

# ANNEXURE B1

## BENEFITS: ALL MEMBERS OTHER THAN SATS CONTINUATION MEMBERS

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## **ANNEXURE B1**

### **1. APPLICABILITY OF ANNEXURE**

The benefits provided for in this annexure (B1) shall apply to all members except SATS continuation members.

### **2. BENEFIT OPTIONS**

2.1 A member shall elect one of the following benefit options:

- 2.1.1 Plan 1 : State + Network;
- 2.1.2 Plan 2 : State + Own Choice;
- 2.1.3 Plan 3 : Private Network Core; and
- 2.1.4 Plan 4 : Private Network Saver.

2.2 Preferred Provider Networks

The following Preferred Provider Networks shall provide benefits for members of the benefit options as indicated:

- 2.2.1 Plan 1 : Prime Cure (Pty) LTD( day to day benefits) and Independent Clinical Oncology Network (ICON)for Oncology benefits.
- 2.2.2 Plan 2 : ICON for Oncology benefits and Transmed Pharmacy Network for Chronic Medicine.
- 2.2.3 Plan 3 and 4 :
  - ICON for Oncology benefits;
  - Transmed Pharmacy Network for Chronic Medicine; and
  - Netcare Hospital Group and Medi-clinic Private Hospital Group for hospitalisation

### **3. PLAN 1 AND 2**

#### **MAJOR MEDICAL BENEFITS**

3.1 A member participating in Plan 1 and 2 shall only receive benefits in respect of Major Medical Benefits defined in clause 5 if such services have been rendered by a State Hospital and have been authorised in terms of the National Health System or by the Principal Officer or his/her delegate in respect of services which do not form part of the services provided directly by the State Hospital. Major Medical Benefits shall include treatment for all the categories of diagnosis and treatment pairs listed in the Act as the prescribed minimum benefits.

3.1.1 Subject to clause 3.1.2: -

3.1.1.1 the diagnosis, treatment and care cost of a prescribed minimum benefit condition, shall be paid at 100% of the costs if those services are obtained from a designated service provider specified in clause 3.1.4 in respect of that condition; and

3.1.1.2 a co-payment as specified in clause 3.1.5 shall be applicable if the beneficiary obtains services from a provider other than a designated service provider, specified in clause 3.1.4.

3.1.2 If the service for a prescribed minimum benefit condition was involuntary obtained from any provider other than a designated service provider specified in clause 3.1.4, then:

3.1.2.1 the Fund shall be liable to pay the diagnosis, treatment and care costs of such service in full; and

3.1.2.2 no co-payment or deductible shall be payable by the member for such service.

The provisions of clause 3.1.1 and 3.1.2 shall be subject to Annexure A of the regulations contained in GNR. 1262 of 20 October 1999, as amended from time to time.

3.1.3 For the purposes of clause 3.1.2 a beneficiary will be deemed to have involuntarily obtained a service from any provider other than a designated service provider if:

- (a) the service was not available from the designated service provider or would not be provided without unreasonable delay;
- (b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
- (c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

3.1.4 The following service providers/ institutions shall be regarded as the designated service provider (DSP) for the prescribed minimum benefits:

- Hospitalisation (including services obtained on an out-patient basis in addition to the benefits provided for by the Care Plans) – State Hospitals (Plan 1 and 2).
- Oncology – State and ICON (Plan 1 and 2 )
- Out of hospital (day to day) services – The Preferred Provider Network (Plan 1) and the member's own choice of supplier (Plan 2).
- Chronic Medicine – The Preferred Provider Network (Plan 1) and the Transmed Pharmacy Network (Plan 2).

3.1.5 The co-payments mentioned in clause 3.1.1.2 are as follows:

3.1.5.1 In the case of hospitalisation:

- A co-payment of 40% based on the total cost of the hospital services including all related medical services by medical practitioners and other auxiliary services.
- The payment of 60% by the Fund will be subject to pre-authorization as well as case management and other managed health care interventions and will be based on the Scale of Benefits or cost whichever is the lesser.

3.1.5.2 In the case of Oncology:

A co-payment of 20% based on the total cost including the services of the Oncologist, Pathology, Radiology and Radiotherapy.

3.1.5.3 In the case of chronic medicine: A co-payment of 20% based on the total cost of the medicine.

3.1.6 All co-payments referred to above shall be paid by the member direct to the supplier concerned.

3.2 If Major Medical Benefits are obtained by a member other than in accordance with clause 3.1, the Principal Officer or his/her delegate may, in his/her sole discretion, authorise the payment of a benefit in respect of such services if:

- (i) such services were necessitated by an emergency;
- (ii) prior authorisation could not be obtained due to the particular circumstances;
- (iii) the services were provided by a hospital other than a State Hospital and the member was transferred to an appropriate State Hospital as arranged by the Fund as soon as the condition of the member allowed such transfer;
- (iv) the services could not readily be obtained from a designated service provider; and
- (v) the Principal Officer or his/her delegate was appraised of the situation on the first working day after the provision of these services commenced.

