ANGLO MEDICAL SCHEME
MANAGED CARE PLAN
ANNEXURE B2

BENEFITS – Effective 1 January 2020

1 Definitions

The following words or expressions have the following meanings:

1.1 "annual family limit" – the total benefit amount that is available to a member family, in respect of a particular benefit, in any one financial year;

1.2 "beneficiary" – a member, adult dependant or child dependant;

1.3 "chronic condition" – is a medical condition that is either a prescribed minimum benefit (PMB) condition as listed in Annexure A to the regulations, or a non-prescribed benefit (non-PMB) condition recognised by the Board of Trustees from time to time;

1.3.1 a prescribed minimum benefit (PMB) condition contemplated in the diagnosis and treatment pairs (DTPs) listed in Annexure A to the regulations that includes the diagnosis, medical management and medicine to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic condition. This includes the prescribed minimum benefit chronic disease list for the following chronic conditions:
Addison's disease; Asthma; Bipolar Mood Disorder; Bronchiectasis; Cardiac failure; Cardiomyopathy; Chronic renal disease; Chronic obstructive pulmonary disease;

Coronary artery disease; Crohn's disease; Diabetes insipidus; Diabetes mellitus Type 1 and 2; Dysrhythmias; Epilepsy; Glaucoma; Haemophilia; Hyperlipidaemia; Hypertension; Hypothyroidism; Multiple sclerosis; Parkinson's disease; Rheumatoid arthritis; Schizophrenia; Systemic lupus erythematosus; Ulcerative colitis; or

1.3.2 a non-prescribed minimum benefit ("non-PMB") chronic condition recognised by the Board of Trustees, that provides for the payment of chronic medicine according to a Medication Reference Price List (MRPL) for the following conditions:

Acne; Allergy management; Alzheimer's disease; Anaemia (chronic non-PMB); Ankylosing Spondylitis (chronic non-PMB); Anxiety Disorder (chronic); Atopic Dermatitis (Eczema); Attention Deficit Disorder; Auto-immune Disorders (non-PMB); Cystic Fibrosis (non-PMB); Cystitis (chronic); Degeneration of the Macula (chronic non-PMB); Depression (non-PMB); Diverticular Disease of the Intestine (non-PMB); Fibrous Dysplasia; Gastro-oesophagael Reflux Disease; Gout (chronic); Hidradenitis Suppurativa; Huntington's Disease; Liver Disease (chronic non-PMB); Ménière Disease; Migraine; Motor Neurone Disease (chronic non-PMB); Muscular Dystrophy & other Myopathies (non-PMB); Narcolepsy; Obsessive Compulsive Disorder; Osteoarthritis; Osteopaenia; Osteoporosis (non-PMB); Other Venous Embolism and Thrombosis; Paget's Disease; Pancreatic Disease (non-PMB);

Peptic Ulcer (non-PMB); Polymyositis; Polyneuropathy (non-PMB); Psoriasis; Pulmonary Embolism; Pulmonary Interstitial Fibrosis (non-PMB); Restless Leg Syndrome; Sarcoidosis (non-PMB); Systemic Sclerosis; Tourette's Syndrome; Trigeminal Neuralgia; Urinary Calculi (chronic non-PMB); Urinary Incontinence (non-PMB);
Rule 1.3 amended 2015-01-01 and 2020-01-01

1.4 "Medication Reference Price List" (MRPL) – a list of fees/prices in respect of medicine for chronic conditions, determined by the Scheme from time to time;

1.5 "designated service provider" (DSP) – a health care provider contracted by the Scheme as the preferred provider for the diagnosis, treatment and care of one or more PMB conditions;
Rule 1.5 amended 2018-01-01

1.5A "network provider" – a health care provider selected by the Scheme as a preferred provider for the diagnosis, treatment and care of defined PMB and/or non-PMB conditions;
Rule 1.5A inserted 2018-01-01

1.6 "National Health Reference Price List" (NHRPL) – a list of fees in respect of relevant health services, published by the Minister of Health or any other appointee as designated by the Minister from time to time;

1.7 "Scheme Reimbursement Rate" (SRR) – is equivalent to one of the

following:

1.7.1 100% of the reimbursement rate charged in respect of the payment of relevant health services as prescribed in the Discovery Health Guide to Fees; or

1.7.2 100% of the reimbursement rate as determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services; or

1.7.3 the dispensing fee for medicines dispensed as regulated by the Medicines and Related Substances Act, (Act 101 of 1965) or the fee agreed by the Board of Trustees from time to time; or

1.7.4 100% of the National Health Reference Price List for health care services published by the Council for Medical Schemes in 2006, plus an inflationary factor equal to:

2020 = 2006 + 234,4%

Rule 1.7 amended 2017-01-01

1.8 "single exit price" (SEP) – the price of a specific drug as regulated by Act 101 of 1965, as amended, and determined annually by the Department of Health.

