
- Complete the member section of the chronic medicine benefit application form, which can be obtained at **www.transmed.co.za** or by contacting the customer service department on **0800 110 268**.
- Ask your healthcare provider to complete the practitioner's section of the form.
- Email the completed application form, together with a copy of the prescription, to the care manager at **chronic@transmed.co.za** or return it to Transmed Medical Fund, PO Box 15079, Vlaeberg 8018.
- If your application is successful, you will receive an authorisation letter listing the approved medication.
- Once you have received this letter, take the original prescription to a network pharmacy² to collect the medication. A co-payment⁸ may apply for using a non-DSP pharmacy.
- If you need to change your chronic medication, ask your healthcare provider to email the new prescription, together with the necessary motivation and laboratory reports (where applicable), to **chronic@transmed.co.za**. Your healthcare provider needs to include the patient's name, membership number, the ICD-10 code pertaining to the condition and the practice number on the prescription. Your healthcare provider can also call **0800 122 263** to do the update telephonically.

What is the chronic disease list (CDL)? (Standard condition list applies)

The CDL includes 26 common chronic conditions and medical schemes have to provide cover for the diagnosis, treatment and care of these conditions.

Table A: PMB CDL

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

Table B: PMB diagnosis and treatment pairs (DTPs)

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

Table C: Non-PMB conditions - additional conditions covered outside the CDL and DTP criteria

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

* These conditions may in some instances be considered as PMB¹⁵ conditions.

Summary of designated service providers and co-payments for chronic medication

Benefit category	Designated service provider (DSP)	Co-payment for voluntary use of a non-DSP pharmacy
Chronic medication	Transmed pharmacy network ² <ul style="list-style-type: none"> • Clicks pharmacy group • Dis-Chem pharmacies • MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) • Contracted independent pharmacies 	Pharmacies used outside the Transmed pharmacy network ² may result in a co-payment ⁸ Reference pricing ¹⁵ is applicable

F: BREAKDOWN OF BENEFITS

Day-to-day cover	
Benefits	Guardian Plan
<p>1 General practitioner (GP) consultations</p> 	<p>Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit¹</p>
<p>2 Specialist consultations</p> 	<p>Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit¹</p>
<p>3 Acute and over-the-counter (OTC) medication</p> 	<p>Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit¹ Acute and OTC formularies⁴ apply Fund exclusions¹⁴ apply</p>
<p>4 Out-of-hospital pathology</p> 	<p>Paid at the Transmed rate* Subject to the availability of funds in the general day-to-day limit¹</p>
<p>5 Out-of-hospital radiology</p> 	<p>Paid at the Transmed rate*</p> <p>Basic radiology (X-rays) Subject to the availability of funds in the general day-to-day limit¹</p>
<p>6 Optical benefits</p> 	<p>Benefit provided through PPN⁹ protocols</p> <p>NETWORK BENEFIT Optical benefits are subject to authorisation by PPN⁹ and clinical protocols/ prescribed rules apply</p> <p>Beneficiaries can claim every 24 months</p> <p>Examination Limited to 1 consultation to the value of R956, including refraction, glaucoma and visual field screening and artificial intelligence for the detection of diabetic retinopathy</p>

Day-to-day cover

Benefits

Guardian Plan

6 Optical benefits (continued)



Frames/Spectacles/Lenses

R1 265 towards frame and/or lens enhancements, together with 1 pair of clear, single-vision lenses to the value of R225 or clear, bifocal lenses to the value of R485 or clear, multifocal lenses to the value of R850

OR

Contact lenses

Limited to R1 580

NON-NETWORK BENEFIT

Members will be liable for a co-payment*⁸ for out-of-network services

Examination

Limited to 1 consultation to the value of R420

Frames/Spectacles/Lenses

R1 012 towards frame and/or lens enhancements, together with 1 pair of clear, single-vision lenses to the value of R225 or clear, bifocal lenses to the value of R485 or clear, multifocal lenses to the value of R850

