# RESOLUTION OF THE BOARD OF TRUSTEES

**THE BOARD OF TRUSTEES RESOLVED TO INCREASE THE SCHEME CONTRIBUTIONS AND BENEFIT LIMITS FOR 2022 AT THE MEETING OF 22 SEPTEMBER 2021 AS FOLLOWS:**

REGISTERED BY ME ON
Mashilo Leboho
2021/11/08
Mashilo Leboho
24/12/2021 11:12:22(UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES
SIGNIFLOW.COM

## 2022 CONTRIBUTION INCREASES

**MANAGED CARE PLAN: approved contribution increase 6%**

**STANDARD CARE PLAN: approved contribution increase 6%**

**VALUE CARE PLAN: approved contribution increase 6%**

## 2022 BENEFIT LIMIT INCREASES

**MANAGED CARE PLAN: approved benefit increase 0%**

**STANDARD CARE PLAN: approved benefit increase 0%**

**VALUE CARE PLAN: approved benefit increase 0%**

## 2022 SCHEME REIMBURSEMENT RATE

**MANAGED CARE PLAN AND STANDARD CARE PLAN: approved SRR increase of 4,5%**

## 2022 RULE AMENDMENTS

**THE TRUSTEES RESOLVED TO AMEND THE RULES ACCORDING TO THE ATTACHED SUMMARY SCHEDULE.**

## 2022 PRICING REPORT

**THE TRUSTEES ACCEPTED AND APPROVED THE 2022 PRICING REPORT AS PRESENTED IN THE MEETING.**

Colleen Catherine Elliott
Colleen Catherine Elliott
30/09/202119:46:19(UTC+02:00)
Signed by Colleen Catherine Elliott,
colleen.elliott9@icloud.com
SIGNIFLOW.COM

**CC ELLIOTT**
**CHAIRMAN**

**DATE**

Duncan MacCallum
30/09/202118:21:38(UTC+02:00)
Signed by Duncan MacCallum,
duncan@drmconsulting.co.za
SIGNIFLOW.COM

**DR MCCALLUM**
**VICE CHAIRMAN**

**DATE**

Fiona Robertson
30/09/202112:19:42(UTC+02:00)
Signed by Fiona Robertson,
Fiona.Robertson@angloamerican.com
SIGNIFLOW.COM

**FK ROBERTSON**
**PRINCIPAL OFFICER**

**DATE**

**Certified as having been adopted in terms of the Scheme Rules.**

REGISTERED BY ME ON
Mashilo Leboho
24/12/2021 14:12:30(UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
SIGNIFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

**ANGLO MEDICAL SCHEME**
**STANDARD CARE PLAN**
**ANNEXURE A1**

## CONTRIBUTIONS - Effective 1 January 2022

### 1 Basis of contributions payable

1.1 The monthly contributions payable by a member in respect of himself and each of his registered dependants, if any, is set out in Table A1.1 below.

**TABLE A1.1**

| Member | Adult Dependant | Child Dependant (see 1.3) |
|---|---|---|
| R2 980 | R2 980 | R895 |

1.2 The total monthly contribution due by a member will be the sum of the contributions payable in respect of himself and each of his/her registered dependants, if any.

1.3 As stated in the Rules of the Scheme, a member's child dependant is –

1.3.1 a dependant who is 23 (twenty-three) years of age, or younger, on 1 January of the financial year for which contributions are raised;

1.3.2 a mentally and/or physically disabled dependant who is above 23 (twenty-three) years of age but whom the Board has permitted to be a "child dependant"; or

1.3.3 a younger sibling of an orphaned child dependant who has been deemed to be a member in terms of Rule 6.3.4.2, provided that such younger sibling is 23 (twenty-three) years of age, or younger.

**2 Contribution penalties for persons joining late in life (with effect from 1 April 2001)**

2.1 Contribution penalties may be applied to a late joiner who, at the date of application for membership or admission as a registered adult dependant, is 35 (thirty five) years of age or older.

2.2 Contribution penalties will not be applied to a late joiner who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001 and who has not had a break in coverage exceeding 3 (three) consecutive months since 1 April 2001.

2.3 Contribution penalties shall only be applied to that portion of the contribution related to the member and/or any adult dependant who qualifies for late joiner penalties.

2.4 Contribution penalties will be reduced if a late joiner can demonstrate a period of creditable coverage, that is, any period during which he was –

2.4.1 a member or a dependant of a medical scheme;

2.4.2 a member or a dependant of an entity doing the business of a medical scheme which, at the time of his membership of such entity, was exempt from the provisions of the Act;

2.4.3 a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received medical benefits from the South African National Defence Force; or

2.4.4 a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 (twenty one) years.

2.5 The Contribution penalty to be applied to a late joiner shall be calculated by determining a specific penalty band applicable to him/her. A late joiner's penalty band is indicated by a specific number of years, calculated according to the following formula –

$$A = B - [35 + C]$$

Where –

*A* = the number of years (which will be used to determine the applicable penalty band)

*B* = the age of the late joiner at the time of his application for membership or admission as a registered adult dependant

*C* = the number of years of creditable coverage which can be demonstrated by the late joiner

2.6 The different penalty bands, as well as the corresponding formulae for determining the Contribution penalty to be applied to a late joiner, are set out in Table A1.2 below.

**TABLE A1.2**

| **PENALTY BAND** | **CONTRIBUTION PENALTY TO BE APPLIED** |
|---|---|
| 1 to 4 years | 0.05 multiplied by the relevant contribution in Table A1.1 |
| 5 to 14 years | 0.25 multiplied by the relevant contribution in Table A1.1 |
| 15 to 24 years | 0.50 multiplied by the relevant contribution in Table A1.1 |
| 25+ years | 0.75 multiplied by the relevant contribution in Table A1.1 |

2.7 Should a late joiner penalty already have been imposed, and evidence of creditable coverage is produced thereafter, the penalty shall be recalculated and the revised penalty shall be applied from that time onwards.

2.8 If, after reasonable effort, a late joiner is unable to obtain documentary proof of periods of creditable coverage, he may produce a sworn affidavit detailing any periods of creditable coverage.

