

**ANNEXURE B.5
BEAT1****5.1 GENERAL CONDITIONS OF THE BENEFIT OPTION**

- (a) The Scheme's benefits on accounts properly lodged in terms of rule 15 shall be granted as shown in each paragraph hereunder, and the member shall be liable for the difference between the Scheme's benefits and the full amount of the account.
- (b) No benefits shall be granted on accounts reaching the Scheme after the last day of the fourth month following the date on which the service was rendered.
- (c) Where an account has been paid by the member in cash, such specified account plus proof of payment must be submitted to the Scheme before the last day of the fourth month following the date on which the service was rendered. The Scheme will then refund the member the applicable benefit amount.
- (d) Direct payment will be made by the Scheme to a supplier of service who renders accounts in accordance with the Scheme tariff or contracted fee as agreed by the Scheme and the supplier.
- (e) A member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.
- (f) Benefits shall be based on the Scheme tariff or contracted fee as agreed by the Scheme and the supplier of service, whichever is applicable.
- (g) The Scheme's financial year shall run from 1 January to 31 December.
- (h) The benefits of the option are limited to In-hospital Scheme benefits, preventative care, wound care and private nursing services once discharged from hospital.

- (i) A member shall qualify for the extent and level of minimum benefits provided for in regulation 8 in terms of the Medical Schemes Act (No. 131 of 1998) and Annexure D1 of these Rules, without deductibles or the use of co-payments.
- (j) The Mediscor Reference Price (MRP) will be applied on all medicines where applicable.

5.2 **CONDITIONS FOR SCHEME BENEFIT PAYMENT**

- (a) Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.
- (b) Full cross subsidisation between members shall apply.
- (c) Granting of benefits under the Scheme Benefits shall be subject to treatment protocols, preferred providers, designated service providers, network option services and/or medicine formularies accepted by the Scheme.
- (d) No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained in advance or, in an emergency, on the first working day after admission to a hospital, by the Scheme or its proxy.
- (e) No benefits in a private hospital or day clinic shall be granted if an authorisation number has not been obtained in advance (in the case of planned major operations and dental procedures – preferably 14 days in advance) or, in an emergency, on the first working day after admission to a hospital, by the Scheme or its proxy.
- (f) If a member or his dependants receive treatment in a private hospital or day clinic without an authorisation number having first been obtained (due to either prior application not made or because a prior application was refused), a **R500** surcharge per admission shall be imposed whenever an application is approved with retrospective effect.

- (g) If an authorisation number has been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the member shall be liable for payment of the excess to the service provider.
- (h) Joint replacement surgery (A joint connects two bones in the body and includes skull joints, throat joints, thorax joints, spine and pelvis joints, both upper limbs and both lower limbs) will be excluded from benefits except for PMB conditions. The following maxima will apply to the prosthesis if pre-authorised by the Scheme or its proxy:
 - (i) Preferred Provider may be appointed by the Scheme;
 - (ii) Co-payments may apply if preferred providers are not utilised.
 - (iii) Hip prosthesis and other major joints shall be limited to R20 800;
 - (iv) Knee prostheses shall be limited to R25 700;
 - (v) Other minor joints shall be limited to R8 800.
- (i) A co-payment of R2 200 per hospital admission will be applicable on all endoscopic investigations. No co-payment shall apply where procedures are performed out of hospital (in doctor's rooms).

5.2.1 **Hospitals: contracted and non-contracted providers**

Claims submitted by a contracted provider for accommodation in a general ward, intensive-care and high-care unit, theatre, and material – 100% of the **contracted fee**. Claims submitted by non-contracted providers – 100% of the **Scheme tariff**.

5.2.2 **Mental health clinics: contracted and non-contracted providers**

Claims submitted by a contracted provider for accommodation and treatment of psychological and psychiatric conditions – 100% of the **contracted fee**. Claims submitted by non-contracted providers – 100% of Scheme tariff. Benefits shall be subject to the following:

- (i) The length of stay shall be limited to 21 days per beneficiary per financial year.

5.2.3 Registered institutions for the treatment of chemical and substance dependence/abuse

Accommodation and treatment for chemical and substance dependence/abuse – 100% of the Scheme tariff. Benefits shall be subject to the following:

- (i) The length of stay shall be limited to 21 days per beneficiary per financial year; or
- (ii) Benefits shall be limited to R18 600 per beneficiary per financial year.