3.3 Should a member suffer from a medical condition that cannot be treated in a State Hospital, the Principal Officer or his/her delegate may on prior application authorise the provision of Major Medical Benefits in respect of such condition by a private medical practitioner and/or a hospital other than a State Hospital. In cases where only the specialist services are not available in a State Hospital, payment for the services of a private specialist will only be considered, if the operation/procedure was performed in a State Hospital. Services related to the Prescribed Minimum Benefits, (PMB) shall be paid at 100% of the cost. The benefit payable in respect of services which are not PMB related shall be 100 % of the Scale of Benefits or of cost, whichever is the lesser or, in the case of such services being provided by a Preferred Provider, the Preferential Tariff or cost, whichever is the lesser, subject to the limits and conditions indicated in clause 3.3.1.

3.3.1 The following services shall be subject to the limits and conditions indicated with due regard to the PMB's:

3.3.1.1 Dialysis:- Limit of R180 000 per beneficiary per financial year.

3.3.1.2 Oncology and radiation:- Benefits restricted to Tier 1 of the South African Oncology Consortium (SAOC) guidelines.

3.3.1.3 Basic Radiology – Limit of R5 000 per family per annum for in-hospital services.

3.3.1.4 Advanced Radiology - Limit of R15 000 per family per annum for in-hospital services. This limit shall also be applicable to the following services if performed on an out-patient basis:

- Computed Tomography
- Magnetic Resonance Imaging
- Angiography
- Interventional radiology
- Nuclear medicine (Isotopes)

3.3.2 In the case of Internal Prostheses, payment for the costs thereof and if applicable the fees of a private specialist, shall be subject to the PMB's, limits and conditions listed in Annexure H.

3.3.3 In the case of the State + Own Choice benefit option (Plan 2), maternity benefits including hospitalisation will be available to members in private institutions subject to pre-authorisation and enrolment on the Transmed maternity programme.

#### 3.4 **CHRONIC MEDICINE BENEFITS: PLAN 1 AND 2**

3.4.1 Chronic medicine benefits for a member participating in Plan 1 shall be available in terms of the stipulations contained in Annexure D.

3.4.2 Subject to clause 5.17.2 the following benefits in respect of chronic medicine shall be available to a member participating in Plan 2, subject to the provisions contained in clause 6.

3.4.2.1 Medicine classified as the “Essential Formulary”, subject to the conditions and stipulations indicated in Annexure F, at 100% of the costs for PMB’s.

3.4.2.2 Where a benefit is subject to a co-payment, the co-payment shall be paid by the member directly to the supplier of the medicine.

### **3.5 SURGICAL, MEDICAL AND ORTHOPEADIC APPLIANCES**

The appliances listed in Annexure G shall be available at 100 % of the cost.

### **3.6 OTHER BENEFITS : PLAN 1**

3.6.1 A member participating in Plan 1 shall have access to the benefits specified in Annexure D at 100% of the costs through a Preferred Provider Network.

3.6.2 All specialist services (including medicine prescribed by such specialist) in excess of the benefits provided by the Preferred Provider Network and other services not forming part of the benefits provided by the Preferred Provider Network, shall be paid at 100 per cent of the Scale of Benefits or cost whichever is the lesser, subject to the following limits:

- Member with no dependants (M 0) R1 860
- Member with dependants (M +) R2 790

### **3.7 OTHER BENEFITS: PLAN 2**

#### **3.7.1 NURSE PRACTITIONERS, GENERAL MEDICAL PRACTITIONERS AND SPECIALISTS.**

3.7.1.1 Consultations in consulting rooms, out-patient sections of hospitals and at member’s residence;

3.7.1.2 Treatment, operations or other procedures in consulting rooms and surgical dressings, injections, including anesthesia and material used in consulting rooms; and

3.7.1.3 Treatment as an out-patient or in the casualty section of a hospital (excluding those services for which provision is made under Major Medical Benefits).

**3.7.2. MEDICINE**

3.7.2.1 Acute medicine dispensed on prescription;

3.7.2.2 Medicine for self-medication; and

3.7.2.3 Medicine not approved as Chronic Medicine.

**3.7.3 OTHER DAY TO DAY BENEFITS**

3.7.3.1 Acupuncture.

3.7.3.2 Audiometry.

3.7.3.3 Chiropody.

3.7.3.4 Chiropractors.

3.7.3.5 Clinical psychological services not regarded as Major Medical Benefits.

3.7.3.6 Dieticians.

3.7.3.7 Homeopaths.

3.7.3.8 Occupational and remedial therapy.

3.7.3.9 Orthoptic treatment.

3.7.3.10 Pathology services out of hospital.

3.7.3.11 Physiotherapy not regarded as Major Medical Benefits

3.7.3.12 Radiology services out of hospital.

3.7.3.13 Speech therapy.

3.7.3.14 Surgical, medical or orthopaedic appliances not regarded as Major Medical Benefits.

The above-mentioned benefits shall be 100 % of the Scale of Benefits or cost whichever is the lesser, subject to the following annual limits and PMB's:

- Member with no dependants (M0) R3 740
- Member with dependants (M+) R5 140

### 3.7.4 BASIC DENTISTRY

3.7.4.1 All basic dentistry at 100 per cent of the Scale of Benefits or cost whichever is the lesser, subject to the following annual limits :

- Member with no dependants (M0) R1 350
- Member with dependants (M+) R1 840

### 3.7.5 SPECIALISED DENTISTRY

3.7.5.1 All specialised dentistry including –

- Dentures;
- Inlays, crowns and bridges;
- Ortodontics; and
- Orthodontic related surgery;
- Periodontic surgery; and
- Dental implants

At 100 per cent of the Scale of Benefits or cost, whichever is the lesser, subject to a limit of R2 400 per beneficiary once every two financial years.

### 3.7.6 OPTICAL BENEFITS

The following optical benefits at 100 per cent of the Scale of Benefits or cost, whichever is the lesser, subject to the indicated limit per beneficiary once every two financial years:

- 3.7.6.1 Spectacles with single vision lenses including consultations, frames and lenses subject to a limit of R670; **or**
- 3.7.6.2 Spectacles with bi-focal, tri- or multi-focal lenses including consultations, frames and lenses subject to a limit of R1 040; **or**
- 3.7.6.3 On acceptable motivation where it is necessary for a beneficiary to obtain both near and distance spectacles instead of bi-focals subject to a limit of R1 040 for both sets of spectacles; **or**
- 3.7.6.4 Contact lenses (all inclusive costs) subject to a limit of R670; **or**

3.7.6.5 Any of the recognised procedures (such as Radial Keratotomy, Excimer Laser or Lasik) to correct refractive errors subject to a limit of R1 040.

### **3.7.7 BENEFITS FOR HIV TREATMENT**

3.7.7.1 Where a beneficiary has been registered on the Transmed HIV Programme, all HIV related claims will be paid as provided for in the Programme.

3.7.7.2 If a beneficiary is not registered on the Transmed HIV Programme, all claims for day to day services will be paid subject to the applicable limits as provided for in clause 3.

3.7.7.3 When the financial limits referred to in clause 3.7.7.2 have been reached, HIV related claims will be paid as follows:

\* If the service was obtained from a state facility, at 100% of the cost;  
or

\*If the service was obtained from a private medical practitioner/supplier, at 80% of the cost. The member shall pay the 20% co-payment directly to the supplier of the service.

## 4. PLAN 3 AND 4

### MAJOR MEDICAL BENEFITS

- 4.1 A member participating in Plan 3 and 4 shall only receive benefits in respect of Major Medical Benefits defined in clause 5 if such services have authorised by the Principal Officer or his/her delegate prior to the rendering of the relevant services. Major Medical Benefits shall include treatment for all categories of diagnosis and treatment pairs listed in the Act as the prescribed minimum benefits.
- 4.1.1 In the case of Plan 3, Major Medical Benefits shall be limited to the Prescribed Minimum Benefits only.
- 4.1.2 The following institutions/service providers shall be regarded as the designated service provider for the prescribed minimum benefits:
- **Hospitalisation:**
    - ❖ Transmed Private Hospital Network.
  - **Oncology:**
    - ❖ Independent Clinical Oncology Network (ICON)
  - **Out of hospital (day to day) services:**
    - ❖ The member's own choice of suppliers.
  - **Chronic Medicine:**
    - ❖ Transmed Pharmacy Network.
  - **Services obtained on an out-patient basis in addition to the benefits provided for by the Care Plans:**
    - ❖ State hospitals

- 4.1.3 In the case of out of hospital benefits in terms of the chronic conditions listed in the Act, the benefits will be provided in accordance with Care Plans approved by the Board from time to time.
- 4.2 The benefit of members participating in Plan 3 and 4 in respect of Major Medical Benefits shall, subject to the limitations imposed in clause 4.4, be 100 % of the Scale of Benefits or the tariffs agreed with a Preferred Provider or of cost, whichever is the lesser or in the case of services provided by a State Hospital at 100 % of the cost according to the National Health System Tariff.
- 4.3 If Major Medical Benefits are obtained by a member other than in accordance with clause 4.1, the Principal Officer or his/her delegate may, in his/her sole discretion, subject to the PMB's authorise the payment of a benefit in respect of such services if:
- 4.3.1 prior authorisation could not be obtained due to the particular circumstances; and
- 4.3.2 the Principal Officer or his/her delegate was appraised of the situation on the first working day after the provision of these services commenced.

