

ANNEXURE B.9**PULSE2****9.1 GENERAL CONDITIONS OF THE BENEFIT OPTION**

- 9.1.1** The benefit option in this Annexure is a network benefit option as per an agreement entered into between the Scheme and a third party provider, Onecare National Network. As such Onecare Health is contracted to provide certain day-to-day benefits, including a specialist Preferred Provider Network to Members. Members may only visit service providers registered on the Onecare National Network.
- 9.1.2** A Hospital Network shall apply for all in-hospital benefits and services, as per an arrangement entered into between the Scheme and the hospital network. As such a pre-negotiated fixed fee will be paid in return for the delivery or arrangement of the delivery of benefits by such a hospital network.
- 9.1.3** The Scheme's or Onecare benefits on accounts properly lodged in terms of rule 15 of the registered Rules shall be granted as shown in each paragraph hereunder, and the Member shall be liable for the difference between Scheme tariff or contracted tariff and the full amount of the account.
- 9.1.4** Where an account has been paid by the Member in cash, such specified account plus proof of payment must be submitted to the Scheme or Onecare before the last day of the 4th (fourth) month following the date on which the service was rendered. The Member will be refunded accordingly.
- 9.1.5** Direct payment will be made 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.
- 9.1.6** No benefits shall be granted on accounts reaching the Scheme or Onecare after the last day of the 4th (fourth) month following the date on which the service was rendered.
- 9.1.7** A Member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.

- 9.1.8** Benefits shall be based on the Scheme tariff or contracted fee as agreed by the Scheme and the supplier of service, whichever is applicable.
- 9.1.9** The Scheme's financial year shall run from 1 January to 31 December.
- 9.1.10** The benefits of this option shall be divided into the following:
- 9.1.10.1** Day-to-day benefits managed and paid by the Scheme's Preferred Provider; Onecare Health, as rendered at a Onecare National Network preferred provider;
 - 9.1.10.2** Scheme Benefits including all in-hospital services and preventative care; and
 - 9.1.10.3** Scheme day-to-day benefits.
- 9.1.11** A Member shall qualify for the extent and level of prescribed 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.
- 9.1.12** The Maximum Medical Aid Price (MMAP) or Onecare will be applied on all medicines where applicable.
- 9.1.13** The day-to-day benefit shall be utilised for out of hospital, day-to-day benefits and is limited to the following maxima per financial year:

M	M1+
R11 000	R21 900

9.2 DAY-TO-DAY BENEFITS PAID BY ONECARE HEALTH

- 9.2.1** The benefits set out in this part of the Annexure may only be obtained from the preferred provider or Designated Service Provider (DSP).
- 9.2.2** The preferred provider or DSP shall render the services in accordance with the provisions of a contract entered into by the Scheme and the preferred provider on a

capitation basis.

9.2.3 Claims relating to the benefits set out below shall be referred to the preferred provider for payment.

9.2.4 Consultations, visits and treatments by general practitioners of the network

100% of Onecare tariff for unlimited Onecare GP consultations.

9.2.5 Out of network consultations, visits and treatments by general practitioners

Every family qualifies for 2 (two) out of network visits with a general practitioner per year which must be pre-authorized by Onecare. Each visit shall be limited to R1 100. The Member shall pay for the visit upfront and then claim back from Onecare. Benefits are at 100% of Onecare tariff and subject to the overall annual day-to-day limit.

9.2.6 Out of hospital specialist visits

Specialist visits shall only be considered if referred by a network provider and if the specialist is part of the Onecare Specialist Service Provider group. These visits must be Pre-Authorised by Onecare. Where no referral and Pre-Authorisation was obtained no benefit will be paid except in the case of an emergency.

