

## ANNEXURE B2

### BENEFITS : SATS CONTINUATION MEMBERS

CLAUSE	TABLE OF CONTENTS	PAGE
1	APPLICABILITY OF ANNEXURE	95
2	BENEFIT OPTIONS	95
3	MAJOR MEDICAL BENEFITS	95
4	DAY TO DAY BENEFITS	99
5	OTHER BENEFITS	100
6.	MAJOR MEDICAL BENEFITS DEFINED	102
7.	PERSONAL HEALTH CARE INFORMATION	109
8.	CONDITIONS APPLICABLE TO CHRONIC MEDICINE BENEFITS	110
9.	EX-GRATIA BENEFITS	111
10	MEDICAL EXPENSES ARISING FROM AN ACCIDENT OR OCCURRENCE CAUSED BY A THIRD PARTY	111
11	INJURY ON DUTY CASES	113

## **ANNEXURE B2**

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

The benefits provided for in this annexure (B2) shall apply to all SATS continuation members.

### **2. BENEFIT OPTIONS**

2.1 A member shall participate in the Guardian Plan:

### **3. GUARDIAN PLAN**

#### **MAJOR MEDICAL BENEFITS**

3.1 A member shall only receive benefits in respect of Major Medical Benefits defined in clause 6 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. In those instances provided for in the Act where the service is not reasonably available, the Fund remains liable to cover the prescribed minimum benefits at cost in whichever setting the member is compelled to seek treatment.

- 3.1.1 The following institutions/service providers shall be regarded as the designated service provider (DSP's) 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.
  - Oncology  
- State and ICON
  - Out of hospital (day to day) services – The member's own choice of supplier.
  - Chronic Medicine – Transmed Pharmacy Network.
- 3.1.2 The benefits shall be 100 % of the costs if obtained from a DSP or if involuntary obtained from a non DSP.
- 3.1.2.1. In the case of out of hospital benefits in terms of the chronic conditions listed in the Act, unlimited benefits will be provided as per the Care Plans approved by the Board from time to time.
- 3.1.3 If the member or his/her dependant voluntary choose not to make use of the designated service provider listed in clause 3.1.1, the following co-payment's, shall be applicable:
- 3.1.3.1 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 practioners 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.
- 3.1.3.2 In the case of Oncology: A co-payment of 20% based on the total cost including the services of the Oncologist, Pathology, Radiology and Radioterapy.
- 3.1.3.3 In the case of chronic medicine: A co-payment of 20% based on the total cost of the medicine.

- 3.1.4 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 subject to the PMB's, authorise the payment of a benefit in respect of such services if:
- (i) prior authorisation could not be obtained due to the particular circumstances;
  - (ii) 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.
  - (iii) 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.
- 3.4 **CHRONIC MEDICINE BENEFITS**
- Subject to clause 6.17.2, the following benefits in respect of chronic medicine shall be available to members, subject to the provisions contained in clause 8.
- 3.4.1 Medicine classified as the “Standard Formulary”, subject to the conditions and stipulations indicated in Annexure F, at 100% of the costs for PMB's.
- 3.4.2 Where a benefit is subject to a co-payment, the co-payment shall be paid by the member directly to the supplier concerned.
- 3.5 **SURGICAL, MEDICAL AND ORTHOPAEDIC APPLIANCES**
- The appliances shall be available as per the conditions and limits specified in Annexure G.

## **4. DAY TO DAY BENEFITS**

4.1 A member shall be entitled to the following benefits subject to the indicated limits:

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

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

4.1.1.2 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).