OR

Contact lenses

Limited to R1 580

Please call PPN*⁹ on **0861 103 529**

7 Basic dentistry



Benefit provided through DENIS*¹⁰

Subject to protocols and limitations

No annual limit and only stated codes covered

Paid at the Transmed rate*

Root canal

Limited to 1 per family per year

Please call DENIS*¹⁰ on **0860 104 941**

8 Specialised dentistry



Benefit provided through DENIS*¹⁰

Subject to protocols and limitations

Limited to R5 090 per family per year

Paid at the Transmed rate*

Crowns

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

Dentures

Limited to 1 set per jaw every 4 years for beneficiaries older than 21

Limited to 1 set of chrome cobalt-frame dentures every 5 years for beneficiaries 21 years and older

Pre-authorisation required

Please call DENIS*¹⁰ on **0860 104 941**

Day-to-day cover (continued)

Benefits	Guardian Plan
<p>9 Dentures</p> 	<p>Benefit provided through DENIS¹⁰</p> <p>R1 290 stand-alone benefit per family for beneficiaries older than 21</p> <p>Amounts in excess of this limit are payable from the available funds in the specialised dentistry limit of R5 090 per family per year</p> <p>Paid at the Transmed rate*</p> <p>Pre-authorization required Please call DENIS¹⁰ on 0860 104 941</p>
<p>10 General day-to-day limit¹¹</p> 	<p>Paid at the Transmed rate*</p> <p>Includes:</p> <ul style="list-style-type: none"> • GP and specialist consultations • Acute and over-the-counter (OTC) medication • Routine pathology and radiology <p>All other day-to-day benefits not specifically mentioned above M0: R5 240 M+: R9 200</p>

Chronic medication

<p>11 Benefits</p> 	<p>The Transmed pharmacy network² is the DSP³ Comprehensive formulary⁴ applies Reference pricing⁵ applies</p>
<p>12 Pharmacies</p> 	<p>The Transmed pharmacy network² consists of:</p> <ul style="list-style-type: none"> • Clicks pharmacy group • Dis-Chem pharmacies • MediRite pharmacy group (pharmacies in Shoprite/Checkers stores) • Contracted independent pharmacies <p>Members may be liable for a co-payment⁸ if a pharmacy outside the Transmed pharmacy network² is used</p>

Major medical cover

<p>13 State hospital admissions</p> 	<p>The DSP³ is State hospitals</p> <p>Paid at the Transmed rate*</p> <p>100% cover at a State hospital, subject to the UPFS¹² for PMB¹⁵ and non-PMB admissions</p>
--	---

Major medical cover

Benefits

Guardian Plan

14 Private hospital admissions



Only PMB¹⁵ conditions for major medical events and selected knee and hip replacements through ICPS¹³

No benefit for non-PMB conditions

If a State hospital is not accessible in terms of the set criteria for PMB¹⁵ treatment, authorisation will be considered for admission to a hospital on the Transmed private hospital network⁶ as the secondary DSP³ and payable at the Transmed rate*

The co-payment⁸ for the voluntary use of a non-DSP will be the amount equal to the difference between the total cost incurred in respect of the hospital services, including all related medical services, and the cost that would have been payable to the State hospital (DSP³) or secondary DSP³ – whichever is applicable

Pre-authorisation required

Please call **0800 225 151**

15 In-hospital services (including GP and specialist services and pathology and radiology)



100% cover for PMB¹⁵ and non-PMB admissions at a State hospital
Subject to the UPFS¹²

Paid at the Transmed rate*

Advanced radiology (MRI and CT scans)

Subject to case management and clinical protocols

Pre-authorisation required

Please call **0800 225 151**

16 In-hospital dentistry



Benefit provided through DENIS¹⁰
Subject to protocols and limitations
Only PMB¹⁵ conditions and certain surgical procedures (fistula closure)

Paid at the Transmed rate*

The fee for the hospitalisation and anaesthetist is paid from the major medical benefit

Dental treatment/procedures are subject to the availability of funds in the specialised dentistry limit of R5 090 per family per year