**ANGLO MEDICAL SCHEME**
**MANAGED CARE PLAN**
**ANNEXURE A2**

## CONTRIBUTIONS - Effective 1 January 2022

### 1 Basis of contributions payable

1.1 The monthly contributions payable by a member in respect of himself and each of his registered dependants, if any, is set out in Table A2.1 below.

**TABLE A2.1**

| Member | Adult Dependant | Child Dependant (see 1.3) |
|---|---|---|
| R5 450 | R5 450 | R1 260 |

1.2 The total monthly contribution due by a member will be the sum of the contributions payable in respect of himself and each of his registered dependants, if any.

1.3 As stated in the Rules of the Scheme, a member's child dependant is –

1.3.1 a dependant who is 23 (twenty-three) years of age, or younger, on 1 January of the financial year for which contributions are raised;

1.3.2 a mentally and/or physically disabled dependant who is above 23 (twenty-three) years of age but whom the Board has permitted to be a "child dependant"; or

1.3.3 a younger sibling of an orphaned child dependant who has been deemed to be a member in terms of Rule 6.3.4.2,

provided that such younger sibling is 23 (twenty-three) years of age, or younger.

**2 Contribution penalties for persons joining late in life (with effect from 1 April 2001)**

2.1 Contribution penalties may be applied to a late joiner who, at the date of application for membership or admission as a registered adult dependant, is 35 (thirty five) years of age or older.

2.2 Contribution penalties will not be applied to a late joiner who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001 and who has not had a break in coverage exceeding 3 (three) consecutive months since 1 April 2001.

2.3 Contribution penalties shall only be applied to that portion of the contribution related to the member and/or any adult dependant who qualifies for late joiner penalties.

2.4 Contribution penalties will be reduced if a late joiner can demonstrate a period of creditable coverage, that is, any period during which he was –

2.4.1 a member or a dependant of a medical scheme;

2.4.2 a member or a dependant of an entity doing the business of a medical scheme which, at the time of his/her membership of such entity, was exempt from the provisions of the Act;

2.4.3 a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received medical benefits from the South African National Defence Force; or

2.4.4 a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 (twenty one) years.

2.5 The contribution penalty to be applied to a late joiner shall be calculated by determining a specific penalty band applicable to him. A late joiner's penalty band is indicated by a specific number of years, calculated according to the following formula –

$$A = B - [35 + C]$$

Where –

*A* = the number of years (which will be used to determine the applicable penalty band)

*B* = the age of the late joiner at the time of his or her application for membership or admission as a registered adult dependant

*C* = the number of years of creditable coverage which can be demonstrated by the late joiner

2.6 The different penalty bands, as well as the corresponding formulae for determining the contribution penalty to be applied to a late joiner, are set out in Table A2.2 below.

**TABLE A2.2**

| **PENALTY BAND** | **CONTRIBUTION PENALTY TO BE APPLIED** |
|---|---|
| 1 to 4 years | 0.05 multiplied by the relevant contribution in Table A2.1 |
| 5 to 14 years | 0.25 multiplied by the relevant contribution in Table A2.1 |
| 15 to 24 years | 0.50 multiplied by the relevant contribution in Table A2.1 |
| 25+ years | 0.75 multiplied by the relevant contribution in Table A2.1 |

2.7 Should a late joiner penalty already have been imposed, and evidence of creditable coverage is produced thereafter, the penalty shall be recalculated and the revised penalty shall be applied from that time onwards.

2.8 If, after reasonable effort, a late joiner is unable to obtain documentary proof of periods of creditable coverage, he may produce a sworn affidavit detailing any periods of creditable coverage.

## 3 Personal medical savings account (PMSA)

3.1 21 (Twenty-one) percent of the member's monthly contribution shall be allocated to that member's savings in his personal medical savings account ("PMSA"). The amount to be allocated in respect of the member and each of his registered dependants, if any, is set out in Table A2.3 below.

**TABLE A2.3**

| **Member** | **Adult Dependant** | **Child Dependant (see 1.3)** |
|---|---|---|
| **R1 145** | **R1 145** | **R265** |

3.2 The total monthly amount to be allocated to the PMSA will be the sum of the member's portion and the portions of each of his registered dependants, if any.

3.3 At the beginning of each financial year, the Scheme shall provide the member with an advance on his total savings for the year ("advance savings"). The member will have available for his use, an amount equal to the total savings that will have been allocated to his PMSA by the end of the financial year. The advance savings shall be available for the member's utilisation in respect of himself and each of his registered dependants, if any, in accordance with paragraph 3.4.

3.4 A member's savings in his PMSA may be utilised for the following specified costs–

3.4.1 the costs which are stipulated as being subject to "available savings in the member's PMSA" in paragraph 6 of Annexure B2;

3.4.2 the costs of a relevant health service for which the Scheme is not liable in terms of paragraph 6 of Annexure B2 (including that portion of any cost which exceeds any limit specified in Annexure B2) provided that such service has been rendered by a supplier in terms of any law, as contemplated in the Act.

3.5 A member's savings in his PMSA may not be utilised in respect of any of the co-payments for prescribed minimum benefits referred to in paragraph 6.1 of Annexure B2.

3.6 The advance savings shall be reduced to the extent that they are utilised in accordance with the provisions of paragraph 3.4. For the purposes of this Annexure A2 and paragraph 6 of Annexure B2, references to "available savings" in a member's PMSA shall, subject to 3.8 below, mean the balance of the member's advance savings, after they have been utilised for the specified costs referred to in 3.4.

3.7 The amount of the member's advance savings that is utilised in accordance with paragraph 3.4 shall be regarded as a debt owed by the

member to the Scheme. The member's monthly portion that is allocated to his PMSA shall therefore be applied by the Scheme to offset any amount of advance savings that the member has utilised.

3.8 If, at the end of a calendar month, the member still has accumulated credit, after his debt has been satisfied in terms of paragraph 3.7, the accumulated credit shall earn interest, which shall be allocated to each member having an accumulated credit on a pro rata basis determined by the month end balances. Bank charges and investment management fees shall be offset against the interest earned prior to the pro rata allocation of interest. For investment purposes, the accumulated credit shall be treated as cash and shall attract a minimum rate of interest equal to the prevailing South African Reserve Bank repurchase rate (REPO rate) as published from time to time. For the purposes of paragraph 6 of Annexure B2, the available savings in that member's PMSA –

3.8.1 shall be calculated, at the commencement of the next financial year, by adding the accumulated credit to the advance savings for that member for the next financial year;

3.8.2 shall be increased monthly by the amount of any interest that has accrued on accumulated credit.