### **4.1.2 MEDICINE**

4.1.2.1 Acute medicine dispensed on prescription;

4.1.2.2 Medicine for self-medication; and

4.1.2.3 Medicine not approved as Chronic Medicine.

### **4.1.3 OTHER DAY TO DAY BENEFITS**

4.1.3.1 Acupuncture.

4.1.3.2 Audiometry.

4.1.3.3 Chiropody.

4.1.3.4 Chiropractors.

4.1.3.5 Clinical psychological services not regarded as Major Medical Benefits.

4.1.3.6 Dieticians.

4.1.3.7 Homeopaths.

4.1.3.8 Occupational and remedial therapy.

4.1.3.9 Orthoptic treatment.

4.1.3.10 Pathology services out of hospital.

4.1.3.11 Physiotherapy not regarded as Major Medical Benefits.

4.1.3.12 Radiology services out of hospital.

4.1.3.13 Speech therapy.

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

4.1.3.15 Minor surgical procedures and investigative procedures in consulting rooms of medical practitioners.

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

- Member with no dependants R1 920
- Member with dependants(M+) R3 370

## **5. OTHER BENEFITS:**

### **5.1 BASIC DENTISTRY**

5.1.1 All basic dentistry at 100 % of the Scale of Benefits or cost whichever is the lesser, subject to a limit of R1 460 per beneficiary per two financial years.

### **5.2 SPECIALISED DENTISTRY**

5.2.1 All specialised dentistry including –

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

At 100% of the Scale of Benefits or cost, whichever is the lesser, subject to a limit of R2160 per beneficiary once every two financial years.

### 5.3 **OPTICAL BENEFITS**

- 5.3.1 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:
- 5.3.1.1 Spectacles with single vision lenses including consultations, frames and lenses subject to a limit of R600; **or**
  - 5.3.1.2 Spectacles with bi-focal, tri- or multi-focal lenses including consultations, frames and lenses subject to a limit of R940; **or**
  - 5.3.1.3 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 R940 for both sets of spectacles; **or**
  - 5.3.1.4 Contact lenses (all inclusive costs) subject to a limit of R600; **or**
  - 5.3.1.5 Any of the recognised procedures (such as Radial Keratotomy, Excimer Laser or Lasik) to correct refractive errors subject to a limit of R940.

### 5.4 **BENEFITS FOR HIV TREATMENT**

- 5.4.1 Where a beneficiary has been registered on the Transmed HIV Programme, all HIV related claims will be paid as provided for in the Programme.
- 5.4.2 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 4.
- 5.4.3 When the financial limits referred to in clause 5.4.2 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.

## **6. MAJOR MEDICAL BENEFITS DEFINED**

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. All requirements and conditions referred to herein shall, in addition to the requirements and limits stipulated in respect of the different benefit options as set out in clause 3 above, apply to benefits in respect of these services:

### **6.1 HOSPITALISATION**

- 6.1.1 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.
- 6.1.2 Medicine, materials, dressings and preparations including medicine dispensed on discharge from a hospital (TTO's) shall be limited to 10 day's supply.
- 6.1.3 Blood transfusions, clinical technology and perfusionist services.

### **6.2 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.

### **6.3 ORGAN TRANSPLANTS**

- 6.3.1 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.
- 6.3.2 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.
- 6.3.3 In cases where the recipient is not a member of the Fund, liability will not be accepted for any costs.
- 6.3.4 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.

### **6.4 MATERNITY BENEFITS**

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

### **6.5 MEDICAL APPLIANCES**

- 6.5.1 Prosthesis and medical appliances which are internally implanted during an operation subject to the conditions and limits stipulated in Annexure H.
- 6.5.2 Surgical, medical or orthopaedic appliances and requirements related to a major medical event in or out of hospital as listed in Annexure G.

## **6.6 RECONSTRUCTIVE SURGERY OF BREASTS**

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

6.6.2 The cost of breast reduction operations are excluded unless specifically authorised by the Principal Officer or his/her delegate of if the services are PMB related.

## **6.7 GENERAL PRACTITIONERS AND SPECIALISTS**

6.7.1 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.

6.7.2 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.

## **6.8 DIAGNOSTIC SERVICES**

6.8.1 Radiology and Pathology services while the beneficiary is hospitalised.

6.8.2 MRI scans (in and out of hospital).

**6.9 AMBULANCE SERVICES**

Ambulance fees or transportation by air ambulance.

