ANNEXURE B1

BENEFITS: ALL MEMBERS
OTHER THAN SATS CONTINUATION MEMBERS

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: Link;

2.1.2 Plan 2: Select; and

2.1.3 Plan 3: Prime

2.2 Preferred Provider Networks

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

2.2.1 Universal Healthcare (Pty) Ltd for all benefits Plan 1.

2.2.2 Independent Clinical Oncology Network (ICON) for Oncology benefits (Plan 2 and 3).

2.2.3 Transmed Oncology Network for oncology medicine (Plan 2 and 3).

2.2.4 Transmed Pharmacy Network for all chronic medicine (Plan 2 and 3).

2.2.5 Private Hospital Network, as well as other Private Hospitals as approved by the Board from time to time for hospitalisation (Plan 2 and 3).

2.2.6 Ophthalmology Management Group for cataract surgery (All plans).

2.2.7 DENIS for all dental benefits (Plan 2).

2.2.8 Preferred Provider Negotiators (PPN) for all optical benefits (Plan 2).

2.2.9 Transmed Pharmacy Network for HIV and AIDS medicine (Plan 2 and 3).

3. PLAN 1 AND 2

MAJOR MEDICAL BENEFITS

3.1 A member participating in Plans 1 and 2 shall only receive benefits in respect of Major Medical Benefits defined in clause 5 if such services is related to the Prescribed Minimum Benefits (PMB) and have been rendered by a State Hospital or if the State is not accessible in terms of the access criteria the secondary Designated Service Provider (DSP) specified in clause 3.1.4 and have been authorised by the Principal Officer or his/her delegate. 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 involuntary 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 Treatment Plans)
    - Plan 1 – State Hospitals and the Universal Private Hospital Network as secondary DSP
    - Plan 2 – State Hospitals and the Transmed Private Hospital Network as secondary DSP.
- Maternity benefits (Plan 2) – Transmed Private Hospital Network.
- Oncology – State and Independent Clinical Oncology Network (ICON).
- Oncology medicine
    - Plan 1 – Universal Healthcare Network
    - Plan 2 – Transmed Oncology Network
- All chronic medicine
    - Plan 1 – Universal Healthcare Network
    - Plan 2 – Transmed Pharmacy Network

- HIV and AIDS medicine
    - Plan 1 – Universal Healthcare Network
    - Plan 2 – Transmed Pharmacy Network
- Cataract surgery
    - Plan 1 – State Hospitals and Universal Cataract Surgery Network
    - Plan 2 – State Hospitals and Transmed Cataract Surgery Network
- All dental benefits
    - Plan 1 – Universal Dental Network
    - Plan 2 – DENIS
- All optical benefits
    - Plan 1 – Universal Optical Network
    - Plan 2 – Preferred Provider Negotiators (PPN)
- Out of hospital (Day-to-Day) services
    - Plan 1 – Universal Healthcare Network
    - Plan 2 –The member's own choice of supplier except for dental and optical benefits.

3.1.5 The detail of the co-payments mentioned in clause 3.1.1.2 for Plan 1 are contained in Annexure D. Detail of the co-payments for Plan 2 are as follows:

3.1.5.1 In the case of elective hospitalisation for admissions other than clause 3.1.5.2:

- A co-payment of an amount equal to the difference in cost between the total cost incurred in respect of the hospital services, including all related medical services by medical practitioners and other auxiliary services, and
    (i) the cost that would have been payable to State; or
    (ii) if the service was not accessible in State, the cost (based on the lowest negotiated tariff with the DSP) that would have been payable to the Transmed Private Hospital Network, for the procedure and associated costs.
- The payment by the Fund will be subject to pre-authorization as well as case management and other managed health care interventions.

3.1.5.2 In the case of voluntary use of a non-DSP hospital, for the below admissions, a co-payment of 30% based on the total hospital account:

- PMB related admissions for children under 12
- admissions for certain dental procedures
- selected non-PMB conditions, e.g., functional endoscopic sinus surgery, tonsillectomy and adenoidectomy, grommets, sterilisations, strabismus (squint eye) and vasectomies

3.1.5.3 In the case of chronic medicine: The difference between the charged dispensing fee and the negotiated network dispensing fee.