Any of the member's specified costs as contemplated in paragraph 3.4 in the next financial year shall be paid firstly out of his/her accumulated credit and, once such accumulated credit has been exhausted, out of his advance savings for that year.

3.9 If a member elects to transfer to another of the Scheme's benefit options, in accordance with Rule 16.2, which does not provide for a PMSA -

3.9.1 if the member has remaining savings in his/her PMSA after they have been used to settle any debt owed to the Scheme, such savings shall be paid to the member by the Scheme within 4 (four months) after the date of transfer to another benefit option (this payment will be subject to any tax directive issued by any tax authority in relation to the remaining savings); or

3.9.2 if the member's debt exceeds the member's savings at the date of transfer to another benefit option, the member shall pay the amount of such excess to the Scheme within 30 (thirty days) of transfer to another benefit option.

3.10 The following shall apply on termination of membership –

3.10.1 if membership terminates for any reason other than death and the member provides written confirmation that he has not been admitted to another medical scheme, or has been

admitted to another medical scheme but has chosen an option that does not provide for a PMSA –

3.10.1.1 if the member has remaining savings in his PMSA after they have been used to settle any debt (including contributions) owed to the Scheme, such savings shall be paid to the member by the Scheme within 4 (four months) after the date of termination of membership (this payment will be subject to any tax directive issued by any tax authority in relation to the remaining savings); or

3.10.1.2 if the member's debt exceeds the member's savings at the date of termination of membership, the member shall pay the amount of such excess to the Scheme within 30(thirty days) of the termination of membership; or

3.10.2 if membership terminates for any reason other than death and the member is admitted to another medical scheme that provides for a PMSA –

3.10.2.1 any of the member's remaining savings, after they have been used to settle any debt (including contributions) owed to the Scheme, will be transferred to the member's new medical scheme; or

3.10.2.2 if the member's debt exceeds the member's savings at the date of termination of membership, the member shall pay the amount of such excess to the Scheme within 30 (thirty days) of the termination of membership; or

3.10.3 if membership terminates as a result of a member's death –

3.10.3.1 and if the deceased member has a registered dependant who becomes a continuation member in terms of Rule 6.3 –

3.10.3.1.1 a PMSA shall be deemed to have been established in respect of the continuation member and the remaining savings of the deceased member, after satisfaction of his debt (including contributions) at the date of death, shall be allocated to the PMSA;

3.10.3.1.2 the available savings in the deceased member's PMSA at the date of such member's death shall be deemed to be the available savings of the continuation member's PMSA; or

3.10.3.2 if the deceased member does not have a registered dependant who becomes a continuation member in terms of Rule 6.3, the provisions of paragraph 3.10.1.1 and 3.10.1.2 shall apply to the member's deceased estate.

**ANGLO MEDICAL SCHEME**
**VALUE CARE PLAN**
**ANNEXURE A3**

**CONTRIBUTIONS - Effective 1 January 2022**

## 1 Basis of contributions payable

1.1 "The total monthly contributions payable by a member in respect of himself and each of his registered dependants, if any, are set out in Table A3.1 below.

**TABLE A3.1**

| Member | Adult Dependant | Child Dependant (see 1.3) |
|---|---|---|
| **R1 075** | **R1 075** | **R265** |

1.2 The total monthly contribution due by a member will be the sum of the contributions payable in respect of himself and each of his registered dependants, if any.

1.3 As stated in the Rules of the Scheme, a member's child dependant is –

1.3.1 a dependant who is 23 (twenty-three) years of age, or younger, on 1 January of the financial year for which contributions are raised;

1.3.2 a mentally and/or physically disabled dependant who is above 23 (twenty-three) years of age but whom the Board has permitted to be a "child dependant"; or

1.3.3 a younger sibling of an orphaned child dependant who has been deemed to be a member in terms of Rule 6.3.4.2,

provided that such younger sibling is 23 (twenty-three) years of age, or younger.

**2 Contribution penalties for persons joining late in life (with effect from 1 April 2001)**

2.1 Contribution penalties may be applied to a late joiner who, at the date of application for membership or admission as a registered adult dependant, is 35 (thirty five) years of age or older.

2.2 Contribution penalties will not be applied to a late joiner who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001 and who has not had a break in coverage exceeding 3 (three) consecutive months since 1 April 2001.

2.3 Contribution penalties shall only be applied to that portion of the contribution related to the member and/or any adult dependant who qualifies for late joiner penalties.

2.4 Contribution penalties will be reduced if a late joiner can demonstrate a period of creditable coverage, that is, any period during which he was –

2.4.1 a member or a dependant of a medical scheme;

2.4.2 a member or a dependant of an entity doing the business of a medical scheme which, at the time of his membership of such entity, was exempt from the provisions of the Act;

2.4.3 a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received

medical benefits from the South African National Defence Force; or

2.4.4 member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years.

2.5 The contribution penalty to be applied to a late joiner shall be calculated by determining a specific penalty band applicable to him. A late joiner's penalty band is indicated by a specific number of years, calculated according to the following formula –

$$A = B - [35 + C]$$

Where –

$A$ = the number of years (which will be used to determine the applicable penalty band)

$B$ = the age of the late joiner at the time of his or her application for membership or admission as a registered adult dependant

$C$ = the number of years of creditable coverage which can be demonstrated by the late joiner

2.6 The different penalty bands, as well as the corresponding formulae for determining the contribution penalty to be applied to a late joiner, are set out in Table A3.2 below.

**TABLE A3.2**

| PENALTY BAND | CONTRIBUTION PENALTY TO BE APPLIED |
|---|---|
| 1 to 4 years | 0.05 multiplied by the relevant contribution in Table A3.1 |
| 5 to 14 years | 0.25 multiplied by the relevant contribution in Table A3.1 |
| 15 to 24 years | 0.50 multiplied by the relevant contribution in Table A3.1 |
| 25+ years | 0.75 multiplied by the relevant contribution in Table A3.1 |

2.7 Should a late joiner penalty already have been imposed, and evidence of creditable coverage is produced thereafter, the penalty shall be recalculated and the revised penalty shall be applied from that time onwards.