5.2.4 Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation

Claims submitted by General Practitioners and Specialists for treatment during hospitalisation – 100% of the Scheme tariff or contracted fee.

5.2.5 Confinements

Benefits shall be paid as follows even if the baby dies before registration:

- (i) Medical practitioners – 100% of the Scheme tariff.
- (ii) Nursing home and hospital fees in accordance with the provisions of paragraph 5.2.1.
- (iii) Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife– 100% of the Scheme tariff . Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding support shall be excluded from benefits.
- (iv) Midwife assisted births at a private midwife birth house – 100% of the Scheme tariff. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits.

5.2.6 Surgical dentistry

Any surgical procedure that needs to be performed in a theatre, after pre-authorisation by the Scheme – 100% of the Scheme tariff, limited to R8 800 per family per financial year. Payment for Maxillofacial and oral surgery is strictly related to the following conditions:

- (i) Severe trauma (soft tissue injuries, fractures of jaws and facial bones);
- (ii) Cleft lip and palate;
- (iii) Crouson's disease;
- (iv) Malunited craniomaxillary disjunction;
- (v) Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);
- (vi) Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);
- (vii) Salivary gland surgery (removal of gland or salivary stone);
- (viii) Life threatening sepsis (Ludwig's angina);
- (ix) Confirmed oral cancer.

5.2.7 Pathology and standard diagnostic imaging during hospitalisation

100% of the Scheme tariff.

5.2.8 Specialised diagnostic imaging during hospitalisation

MRI scans, CT scans, computer tomographic studies and isotope studies – 100% of Scheme tariff, subject to pre-authorisation.

5.2.9 Supplementary benefits during hospitalisation

Supplementary benefits include services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropracist, dieticians, speech therapists, bio kinetics, private nursing and social workers – 100% of Scheme tariff on condition that the claim is related to the hospital admission of the patient.

5.2.10 Blood transfusions

Blood, operators' fees, transport charges and apparatus – 100% of the Scheme tariff.

5.2.11 Internal Prosthesis surgically implanted during operations/ hospitalisation

Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of 52 000 per family per financial year: Benefits will not be pro-rated but will be subject to the following conditions and maxima:

- (i) Pre-authorisation by the Scheme.
- (ii) Preferred providers may be appointed by the Scheme.
- (iii) Co-payments may apply if preferred providers are not utilised.
- ((iv) Vascular prosthesis shall be limited to R19 700.
- (v) Endovascular prosthesis – no benefit
- (vi) Spinal prosthesis shall be limited to R19 700.
- (vii) Artificial disk (single level based) – no benefit.
- (viii) Drug eluting stent – no benefit.
- (ix) Mesh shall be limited to R6 900.
- (x) Gynaecological/Urological prosthesis shall be limited to R5 700.
- (xi) Lens implant shall be limited to R4 400 per lens.

5.2.12 External prosthesis after operations

Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of R12 600 per family per condition per financial year. Benefits shall be subject to the following:

- (i) Pre-authorisation by the Scheme.
- (ii) Two quotations may be required.
- (iii) Preferred providers may be appointed by the Scheme.
- (iv) Artificial limbs are limited to one limb per 60 months.

5.2.13 Orthopaedic and medical appliances during hospitalisation

Back, leg, arm and neck supports, crutches, surgical foot wear and elastic stockings provided before discharge from hospital – 100% of the Scheme tariff.

5.2.14 Organ transplants

PMB conditions only. 100% of the Scheme tariff subject to pre-authorisation and application of Scheme protocols.

5.2.15 Peritoneal dialysis and haemodialysis

100% of the Scheme tariff subject to pre-authorisation and application of Scheme protocols.

5.2.16 Ambulance and emergency evacuation services

100% of the cost of ambulance services on condition that the service has previously or, in an emergency, on the first working day after evacuation, been approved as clinically necessary the preferred provider for ambulance services. No benefits shall be payable if the evacuation service was requested and delivered by a service provider other than the preferred provider.

5.2.17 Oncology

Radiation, chemotherapy, pathology, diagnostic imaging and consultations - 100% of the Scheme tariff. Benefits shall be subject to the following:

- (i) Pre-authorisation by the Scheme;
- (ii) Preferred providers may be appointed;
- (iii) Scheme protocol shall apply.
- (iv) Mediscor Reference Price (MRP) will be applied to medicine claims where applicable

5.2.18 Alternatives to hospitalisation

Services rendered by step-down facilities approved by the Scheme, registered private nurses and hospices – 100% of the fees approved by the Scheme. Pre-authorisation shall apply.