3.1.5.4 A co-payment of 20% based on the total cost for cataract surgery.

3.1.5.5 In the case of Oncology out of hospital: A co-payment of 20% applies to the Oncologist services.

3.1.5.6 In the case of HIV and AIDS medicine: The difference between the changed dispensing fee and the negotiated network-dispensing fee.

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

3.2 BENEFITS: PLAN 1

3.2.1 Members participating in Plan 1 shall receive benefits subject to the limits and conditions, contained in Annexure D.

3.3 BENEFITS: PLAN 2

3.3.1 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 or Private Network Hospital and the member was transferred to an appropriate State Hospital or Private Network 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 DSP 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 DSP Hospital.

In cases where only the specialist services are not available in a DSP Hospital, payment for the services of a private specialist will only be considered if the operation/procedure was performed in a DSP Hospital. Services shall be paid at 100% of the cost. The case of such services being provided by a Preferred Provider, the negotiated Tariff or cost, whichever is the lesser, subject to the limits and conditions indicated in clause 3.4.1.

3.4.1 The following benefits shall be subject to the limits and conditions indicated with due regarded to the PMB's:

3.4.1.1 Oncology and radiation: Benefits restricted to Tier 1 of the South African Oncology Consortium (SAOC) guidelines. PET scan – maximum 1 per beneficiary per annum.

3.4.1.2 For chronic medicines 100% benefit will be paid to a maximum cost equal to the Formulary Reference Price.

3.4.2 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.

3.4.3 The following admissions will be available to members in Transmed Private Hospital Network subject to pre-authorisation

- admissions for maternity
- PMB related admissions for children under 12
- admissions for medical emergencies, accidents, or trauma
- admissions for psychiatric treatment
- admissions for certain dental procedures
- selected non-PMB conditions, e.g., functional endoscopic sinus surgery, tonsillectomy and adenoidectomy, grommets, sterilisations, strabismus (squint eye) and vasectomies
- admissions related to cancer surgery
- admission for cataract surgery

3.4.4 Subject to clause 8.2 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.

3.4.4.1 Medicine as per the applicable Formulary specified under the "Core PMB Conditions List", subject to the conditions and stipulations indicated in Annexure F, at 100% of the negotiated DSP rate.

3.4.4.2 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.

3.4.5 Emergency treatment including consultation and procedure in an emergency room or casualty facility for children under 12 years old, subject to pre-authorisation.

3.5 SURGICAL, MEDICAL AND ORTHOPAEDIC APPLIANCES

The appliances listed in Annexure G shall be available at 100 % of the cost.
This benefit is linked to the associated diagnosis being defined as PMB.

3.6 DAY TO DAY BENEFITS: PLAN 2

3.6.1 NURSE PRACTITIONERS, GENERAL MEDICAL PRACTITIONERS AND SPECIALISTS.

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

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

3.6.1.3 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).

3.6.2. MEDICINE

3.6.2.1 Acute medicine dispensed on prescription subject to the Transmed Acute Medicine formulary; and

3.6.2.2 Medicine for self-medication (OTC) subject to the Transmed OTC Formulary and the following sub-limits:

3.6.2.2.1 Transaction limit of R280; and total benefit limit of R1 500 per family per annum, subject to the overall annual limit for day-to-day benefits.

3.6.3 OTHER DAY TO DAY BENEFITS

3.6.3.1 Acupuncture.

3.6.3.2 Audiometry.

3.6.3.3 Chiropody.

3.6.3.4 Chiropractors.

3.6.3.5 Clinical psychological services not regarded as Major Medical Benefits.

3.6.3.6 Dieticians.

3.6.3.7 Homeopaths.

3.6.3.8 Occupational and remedial therapy.

3.6.3.9 Orthoptic treatment.

3.6.3.10 Pathology services out of hospital.

3.6.3.11 Physiotherapy not regarded as Major Medical Benefits.

3.6.3.12 Radiology services out of hospital.

3.6.3.13 Speech therapy.

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

3.6.3.15 Incontinence Diapers.

The above-mentioned benefits shall be paid at 100% of the Transmed rate, subject to the following annual limits and PMB's:

- Member with no dependants (M0) R 8 000
- Member with dependants (M+) R10 940

3.6.4 BASIC DENTISTRY AND SPECIALISED DENTISTRY

All dental benefits applicable to Plan 2 are contained in Annexure K.