2.8 If, after reasonable effort, a late joiner is unable to obtain documentary proof of periods of creditable coverage, he/she may produce a sworn affidavit detailing any periods of creditable coverage.

**ANGLO MEDICAL SCHEME**
**STANDARD CARE PLAN**
**ANNEXURE B1**

## BENEFITS – Effective 1 January 2022

### 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 an additional non-prescribed minimum 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 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 PMB 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-PMB chronic condition recognised by the Board of Trustees, that provides for the payment of chronic medicine according to a Medicine Reference Price List (MRPL) for the following conditions:

Acne; Allergy management; Alzheimer's Disease; Anaemia (chronic non-PMB); Ankylosing Spondylitis (non-PMB); Atopic Dermatitis (Eczema); Attention Deficit Disorder; Benign Prostatic Hyperplasia; Degeneration of the Macula (non-PMB); Depression (non-PMB); Gastro-oesophagael Reflux Disease; Gout (chronic); Ménière Disease; Migraine; Osteoarthritis; Osteoporosis (non-PMB); Other Venous Embolism and Thrombosis; Peptic Ulcer (non-PMB); Psoriasis Vulgaris; and Pulmonary Embolism.

1.4 "Medication Reference Price List" (MRPL) – a list of fees/prices in respect of medicines, 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;

1.6 "network provider" – a health care provider selected by the Scheme as a preferred provider for the diagnosis, treatment and care of defined PMB or non-PMB conditions;

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

1.8 "Scheme Reimbursement Rate" (SRR) – is equivalent to one of the following:

1.8.1 100% of the reimbursement rate charged in respect of the payment of relevant health services as prescribed in the Discovery Health Guide to Fees or the Discovery Health Network rate; or

1.8.2 100% 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

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

1.8.4 100% of the NHRPL last published in 2006, plus an inflationary factor equal to:

**2022 = 2006 + 253%**

1.9 "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.

1.10 "specialised medicine and technology" (SMT) – specified medicines and technologies or medical devices.

## 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 Medicine 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;

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;

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. 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

3.3.8 Organ Transplant Management Programme.

3.4 Where the Scheme has adopted a disease or condition 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.

## 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 post receiving the service or admission to a hospital. 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.

## 5 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.

## 5.1 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 network provider.

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

5.1.1.1 Alcohol and Drug Dependency; the DSP is SANCA;

5.1.1.2 Ambulance services; the DSP is Netcare 911;

5.1.1.3 Diabetes Management; the DSP is The Centre for Diabetes and Endocrinology (CDE);

5.1.1.4 HIV/AIDS medicine; the DSP is Dis-Chem Direct;

5.1.1.5 Oxygen therapy, including the cost of hiring of apparatus (device and consumables), the DSP is VitalAire;

5.1.1.6 Services and medical and surgical appliances supplied by Orthotists and Prosthetists; the DSP is the Discovery Health Network of

Orthotists and Prosthetists,

5.1.1.7 Basic dental benefits and dentures; the DSP is Dental Risk Company (DRC); and

5.1.1.8 Hospital accommodation, emergency and theatre services including the supporting equipment, personnel and related medicine costs; the DSP is the Scheme Hospital DSP, subject to the nearest hospital being situated within a 50-kilometer radius of the beneficiary's permanent or temporary residence or place of work.

To increase the radius where there is no Scheme DSP from a radius within 35 km to 50 km, remains unfair.

The proposed Rule remains rejected.

If there is no Scheme DSP hospital within the ~~50~~-kilometer radius, admission to the nearest non-DSP hospital will be deemed an involuntary admission and no co-payment will apply.

No co-payment will be due in respect of a hospital admission to a non-DSP hospital in the event of a medical emergency.

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 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.

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 member 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.

## 5.2 ALCOHOL AND DRUG DEPENDENCY

Subject to PMB regulations and pre-authorisation a beneficiary is entitled to 100% of the SRR, or actual cost, if lower, of treatment for alcohol and drug dependency subject to the following:

### 5.2.1 Hospitalisation

Subject to admission to the Scheme Hospital DSP or the Alcohol and Drug Dependency DSP, SANCA, a beneficiary is entitled to 100% of the SRR for the treatment of alcohol and / or drug detoxification for three days.

Thereafter, subject to admission to SANCA, a beneficiary is entitled to 100% of the SRR for the treatment of the dependency for a maximum of twenty-one days.

5.2.2 **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 and / or drug dependency, subject to PMB regulations.

5.2.3 **Professional Services Out of hospital**

Subject to the annual family limit for Consultations, Visits and Acute Medicines, detailed in Table B1.2, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of professional services rendered out of hospital, in connection with the treatment of alcohol and / or drug dependency.

5.3 **OUT OF HOSPITAL ALTERNATIVE AND ALLIED HEALTH CARE**

Subject to the exclusions in Annexure C, PMB regulations, and the overall annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4, and the sub-limit for Out of Hospital Alternative and Allied Health Care services detailed in Table B1.1 below, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following:

5.3.1 acupuncture;

5.3.2 audiology;

5.3.3 chiropody and podiatry services;

5.3.4 chiropractic consultations, including x-rays;

5.3.5 clinical psychology;

5.3.6 dietician services;

5.3.7 homeopathic consultations and procedures, including non-NAPPI coded medicines compounded and dispensed by the practitioner;

5.3.8 naturopathy;

5.3.9 orthoptics;

5.3.10 physiotherapy;

5.3.11 nurse practitioner consultations and procedures;

5.3.12 social services;

5.3.13 speech and occupational therapy; and

5.3.14 orthotists and prosthetists.

**OUT OF HOSPITAL ALTERNATIVE AND ALLIED HEALTH CARE**

**OUT OF HOSPITAL SUB-LIMIT 1**

**TABLE B1.1**

| | |
|---|---|
| **Member/Adult dependant** | **R3 550** |
| **Child dependant** | **R745** |

## 5.4 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 hours 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.