Pre-authorisation required

Please call **0800 225 151**

17 Internal prostheses



Only PMB¹⁵ conditions and selected knee and hip replacements – refer to page 7

Subject to individual prosthesis limits – refer to Annexure A on page 18

Medical motivation may be required

Pre-authorisation required

Please call **0800 225 151**

Major medical cover (continued)	
Benefits	Guardian Plan
<p>18 Orthopaedic, surgical and medical appliances</p> 	<p>Subject to individual appliance limits – refer to Annexure B on page 19</p> <p>Medical motivation may be required</p> <p>Pre-authorisation required Please call 0800 225 151</p>
<p>19 Organ transplants</p> 	<p>Subject to case management and clinical protocols</p> <p>Harvesting cost of organs (both live and cadavers) is subject to PMB¹⁵ legislation</p> <p>International donors The cost of an international donor search and harvesting will be limited to R225 000 (irrespective of the rand/dollar/euro exchange rate)</p> <p>In all cases, special approval is required from the Principal Officer or his delegate before an international donor search can be funded and a confirmation of the non-availability of a suitable local donor is required</p> <p>The recipient must be a Transmed member</p> <p>Pre-authorisation required Please call 0800 225 151</p>
<p>20 Ambulance services</p> 	<p>Transfer protocols apply</p> <p>Paid at the Transmed rate*</p> <p>Pre-authorisation required Please call 0800 115 750</p>
<p>21 Emergency visits in hospital casualties</p> 	<p>Paid at the Transmed rate* if life-treating</p> <p>Authorisation is required within 1 working day of the emergency treatment</p> <p>If no authorisation is obtained, services will be paid from general day-to-day*¹ benefits, subject to the availability of funds</p> <p>Please call 0800 225 151</p>
<p>22 Dialysis</p> 	<p>The DSP³ is State hospitals</p> <p>100% cover at a State hospital, subject to the UPFS¹²</p> <p>Paid at the Transmed rate*</p>

Major medical cover

Benefits	Guardian Plan
<p>22 Dialysis (continued)</p> 	<p>If a State hospital is not accessible in terms of the set criteria, authorisation can be obtained for admission to a hospital on the Transmed private hospital network⁶ as secondary DSP³ or approved dialysis centres</p> <p>Pre-authorisation required Please call 0800 225 151</p>
<p>23 Oncology (cancer) treatment</p> 	<p>The Independent Clinical Oncology Network (ICON⁷) of private oncologists and State hospitals are DSPs³</p> <p>Paid at the Transmed rate*</p> <p>Benefits are restricted to tier 1 of the South African Oncology Consortium (SAOC) guidelines</p> <p>Limited to 1 PET scan per beneficiary per year</p> <p>A 20% co-payment⁸ applies for using a provider other than an ICON⁷ service provider or the State</p> <p>Oncology (cancer) medication to be obtained through the Transmed oncology network and is subject to evidence-based clinical protocols</p> <p>Reference pricing⁵ applies to oncology (cancer) medication</p> <p>Pre-authorisation required Please call 0800 225 151</p>
<p>24 HIV/AIDS benefit</p> 	<p>Members are encouraged to register on the HIV YourLife programme</p> <p>Obtain medicine from a Transmed pharmacy network² or courier pharmacy, as selected during enrolment</p> <p>Members may be liable for a co-payment⁸ if a pharmacy outside the Transmed pharmacy network² is used</p> <p>Reference pricing⁵ applies</p> <p>Pre-authorisation required Please call 0860 109 793 (all calls are handled confidentially)</p>
<p>25 Cataract surgery</p> 	<p>The Ophthalmology Management Group (OMG¹¹) network and State hospitals are DSPs³</p> <p>Paid at the Transmed rate*</p> <p>A 20% co-payment⁸ on the total hospital and associated provider costs applies for using a provider other than an OMG¹¹ provider or the State</p> <p>In addition to cataract surgery, the following services will be covered, subject to pre-authorisation:</p> <ul style="list-style-type: none"> • the consultation during which the diagnosis is made and confirmed