#### **4.4 LIMITATIONS ON MAJOR MEDICAL BENEFITS (PLAN 3 AND 4)**

4.4.1 Major Medical benefits for Plan 3 shall be limited to the Prescribed Minimum Benefits only.

4.4.2 All hospitalisation for non-emergency admissions or procedures not relating to a Prescribed Minimum Benefit shall be subject to a deductible.

4.4.2.1 The following deductible shall be applicable.

For admission to -	Deductible
• Day Clinic	R1 000
• Hospital for a day procedure (no overnight stay)	R1 500
• Hospital for a procedure with a length of stay of less than 5 days	R2 000
• Hospital for a procedure with a length of stay of 5 days or more	R2 500

4.4.2.2 The deductible shall be paid by the member direct to the hospital concerned.

4.4.2.3 A refund of the cost paid in respect of a deductible may be claimed from the member's PMSA subject to the conditions stipulated in clause 7. (Plan 4 only)

4.4.2.4 Deductibles shall not be applicable on complications arising after the original admission and shall not be applicable to re-admission due to complications.

4.4.3 Oncology benefits shall be provided by a Designated Service Provider (ICON) and shall be subject to the following conditions/limitations:

- Benefits will be based on Tier 1 of the South African Oncology Consortium (SAOC) guidelines. Access to higher Tier levels subject to authorisation by the Principal Officer or his/her delegate and an annual financial limit of R250 000 per beneficiary subject to Regulations 15H and I, shall be applicable to Plan 4 only.

- Access to non-DSP oncologist will be allowed subject to pre-authorisation by the Principal Officer or his/her delegate.
- In cases where a member voluntary elects to use a non-DSP oncologist the following co-payment shall apply:
- A co-payment of 20% based on the total cost including the services of the Oncologist, Pathology, Radiology and Radiotherapy.

4.4.4 If the member or his/her dependant voluntary choose not to make use of the designated service provider listed in clause 4.1.2, the following co-payments shall be applicable:

4.4.4.1 In the case of hospitalisation:

- A co-payment of 20% based on the total hospitalisation account.

4.4.4.2 In the case of chronic medicine:

- A co-payment of 20 % based on the total cost of the medicine.

4.4.5 The following sub-limits shall be applicable for in-hospital Radiology for non-PMB conditions.

4.4.5.1 Basic Radiology – Limit of R5000 per family per annum

4.4.5.2 Advanced Radiology – Limit of R1 500 per family per annum. This limit shall also be applicable to the following services if performed on an out-patient basis:

- Computed Tomography
- Magnetic Resonance Imaging
- Angiography
- Interventional radiology
- Nuclear medicine (Isotopes)

#### 4.5 **ADDITIONAL BENEFITS**

##### 4.5.1 **BENEFITS FOR HIV TREATMENT (PLAN 3 AND 4)**

4.5.1.1 Where a beneficiary has been registered on the Transmed HIV Programme, all HIV related claims will be paid as provided for in the Programme.

4.5.1.2 If a beneficiary is not registered on the Transmed HIV Programme, all claims for day to day services will be paid as follows:

\* If the service was obtained from a state facility, at 100% of the cost; or

\* If the service was obtained from a private medical practitioner/supplier, at 80% of the cost. The member shall pay the 20% co-payment directly to the supplier of the service.

#### 4.5.2 **ORTHODONTICS (PLAN 4 ONLY)**

4.5.2.1 Orthodontic treatment/benefits as authorised by the Principal Officer or his/her delegate.

4.5.5.2 Orthodontic benefits shall be subject to a maximum amount of R6 480 per beneficiary once in a lifetime.

#### 4.6 **CHRONIC MEDICINE BENEFITS: PLAN 3 AND 4**

4.6.1 Subject to clause 5.17.2 the following chronic medicine benefits shall be available to members participating in Plan 3 and 4 subject to the provisions contained in clause 6:

4.6.1.1 Medicine classified as the “Core PMB Formulary”, subject to the conditions and stipulations indicated in Annexure F, at 100% of the costs for PMB’s.

4.6.1.2 Where a benefit is subject to a co-payment the co-payment shall be paid by the member directly to the supplier concerned.

4.6.1.3 A refund may be claimed from the member’s PMSA for non-PMB’s subject to the conditions stipulated in clause 7 (Plan 4).

**4.7 BENEFITS PAYABLE FROM A PERSONAL MEDICAL SAVINGS ACCOUNT: PLAN 4**

4.7.1 All other non – PMB benefits not provided for in any of the other clauses listed above, shall be funded through a Personal Medical Savings Account, subject to the conditions laid down in clause 7.

4.7.2 The applicable benefits are defined in clause 8.

## **5. MAJOR MEDICAL BENEFITS DEFINED (PLAN 3 AND 4)**

The following services shall be regarded as Major Medical Benefits. The benefits shall be 100 % of the Scale of Benefits or cost, whichever is the lesser, subject to the requirements and conditions as well as the co-payments referred to in clause 4.4. All requirements and conditions referred to herein shall, in addition to the requirements stipulated in respect of the applicable benefit options as set out in clauses 3 and 4 above, apply to benefits in respect of these services:

In the case of Plan 3 all Major Medical Benefits shall be limited to the Prescribed Minimum Benefits only.