100% of Scheme tariff limited to the following maxima per financial year which shall be subject to the overall annual day-to-day limit:

M	M1+
R2 200	R4 400

9.2.7 Medicine benefit

9.2.7.1 The following principles apply for the reimbursement of medicine:

- 9.2.7.1.1** Where medicines have generic alternatives registered with the Medicines Control Council (MCC) of South Africa, the contracted network will reimburse those medicines up to the Onecare protocols and reference pricing or Maximum Medical Aid Price (MMAP) for that active ingredient;
- 9.2.7.1.2** Benefit amount of medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as determined by the Scheme, plus VAT where applicable;
- 9.2.7.1.3** A Member must apply on the Onecare prescribed application form to qualify for chronic medicine benefits and when approved, . a Member shall qualify for benefits from the date on which the application was received by the Scheme or its proxy;
- 9.2.7.1.4** Approved PMB, CDL and non-CDL chronic medicine costs will be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs will continue being paid;
- 9.2.7.1.5** Designated service providers (DSP) may apply; and
- 9.2.7.1.6** Network Provider formularies (medicine list) shall apply.

9.2.7.2 Medicine for non-CDL chronic conditions

The Onecare benefit for medicine for non-CDL chronic conditions is subject to the use of a formulary (medicine list) and must be prescribed by the selected network provider. 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, Onecare will reimburse that product at 75% and the Member will have a 25% co-payment.

The following maxima per financial year will apply:

M	M1+
R6 600	R13 100

9.2.7.2.1 Specified chronic conditions.

Acne	Major depression*
Allergic Rhinitis	Migraine prophylaxis
Alzheimer's disease	Neuropathy
Aplastic anaemia	Osteoarthritis
Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactive Disorder (ADHD)	Obsessive compulsive disorder
Benign Prostatic Hypertrophy	Osteoporosis
Chronic anaemia	Paget's disease
Eczema	Polycystic ovarian disease
Endometriosis	Psoriasis
Female menopause	Pulmonary embolism
Gastro Oesophageal Reflux Disease (GORD)	Stroke
Gout prophylaxis	Urinary incontinence
Hypophyseal adenoma	

9.2.7.3 Medicine for Chronic Disease List (CDL) conditions:

Onecare's medicine benefits for CDL chronic medicines, prescribed by a medical practitioner are subjected 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 non-formulary medicine, the medicine item will be reimbursed at 75% of Scheme tariff and the Member will have a 25% co-payment. A Member shall apply to Onecare to qualify for these medicines on the CDL chronic benefit.

9.2.7.4 Acute medicine

Acute medicine prescribed by a network practitioner, dentist or person legally authorised thereto by law and over the counter medicine - 100% of Scheme tariff. Over the counter medicine shall be limited to R1 100 per family per year and is subject to the acute medicine limit. No benefit shall apply to non-formulary acute medicine. Benefits shall be

subject to the overall day-to-day benefit, the Onecare formulary and the following maxima per financial year:

M	M1+
R3 500	R7 000

9.2.8 Dental benefits

9.2.8.1 100% of Scheme tariff for basic dentistry and specialised dentistry subject to the following provisions of the preferred provider:

9.2.8.1.1 Only basic primary care according to a network approved tariff list shall be covered;

9.2.8.1.2 1 (one) consultation, primary extractions, fillings and scaling and polishing at a preferred provider;

9.2.8.1.3 Basic dentistry will be subject to the overall day-to-day limits; and.

9.2.8.1.4 Pre-Authorisation must be obtained from Onecare for specialised dentistry which includes root canal treatment, prosthodontics (crowns, bridges, inlays, veneers and dentures), periodontics (gums and related problems), orthodontic services, implants and all surgery and laboratory costs related to the services mentioned.

Specialised dentistry benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

M	M1+
R5 300	R6 700

9.2.8.2 The dental benefit excludes the following:

9.2.8.2.1 Orthodontic therapy for patients older than 18 (eighteen) years;

9.2.8.2.2 Complications with removable dentures; and

9.2.8.2.3 MRI and CT scans for any dento-alveolar procedure.

9.2.9 Supplementary benefits out of hospital referred by a network GP only

Supplementary benefits include services rendered by physiotherapists, chiropractors, audiologists, occupational therapists, podiatrists/chiropracist, dieticians, speech therapists, biokinetics, psychologists, orthoptists, social workers, homeopaths and acupuncture. Homeopathic benefits include consultations and registered homeopathic medicine. 100% of Scheme tariff limited to available day-to-day limits and the following maxima per financial year:

M	M1+
R3 100	R6 100

9.2.10 Pathology and standard diagnostic imaging out of hospital

100% of the Scheme tariff subject to the Network Provider request, protocol and tariff list as well as overall annual day-to-day limit. No benefit shall apply if the tariffs are not on the approved tariff list. Only black and white x-rays in single or two dimensional views of limbs, spinal column and abdomen will be covered.