3.6.5 OPTICAL BENEFITS

All optical benefits applicable to Plan 2 are contained in Annexure M.

3.6.6 BENEFITS FOR HIV AND AIDS TREATMENT

3.6.6.1 HIV and AIDS related claims will be paid as follows:

- If the service was obtained from a DSP facility, at 100% of the cost subject to pre-authorisation; or
- If the service was obtained voluntary from a non-DSP, at 80% of the cost. The member shall pay the 20% co-payment directly to the supplier of the service.
- If medicine is obtained voluntary from a pharmacy outside of the Transmed pharmacy network, the member may be liable for a co-payment equal to the difference between the charged dispensing fee and the negotiated network-dispensing fee.

3.6.7 EARLY DETECTION BENEFITS

3.6.7.1 The following tests will be paid at 100% of the Transmed rate, at the indicated frequency for beneficiaries within the defined target groups. No pre-authorisation is required.

Tests reimbursed in terms of the Early Detection Benefit

Test	Related Disease	Target Group	Frequency
Health check *Cholesterol (finger prick *Glucose (finger prick) *Blood pressure *Body mass index	Cholesterol Diabetes mellitus Blood pressure	All patients > 25	One test per beneficiary per annum
Total Cholesterol (Lipogram)	Hypercholesterolemia	All patients > 25 years	One test per beneficiary per annum
Glucose level (finger prick test)	Diabetes	All patients > 25 years	One test per beneficiary per annum
PSA level	Prostate cancer	Male patients > 45 years	One test per beneficiary per annum
Fecal Occult Blood test (FOBT)	Colon cancer	All patients > 50 years	One test per beneficiary per annum
PAP smear - Standard -Liquid based Cytology Smear	Cervical cancer	Female patients > 18 years	One test per beneficiary per annum
Mammogram	Breast cancer	Female patients > 40 years	One test per beneficiary every 2 years
Quantitative PCR	HIV in Newborns	Newborn babies to HIV positive mothers	Once off

*Available at DSP pharmacies providing clinic services

3.6.7.2 Tests for beneficiaries who fall outside the target groups or tests in addition to the allocated frequency will be subject to pre-authorisation.

3.6.8 PREVENTATIVE CARE BENEFITS

3.6.8.1 Contraceptive benefits shall be available to all female beneficiaries subject to medicine used for primary use of contraception.

3.6.8.2 Flu vaccination benefits shall be available to all beneficiaries subject to the applicable Flu Vaccination formulary.

3.6.8.3 Circumcision procedures out of hospital/in rooms, subject to a limit of R2 800 per case.

3.6.8.4 HPV Vaccination for all beneficiaries 9-26 years subject to the applicable formulary.

3.6.8.5 Pneumococcal Vaccination for children under 6 years and subject to Treatment Plan Authorisation for High-Risk Adult Patients.

3.6.8.6 Immunisations as per Department of Health Schedule and subject to applicable formulary.

4. PLAN 3

MAJOR MEDICAL BENEFITS

4.1 A member participating in Plan 3 shall only receive benefits in respect of Major Medical Benefits defined in clause 5 if such services are classified as Prescribed Minimum Benefits (PMB) and have been 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 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).
- **Oncology medicine**
  - Transmed Oncology Network.
- **Cataract Surgery**
  - Ophthalmology Management Group (OMG).
- **Out of hospital (day to day) Services**
  - The member's own choice of healthcare providers.
- **Chronic Medicine:**
  - Transmed Pharmacy Network.
- **HIV and AIDS Medicine:**
  - Transmed Pharmacy Network.
- **Services obtained on an out-patient basis in addition to the benefits provided for by the Treatment Plans:**
  - State hospitals.