### **5.1 HOSPITALISATION**

5.1.1 Accommodation in a general ward of a hospital or facility, registered in terms of the stipulations contained in the Act including all services rendered during hospitalisation as well as theatre, intensive care and high care fees.

5.1.2 Medicine, materials, dressings and preparations including medicine dispensed on discharge from a hospital (TTO's) shall be limited to 10 day's supply.

5.1.3 Blood transfusions, clinical technology and perfusionist services.

### **5.2 OUT-PATIENT TREATMENT**

Treatment (including material and services) at the out-patient section of a hospital for such conditions as may be authorised by the Principal Officer or his/her delegate from time to time, including chemotherapy and dialysis.

### **5.3 ORGAN TRANSPLANTS**

- 5.3.1 Harvesting costs of organs (both live and cadaver), hospital and all related services, where both the donor and recipient are members of the Fund, will be covered subject to pre-authorisation by the Principal Officer or his/her delegate.
- 5.3.2 In cases where the donor is not a member of the Fund, but the recipient is a member of the Fund, payment of the donor costs will be considered based on the merits of the case and subject to approval by the Principal Officer or his/her delegate.
- 5.3.3 In cases where the recipient is not a member of the Fund, liability will not be accepted for any costs.
- 5.3.4 In cases where costs involved are in an overseas currency, payment will be limited to the value of the benefit in South African currency for the equivalent service in South Africa.

### **5.4 RADIAL KERATOTOMY/EXCIMER LASER**

Surgically related services and procedures. Where these services/procedures relates to the correction of refraction errors, it will be regarded as part of the optical benefits. Payments for these services shall be subject to the provisions in respect of optical benefits for the different benefit options.

### **5.5 MATERNITY BENEFITS**

Services related to a maternity case (including a caesarean section and false labour) rendered by a hospital or other institution, a recognised maternity nurse or a certificated midwife, a general medical practitioner, or specialist.

### **5.6 MEDICAL APPLIANCES**

- 5.6.1 Prosthesis and medical appliances which are internally implanted during an operation subject to the conditions and limits listed in Annexure H.

5.6.2 Surgical, medical or orthopaedic appliances and requirements related to a major medical event in or out of hospital as listed in Annexure G.

#### **5.7 RECONSTRUCTIVE SURGERY OF BREASTS**

5.7.1 Reconstructive surgery of a breast as well as the cost for the prosthesis and the implantation thereof.

5.7.2 The cost of breast reduction operations are excluded unless specifically authorised by the Principal Officer or his/her delegate.

#### **5.8 GENERAL PRACTITIONERS AND SPECIALISTS**

5.8.1 Services of a general medical practitioner or specialist for operations and surgical procedures and visits, in hospitals, institutions or theatres registered in terms of the stipulations contained in the Act.

5.8.2 Second opinion consultations/reports in and out of hospital required in terms of the National Health System or by the Principal Officer or by his/her delegate.

#### **5.9 DIAGNOSTIC SERVICES**

5.9.1 Radiology and Pathology services while the beneficiary is hospitalised.

5.9.2 MRI scans (in and out of hospital).

#### **5.10 AMBULANCE SERVICES**

Ambulance fees or transportation by air ambulance.

#### **5.11 PHYSIOTHERAPY**

Treatment related to a major medical event in or out of hospital.

#### **5.12 CLINICAL PSYCHOLOGICAL SERVICES**

Treatment related to a major medical event, in or out of hospital.

**5.13 OXYGEN**

Oxygen prescribed by a medical practitioner in or out of hospital, related to a major medical event.

**5.14 SPECIAL MEDICINE PREPARATIONS FOR SPECIFIC MEDICAL CONDITIONS**

Special medicine preparations authorised by the Principal Officer or his/her delegate from time to time.

**5.15 PRIVATE NURSING AND FRAIL CARE**

Benefits include the following:

5.15.1 Private nursing (excluding midwife which shall be covered under maternity benefits).

5.15.2 Hospice (in-patient or home visits).

5.15.3 Frail Care Centre services (including drugs used in these centres).

5.15.4 Accommodation, treatment and other services rendered by Rehabilitation Hospitals.

## **5.16 BENEFITS IN COUNTRIES OUTSIDE SOUTH AFRICA**

5.16.1 Subject to clauses 5.16.2 to 5.16.10, no benefits shall be payable in respect of any medical services (which include Major Medical Benefits, chronic medicine and day to day medical benefits) rendered outside the Republic of South Africa.

5.16.2 A member and the dependants of any member who were resident in Namibia on 1 October 1996 and who continued to live in Namibia without interruption after that date shall, notwithstanding clause 5.16.1, be entitled to receive the same benefits as a member resident in South Africa.