9.2.11 Optometry benefits

100% of Scheme tariff, subject to the Optical Management Program and clinical necessity. Benefits shall be limited to the day-to-day overall limit and the following maxima once every 24 (twenty-four) months:

M	M1+
R3 100	R4 800

9.3 CONDITIONS FOR THE SCHEME BENEFIT PAYMENT

- 9.3.1** Comprehensive benefits are offered for all pre-authorized services and authorized emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.
- 9.3.2** Full cross subsidisation between Members shall apply without an annual limit.
- 9.3.3** 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.
- 9.3.4** The Netcare hospital group is contracted as the Designated Service Provider (DSP) for all in-hospital services. Should a Member voluntarily choose not to make use of a Hospital forming part of the Hospital Network for this benefit option, a maximum co-payment of R5 000 shall apply to the voluntary use of a non-designated service provider.
- 9.3.5** 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 1st (first) working day after admission to a hospital, by the Scheme or its proxy.
- 9.3.6** No benefits in a Hospital forming part of the Hospital Network or day clinic shall be granted by the Scheme or its proxy, if Pre-Authorisation and an authorisation number have not been obtained in advance:
- 9.3.6.1** In the event of planned major operations and dental procedures, at least 14 (fourteen) days before the event; or
- 9.3.6.2** In an emergency, on the 1st (first) working day after admission.
- 9.3.7** If a Member or his Dependant(s) receive treatment in a Hospital forming part of the Hospital Network or day clinic without first obtaining Pre-Authorisation and an authorisation number, 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.
- 9.3.8** If Pre-Authorisation and an authorisation number has been obtained for treatment in a Hospital forming part of the Hospital Network 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.

9.3.9 Hospitals: DSP network providers and non-DSP providers

Claims submitted by a DSP network 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-DSP providers – 100% of **Scheme tariff** and a co-payment of up to a maximum of R5 000 where services are authorised or approved by the Scheme, in its sole discretion.

9.3.10 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** where services are authorised or approved by the Scheme, in its sole discretion. Benefits shall be subject to the following:

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

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

Accommodation and treatment for chemical and substance dependence/abuse – 100% of Scheme tariff. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits are subject to the following:

9.3.11.1 The length of stay shall be limited to 21 (twenty-one) days per beneficiary per financial year; or

9.3.11.2 Benefits shall be limited to R19 200 per beneficiary per financial year.

9.3.12 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 Scheme tariff or contracted fee.

9.3.13 Confinements

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

9.3.13.1 Medical practitioners – 100% of the Scheme tariff;

9.3.13.2 Nursing home and hospital fees in accordance with the provisions of rule 9.3.9 of Annexure B9 of the registered Rules;

9.3.13.3 Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife – 100% of Scheme tariff. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits; and

9.3.13.4 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.

9.3.14 Surgical dentistry

Any surgical procedure that needs to be performed in a theatre, after Pre-Authorisation by the Scheme – 100% of Scheme tariff. Payment for Maxillofacial and oral surgery is strictly related to the following conditions:

9.3.14.1 Severe trauma (soft tissue injuries, fractures of jaws and facial bones);

9.3.14.2 Cleft lip and palate;

9.3.14.3 Crouson's disease;

9.3.14.4 Malunited craniomaxillary disjunction;

- 9.3.14.5 Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);
- 9.3.14.6 Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);
- 9.3.14.7 Salivary gland surgery (removal of gland or salivary stone);
- 9.3.14.8 Life threatening sepsis (Ludwig's angina); and
- 9.3.14.9 Confirmed oral cancer.