5.2.19 Take home medicine after discharge from hospital

Medicine prescribed by the treating doctor upon discharge from hospital (and relating to the admission), to take home, will be paid at 100% of Scheme tariff, subject to MRP and a maximum supply of seven days.

5.2.20 Prescribed Minimum Benefits (PMBs)

A member shall apply on the Scheme's prescribed application form to qualify for a limited set of 270 conditions as specified in Annexure A of the Regulations in terms of the Medical Schemes Act (no 131 of 1998) and Annexure D1 of these Rules – 100% of the cost. Benefits shall be subject to the following:

- (i) Pre-authorisation
- (ii) The Scheme treatment protocols and clinical funding guidelines
- (iii) Designated service providers (DSP)
- (iv) Formularies
- (v) Mediscor Reference Price (MRP)

The Scheme's medicine benefits for CDL chronic medicines, prescribed by a medical practitioner are subject to a formulary (medicine list). Medicines on the formulary will be reimbursed at 100% of Scheme tariff without a co-payment. If a member, however, opts to use a non-formulary medicine, the Scheme will reimburse that product at 65% and the member will have a 35% co-payment. A member shall apply (obtain pre-authorisation) on the Scheme's prescribed application form to qualify for these medicines on the CDL chronic benefit. A member shall qualify for benefits from the date on which the application was received by the Scheme or its proxy.

5.2.21 Preventative care

100% of the Scheme tariff for:

Preventative Care Benefit	Gender and Age Group	Quantity and Frequency	Benefit Criteria
Influenza vaccine	All ages	One per beneficiary per financial year	Applicable to all active members and beneficiaries
Pneumonia Programme	Children < 2yrs High risk adult group	Once in 60 months	<u>Funding for children < 2years:</u> Parents to contact The Scheme in advance to pre-arrange funding prior to obtaining the vaccine <u>Funding for adults:</u> The Scheme will identify certain high risk individuals who will be advised to be immunised
Paediatric immunisations	Funding for all paediatric vaccines according to the State recommended programme for babies and children		
Female contraceptives	All females of child bearing age	Quantity and frequency depending on product up to the maximum allowed amount. Mirena device - one device in 60 months	Limited to R1 400 per family per financial year Includes all items classified in category of female contraceptives
Document Based Care (DBC) Back rehabilitation programme	All ages	Up to 6 weeks treatment plan as per approval	Applicable to beneficiaries who have serious spinal or back problems and may require surgery. The Scheme identifies appropriate participants for evaluation at the DBC Centre. Based on the outcomes of the

			evaluation, a rehabilitation treatment plan is drawn up and initiated which lasts approximately 6 weeks.
Biometric screening: - Glucose test (finger prick test) - Cholesterol test (finger prick test) - Blood Pressure - Body Mass Index (BMI)	All beneficiaries 10 years and older	One per beneficiary per financial year	A screening benefit package at selected Preferred Provider Pharmacies.

5.2.22 Wound care and related private nursing services

Wound care including dressings and Negative Pressure Wound Therapy (NPWT) treatment and related private nursing services – 100% of Scheme tariff with a maximum of R2 300 per family per financial year.

5.2.23 International emergency medical cover

Over and above the provisions for foreign claims, referred to in Rule 16.12, members and their dependents qualify for the following additional benefit:

100% for the cost of services for worldwide international emergency medical cover: Provided that benefits are subject to the following:

- (i) The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs.
- (ii) Beneficiaries have access to 90 days cover per trip.
- (iii) A member has to notify the preferred provider at least 48 hours in advance when he and or his dependents are travelling overseas. Failure to notify the preferred provider will result in claims not entertained.
- (iv) General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.

5.3 **MAXIMUM BENEFITS**

Where a maximum amount of benefits has been imposed per financial year, the benefits shall be calculated at the maximum for the financial year in which the service was rendered. Where maximum benefits apply to a financial year, the maximum benefits for which a member and his dependants qualify shall be determined in accordance with the actual membership status at the date on which the service is rendered.

Benefit maxima for members shall be calculated pro-rata for the financial year in which they join the Scheme as referred to in paragraph 5.1(e).