Major medical cover (continued)	
Benefits	Guardian Plan
<p>25 Cataract surgery (continued)</p> 	<ul style="list-style-type: none"> the relevant tests performed to make the diagnosis, as per the applicable algorithm medication administered as part of the procedure, as per the applicable algorithm any other indicated services, as per the applicable algorithm <p>Pre-authorisation required Please call 0800 225 151</p>
<p>26 Terminal benefit care</p> 	<p>Subject to pre-authorisation (home assessment if indicated)</p> <p>Once-off limit of R25 000 per beneficiary (this is an additional benefit and the financial limit is not applicable to any services rendered that qualify for payment in terms of the PMB¹⁵ legislation)</p> <p>Only applicable for treatment provided in an accredited facility (hospice/sub-acute/homecare by a registered nurse)</p> <p>Pre-authorisation required Please call 0800 225 151</p>
<p>27 Prescribed minimum benefits (PMBs)</p> 	<p>Hospitalisation 100% cover at a State hospital, subject to the UPFS¹²</p> <p>If a State hospital is not accessible in terms of the set criteria, authorisation can be obtained for admission to a hospital on the Transmed private hospital network⁶ as the secondary DSP³ and payable at the Transmed rate*</p> <p>The co-payment⁸ for the voluntary use of a non-DSP will be the amount equal to the difference between the total cost incurred in respect of the hospital services, including all related medical services, and the cost that would have been payable to the State hospital (DSP³)</p> <p>If the PMB¹⁵ service was not accessible in a State hospital, but available at a Transmed private hospital network⁶ hospital, and the member voluntarily uses a non-network private hospital, the co-payment⁸ will be the amount equal to the difference between the total cost incurred in respect of the hospital services, including all related medical services, and the cost that would have been payable to the State hospital (DSP³)</p> <p>Treatment plan services Paid at the Transmed rate* or at cost Subject to the approved treatment plan services Supplier of own choice may be used for PMB¹⁵ CDL conditions</p>

Major medical cover

Benefits

Guardian Plan

27 Prescribed minimum benefits (PMBs)

(continued)



Chronic medication - the Transmed pharmacy network^{*2} consists of:

- Clicks pharmacy group
- Dis-Chem pharmacies
- MediRite pharmacy group (pharmacies in Shoprite/Checkers stores)
- Contracted independent pharmacies

Members may be liable for a co-payment^{*8} if a pharmacy outside the Transmed pharmacy network^{*2} is used

Additional benefit

28 Health advisor



Free access to Hello Doctor, a mobile phone-based service that gives you access to doctors 24 hours a day, 7 days a week

You can get expert health advice from qualified South African medical doctors through your phone, tablet or computer, at absolutely no cost to you!

Just download the app, request a call and the doctor will phone you back within an hour

Refer to page 21 for more information

Preventative care

29 Flu vaccinations



Available to all beneficiaries
The Transmed pharmacy network^{*2} is the DSP^{*3}
Paid at the Transmed rate*
Subject to the flu vaccination formulary^{*4}
One vaccination per beneficiary per year

30 Pneumococcal vaccination



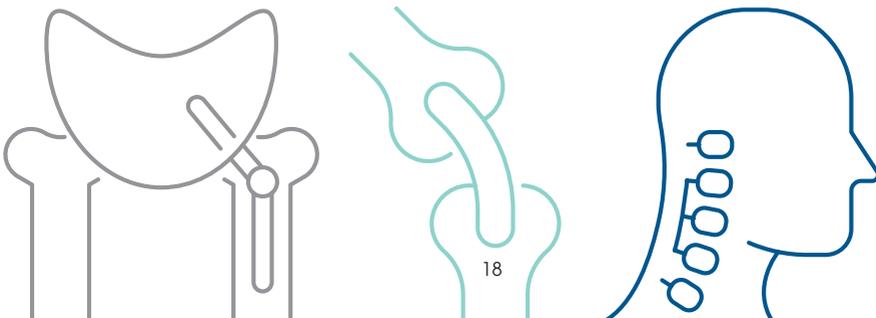
Available to all beneficiaries over the age of 65 years
Subject to an approved treatment plan
The Transmed pharmacy network^{*2} is the DSP^{*3}
Paid at the Transmed rate*
Subject to the applicable formulary^{*4}



ANNEXURE A: INTERNAL PROSTHESES

Prosthesis	Sub-limit	Combined annual sub-limit
1. Cardiac stents (per stent) up to a maximum of three	R25 650	R77 000 per beneficiary per year
2. Cardiac valves (per valve)	R37 500	
3. Grafts (per graft)	R28 500	
4. Hernia mesh	R11 000	
5. Partial hip replacement	R36 000	
6. Total hip replacement	R67 760	
7. Hip revision	R50 000	
8. Total knee replacement	R61 300	
9. Knee revision	R45 000	
10. Partial knee replacement	R30 000	
11. Pacemaker and leads	R44 000	
12. Total shoulder replacement	R57 200	
13. Cervical and lumbar disc replacements	R30 000	
14. Spinal fusion (per procedure)	R55 660	
15. Non-specified items	R25 000	
16. Brain stimulator	R200 000	Per beneficiary per year
17. Endovascular aneurysm repair (EVAR), Anaconda and equivalents	R280 000	Per beneficiary per year
18. Pacemaker plus defibrillator	R280 000	Per beneficiary per year
19. Pacemaker (double chamber)	R120 000	Per beneficiary per year
20. Transcatheter aortic valve implantation (TAVI)	R280 000	Per beneficiary per year

Please note: These prostheses are only reimbursed for **PMB¹⁵ conditions** or unless otherwise specified in the guide.