1.9 "specialised medicine and technology" (SMT) – medicines and technologies or devices costing in excess of R5 000 per unit or per treatment per beneficiary per month.
Rule 1.9 inserted 2020-01-01

2 Pro-ration of benefits

A member or registered dependant who is admitted to the Scheme during the course of a financial year shall have his/her benefits pro-rated. The benefits to which he/she is entitled will therefore be adjusted in proportion to the period of his/her membership, which will be calculated from the admission date to the end of that financial year.

3 Management Programmes

The following management programmes have been adopted by the Scheme:

3.1 The Chronic Medication Management Programme – a programme which authorises the use of scientifically evidenced, clinically appropriate, cost effective medicine for a chronic condition following the confirmation of the diagnosis and severity of the condition;
Rule 3.1 amended 2015-01-01 and 2018-01-01

3.2 The Hospital Benefit Management Programme – a programme which involves the approval of all hospital events and on-going monitoring, by or on behalf of the Scheme, of the hospital treatment of all medical conditions;
Rule 3.2 amended 2018-01-01

3.3 The Disease/Condition Management Programme – a programme which follows scientifically evidenced clinical protocols and includes the review and monitoring of patients with defined medical conditions to ensure clinically appropriate, cost effective treatment. Where required, benefits may be extended beyond the PMB limitations to achieve the desired clinical outcome.

Rule 3.1 amended 2015-01-01 and 2018-01-01

Specific Disease/Condition Management Programmes include:

3.3.1 The HIV / AIDS Management Programme;

3.3.2 The Renal Disease Management Programme;

3.3.3 The Maternity Management Programme;

3.3.4 The Oncology Management Programme;

3.3.5 The Diabetes Management Programme;

3.3.6 The Alcohol and Drug Dependency Programme;

3.3.7 Oxygen Therapy Management Programme; and
Rule 3.3.7 inserted 2018-01-01

3.3.8 Organ Transplant Management Programme.
Rule 3.3.8 inserted 2018-01-01

3.4 Where the Scheme has adopted a disease management programme for a particular condition, the benefit in respect of such a programme is subject to pre-authorisation.

If the Scheme has contracted a DSP to manage the programme, a beneficiary voluntarily obtaining services from a provider other than a DSP, will be liable to pay any difference between the actual cost incurred and the cost that would have been incurred had the service been obtained from a DSP, unless otherwise specified in the Rule relating to the condition.

Rule 3.4 amended 2015-01-01 and 2018-01-01

4 Pre-authorisation

Pre-authorisation is the procedure a beneficiary needs to follow to obtain prior approval based on clinical criteria to secure access to benefits and to facilitate the correct payment processes. It is not a guarantee of the availability of benefits nor the payment thereof.

Where a benefit is subject to pre-authorisation, a beneficiary shall obtain authorisation 48 hours prior to obtaining the relevant health service to which the benefit relates, unless a medical emergency, in which case authorisation shall be obtained on the next working day. Retrospective authorisations will be considered.

Authorisation of a relevant health service granted by the Scheme is valid for a maximum of 4 months and may not be carried over to the following benefit year.

Rule 4 amended 2018-01-01, 2019-01-01 and 2020-01-01

5 Excess Tariff Cover (Top-Up rate)

Subject to the requirements of the Hospital Benefit Management Programme and the provisions of Annexure C, if a beneficiary is hospitalised or treated in an accredited doctor's facility, all specialist professional services relating to in-hospital benefits (excluding Pathology and Radiology and Allied health services) will not be subject to the normal rate but will be paid up to a maximum of **230%** of the SRR.

Rule 5 amended 2013-01-01 and 2018-01-01

6 Benefits

The benefits to which a member is entitled in respect of himself/herself, and each of his/her registered dependants, are set out below.

Where a benefit is "subject to available savings in the member's Personal Medical Savings Account (PMSA)" the benefit shall be paid at 100% of the SRR, or the actual cost, if lower or paid at the actual amount charged by the provider on written request from the member, and subject to a limit equal to the available savings in that member's PMSA. The benefit shall be paid, firstly, out of any accumulated credit that the member may have and then out of his/her advance savings for that financial year.

Rule 6 amended 2017-01-01

6.1 PRESCRIBED MINIMUM BENEFITS (PMBs)

A beneficiary is entitled to 100% of the cost of the diagnosis, treatment and care of the PMB conditions contemplated by the Act, provided that any services in relation to PMB conditions are obtained from a registered health care provider or public hospital or, where specified, a DSP or a

network provider.