## 5.5 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.

## 5.6 CONSULTATIONS, VISITS AND ACUTE MEDICINE AND PHARMACIST ADVISED THERAPY (PAT)

### 5.6.1 Out of Hospital Consultations

Subject to the exclusions in Annexure C, PMB regulations, and the annual family limit detailed in Table B1.4 for Out of Hospital Services and Medicines and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations and procedures by general practitioners, nurse practitioners and medical specialists, out of hospital.

#### 5.6.1.1 Consultations for Immunisation

A beneficiary is entitled to 100% of the SRR, 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.

### 5.6.2 Acute Medicine

5.6.2.1 Subject to the MRPL, exclusions in Annexure C, PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute

Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled to 100% of the SEP including the SRR for the dispensing fee for prescribed acute medicine obtained from a pharmacy or a registered dispensing practitioner which is not approved as medicine in respect of a chronic condition, or NAPPI coded medicine prescribed or dispensed by a registered homeopath.

5.6.2.2 Subject to the exclusions in Annexure C, PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled to 100% of the SEP for injection material provided or prescribed by a general practitioner or a medical specialist.

The annual family limit in respect of Out of Hospital Consultations, Visits and Acute Medicines and PAT 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 B1.2 below.

Any one beneficiary in a member family may use a portion, or the full amount, of the annual sub- limit.

**OUT OF HOSPITAL CONSULTATIONS, VISITS AND ACUTE MEDICINES AND PHARMACIST ADVISED THERAPY (PAT) SUB- LIMITS**

**OUT OF HOSPITAL SUB-LIMIT 2**

**TABLE B1.2**

| | |
|---|---|
| **Member/Adult dependant** | **R5 165** |
| **Child dependant** | **R2 580** |

5.7 **DENTAL**

5.7.1 **Basic dental services**

Subject to Scheme protocols, and the Scheme DSP, Dental Risk Company (DRC), a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following out of hospital basic dental services:

5.7.1.1 Two consultations per beneficiary per year which are 180 days apart, including one local anaesthetic per visit;

5.7.1.2 One scaling, polishing, and fluoride treatment every 180 days;

5.7.1.3 Two intra-oral radiographs per visit every 180 days;

5.7.1.4 Extractions, pre-authorisation is required for more than four extractions per beneficiary per year;

5.7.1.5 Amalgam and resin restorations, authorisation is required after the fifth restoration per beneficiary per year; and

5.7.1.6 One pair of plastic dentures per beneficiary every four years, including one annual relining and repair per year.

Where a beneficiary elects not to use the DSP, the member shall be liable to pay the provider the difference between 80% of the SRR and the claimed amount.

5.7.2 **Additional Basic and Specialised Dentistry**

Subject to the annual combined family limit for additional basic and specialised dentistry, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of in- or out-of hospital basic dental and specialised services, including root canal treatment, orthodontic treatment, crowns or bridges, periodontic treatment, maxillo-facial treatment, osseo-integrated implants and any other dental services, including the cost of appliances and prosthesis not covered under basic dental services, Rule 5.7.1.

The annual family limit in respect of additional basic 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 B1.3 below.

Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

**ADDITIONAL BASIC AND SPECIALISED DENTISTRY LIMITS**

**TABLE B1.3**

| | |
|---|---|
| **Member/Adult dependant** | **R1 435** |
| **Child dependant** | **R360** |

5.7.3 **Dental hospitalisation**

Subject to pre-authorisation and the Scheme Hospital DSP or an accredited dental practitioner's room, unattached theatre unit or registered day clinic, 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 either a dentist or a maxillo-facial surgeon.

5.8 **ENDOSCOPIC PROCEDURES (gastroscopies, colonoscopies, sigmoidoscopies and proctoscopies)**

5.8.1 Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR or the actual cost, if lower, of hospitalisation 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 contracted to perform endoscopic procedures. This Rule will not apply in respect of a medical emergency endoscopic procedure and treatment. An emergency endoscopic procedure will not be subject to the Scheme Hospital DSP for hospital services detailed in Rule 5.9.1.

5.8.2 Subject to PMB regulations, 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 voluntarily admitted to a non-network registered hospital specifically for the purpose of an endoscopic procedure. No co-payment will be due in respect of a medical emergency procedure.

5.9 **HOSPITALISATION**

5.9.1 **General**

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, inclusive of fixed fee procedures, for all hospital services received in hospitals on the Scheme Hospital DSP or in nursing homes, day clinics, unattached

theatre units and government and provincial hospitals.

A co-payment of **R3 200** is payable by the member if a beneficiary is voluntarily admitted to a non-DSP hospital. No co-payment will be due in respect of a medical emergency.

5.9.2 **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.

5.9.3 **Ward Fees**

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR of ward fees in a hospital detailed in Rule 5.9.1.

5.9.3.1 general ward fees; and

5.9.3.2 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.

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

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR for ward and theatre drugs, surgicals, prostheses and appliances that are prescribed and used while the beneficiary is resident in a hospital detailed in Rule 5.1.1.9.

5.9.4.1 In the case of prescribed drugs, the SEP for such drugs;

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

5.9.4.3 In the case of appliances, paid up the limit in Rule 5.14; and

5.9.4.4 In the case of internal surgical prostheses, subject to Rule 5.24.

5.9.5 **Theatre Fees and Materials**

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR for theatre fees, labour ward charges and dressings and materials used in theatre in a hospital detailed in Rule 5.9.1.

5.9.6 **Consultations In Hospital**

Subject to PMB regulations, a beneficiary is entitled to

100% of the SRR, or the actual cost, if lower, of consultations and procedures performed in a hospital by general practitioners, nurse practitioners and medical specialists and related allied health services (excluding, audiologists, orthoptists, chiropodists, podiatrists, and chiropractors).

5.9.6A Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of specified procedures usually performed in a hospital by a specialist when performed in a consulting room in lieu of a hospital admission.

5.9.7 **Home Nursing**

Subject to pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR**,** or the actual cost if lower, of nursing at home in lieu of hospitalisation according to Scheme protocols.

5.9.8 **Terminal Care**

Subject to PMB regulations and 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 in a registered terminal care facility or care provided in a home setting as an out-patient by a qualified palliative care provider.

5.9.9 **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.

5.10 **HIV / AIDS**

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

5.10.1 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

5.10.2 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 co-payments, Rules 3.4 and 5.1 above.