ANNEXURE B: ORTHOPAEDIC, SURGICAL AND MEDICAL APPLIANCES

Appliances	Limits (per beneficiary)
1. Wheelchairs (subject to clinical criteria) Non-motorised wheelchair OR Motorised wheelchair	R9 900 (once every five years)
2. Hand prosthesis	R10 000 (once every two years)
3. Arm prosthesis – below elbow	R26 000 (once every two years)
4. Arm prosthesis – above elbow	R120 000 (once every two years)
5. Above knee prosthesis	R150 000 (once every two years)
6. Below knee prosthesis	R120 000 (once every two years)
7. Silicone sleeve replacements for all artificial limbs	R20 000 (once per year)
8. Back brace following surgical procedures	R25 000 (once per year)
9. Walking aids	R2 660 (once per year)
10. Hearing aids Per ear Hearing aid repairs	Once every three years R9 284 Part of the hearing aid limit

G: HOW TO CLAIM

All accounts must reach the Fund not later than the last day of the fourth month following the month in which the services were rendered. Claims received after this date will not be paid.

Ensure that all accounts contain the following details:

- Your membership number
- Your initials and surname
- The patient's name and dependant code as it appears on the principal member's membership card
- The date on which the service was rendered
- The name and practice number of the healthcare provider
- The referring healthcare provider's practice number (on specialist accounts)
- The tariff code(s)
- The required ICD-10 code(s)
- The patient's ID number or date of birth

How to submit your claim

Email: claims@fransmed.co.za

Post: Transmed Claims Department, PO Box 2269, Bellville 7535



H: EX GRATIA

Ex gratia is an additional financial benefit that members can apply for when they experience financial hardship related to unforeseen medical expenses.

What you need to know about the application process

- The submission of an ex gratia application is not a guarantee that assistance will be granted.
- The committee won't consider any advance payment of medical treatment.
- Members are requested to provide full details of the financial assistance required. Details such as duration, cost involved and motivation for the necessity of expenses are essential for the committee to consider an application.
- The ex gratia committee meets once a month.
- A reply to your application could take up to 30 days and the decision will be issued in writing.
- The decision of the committee is final and no further correspondence regarding the application will be considered once the decision has been announced.

An application form can be obtained from **www.transmed.co.za** or from the customer service department on **0800 110 268**.

How to submit your application

Email: exgratia@transmed.co.za

Post: Transmed Ex Gratia Committee, PO Box 2269, Bellville 7535

Talk to a doctor on your phone, anytime, anywhere – for free.

As a Transmed member, you get free access to Hello Doctor, a mobile phone-based service that gives you access to a doctor 24 hours a day, seven days a week. You can get expert health advice from qualified South African medical doctors through your phone, tablet or computer, at absolutely no cost to you! Just download the app, request a call and the doctor will phone you back within an hour.

The following Hello Doctor platforms are available to access this service:

The website at www.hellodoctor.co.za:

You can log in to your personal profile on the Hello Doctor website using your access details and request a call back or simply send a text message to a doctor.

The app:

Download the Hello Doctor app by visiting the Apple App or Google Play stores. You can sign in using your access details and request a call back or send a text message to a doctor.

Unstructured supplementary service data (USSD):

You can dial *120*1019# from your mobile phone and follow the menu prompts to request a call back from a doctor or send a text message to the number that they provide.

J: MEMBERSHIP

The Transmed Medical Fund is a medical scheme that is open to employees and pensioners of the Transnet Group, its subsidiaries and former subsidiaries.

Dependants

In terms of the Fund's rules, the following persons may be registered as dependants, provided that they are not a member or a registered dependant of a member of any other medical scheme.