6.1.1A Rule 6.1.1A inserted 2017-01-01 and deleted 2018-01-01

6.1.1 Designated Service Providers (DSPs) have been contracted by the Scheme for the provision of services to beneficiaries relating to the following benefits:

6.1.1.1 Alcohol and Drug Dependency; the DSP is SANCA;

6.1.1.2 Ambulance services; the DSP is Netcare 911;

6.1.1.3 Diabetes Management; the DSP is The Centre for Diabetes and Endocrinology (CDE);
Rule 6.1.1.3 inserted 2013-01-01

6.1.1.4 HIV/AIDS medicine; the DSP is Dis-Chem Direct;
Rule 6.1.1.4 amended 2018-01-01

6.1.1.5 Oxygen therapy, including the cost of hiring of apparatus; the DSP is VitalAire;
Rule 6.1.1.5 amended 2011-06-07

6.1.1.6 Deleted 2018-01-01 and inserted under 1.5A

6.1.1.7 Out of hospital terminal care; the DSP is all providers registered with Hospice Palliative Care Association of South Africa (HPCA); and

6.1.1A re-numbered to 6.1.1.7 2018-01-01

6.1.1.8 Services and medical and surgical appliances supplied by Orthotists and Prosthetists; the DSP is the Discovery Health Network of Orthotists and Prosthetists.
Rule 6.1.1.8 inserted 2018-01-01

A co-payment will be imposed if a beneficiary voluntarily obtains such services from a non-DSP. This co-payment will be the difference between the actual cost incurred and the cost that would have been incurred had the service been obtained from a public hospital or the DSP or is the specified value detailed in the Rule relating to the relevant benefit. No co-payment will be imposed on a member if the service was involuntarily obtained from a non-DSP.
Rule 6.1.1 amended 2018-01-01

A co-payment as contemplated above will be imposed in those instances where a beneficiary voluntarily declines a chronic drug that is specified on the MRPL and chooses to use another drug instead.

In the case of diabetic members not registered with CDE, the co-payment will be 20% of the SRR for services rendered including hospitalisation, or 20% of the MRPL for medicines dispensed.
Rule 6.1 amended 2015-01-01

6.2 ALCOHOL AND DRUG DEPENDENCY

Subject to registration on the Alcohol and Drug Dependency Management Programme, and SANCA, a beneficiary is entitled to the following:

6.2.1 Hospitalisation

A beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for a maximum of twenty-one days of hospitalisation, for alcohol or drug dependency, per annum, subject to PMB regulations.

6.2.2 Professional Services In Hospital

A beneficiary is entitled to 100% of the SRR, or the actual cost if lower, of professional services rendered in hospital in connection with the treatment of alcohol or drug dependency, subject to PMB regulations.

6.2.3 Professional Services Out of Hospital

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the actual amount charged by the provider, for professional services rendered out of hospital in connection with the treatment of alcohol or drug dependency, except in the case of a PMB.

Where a beneficiary elects not to participate in the Alcohol and Drug Dependency Management Programme, the benefit allowed will be subject to Rule 6.1 above.

6.3 **ALTERNATIVE HEALTH CARE PRACTITIONERS**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following:

6.3.1 homeopathic consultations, procedures and medicines, including non-NAPPI coded medicines compounded and dispensed by the practitioner;
Rule 6.3.1 amended 2018-01-01

6.3.2 Rule deleted 2018-01-01

6.3.3 naturopathy services; and

6.3.4 acupuncture.
Rule 6.3.4 inserted 2015-01-01

6.4 **AMBULANCE SERVICES**

Subject to the PMB regulations, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of emergency transport and other ambulance services when obtained from the Scheme's DSP, Netcare 911. Where a beneficiary elects not to use the DSP, the member will be required to pay 20% of the cost of the service.

The use of any ambulance service (whether in respect of a PMB condition or non-PMB condition) is subject to authorisation within 48 hour post receiving the service or admission to a hospital, or on the next working day whichever is the sooner.

A member will be required to pay the full cost of a non-medically justifiable use of an ambulance service.
Rule 6.4 amended 2018-01-01 and 2019

6.5 **ALLIED HEALTH CARE SERVICES**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the actual amount charged by the provider for the following out of hospital allied health care services:

6.5.1 audiology;

6.5.2 physiotherapy;

6.5.3 clinical psychology;

6.5.4 orthoptics;

6.5.5 speech and occupational therapy;

6.5.6 chiropody and podiatry services;

6.5.7 dietician services;

6.5.8 social services;

Rule 6.5.9 deleted 2015-01-01

6.5.10 private nurse consultations and procedures;

Rule 6.5.10 inserted 2018-01-01, and amended 2020-01-01

6.5.11 orthotists and prosthetists; and

Rule 6.5.11 inserted 2018-01-01

6.5.12 chiropractic consultations, including x-rays.