- 5.16.3 Notwithstanding the provisions of clauses 5.16.1 and 5.16.2 a member in Namibia shall receive the same medical benefits as his or her South African counterpart, if such benefits have been extended to such member specifically in terms of an interim agreement between the Fund, the Employer and the member concerned.
- 5.16.4 Notwithstanding the provisions of clause 5.16.1 and subject to clauses 5.16.5 and 5.16.6, a member who applied to the Board before 31 March 1997, and who's application was approved, may obtain benefits in respect of medical services rendered outside South Africa, on condition that the benefit shall be limited to the value of the benefit in South African currency that he/she would have received had the service been rendered in South Africa.
- 5.16.5 The member shall settle the account and may subsequently claim a refund following the procedure provided for in rule 14.
- 5.16.6 A member shall pay an additional amount of R50.00 per month for the benefits provided for in clause 5.16.4.
- 5.16.7 Should the member elect to cancel the payment of R50 per month referred to in clause 5.16.6, the benefits referred to in clause 5.16.4 shall lapse and shall not be reinstated at a later stage.
- 5.16.8 Notwithstanding the provisions of clause 5.16.1, any member who emigrates from South Africa or will be outside South Africa for a period of not less than six months, may apply to the Board to acquire absentee membership status referred to in clause 5.16.9.

5.16.9 Absentee membership status allows the member to retain his/her membership, but excludes all benefits, at a payment of R10 per month per member. The amount of R10 is payable over and above any contribution received by the Fund from an employer on behalf of the member.

5.16.10 Absentee membership status may be terminated or converted into full membership status by the member, giving the Fund one calendar month's written notice, provided that the member shall be required to pay full membership contributions for a period of not less than 12 months after the date of conversion before he/she will again qualify for absentee membership.

#### **5.17 ADDITIONAL BENEFITS (PLAN 2, 3 AND 4)**

##### **DISEASE MANAGEMENT PROGRAM BENEFITS**

5.17.1 In the case of a beneficiary who has been officially enrolled on to the Disease Management Program, additional benefits shall be available for services which are authorised by the Principal Officer or his/her delegate, in terms of the Disease Management Program.

5.17.1.1 This benefit shall only be applicable to services approved in terms of the specific condition/s for which the beneficiary has officially been enrolled.

##### **CHRONIC DISEASE CARE PLANS**

In the case of a beneficiary who has been identified with at least one of the Chronic Disease List (CDL) conditions listed in Annexure E, and other chronic DTP PMB conditions unlimited benefits shall be available for all necessary out of hospital expenses.

5.17.2.1 Benefits shall be provided in accordance with Care Plans developed for each of the CDL conditions as approved by the Board from time to time.

5.17.3 The benefits mentioned in clause 5.17.1 shall be limited to a maximum amount of R780 per beneficiary per annum subject to PMB's.

5.17.3.1 The Principal Officer or his/her delegate may authorise payment for benefits in excess of the limit of R780, provided such services were necessitated by the clinical protocols applicable to the Disease Management Program.

## **6. CONDITIONS APPLICABLE TO CHRONIC MEDICINE BENEFITS (PLAN 2, 3 AND 4)**

Subject to clause 5.17.2 the following provisions shall apply to benefits in respect of chronic medicine in addition to the conditions stipulated in clauses 3 and 4:

- 6.1 A member shall only receive chronic medicine benefits if:
  - 6.1.1 the use of the chronic medicine has been approved by the Principal Officer or his/her delegate; and
  - 6.1.2 the use remains within the level determined by the Principal Officer or his/her delegate.
- 6.2 For the purposes of applying these Rules, chronic medicine shall be regarded as medicine which was approved by the Principal Officer or his/her delegate as chronic medicine.
- 6.3 Participation in the chronic medicine pool shall be subject to approval by the Principal Officer or his/her delegate.
- 6.4 The commencing date of chronic medicine benefits shall be the date on which the Principal Officer or his/her delegate approves the application of the member.

## **7. PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA) (PLAN 4)**

- 7.1 On selection of a benefit option which provides for a PMSA, a PMSA, held by the Fund, shall be established in the name of the member concerned into which the contributions payable in respect of the PMSA component shall be credited and benefits in respect thereof, shall be debited.
- 7.1.1 The amount allocated to a member's PMSA shall not exceed 25% of the total gross contribution made in respect of the member during the financial year concerned.
- 7.2 Subject to sufficient funds being available at the date on which a claim is processed, the benefits indicated in clause 8, shall be: 100 % of the cost, or the Scale of benefits, whichever is the lesser.
- 7.3 An automatic interest free advance equal to the full amount that will be paid into the member's PMSA for a financial year, shall be made available to the member at the start of each financial year.
- 7.3.1 In the case of a member who is admitted after the start of the financial year the advance shall be calculated on a pro rata basis from the date of admission to the end of the particular financial year.
- 7.4 If the claim amount exceeds the funds available, the claim shall be partially paid from available funds and the member shall pay the balance due, to the supplier of the service.
- 7.4.1 A claim for services not previously paid due to lack of funds, may be re-submitted and shall be paid from available funds, provided that the claim was submitted to the Fund in accordance with the stipulations of Rule 14.