4.1.2 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 Treatment Plans approved by the Board from time to time.

4.2 The benefit of members participating in Plan 3 in respect of Major Medical Benefits shall, subject to the limitations imposed in clause 4.4, be 100 % of the Transmed rate or in the case of services provided by a State Hospital at 100 % of the cost according to the Uniformed Patient Fee System.

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)

4.4.1 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.
- PET scan – maximum 1 per beneficiary per annum.
- 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 a co-payment of 20% applies on the Oncologist services.

4.4.2 If the member or his/her dependants voluntary choose not to make use of the designated service provider listed in clause 4.1.1, the following co-payments shall be applicable:

4.4.2.1 In the case of hospitalisation: A co-payment of 30% based on the total hospital account.

4.4.2.2 In the case of chronic medicine: The difference between the charged dispensing fee and the negotiated network dispensing fee.

4.4.2.3 A co-payment of 20% based on the total cost for cataract surgery.

4.4.2.4 In the case of HIV and AIDS medicine: The difference between the charged dispensing fee and the negotiated network dispensing fee.

4.4.3 The appliances and prostheses listed in Annexures G and H shall be available at 100% of the cost subject to the associated diagnosis being defined as PMB.

4.5 OTHER BENEFITS: PLAN 3

4.5.1 NURSE PRACTITIONERS, GENERAL MEDICAL PRACTITIONERS AND SPECIALISTS.

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

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

4.5.1.3 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).

4.5.2 BENEFITS FOR HIV AND AIDS TREATMENT

4.5.2.1 HIV and AIDS related claims will be paid as follows:

- If the service was obtained from a DSP facility, at 100% of the cost subject to pre-authorisation; or
- If the service was obtained voluntary from a non DSP, at 80% of the cost. The member shall pay the 20% co-payment directly to the supplier of the service.
- If medicine is obtained voluntary from a pharmacy outside of the Transmed pharmacy network, the member may be liable for a co-payment equal to the difference between the charged dispensing fee and the negotiated network-dispensing fee.

4.5.3 EARLY DETECTION BENEFITS

4.5.3.1 The following tests will be paid at 100% of the Transmed rate, at the indicated frequency for beneficiaries within the defined target groups. No pre-authorisation is required.

Tests reimbursed in terms of the Early Detection Benefit

Test	Related Disease	Target Group	Frequency
Health check *Cholesterol (finger prick) *Glucose (finger prick) *Blood pressure *Body mass index	Cholesterol Diabetes mellitus Blood pressure	All patients > 25	One test per beneficiary per annum
Total Cholesterol (Lipogram)	Hypercholesterolemia	All patients > 25 years	One test per beneficiary per annum
Glucose level (finger prick test)	Diabetes	All patients > 25 years	One test per beneficiary per annum
PSA level	Prostate cancer	Male patients > 45 years	One test per beneficiary per annum
Fecal Occult Blood test (FOBT)	Colon cancer	All patients > 50 years	One test per beneficiary per annum
PAP smear - Standard -Liquid based Cytology Smear	Cervical cancer	Female patients > 18 years	One test per beneficiary per annum
Mammogram	Breast cancer	Female patients > 40 years	One test per beneficiary every 2 years
Quantitative PCR	HIV in Newborns	Newborn babies to HIV positive mothers	Once off

*Available at DSP pharmacies providing clinic services

4.5.3.2 Tests for beneficiaries who fall outside the target groups or tests in addition to the allocated frequency will be subject to pre-authorisation.

4.5.4 PREVENTATIVE CARE BENEFITS

4.5.4.1 Contraceptive benefits shall be available to all female beneficiaries subject to medicine used for primary use of contraception.

4.5.4.2 Flu vaccination benefits shall be available to all beneficiaries subject to the applicable Flu Vaccination formulary.