Rule 6.5.12 inserted 2018-01-01
Rule 6.5 amended 2018-01-01

6.6 BLOOD TRANSFUSIONS

A beneficiary is entitled to 100% of the cost of blood transfusions, including the cost of material, blood and blood products, apparatus and operator's fees.

6.7 CONSULTATIONS AND VISITS

6.7.1 Consultations and Visits Out of Hospital

6.7.1.1 General practitioners, nurse practitioners, anaesthetists, radiologists and pathologists

Subject to the exclusions in Annexure C, the PMB regulations and the available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR, or if instructed by the member, 100% of the actual amount charged by the provider for out of hospital consultations, procedures and visits.

Rule 6.7.1 amended 2016-01-01, 2018-01-01 and 2020-01-01

Rule 6.7.1.1.1 deleted 2020-01-01

6.7.1.2 **Medical specialists (excluding radiologists and pathologists)**

Subject to the exclusions in Annexure C, the PMB regulations and the available savings in the member's PMSA, all out of hospital consultations and visits performed by medical specialists, including maxillo-facial surgeons, excluding equipment fees and materials, will be reimbursed up to a maximum of 125**%** of the SRR.

6.7.1.2.1 Procedures performed during consultations and visits contemplated in 6.7.1.2, subject to a defined list, will be paid out of the risk benefit at 125% of the SRR, or actual cost, whichever is the lower.

Rule 6.7.1 and sub-Rules amended and renumbered 2018-01-01

6.7.1B Subject to the exclusions in Annexure C, the PMB regulations and the available savings in the member's PMSA, out of hospital consultations and procedures, as defined in the GP Network Agreement, performed by general medical practitioners who are contracted to the Discovery Health GP Network, will not be subject to the normal SRR, but will be reimbursed at the Discovery Health GP Network Rate, and a beneficiary will not attract an additional out-of-pocket charge in respect of such consultations and procedures.

Rule 6.7.1B insert 2016-01-01

6.7.2 **Consultations in Hospital**

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations, visits and procedures in hospital, by general practitioners, nurse practitioners, radiologists, pathologists and allied healthcare practitioners (excluding, audiologists, orthoptists, chiropodists, podiatrists, and chiropractors).

Rule 6.7.2 amended 2016-01-01 and 2018-01-01

6.7.3 **Consultations for immunisation**

A beneficiary is entitled to 100% of the SRR, the Discovery Health GP Network Rate or the actual cost, if lower, of one consultation per annum by a general practitioner or nurse practitioner to be inoculated against influenza and, according to age, one consultation per lifetime to be inoculated against the pneumococcal virus.

Rule 6.7.3 inserted 2016-01-01

6.8 DENTAL

Dental out of hospital

6.8.1 Subject to Annexure C and the annual family limit for conservative and specialised dentistry, reflected in Table B2.1 below, a beneficiary is entitled to:

Rule 6.8.1 amended 2014-01-01 and 2018-01-01

6.8.1.1 100% of the SRR, or the actual cost, if lower, of conservative dental services out of hospital, such as

consultations, fillings, extractions, x-rays and prophylaxis; and
Rule 6.8.1.1 inserted 2018-01-01

6.8.1.2 125% of the SRR, or the actual cost, if lower, of specialised dental services out of hospital when performed by dental specialists; and
Rule 6.8.1.2 inserted 2018-01-01

6.8.1.3 100% of the SRR of dental models; metal and porcelain inlays and foils; crown and bridgework; dentures; orthodontia; osseo-integrated implants or other similar tooth implants; appliances and prostheses whether obtained in or out of hospital.
Rule 6.8.1.3 inserted 2018-01-01

The annual family limit in respect of conservative and specialised dentistry will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary, reflected in Table B2.1 below. Any one beneficiary may use a portion, or the full amount, of the annual family limit.

TABLE B2.1

CONSERVATIVE AND SPECIALISED DENTISTRY LIMITS

Member/Adult dependant	**R3 845**
Child dependant	**R1 450**

6.8.2 **Further Conservative and Specialised Dentistry in or out of hospital**

Subject to Annexure C and the available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR, or the actual cost if lower, for further conservative dental services and 125% of the SRR, or the actual cost if lower, for further specialised dental services, whether obtained in or out of hospital, including the cost of dental models; metal and porcelain inlays and foils; crown and bridgework; dentures; orthodontia; osseo-integrated implants or other similar tooth implants; appliances and prostheses.