Your spouse

This refers to a member's wife, husband or partner. If you are divorced, your former spouse cannot be registered as a dependant.

Your immediate family/spouse's immediate family

This refers to a parent, brother or sister in respect of whom the member/spouse is liable for family care and support.

Your children

This refers to a member's natural child, stepchild, a legally adopted child, an illegitimate child, a child in the process of being legally adopted or placed in foster care, a child for whom the member has a duty of support, or a child placed in the custody of the member or his/her spouse or partner.



J. MEMBERSHIP (CONTINUED)

Note the following:

- * Child dependant contributions are payable for a maximum of four dependants.
- * Child dependants older than 21 who are studying full- or part-time and are financially dependent on the member will pay child dependant contributions until the age of 24 (proof of registration at an accredited institution will be required).
- ** Dependants older than 21 (or 24 in the case of studying children) who are financially dependent on the member will pay adult dependant contributions.

Dependants of deceased members

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

Membership amendments

A member must complete a membership amendment form and submit it to the Fund within 30 days of the change, in the following instances:

- when you register/cancel the membership of dependants
- when a member divorces his/her spouse
- when registered dependants no longer qualify as dependants
- when there are any changes to a member's residential and/or postal address, email address, cell phone number or other telephone numbers and banking details.

Termination of membership

Resignation

Members may terminate their membership by giving one calendar month's written notice. This will also terminate the membership of their registered dependants. All rights to benefits will cease except for claims in respect of services rendered prior to resignation.

Waiting periods

The Fund applies a waiting period, which is often referred to as underwriting.

The rules of the Fund stipulate two types of waiting periods to be imposed when a member/dependant joins the Fund:

1. a general waiting period of three months
2. a condition-specific waiting period of 12 months for certain pre-existing conditions (e.g. nine months for an existing pregnancy).

Late-joiner penalties

Medical schemes can impose late-joiner penalties on individuals who join after the age of 35 and who have never been members of or haven't belonged to a medical scheme for a specified period of time. Depending on the number of years that they have not belonged to a medical scheme, late-joiner penalties will be added to members' monthly contributions. It is calculated as a percentage of the contribution and can range from 5% to 75%. Late-joiner penalties are applied to discourage members from only joining medical schemes when they are older or ill, as this will make medical schemes unaffordable.



Update your banking details

Fraud risk has forced Transmed to stop any refunds to members by cheque. It is therefore of the utmost importance that you ensure your banking details are updated with the Fund. If you have not received a refund in the past year or if your banking details have changed recently, you must ensure that the updated details reach Transmed within 30 days of the change, as stipulated in the Transmed rules. The Fund will not be liable if the member has neglected to follow this rule and money is deposited into an incorrect bank account.

To update your banking details, the following information is required:

- a copy of your ID; and
- a bank account statement or letter from the bank with a bank stamp as confirmation (not older than three months).

Please remember to include your membership number in the communication.

Complaint and dispute resolution process

Transmed takes pride in delivering excellent service and strives to have open communication with its members. Please note that there is a formal complaint and dispute resolution process that can be followed when you are dissatisfied with services rendered by the Fund.

Any enquiry must first be directed to the Administrator of the Fund. This can be done by calling the customer service department toll free on **0800 110 268** or by sending an email to **enquiries@transmed.co.za**. Should you not be satisfied with the response to your enquiry, you can email **complaints@transmed.co.za**.

Should you still not be satisfied with the response to your enquiry, you can direct your complaint to the Fund at **fundmanagement@transmed.co.za**.

If your complaint is still not resolved, you can contact the Regulator, who will evaluate your complaint as an independent entity.

Complaints department at the Council for Medical Schemes

Customer Care: **0861 123 267**
Email: **complaints@medicalschemes.co.za**



K: IMPORTANT CONTACT DETAILS

Customer service department (general queries)
0800 110 268

Chronic medication application
0800 122 263

Hospital and major medical pre-authorisation
0800 225 151

Ambulance authorisation
0861 115 750

Optical services (PPN)
0861 103 529

Dental services (DENIS)
0860 104 941

Fraud hotline
0800 000 436

HIV YourLife Programme
0860 109 793

WhatsApp
0860 005 037

Postal address

Transmed Medical Fund, PO Box 2269, Bellville 7535

Website

www.transmed.co.za

**FOR ALL
OUR PEOPLE**