- 7.5 Should a member terminate membership during a financial year, the liability of the Fund to pay benefits under the member's PMSA shall be limited to that amount available in such member's PMSA, and any amount paid to or on behalf of the member which is in excess thereof shall be recoverable by the Fund.
- 7.6 Funds deposited in a member's PMSA shall be available for the exclusive benefit of the member and his/her dependants. Any balance in the member's PMSA at the end of a financial year accumulates in his/her name.
- 7.6.1 The funds in a member's PMSA shall not be used to pay for the costs of a prescribed minimum benefit.
- 7.7 Interest shall accrue on an annual basis. The interest shall be calculated on the average monthly balance in the member's PMSA for a financial year and shall be credited to the member's PMSA at the start of the next financial year.
- 7.7.1 In the event of a member resigning from the Fund before the end of a financial year, interest shall be calculated on a pro rata basis. The interest, together with any balance in the member's PMSA, shall be paid to the member/employer as provided for in clause 7.10 or shall be transferred to another medical scheme as provided for in clause 7.11.
- 7.7.2 The rate of interest payable shall be determined by the Board from time to time.
- 7.8 Upon the death of the member, the balance due to the member shall be transferred to the PMSA of his/her dependants who continue membership of the Fund or paid into his /her estate in the absence of such dependants.
- 7.9 On transfer to another option of the Fund, which does not provide for such an account, any balance in the PMSA will be paid to the member in cash or to the Employer who pays contributions in respect of a member, who shall refund the member subject to applicable taxation laws.

- 7.10 Should a member terminate membership of the Fund and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme which does not provide for a PMSA the balance due to the member shall be paid to the Employer who pays contributions in respect of a member immediately after termination of membership. The Employer shall refund the member subject to applicable taxation laws. In the case of a continuation member, the balance due to the member shall be refunded to the member immediately after termination of membership, subject to applicable taxation laws.
- 7.11 Should a member be admitted to membership of another medical scheme, which provides for a similar account, the balance due to a member shall be transferred to such medical scheme when such member is enrolled in such other medical scheme.

- 7.12 The funds in a member's PMSA shall not be used to offset contributions and shall be excluded from the calculation of the mandatory net assets of the Fund.
- 7.12.1 The Fund shall be entitled to use funds in the member's PMSA to offset debt owed by the member to the Fund, following the termination of the member's membership of the Fund.
- 7.13 The funds in a member's PMSA may be used to offset co-payments, except in respect of PMB's subject to the following conditions:
- 7.13.1 Co-payments shall be paid by members direct to the supplier concerned and a refund shall be made to the member on application, subject to the availability of funds carried over from previous financial years (accumulated funds).
- 7.13.2 Funds allocated to the member's PMSA for a current financial year shall not be used for this purpose.
- 7.14 The Fund shall provide the Registrar with the particulars prescribed by the Act with regard to the PMSA of members of the Fund.

## **8. BENEFITS PAYABLE FROM THE MEMBER'S PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA) (PLAN 4)**

The following benefits shall be paid for at the lesser of 100 % of the cost or the Scale of Benefits, from the member's Personal Medical Savings Account (PMSA), subject to available funds, clause 7.6.1 and other conditions that apply in terms of these Rules:

### **8.1 NURSE PRACTITIONERS, GENERAL MEDICAL PRACTITIONERS AND SPECIALISTS**

- 8.1.1 Consultations in consulting rooms, out-patient sections of hospitals and at member's residence;
- 8.1.2 Treatment, operations or other procedures provided in consulting rooms, out-patient sections of hospitals and a member's residence including surgical dressings, injections, anaesthesia and material used (excluding the treatment for chemotherapy for which provision is made under Major Medical Benefits); and
- 8.1.3 Treatment as an out-patient or in the casualty section of a hospital (excluding those services for which provision are made under Major Medical Benefits).

### **8.2 DIAGNOSTIC SERVICES**

Radiology and Pathology services out of hospital.

### **8.3 PARAMEDICAL, MEDICAL AUXILIARIES AND COMPLEMENTARY PRACTITIONERS**

Services and prescribed medicines for the following:

- 8.3.1 Acupuncture.
- 8.3.2 Audiometry.
- 8.3.3 Chiropody.
- 8.3.4 Chiropractors.
- 8.3.5 Dieticians.
- 8.3.6 Homeopaths.
- 8.3.7 Occupational and Remedial Therapy.
- 8.3.8 Orthoptic treatment.
- 8.3.9 Speech Therapy.

### **8.4 MEDICINE**

- 8.4.1 Acute medicines dispensed on prescription.
- 8.4.2 Over the counter medicine for self-medication (medicine obtainable without prescription) and pharmacist supplied services (where available).
- 8.4.3 Medicine which have not been approved as chronic medicine under the chronic medicine benefit.