Rule 6.8.2 amended 2014-01-01, 2015-01-01 and 2018-01-01

6.8.3 **Dental services in hospital**

Subject to pre-authorisation, a beneficiary is entitled to 100% of the Scheme Reimbursement Rate (SRR), or the actual cost, if lower, of hospitalisation in the case of trauma, patients under the age of seven years requiring dental treatment under anaesthetic and the removal of impacted third molars, by a dentist or, if provided by maxillo-facial surgeon, a beneficiary is entitled to up to 230% of the SRR.

Rule 6.8.3 renumbered and amended 2018-01-01

Rule 6.8 renumbered 2018-01-01

6.8A ENDOSCOPIC PROCEDURES (gastroscopies, colonoscopies, sigmoidoscopies and proctoscopies)

6.8A.1 A beneficiary is entitled to 100% of the SRR or the actual cost, if lower, of hospitalisation and up to 230% of SRR, or the actual cost, if lower, of specialist services for an endoscopic procedure if performed in an accredited doctor's room, unattached theatre unit or registered day clinic on the Scheme's defined list of network facilities. This Rule will not apply in respect of a medical emergency procedure.

Rule 6.8A.1 amended 2018-01-01

6.8A.2 A beneficiary is entitled to 100% of the SRR of hospitalisation, or the actual cost if lower, and a co-payment of **R3 200** is payable by the member if a beneficiary is admitted to a non-network registered hospital specifically for an endoscopic procedure. No co-payment will be due in respect of a medical emergency procedure.

Rule 6.8 inserted 2017-01-01

6.9 HOSPITALISATION

6.9.1 **General**

A beneficiary is entitled to 100% of the SRR, inclusive of fixed fee procedures, as negotiated between the Scheme and the hospital concerned, for all services received in nursing homes, day clinics, unattached theatre units, private hospitals, and government and provincial hospitals.

6.9.2 **Pre-Authorisation**

Any hospital admission is subject to pre-authorisation 48 hours prior to obtaining the relevant health service, unless a medical emergency, in which case authorisation shall be obtained on the next working day. Retrospective authorisations will be considered.

Rule 6.9.2 amended 2018-01-01 and 2019-01-01

6.9.3 **Co-payments**

A co-payment of a minimum of **R410** per day and a maximum of **R1 230** per hospital stay, is payable by members in respect of all hospital admissions including day cases, except where otherwise specified, in which case this co-payment will be waived. No co-payment will be due in respect of a PMB condition.

Rule 6.9.3 amended 2017-01-01 and 2018-01-01

6.9.4 **Ward Fees**

A beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for:

6.9.4.1 general ward fees; and

6.9.4.2 high care and intensive care unit fees, where occupation of such unit is certified by a medical practitioner as being clinically appropriate and necessary for the recovery of the patient.

6.9.5 **Ward and Theatre Drugs, Appliances and Surgical Prostheses**

A beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for ward and theatre drugs, surgicals and appliances that are prescribed and used while the beneficiary is resident in any nursing home, hospital or sanatorium, subject to:

6.9.5.1 in the case of prescribed drugs, the SEP for such drugs;

6.9.5.2 in the case of 'To Take Out' drugs (TTOs), a limit of seven day's supply on discharge;

6.9.5.3 in the case of appliances, subject to Rule 6.14; and

6.9.5.4 in the case of internal surgical prostheses, subject to Rule 6.20

Rule 6.9.5.4 inserted 2018-01-01

6.9.6 **Theatre Fees and Materials**

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for theatre fees, labour ward charges and dressings and materials used in theatre.

Rule 6.9.6 amended 2018-01-01

6.9.7 Rule 6.9.7 deleted 2018-01-01

6.9.8 **Private Nursing**

A beneficiary is entitled to 100% of the SRR**,** or the actual cost, if lower, of private nursing in lieu of hospitalisation, provided that such services are pre-authorised by the Scheme.

6.9.9 **Frail Care**

A beneficiary is entitled to 100% of the SRR of medically related frail care services according to Scheme protocol obtained at a registered frail care centre, subject to pre-authorisation by the Scheme and a limit of **R70 710** per beneficiary per annum.

6.9.10 **Step Down Nursing Facilities**

Subject to pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of services in a step down nursing facility according to Scheme protocols.

Rule 6.9.10 amended 2016-01-01 and 2018-01-01

Rule 6.9.10.1 deleted 2018-01-01

Rule 6.9.10.2 deleted 2016-01-01

6.9.10 **Hospice Facilities**

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Subject to pre-authorisation by the Scheme, a beneficiary is

entitled to 100% of the cost of palliative treatment and terminal care in the case of imminent death, as negotiated with the Hospice Palliative Care Association of South Africa (HPCA), in an HPCA facility or the care provided in a home setting as an out-patient.