5.11 **INFERTILITY**

Subject to PMB regulations and the exclusions as reflected in Annexure C, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the investigation and treatment of infertility out of hospital, subject to:

5.11.1 the annual family limits for Out of Hospital

Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 and the Out of Hospital Services and Medicines detailed in Table B1.4.

5.12 **MATERNITY**

Subject to PMB limitations, a beneficiary is entitled to 100% of all costs related to the delivery of a child and the cost of all ante-natal care if hospitalisation is medically required prior to the date of delivery.

5.12.1 **Confinement in a Hospital (subject to Rule 5.1)**

A beneficiary is entitled to 100% of the cost for services provided for normal delivery or for a Caesarean section if medically appropriate in a hospital on the Scheme Hospital DSP or a private nursing home or a low- risk Obstetric Unit.

A co-payment of **R3 200** is payable by the member if a beneficiary is voluntarily admitted to a non-DSP hospital. No co-payment will be due in respect of a medical emergency.

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

Subject to pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following additional non-PMB benefits:

5.12.2.1 8 ante- or post-natal consultations with general practitioners, nurse practitioners and

obstetricians in or out of hospital, inclusive of 2, two-dimensional ultrasound pregnancy scans per pregnancy.

Should a beneficiary not obtain pre-authorisation, the cost of all non-PMB out of hospital ante-natal and post-natal care, including ultrasound scans, shall be reimbursed according to Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2, and the annual family limit for out of hospital radiology services, detailed in Table B1.6.

## 5.13 MAXILLO-FACIAL AND ORAL SURGERY

5.13.1 Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the cost of maxillo-facial and oral surgery limited to the diagnosis, treatment and care of PMB conditions when obtained from a maxillo-facial or oral surgeon.

## 5.14 MEDICAL AND SURGICAL APPLIANCES

5.14.1 A beneficiary is entitled to 100% of the SRR of medical and surgical appliances, subject to pre-authorisation for any appliances in excess of **R3 000** per appliance and an annual family limit of **R9 795.** Medical and surgical appliances obtained from Orthotists and Prosthetists will

be paid up to the Discovery Health Network rate.

5.14.2 Subject to pre-authorisation and the annual family limit for medical and surgical appliances, a beneficiary is entitled to 100% of the cost of one wheelchair, per beneficiary, every two years.

5.14.3 Subject to pre-authorisation and a prescription by an Ear, Nose and Throat specialist for beneficiaries younger than 60 years and the annual family limit for medical and surgical appliances, a beneficiary is entitled to 100% of the cost of one pair of hearing aids, per beneficiary, every two years.

5.14.4 Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of 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.

A beneficiary who voluntarily obtains such services from a non-DSP will be liable for a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the services been obtained from the DSP.

## 5.15 MEDICINES

5.15.1 A beneficiary is entitled to 100% of the MRPL of prescribed medicines, subject to a maximum of one month's supply or repeat thereof.

The member is liable for a co-payment equal to the difference between the actual cost of a medicine if priced higher than the agreed MRPL and the price of the approved medicine on the MRPL.

5.15.2 **Acute Medicines**

A beneficiary is entitled to 100% of prescribed acute medicines subject to the exclusions in Annexure C, PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub- limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2.

The annual family limit in respect of acute medicines 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 B1.2. Any one beneficiary in a member family may use a portion, or the full amount, of the annual sub-limit.

5.15.3 **Chronic Medicine**

5.15.3.1 **PMB Conditions**

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

5.15.3.2 **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 **R4 740** per beneficiary and provided that:

5.15.3.2.1 the medicine has been approved on the Chronic Medicine Programme; and

5.15.3.2.2 The medicine is included on the MRPL.

5.15.4 **Vaccines**

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

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

5.15.4.2 according to age, one human papilloma virus vaccine per lifetime; and

5.15.4.3 subject to PMB regulations, a Covid-19 vaccine and the administration fee.

5.15.5 **Homeopathic Medicines**

Subject to the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2, a beneficiary is entitled to 100% of SRR of NAPPI coded homeopathic medicines.

5.15.6 **Pharmacist Advised Therapy (PAT)**

Subject to PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2, a beneficiary may obtain medicines on the advice of a pharmacist and is entitled to 100% of the cost of certain

medicines limited to **R115** per pharmacist advised prescription. A member is limited to 5 pharmacist advised prescriptions per family per three months.

5.16 **ONCOLOGY**

5.16.1 Subject to the PMB regulations, the Scheme protocols as endorsed by the South African Oncology Consortium, registration on the Oncology Management Programme or registration for benefits when in remission, and a limit of **R310 000** per beneficiary per 12-month treatment cycle, a beneficiary is entitled to:

5.16.1.1 100% of the SRR, or the actual cost, of consultations and procedures performed by general practitioners and medical specialists and diagnostic tests and materials;

5.16.1.2 100% of the SRR, or the actual cost, of radiotherapy and chemotherapy treatment;

5.16.1.3 the SEP of cytostatics, adjuvant and palliative medicines used in chemotherapy treatment subject to the MRPL; and

5.16.1.4 the facility fees.

5.16.2 Once the benefit limit has been exhausted, subject to PMB regulations, Scheme protocols and the continued registration on the Oncology Management Programme, or registration for benefits when in remission, a beneficiary is entitled to:

5.16.2.1 80% of the SRR, or the actual cost, of consultations and procedures by general practitioners and medical specialists;

5.16.2.2 80% of the SRR, or the actual cost, if lower, of radiotherapy and chemotherapy treatment;

5.16.2.3 80% of the SEP of cytostatics adjuvant and palliative medicines used in chemotherapy treatment subject to the MRPL; and

5.16.2.4 80% of the facility fees.

5.16.3 Subject to the PMB regulations, the Scheme protocols, registration on the Oncology Management Programme or registration for benefits when in remission, and registration for the Oncology Specialised Medicine Benefit, a beneficiary is entitled to 80% of the SEP of specified innovative or high cost medicines which will accrue to the oncology limit and, once the limit has been exhausted, will continue to be reimbursed at 80% of the SEP.