**8.5 DENTISTRY**

All services.

**8.6 OPTICAL BENEFITS**

All services.

**8.7 PHYSIOTHERAPY**

Treatment not listed as Major Medical Benefits in clause 5.

**8.8 CLINICAL PSYCHOLOGICAL SERVICES**

Treatment not listed as Major Medical Benefits in clause 5.

**8.9 SURGICAL, MEDICAL OR ORTHOPAEDIC APPLIANCES**

Surgical, medical or orthopaedic appliances out of hospital not listed as Major Medical Benefits in Annexure G.

**9. PERSONAL HEALTH CARE INFORMATION**

A member has access to the following services at no cost to the member:

**9.1 AUDIO HEALTH LIBRARY**

Topics ranging from emergency situations to childhood diseases accessible by telephone 24-hours a day.

**9.2 NURSE HELPLINE**

Everyday health decisions and health counselling accessible by telephone 24-hours a day.

## **10. EX-GRATIA BENEFITS**

10.1 The Board may upon application by a member grant ex-gratia benefits in respect of the member's medical expenses.

10.2 The Board shall consider such an application against guidelines prescribed by the Board from time to time, and which shall include the following considerations:

10.2.1 Are the medical services or medication absolutely necessary?

10.2.2 Did the member in the past incur medical expenses prudently and with responsibility?

10.2.3 Is the financial position of the member such that payment for the relevant expenses is likely to cause undue hardship?

10.3 The Board may in order to assist it in its consideration of such an application, require the member concerned to subject himself/herself to a medical examination or an enquiry in respect of the necessity of his or her medical expenditure. The cost of which shall be paid by the Fund in the case of a successful application.

## **11. MEDICAL EXPENSES ARISING FROM AN ACCIDENT OR OCCURRENCE CAUSED BY A THIRD PARTY**

11.1 The Fund shall not be liable for the costs of whatever nature incurred, or to be incurred, which arise out of an injury suffered by a member or his/her dependants, and for which any other party may be liable (“the claim”), unless the Principal Officer or his/her delegate is satisfied that there is no reasonable prospect of the member or dependant recovering compensation from the other party.

11.2 Where there is no entitlement to benefits in terms of clause 11.1 above, the Fund may, subject to the following conditions, at its sole and absolute discretion, advance to or on behalf of the member in the form of a loan, such amounts or benefits as would not exceed the amounts or benefits for which the Fund would have been liable, had another party not been liable there for in circumstances envisaged in clause 11.1 above (“the expenses”):

11.2.1 The member shall duly inform the Fund to the satisfaction of the Principal Officer or his/her delegate, of the claim and of all facts relevant thereto, and shall submit to the Fund within the time period applicable to normal claims for benefits under the Rules of the Fund, proof of the expenses which he/she wishes the Fund to pay on his behalf;

11.2.2 The member shall provide the Fund with proof that he/she has instituted a claim against the other party for such expenses, and shall diligently pursue such a claim in the interests of the Fund, and provide the Fund with regular reports as to the progress of the claim, and authorise the Fund to obtain on his/her behalf, information or documentation relating to the merits and/or quantum of the claim, in the manner and form as the Fund may require from time to time.

11.3 In the event of the member not complying with the terms of clause 11.2 above, then notwithstanding any other rights which the Fund may have in terms of these Rules,

- 11.3.1 the member agrees to cede and assign to the Fund, his/her right to claim the expenses from the other party, in which event the member shall provide the Fund with such assistance and co-operation as the Fund may reasonably require to pursue such claim, from time to time;
- 11.3.2 all expenses paid by the Fund in respect of the amounts or benefits which the Fund has actually paid and for which the Fund would not have been liable in circumstances envisaged in clause 11.1 above, shall immediately become due, owing and payable by the member to the Fund.
- 11.4 The member or his/her dependant shall be obliged to pay to the Fund, without deduction, the full amount of the expenses actually recovered or awarded to the member or his/her dependant, relating to the service which the member or his/her dependant has received or benefited or will receive or benefit from advances contemplated above.
- 11.5 Where an amount has actually been recovered, or a provision or undertaking has been made by the other party to pay for or cover any future medical expenses arising out of a claim contemplated in clause 11.1 above, the Fund shall not be obliged to pay for such expenses, and all the provisions above relating to expenses already incurred, shall apply *mutatis mutandis* to claims and expenses for future medical expenses to be incurred.

## **12. INJURY ON DUTY CASES**

- 12.1 The Fund shall accept liability for the costs due by the Company / Employer in respect of a member injured in an accident on or before 31 March 1990 arising from and in the course of his employment. The Company/Employer must reimburse the Fund according to existing agreements for the cost incurred.
- 12.2 All cases occurring on or after 1 April 1990 shall be dealt with by the Workmen's Compensation Commissioner.