Rule 6.9.10A inserted 2016-01-01and amended 2017-01-01

6.10 **HIV / AIDS**

Subject to PMB limitations, a beneficiary is entitled to 100% of the cost of the diagnosis, treatment and care of HIV/AIDS.

6.10.1 Subject to registration on the HIV Management Programme, a beneficiary is entitled to 100% of the cost of services relating to the treatment or management of HIV/AIDS and, where required to achieve the desired clinical outcome, to benefits extended beyond the PMB limitations; and

6.10.2 the SEP and the dispensing fee for medicine for the treatment of HIV/AIDS, provided that the medicine is obtained directly from the DSP, Dis-Chem Direct.

Where a beneficiary elects not to use the DSP, the benefit allowed will be subject to Rule 6.1 above.

Rule 6.10 amended 2015-01-01 and 2018-01-01

6.11 **INFERTILITY**

Subject to PMB regulations and the exclusions as reflected in Annexure

C, a beneficiary is entitled to:
Rule 6.11 amended 2018-01-01

6.11.1 125% of the SRR, or the actual cost, if lower, of the investigation if performed by a medical specialist or 100% of the SRR if performed by a general practitioner; and
Rule 6.11.1 amended 2018-01-01

6.11.2 subject to available savings in the member's PMSA, non-PMB prescribed medicines for the treatment of infertility.
Rule 6.11.2 amended 2018-01-01

6.12 **MATERNITY**

Subject to PMB limitations, a beneficiary is entitled to 100% of the cost of maternity benefits.

Subject to registration on the Maternity Management Programme, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following additional benefits:
Rule 6.12 amended 2018-01-01

6.12.1 **Ante-natal Consultations and Post-natal Care**

A beneficiary is entitled to 100% of the SRR, or the actual cost if lower, of 12 ante- or post-natal consultations and visits with general practitioners and nurse practitioners, or up to 125% of the SRR if consulting an obstetrician, in or out of hospital inclusive of 2, two dimensional ultra sound pregnancy scans

per pregnancy and, if required, the cost of additional scans authorised in terms of the Maternity Management Programme.

Should a beneficiary not register on the Maternity Management Programme the cost of all non-PMB out of hospital ante-natal and post-natal care, including all ultrasound scans, shall be reimbursed according to Rule 6.7, Consultations and Visits.
Rule 6.12.1 amended 2013-01-01, 2015-01-01, 2018-01-01 and 2019-04-01
Rule 6.12.2 deleted 2015-01-01

6.12.3 **Confinement in a Hospital (subject to Rule 6.1)**

A beneficiary is entitled to 100% of the cost for services provided for normal delivery at a hospital, private nursing home or a low-risk Obstetric Unit, or for a Caesarean section if medically appropriate.
Rule 6.12.3 amended 2017-01-01 and 2018-01-01

Rule 6.12.4 deleted 2017-01-01
Rule 6.12.5 deleted 2013-01-01

6.13 MAXILLO-FACIAL AND ORAL SURGERY

6.13.1 Subject to PMB regulation and pre-authorisation, a beneficiary is entitled to maxillo-facial and oral surgery limited to the diagnosis, treatment and care of PMB conditions in hospital.
Rule 6.13.1 amended 2018-01-01
Rule 6.13.2 deleted 2018-01-01

6.13.3 Non-PMB conditions in respect of maxillo-facial or oral surgery will be subject to the annual family limit for conservative and specialised dentistry, thereafter, subject to the available savings in the member's PMSA and shall be paid up to 125% of the SRR for dental specialist services.
Rule 6.13.3 amended 2018-01-01

Rule 6.13 amended 2014-01-01

6.14 **MEDICAL AND SURGICAL APPLIANCES**

6.14.1 Excluding the appliances referred to in paragraphs 6.14.2 and 6.14.3, a beneficiary is entitled to 100% of the SRR of medical and surgical appliances, subject to pre-authorisation for any appliances in excess of **R1 000** per appliance and an annual family limit of **R16 080.**

Medical and surgical appliances obtained from Orthotists and Prosthetists are subject to the Scheme's DSP and the Discovery Health Network rate.
Rule 6.14.1 amended 2013-01-01 and 2018-01-01

6.14.2 Subject to pre-authorisation, a beneficiary is entitled to 100% of the cost of one wheelchair per beneficiary every two years to a limit of **R25 305** per beneficiary.
Rule 6.14.2 amended 2013-01-01 and 2018-01-01

6.14.3 A beneficiary is entitled to 100% of the cost of hearing aids,

subject to a prescription from an Ear, Nose and Throat specialist for beneficiaries younger than 60 years, as well as pre-authorisation by the Scheme and a limit of **R20 240** per hearing aid per beneficiary every two years.