4.5.4.3 Circumcision procedures out of hospital/in rooms, subject to a limit of R2 800 per case.

4.5.4.4 HPV Vaccination for all beneficiaries 9-26 years subject to the applicable formulary.

4.5.4.5 Pneumococcal Vaccination for children under 6 years and subject to Treatment Plan Authorisation for High-Risk Adult Patients.

4.5.4.6 Immunisations as per Department of Health Schedule and subject to applicable formulary.

4.6 CHRONIC MEDICINE BENEFITS

4.6.1 Subject to clause 7.2 the following chronic medicine benefits shall be available subject to the provisions contained in clause 6:

4.6.1.1 Medicine as per the applicable Formulary specified under the "Core PMB Conditions List", subject to the conditions and stipulations indicated in Annexure F, at 100% of the negotiated DSP rate.

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.

5. MAJOR MEDICAL BENEFITS DEFINED

The following services shall be regarded as Major Medical Benefits only if they are classified as Prescribed Minimum Benefits (PMB). 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:

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, will be covered subject to PMB legislation and to pre-authorisation by the Principal Officer or his/her delegate.

5.3.2 In cases where the recipient is not a member of the Fund, liability will not be accepted for any costs.

5.3.3 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.

5.3.4 The cost of the international donor search and harvesting shall be limited to R225 000 (irrespective of Rand/Dollar/Euro exchange rate) subject to the PMB regulations and authorisation by the Principal Officer or his/her delegate.

5.4 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.

5.5 MEDICAL APPLIANCES

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

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

5.6 RECONSTRUCTIVE SURGERY OF BREASTS

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

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

5.7 GENERAL PRACTITIONERS AND SPECIALISTS

5.7.1 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.

5.7.2 Second opinion consultations/reports in and out of hospital required by the Principal Officer or by his/her delegate.

5.8 DIAGNOSTIC SERVICES

5.8.1 Radiology and Pathology services while the beneficiary is hospitalised.

5.8.2 MRI scans (in and out of hospital).

5.9 AMBULANCE SERVICES

Ambulance fees or transportation by air ambulance.

5.10 PHYSIOTHERAPY

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

5.11 CLINICAL PSYCHOLOGICAL SERVICES

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

5.12 OXYGEN

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

5.13 SPECIAL MEDICINE PREPARATIONS FOR SPECIFIC MEDICAL CONDITIONS

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

5.14 HOME NURSING AND TERMINAL CARE

Benefits are subject to authorisation by the Principal Officer or his/her delegate and include the following:

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

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

5.14.3 Terminal Care Benefit of R25 000 per beneficiary for services received in an accredited facility including Hospice/Sub Acute or for home care by registered nurse. This is an additional benefit, and the financial limit is not applicable to any services rendered which qualify for payment in terms of the PMB legislation.

6. CONDITIONS APPLICABLE TO CHRONIC MEDICINE BENEFITS (PLAN 2 AND 3)

Subject to clause 7.2 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. ADDITIONAL BENEFITS (PLAN 2 AND 3)

7.1 DISEASE MANAGEMENT PROGRAM BENEFITS

7.1.1 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.

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

7.2 CHRONIC DISEASE TREATMENT PLANS

7.2.1 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.

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

7.3 MATERNITY TREATMENT PLAN

Benefits shall be provided in accordance with the developed Treatment Plan as approved by the Board from time to time.

8. BENEFITS IN COUNTRIES OUTSIDE SOUTH AFRICA

8.1 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 be entitled to receive the same benefits as a member resident in South Africa.

8.2 Notwithstanding the provisions of clauses 8.1 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.

8.3 Subject to clauses 8.4, 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.

8.4 The claims procedure as stipulated in Rule 14 shall be applicable.

9. PERSONAL HEALTH CARE INFORMATION

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

9.1 HEALTH ADVICE LINE

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 Claims for treatment of injuries or expenses recoverable from third parties, shall be supported by a statement, setting out particulars of the circumstances in which the injury was sustained. Any amounts recovered from a third party for medical expenses paid by the Fund must be refunded to the Fund.

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.