9.3.15 Pathology and standard diagnostic imaging during hospitalisation

Benefits at 100% of Scheme tariff.

9.3.16 Specialised diagnostic imaging during hospitalisation,

MRI scans, CT scans, computer tomographic studies and isotope studies - 100% of Scheme tariff, subject to Pre-Authorisation.

9.3.17 Supplementary benefits during hospitalisation

Supplementary benefits includes services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropract, 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 and is in line with the Scheme funding guidelines and protocols.

9.3.18 Blood transfusions

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

9.3.19 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 Scheme tariff after discount with a

maximum of R76 700 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits will not be pro-rated, further that benefits are subject to the following conditions, maxima and prescribed minimum benefits (PMB's):

- 9.3.19.1** Pre-Authorisation by the Scheme;
- 9.3.19.2** Preferred providers may be appointed by the Scheme;
- 9.3.19.3** Co-payments may apply if preferred providers are not utilised;
- 9.3.19.4** Vascular prosthesis shall be limited to R28 300;
- 9.3.19.5** Pacemaker dual chamber R38 300*;
- 9.3.19.6** Spinal prosthesis shall be limited to R28 300;
- 9.3.19.7** Artificial disk (single level based) shall be limited to R12 400;
- 9.3.19.8** Drug eluting stent shall be limited to R12 400;
- 9.3.19.9** Mesh shall be limited to R12 400;
- 9.3.19.10** Gynaecological/Urological prosthesis shall be limited to R9 200;
- 9.3.19.11** Lens implant shall be limited to R7 900 per lens;
- 9.3.19.12** Knee prosthesis shall be limited to R39 500;
- 9.3.19.13** Hip prosthesis and other major joints shall be limited to R33 800; and
- 9.3.19.14** Other minor joints shall be limited to R14 700.

* Subject to clinical motivation, treatment protocols, DSP and Scheme approval.

9.3.20 External prosthesis after operations

Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons – 100% of Scheme tariff after discount with a maximum of R18 600 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits shall be subject to the following:

- 9.3.20.1** Pre-Authorisation by the Scheme;
- 9.3.20.2** 2 (two) quotations may be required;

9.3.20.3 Preferred providers may be appointed by the Scheme; and

9.3.20.4 Artificial limbs are limited to 1 (one) limb every 60 (sixty) months.

9.3.21 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 Scheme tariff.

9.3.22 Ambulance and emergency evacuation services

Benefits shall be subject to Pre-Authorisation/approval by the Scheme's Preferred Provider for Ambulance services, ER24.

100% of Scheme tariff for ambulance services on condition that the service has previously or, in an emergency, on the 1st (first) working day after evacuation has been approved as clinically necessary by 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.

9.3.23 Oncology

Radiation, chemotherapy, radiation therapy, pathology, radiology and consultations - 100% of the Scheme tariff or negotiated tariffs. Benefits shall be subject to the following:

9.3.23.1 Pre-Authorisation by the Scheme;

9.3.23.2 Preferred providers may be appointed;

9.3.23.3 Scheme protocol shall apply; and

9.3.23.4 Mediscor Reference price (MRP) will be applied to medicine claims where applicable.

9.3.24 Peritoneal dialysis and haemodialysis during hospitalisation

100% of Scheme tariff subject to Pre-Authorisation, application of Scheme protocols and designated service providers (DSPs) appointed by the Scheme to provide diagnosis, treatment and care in respect of the aforesaid medical condition/s.

9.3.25 Organ transplants

Benefits for PMB conditions only. 100% of the Scheme tariff subject to Pre-Authorisation, application of the Scheme protocols and designated service providers (DSPs) appointed by the Scheme to provide diagnosis, treatment and care in respect of the aforesaid medical condition/s.

9.3.26 Take home medicine after discharge from hospital

Medicine prescribed by the treating doctor on discharge from hospital, to take home, will be paid at 100% of Scheme tariff, subject to MRP and a maximum supply of 7 (seven) days.