5.17 **OPHTHALMOLOGY (cataract surgery with intraocular lens replacement)**

5.17.1 Subject to the PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the cost of cataract surgery with an intraocular lens replacement procedure if performed in an accredited ophthalmologist's room or registered day clinic on the Scheme's defined list of network facilities; and

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

5.18 **OPTICAL SERVICES**

5.18.1 Subject the annual family limit of **R2 280**, a beneficiary is entitled to 100% of the cost of spectacles (including lenses and frames), contact lenses, where they have been prescribed for normal eye complaints, and non-PMB intraocular lenses; and

5.18.2 a beneficiary is limited to **R415** per optic examination or test supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner annually.

5.18.3 This benefit excludes the costs of sunglasses.

5.19 **OUT OF HOSPITAL SERVICES AND MEDICINES (INCLUDING CONSULTATIONS, VISITS AND PROCEDURES, ALTERNATIVE AND ALLIED HEALTH CARE, ACUTE MEDICINE AND PHARMACIST ADVISED THERAPY (PAT)**

Subject to the exclusions in Annexure C, PMB regulations, and the annual family limit for Out of Hospital Services and Medicines, detailed in Table B1.4 below, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations and procedures provided by general practitioners, specialist and alternative and allied health care practitioners and out of hospital acute medicine prescribed by registered practitioners in accordance with the discipline's scope of practice including PAT.

The annual family limit in respect of out of hospital services 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 B1.4 below. Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

**OUT OF HOSPITAL SERVICES AND MEDICINES LIMITS**

**TABLE B1.4**

| | |
|---|---|
| **Member/Adult dependant** | **R5 500** |
| **Child dependant** | **R2 745** |

## 5.20 PATHOLOGY

### 5.20.1 Pathology Services Out of Hospital

Subject to PMB regulations and the annual family limit for pathology, 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, out of hospital.

The annual family limit in respect of pathology 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 B1.5 below. Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

**OUT OF HOSPITAL PATHOLOGY SERVICES LIMITS**

**TABLE B1.5**

| | |
|---|---|
| **Member/Adult dependant** | **R1 395** |
| **Child dependant** | **R500** |

5.20.2 **Pathology Services In Hospital**

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

5.20.3 **Cancer Screening Tests**

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

## 5.21 RADIOLOGY

### 5.21.1 Radiological Services Out of Hospital

Subject to PMB regulations and the annual family limit for radiology, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of radiological services and materials, out of hospital.

The annual family limit in respect of radiology 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 the table B1.6 below. Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

**OUT OF HOSPITAL RADIOLOGY SERVICES LIMITS**

**TABLE B1.6**

| | |
|---|---|
| **Member/Adult dependant** | **R1 820** |
| **Child dependant** | **R1 100** |

### 15.21.2 Radiological Services In Hospital

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

15.21.3 **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.

15.21.4 **Densitometry**

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

15.21.5 **Mammograms**

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

5.22 **RENAL DIALYSIS**

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.

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

Subject to PMB regulations, Scheme protocols and pre-authorisation a beneficiary is entitled to 80% 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.

5.24 **SURGICAL PROSTHESES (INTERNAL)**

Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR for internal prostheses limited to **R68 470** per beneficiary per annum.

5.25 **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.

5.26 **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.

## 6 THIRD PARTY LIABILITY

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:

6.1 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.

## 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 costs 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 Rule 7.2, 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.

**ANGLO MEDICAL SCHEME**
**MANAGED CARE PLAN**
**ANNEXURE B2**

## BENEFITS – Effective 1 January 2022

### 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); Benign Prostatic Hyperplasia; 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); Myasthenia

Gravis; 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);

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;

1.6 "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;

1.7 "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;

1.8 "Scheme Reimbursement Rate" (SRR) – is equivalent to one of the following:

1.8.1 100% of the reimbursement rate charged in respect of the payment of relevant health services as prescribed in the Discovery Health Guide to Fees or the Discovery Health Negotiated rate; or

1.8.2 100% 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

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

1.8.4 100% NHRPL last published in 2006, plus an inflationary factor equal to:

**2022 = 2006 + 253%**

1.9 "single exit price" (SEP) – the price of a specific drug as regulated by Act 101 of 1965, as amended, and determined annually by the by the Minister of Health on recommendation of the Pricing Committee as provided for in the Medicines and Related Substances Act.

1.10 "specialised medicine and technology" (SMT) – medicines and technologies or medical devices costing in excess of **R5 000**.

## 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;

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;

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.

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

3.3.8 Organ Transplant Management Programme.

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.

## 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 post an admission or service for which pre-authorisation is required. 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.

## 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.

## 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.

### 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.

6.1.1 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);

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;

6.1.1.6 Services and medical and surgical appliances supplied by Orthotists and Prosthetists; the DSP is the Discovery Health Network of Orthotists and Prosthetists; and

6.1.1.7 Endoscopic procedures and cataract surgery; the DSP is the Discovery Health Network of Day-Clinics.

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 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.

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 member 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.

## 6.2 ALCOHOL AND DRUG DEPENDENCY

Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR, or actual cost, if lower, of treatment for alcohol and drug dependency subject to the following:

### 6.2.1 Hospitalisation

Subject to admission to a hospital or the Scheme Alcohol and Drug Dependency DSP, SANCA, a beneficiary is entitled to 100% of the SRR for the treatment of alcohol and / or drug detoxification for three days.

Thereafter, subject to admission to SANCA, a beneficiary is entitled to 100% of the SRR for the treatment of the dependency for a maximum of twenty-one days.

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 legislation.

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.

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;

6.3.2 naturopathy; and

6.3.3 acupuncture.

## 6.4 AMBULANCE SERVICES

Subject to the PMB legislation, 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.

## 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;

6.5.9 nurse practitioner consultations and procedures;

6.5.10 orthotists and prosthetists; and

6.5.11 chiropractic consultations, including x-rays.

## 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 legislation 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.

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

Subject to the exclusions in Annexure C, the PMB legislation 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.

6.7.1.3 **Discovery Health GP Network**

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.

6.7.1.4 **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.

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).

6.7.3 **Consultations and procedures in lieu of hospitalisation**

Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR, inclusive of the Top-Up rate, or the actual cost, if lower, of specified procedures usually performed in a hospital by a specialist when performed in a consulting room in lieu of a hospital admission.

## 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:

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

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

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.

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 970** |
| **Child dependant** | **R1 500** |

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.

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.