6.14.4 Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% for the SRR of oxygen therapy to save or maintain life, including the cost of hiring of the apparatus for administration, when obtained from the Scheme's DSP, VitalAire. This benefit is not subject to the annual family limit for medical and surgical appliances.
Rule 6.14.4 amended 2011-06-07 and 2018-06-07

A beneficiary who voluntarily obtains services from a non-DSP will be subject Rule 6.1.
Rule 6.14 amended 2018-01-01

6.15 **MEDICINES**

A beneficiary is entitled to one month's supply in respect of medicines obtained on a prescription or repeat thereof.

6.15.1 **Acute Medicine**

Subject to exclusions in Annexure C, available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR or actual amount charged for:

6.15.1.1 prescribed acute medicine obtained from a

pharmacy or registered dispensing practitioner, which is not approved as medicine in respect of a chronic condition; and

6.15.1.2 100% of the SRR for materials required for injections.

Rule 6.15.2. amended 2018-01-01

6.15.2 **Homeopathic Medicines**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR of homeopathic medicines.

6.15.3 **Pharmacist Advised Therapy (PAT)**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the cost of certain medicines on the advice of a pharmacist.

Rule 6.15.3 amended 2018-01-01

6.15.4 **Chronic Medicine**

6.15.4.1 **PMB Conditions**

Subject to registration on the Chronic Medicine Management Programme and PMB regulations, a beneficiary is entitled to prescribed chronic medicine for a PMB condition at 100% of the price specified on the MRPL, and the dispensing fee at

the SRR.

6.15.4.1.1 Deleted.

6.15.4.2 **Non-PMB Conditions**

Subject to registration of the non-PMB chronic condition, a beneficiary is entitled to 100% of the price specified on the MRPL and the dispensing fee at the SRR for non-PMB chronic conditions as listed in Rule 1.3.2 above, subject to an annual limit of **R17 720** per beneficiary and provided that;

6.15.4.2.1 the medicine has been approved on the Chronic Medicine Management Programme; and

6.15.4.2.2 the medicine is included on the MRPL.

Rule 6.15.4. amended 2015-01-01 and 2018-01-01

6.15.4.3 **Vaccines**

A beneficiary is entitled to 100% of the SEP and the dispensing fee of:

6.15.4.3.1 one influenza vaccine per annum and one pneumococcal virus vaccine per lifetime according to age; and

6.15.4.3.2 a beneficiary, according to age, is entitled to one human papilloma virus

vaccine per lifetime.

Rule 6.15.4.2 inserted 2016-01-01, and amended 2020-01-01

6.16 **ONCOLOGY (Subject to PMB regulations)**

Subject to the PMB regulations and registration on the Oncology Management Programme, a beneficiary is entitled to:

6.16.1 125% of the SRR, or the actual cost, if lower, of consultations, visits and procedures by medical specialists and 100% of the SRR, or actual cost, if lower, of consultations, visits and procedures by general practitioners;

Rule 6.16.1 amended 2018-01-01

6.16.2 100% of the SRR, or the actual cost, if lower, of radiotherapy and chemotherapy treatment; and

6.16.3 the SEP of cytostatics used in chemotherapy treatment subject to the MRPL.

6.16 A **OPHTHALMOLOGY (cataract surgery with intraocular lens replacement)**

6.16A.1 Subject to the PMB regulations and pre-authorisation, a beneficiary is entitled to 230% of the SRR, or the actual cost, if lower, of cataract surgery and 100% of the SRR, or the actual cost, if lower of an intraocular lens replacement and the hospitalisation, if performed in an accredited ophthalmologist's

room or registered day clinic on the Scheme's defined list of network facilities; and

Rule 6.16A1 amended 2018-01-01

6.16A2 if a beneficiary voluntarily uses a non-network facility, a co-payment of **R1 000** is payable by the member.

Rule 6.16A inserted 2017-01-01

6.17 **OPTICAL SERVICES**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the actual amount charged by the provider, for optical services supplied by a registered optometrist, opthalmologist or supplementary optical practitioner for optic examinations or tests, frames, lenses (including contact lenses) and non-PMB intraocular lenses.

Rule 6.17 amended 2018-01-01

6.18 **PATHOLOGY**

6.18.1 **Pathology Services Out of Hospital**

A beneficiary is entitled to 100% of the SRR, or actual cost, if lower, of pathology services rendered by a registered pathologist or medical technologist, out of hospital.

