ANNEXURE B2

BENEFITS: SATS CONTINUATION MEMBERS

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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 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 3.1.1 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. 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.

- Certain non-PMB conditions as provided for in clause 3.3.1 and Annexure G shall form part of the benefits subject to provisions contained in the Rules.
- All other Major Medical benefits for non-PMB conditions shall be covered as benefits only if services have been rendered by State facilities.

3.1.1 The following institutions/service providers shall be regarded as the Designated Service Provider (DSP's) for the prescribed minimum benefits and/or other benefits:

- Hospitalisation (including services obtained on an out-patient basis in addition to the benefits provided for by the Treatment Plans) – State Hospitals and Transmed Private Hospital Network as secondary DSP.
- Oncology – The State and Independent Clinical Oncology Network (ICON).
- Oncology Medicine –Transmed Oncology Network.
- Chronic Medicine – Transmed Pharmacy Network.
- HIV and AIDS Medicine – Transmed Pharmacy Network.
- Cataract surgery – The State and Ophthalmology Management Group.
- Improved Clinical Pathway Services (ICPS) for Joint Replacements.
- Preferred Provider Negotiators (PPN) for all optical benefits.
- DENIS for all dental benefits.
- Out of hospital (day to day) services – The member's own choice of supplier.

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 Treatment Plans approved by the Board from time to time.

3.1.3 If the member or his /her dependants voluntary choose not to make use of the designated service provider listed in clause 3.1.1, the following co-payments shall be applicable:

3.1.3.1 In the case of hospitalisation:

- 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 shall be subject to pre-authorisation as well as case management and other managed care interventions.

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

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

3.1.3.4 In the case of cataract surgery: A co-payment of 20% based on the total cost for cataract surgery.

3.1.3.5 In the case of Joint Replacements (PMB and non-PMB):

- 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 the cost that would have been payable to the DSP.

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

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 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.

(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 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 related to the Prescribed Minimum Benefits (PMB) shall be paid at 100 % of the cost.

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

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

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

3.3.1.2 Benefits for Joint Replacements shall be provided by a Designated Service Provider (ICPS) and shall be subject to pre-authorisation and other managed care interventions as well as protocols and payment of a global fee as per agreement between ICPS and the Fund.

3.3.2 Internal Prostheses shall be subject to the PMB's, limits and conditions listed in Annexure J.

3.3.3 The following preventative care benefits shall be available:

3.3.3.1 Flu vaccination benefits shall be available to all beneficiaries subject to the applicable Flu Vaccination Formulary.

3.3.3.2 Pneumococcal vaccination benefits subject to Treatment Plan authorisation.

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

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 I.

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 subject to the Transmed Acute Medicine Formulary;

4.1.2.2 Medicine for self-medication (OTC) subject to the Transmed OTC Formulary; 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.

4.1.3.16 Incontinence Diapers

The above-mentioned benefits shall be 100 % of the Transmed rate, subject to the following annual Day to Day benefit limits:

- Member with no dependants (M0) R5 040
- Member with dependants (M+) R8 850

4.1.4 BASIC AND SPECIAL DENTISTRY

All dental benefits as set out in Annexure L.

4.1.5 OPTICAL BENEFITS

All optical benefits as set out in Annexure M.

5. OTHER BENEFITS

5.1 BENEFITS FOR HIV AND AIDS TREATMENT

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

- If the service was obtained from a state 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.

6. MAJOR MEDICAL BENEFITS DEFINED

The following services shall be regarded as Major Medical Benefits. The benefits shall be 100 % of the Transmed rate. 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, will be covered subject to PMB legislation and pre-authorisation by the Principal Officer or his/her delegate.

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

6.3.3 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.

6.3.4 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 pre-authorisation by the Principal Officer or his/her delegate.

6.4 MATERNITY BENEFITS

Services related to a maternity case (including a caesarean 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 I.

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 is 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 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 HOME NURSING AND TERMINAL CARE

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

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

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

6.14.3 Terminal Care Benefits 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.

6.15 RADIAL KERATOTOMY/EXCIMER LASER

Surgically related services and procedures. Where these services/procedures relate 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 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.

6.16.2 Subject to clauses 6.16.3, 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.

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

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 TREATMENT PLANS

6.17.2 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.

6.17.2.1 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. PERSONAL HEALTH CARE INFORMATION

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

7.1 HEALTH ADVICE LINE

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 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.

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.