9.3.27 Biological medicine or other high cost medicine

100% of Scheme tariff with a maximum of R112 800 per beneficiary per financial year for any medicinal product manufactured in or extracted from biological sources, or other high cost speciality medicines, including rational designed medicines. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits shall be subject to the following:

9.3.27.1 Pre-Authorisation with a motivation from the treating medical practitioner;

9.3.27.2 The Scheme treatment protocols;

9.3.27.3 Designated service providers; and

9.3.27.4 Mediscor Reference Price (MRP).

9.3.28 Maternity benefit

- 9.3.28.1 Antenatal consultations – 100% of Scheme tariff with a maximum of up to 12 (twelve) antenatal consultations per beneficiary per financial year; and
- 9.3.28.2 Ultrasound sonar – 100% of Scheme tariff for 2 (two) ultrasound sonar per beneficiary per financial year.

9.4

THE SCHEME DAY-TO-DAY BENEFIT

- 9.4.1 The services set out in this section 9.4 of the Annexure will not be subject to the overall day-to-day benefit and related claims should be submitted to the Scheme for payment.

9.4.2 Specialised diagnostic imaging out of hospital

100% of Scheme tariff, subject to the following conditions:

- 9.4.2.1 MRI and CT scans shall be limited to 3 (three) scans per beneficiary;
- 9.4.2.2 PET scans shall be limited to 1 (one) scan per beneficiary; and
- 9.4.2.3 A Pre-Authorisation for specialised radiology must be obtained.

9.4.3 Orthopaedic and medical appliances out of hospital

- 9.4.3.1 Back, leg, arm and neck supports, crutches, surgical foot wear, elastic stockings, Stoma products, Oxygen and Diabetic supplies for non-PMB conditions - 100% of Scheme tariff after discount with a combined maximum of R7 500 per family per financial year;
- 9.4.3.2 Wheel chairs limited to R9 600 every 48 (forty-eight) months per family; and
- 9.4.3.3 Hearing aids and/or repair limited to R20 800 per beneficiary per 24 (twenty-four) months.

Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

9.4.4 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, limited to R7 200 per family per financial year.

9.4.5 Preventative care

9.4.5.1 Benefits at 100% of Scheme tariff for:

Preventative Care Benefit	Gender and Age Group	Quantity and Frequency	Benefit Criteria
Influenza vaccine	All ages	1 (one) per beneficiary per financial year	Applicable to all active Members and beneficiaries. May be obtained at a selected Preferred Provider or Onecare Contracted General Practitioner.
Pneumonia Programme	Children < 2 (two) years High risk adult group	Once in 60 (sixty) months	<u>Funding for children < 2 (two) years:</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 the product up to the maximum allowed	Limited to R1500 per family per financial year. Includes all the items classified in the category of female contraceptives.

		amount. Mirena device – 1 (one) device in 60 (sixty) months.	
Document Based Care (DBC) Back rehabilitation programme	All ages	Up to 6 (six) 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 (six) weeks.
Biometric screening: - Glucose test (finger prick test) - Cholesterol test (finger prick test) - Blood Pressure - Body Mass Index (BMI)	All beneficiaries 10 (ten) years and older	1 (one) per beneficiary per financial year	A screening benefit package at selected Preferred Providers.

9.4.6 International emergency medical cover

Over and above the provisions for foreign claims, referred to in rule 16.12 of the registered Rules, Members and their Dependant(s) qualify for the following additional benefit:

100% of Scheme tariff for the cost of services for worldwide international emergency medical cover Pre-Authorised/approved by the Scheme's Preferred Provider, ER24.

Benefits are subject to the following:

- 9.4.6.1** The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs;
- 9.4.6.2** Beneficiaries have access to 90 (ninety) days cover per trip;
- 9.4.6.3** A Member has to notify the preferred provider at least 48 (forty-eight) hours in advance when he and or his Dependant(s) are travelling overseas. Failure to notify the preferred provider will result in claims not entertained; and
- 9.4.6.4** General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.

9.4.7 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.

9.5 MAXIMUM BENEFITS

Where the 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 the Member and his Dependant(s) 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 rule 9.1.7 of this Annexure B9 of the registered Rules.