6.18.2 **Pathology Services In Hospital**

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of pathology services rendered by a registered pathologist or medical technologist, in hospital.

6.18.3 **Cancer Screening Tests**

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of one PAP smear or Prostate Specific Antigen (PSA) screening test, per annum, if rendered by a registered pathologist and medical technologist, in or out of hospital.

Rule 6.18.3 amended 2018-01-01

6.19 **RADIOLOGY**

6.19.1 **Radiological Services Out of Hospital**

A beneficiary is entitled to 100% of the SRR, or actual cost, if lower, of radiological services and costs of materials out of hospital.

6.19.2 **Radiological Services In Hospital**

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of radiological services and costs of materials, in hospital.

6.19.3 **MRIs, CT Scans and Isotope Therapy**

Subject to pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of Magnetic Resonance Imaging Scans (MRI Scans), Computerised Axial Tomography Scans (CT Scans) and isotope therapy, both in and out of hospital.

6.19.4 **Densitometry**

Subject to pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of densitometry limited to one scan per annum.

6.19.5 **Mammograms**

Subject to pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of mammograms.

6.20 **RENAL DIALYSIS (subject to PMB regulations)**

Subject to PMB regulations, pre-authorisation and registration on the Renal Disease Management Programme, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of renal dialysis.

6.20 A **SPECIALISED MEDICINE AND TECHNOLOGY (SMT) OUT OF HOSPITAL BENEFIT**

Subject to PMB regulations, Scheme protocols and pre-authorisation a beneficiary is entitled to 100% of the SRR of certain specified specialised medicines and technology or devices costing in excess of R5 000 per unit or per treatment per beneficiary per month that are not covered by other Scheme benefits.

Rule 5.19A inserted 2020-01-01

6.21 **INTERNAL SURGICAL PROSTHESES**

Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR, for internal prostheses, with a limit of **R140 595** per beneficiary per annum.

6.21 THIRD PARTY LIABILITY

A Rule 5.20A inserted 2018-01-01

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of relevant health care services obtained by a member when involved in an incident which is covered by any statutory compensation provision or, in respect of which, the member has a civil claim against a third party, subject to:

6.21A.2 the member agreeing, by way of a signed undertaking, to reimburse the Scheme the amount of such benefits paid by the Scheme from any payment received in respect of medical treatment costs made by the statutory body or third party.

6.22 TRANSPLANTS

Subject to PMB regulations, pre-authorisation and registration on the Organ Transplant Management Programme, a beneficiary is entitled to 100% of the cost, of services relating to organ transplants.

Hospitalisation includes harvesting of the organ, post-operative care of member and donor, anti-rejection medicines, professional services in hospital and payment of any other costs relating to the donor, if authorised in accordance with the Organ Transplant Management Programme.

Rule 6.22 amended 2017-01-01 and 2018-01-01

6.23 **WELLNESS**

A beneficiary is entitled to 100% of the SRR, of one screening benefit group of tests consisting of a blood glucose test, a blood pressure test, a cholesterol test and a Body Mass Index (BMI) if performed at a Discovery Network Partner as detailed on the Discovery website.

Rule 6.23 amended 2018-01-01 and 2019

7 INTERNATIONAL CLAIMS - TRAVEL OR RESIDENCE OUTSIDE THE BORDERS OF SOUTH AFRICA

7.1 A member who incurs a cost of a relevant health service outside the borders of South Africa shall:

7.1.1 be liable for the payment for such service, in full, in the country where the service was provided; and

7.1.2 claim the cost of the service from any existing third party health insurance or travel insurance to which the member may be entitled, other than the Scheme.

7.2 A Member with no, or insufficient third party health insurance or travel insurance, may submit a claim to the Scheme for the cost of the service or any un-covered portion, as the case may be, in accordance with the Scheme Rules, including having obtained authorisation for the service rendered where required, within four months from the date of service, on completion of the International Claim form, which shall be submitted to the Scheme together with:

7.2.1 a detailed account or statement for the full service;

7.2.2 a detailed account or statement for the shortfall or uncovered

service; and

7.2.3 proof of payment of the service,

to be submitted in English or accompanied by a sworn English translation.

7.3 Any payment towards the cost of a claim submitted in accordance with the Rule 6.2, shall be made in a Rand amount into a South African bank account held in the member's name, determined by the Scheme in its absolute discretion, in accordance with the benefit entitlement of the member in terms of the Rules and based on the average SRR for the same or similar service in South Africa.

7.4 Where detail of the service is not provided, the Scheme cannot process the claim and no payment shall be considered.

Rule 7 inserted 2018-01-01.

Rule 7.2 amended 2020-01-01