**6.10 PHYSIOTHERAPY**

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

**6.11 CLINICAL PSYCHOLOGICAL SERVICES**

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

**6.12 OXYGEN**

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

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

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

**6.14 PRIVATE NURSING AND FRAIL CARE**

Benefits include the following:

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

6.14.2 Hospice (in-patient or home visits).

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

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

## 6.15 **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.

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

6.16.1 Subject to clauses 6.16.2 to 6.16.9, 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.

6.16.2 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 6.16.1, be entitled to receive the same benefits as a member resident in South Africa.

6.16.3 Notwithstanding the provisions of clause 6.16.1 and subject to clauses 6.16.4 and 6.16.5, 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.

6.16.4 The member shall settle the account and may subsequently claim a refund following the procedure provided for in rule 14.

- 6.16.5 A member shall pay an additional amount of R50.00 per month for the benefits provided for in clause 6.16.3.
- 6.16.6 Should the member elect to cancel the payment of R50 per month, the benefits referred to in clause 6.16.3 shall lapse and shall not be reinstated at a later stage.
- 6.16.7 Notwithstanding the provisions of clause 6.16.1, 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 6.16.8.
- 6.16.8 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.
- 6.16.9 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.

## **6.17 ADDITIONAL BENEFITS**

### **DISEASE MANAGEMENT PROGRAM BENEFITS**

6.17.1 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.

6.17.1.1. 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**

6.17.2 In the case of a beneficiary who has been indentified 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.

6.17.2.1 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.

6.17.3 The benefits mentioned in clause 6.17.1 shall be limited to a maximum amount of R780 per beneficiary per annum subject to PMB's.

6.17.3.1 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.

## **7. PERSONAL HEALTH CARE INFORMATION**

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

### **7.1 AUDIO HEALTH LIBRARY**

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

### **7.2 NURSE HELPLINE**

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

## **8. CONDITIONS APPLICABLE TO CHRONIC MEDICINE BENEFITS**

Subject to clause 6.17.2, the following provisions shall apply to benefits in respect of chronic medicine in addition to the conditions stipulated in clause 3:

- 8.1 A member shall only receive chronic medicine benefits if:
  - 8.1.1 the use of the chronic medicine has been approved by the Principal Officer or his/her delegate; and
  - 8.1.2 the use remains within the level determined by the Principal Officer or his/her delegate or as stipulated in the PMB's.
- 8.2 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.
- 8.3 Participation in the chronic medicine pool shall be subject to approval by the Principal Officer or his/her delegate.
- 8.4 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.

## **9. EX-GRATIA BENEFITS**

- 9.1 The Board may upon application by a member grant ex-gratia benefits in respect of the member's medical expenses.
- 9.2 The Board shall consider such an application against guidelines prescribed by the Board from time to time, and which shall include the following considerations:
- 9.2.1 Are the medical services or medication absolutely necessary?
- 9.2.2 Did the member in the past incur medical expenses prudently and with responsibility?
- 9.2.3 Is the financial position of the member such that payment for the relevant expenses is likely to cause undue hardship?
- 9.3 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.

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

- 10.1 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.

10.2 Where there is no entitlement to benefits in terms of clause 10.1 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 therefor in circumstances envisaged in clause 10.1 above (“the expenses”):

10.2.1 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;

10.2.2 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.

10.3 In the event of the member not complying with the terms of clause 10.2 above, then notwithstanding any other rights which the Fund may have in terms of these Rules,

10.3.1 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;

10.3.2 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 10.1 above, shall immediately become due, owing and payable by the member to the Fund.

10.4 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.

10.5 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 10.1 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.

## **11. INJURY ON DUTY CASES**

11.1 The Fund shall accept liability for the costs due by the Company in respect of a member injured in an accident on or before 31 March 1990 arising from and in the course of his employment.

11.2 The Company shall reimburse the Fund for the cost incurred.