**6.9 ENDOSCOPIC PROCEDURES (gastroscopies, colonoscopies, sigmoidoscopies and proctoscopies)**

6.9.1 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 endoscopic procedure and treatment.

6.9.2 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.

## 6.10 HOSPITALISATION

### 6.10.1 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.

### 6.10.2 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.

### 6.10.3 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.

6.10.4 **Ward Fees**

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

6.10.4.1 general ward fees; and

6.10.4.2 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.

6.10.5 **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:

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

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

6.10.5.3 in the case of appliances, subject to Rule 6.15; and

6.10.5.4 in the case of internal surgical prostheses, subject to Rule 6.24

6.10.6 **Theatre Fees and Materials**

Subject to PMB legislation, 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.

6.10.7 **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 **R73 040** per

6.10.8 **Home Nursing**

Subject to pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR**,** or the actual cost if lower, of nursing at home in lieu of hospitalisation according to Scheme protocols.

6.10.9 **Terminal Care**

Subject to PMB regulations and 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 in a registered terminal care facility or care provided in a home setting as an out-patient by a qualified palliative care provider.

6.10.10 **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.

6.11 **HIV / AIDS**

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

6.11.1 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

6.11.2 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 a co-payment, Rule 6.1 above.

6.12 **INFERTILITY**

Subject to PMB legislation and the exclusions as reflected in Annexure C, a beneficiary is entitled to:

6.12.1 125% 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

6.12.2 subject to available savings in the member's PMSA, non-PMB prescribed medicines for the treatment of infertility.

6.13 **MATERNITY**

Subject to PMB limitations, a beneficiary is entitled to 100% of the cost of all costs related to the delivery of a child and all antenatal care if hospitalisation is medically required prior to the date of delivery.

6.13.1 **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.

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

Subject to pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following additional non-PMB benefits:

6.13.2.1 12 ante- or post-natal consultations and visits with general practitioners or 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.

Should a beneficiary not obtain pre-authorisation, 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.

## 6.14 MAXILLO-FACIAL AND ORAL SURGERY

6.14.1 Subject to PMB legislation 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.

6.14.2 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.

6.15 **MEDICAL AND SURGICAL APPLIANCES**

6.15.1 Excluding the appliances referred to in paragraphs 6.15.2 and 6.15.3, a beneficiary is entitled to 100% of the SRR of medical and surgical appliances, subject to pre-authorisation for any appliances in excess of **R3 000** per appliance and an annual family limit of **R16 610.**

Medical and surgical appliances obtained from Orthotists and Prosthetists will be paid up to the Discovery Health Network rate.

6.15.2 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 **R26 140** per beneficiary.

6.15.3 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 900** per hearing aid per beneficiary every two years.

6.15.4 Subject to PMB legislation 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.

A beneficiary who voluntarily obtains services from a non-DSP will be subject a co-payment, Rule 6.1.

6.16 **MEDICINES**

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

6.16.1 **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:

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

6.16.1.2 100% of the SRR for materials required for injections.

6.16.2 **Homeopathic Medicines**

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

6.16.3 **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.

6.16.4 **Chronic Medicine**

6.16.4.1 **PMB Conditions**

Subject to registration on the Chronic Medicine Management Programme and PMB legislation, 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.

6.16.4.2 **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 **R18 300** per beneficiary and provided that;

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

6.16.4.2.2 the medicine is included on the MRPL.

6.16.4.3 **Vaccines**

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

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

6.16.4.3.2 according to age, one human papilloma virus vaccine per lifetime; and

6.16.4.3.3 subject to PMB regulations, a Covid-19 vaccine and administration fee.

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

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

6.17.1 125% 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;

6.17.2 100% of the SRR, or the actual cost, if lower, of radiotherapy and chemotherapy treatment; and

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

6.18 **OPHTHALMOLOGY (cataract surgery with intraocular lens replacement)**

6.18.1 Subject to the PMB legislation 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

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

## 6.19 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, ophthalmologist or supplementary optical practitioner for optic examinations or tests, frames, lenses (including contact lenses) and non-PMB intraocular lenses.

## 6.20 PATHOLOGY

### 6.20.1 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.

### 6.20.2 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.

### 6.20.3 Cancer Screening Tests

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of one PAP smear or one Prostate Specific Antigen (PSA) screening test, per annum, if rendered by

a registered pathologist and medical technologist, in or out of hospital.

## 6.21 RADIOLOGY

### 6.21.1 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.

### 6.21.2 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.

### 6.21.3 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.

### 6.21.4 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.

### 6.21.5 Mammograms

Subject to pre-authorisation, a beneficiary is entitled to

100% of the SRR, or the actual cost, if lower, of mammograms.

6.22 **RENAL DIALYSIS (subject to PMB legislation)**

Subject to PMB legislation, 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.

6.23 **SPECILISED MEDICINE AND TECHNOLOGY (SMT) OUT OF HOSPITAL BENEFIT**

Subject to PMB legislation, 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.

6.24 **INTERNAL SURGICAL PROSTHESES**

Subject to PMB legislation and pre-authorisation, a beneficiary is entitled to 100% of the SRR, for internal prostheses, with a limit of **R145 235** per beneficiary per annum.

6.25 **TRANSPLANTS**

Subject to PMB legislation, 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.

6.26 **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.

## 7 THIRD PARTY LIABILITY

Subject to PMB legislation, 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:

7.1 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.

## 8 INTERNATIONAL CLAIMS – TRAVEL OR RESIDENCE OUTSIDE THE BORDERS OF SOUTH AFRICA

8.1 A member who incurs a cost of a relevant health service outside the

borders of South Africa shall:

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

8.1.2 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.

8.2 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:

8.2.1 a detailed account or statement for the full service;

8.2.2 a detailed account or statement for the shortfall or uncovered services; and

8.2.3 proof of payment of the service.

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

8.3 Any payment towards the cost of a claim submitted in accordance

with the Rule 6 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.

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

**ANGLO MEDICAL SCHEME**
**VALUE CARE PLAN**
**ANNEXURE B3**

## BENEFITS – Effective 1 January 2022

### 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 a prescribed minimum benefit (PMB) condition as listed in Annexure A to the regulations;

1.3.1 A prescribed minimum benefit (PMB) condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A to the regulations, that includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specific chronic condition. This includes the PMB chronic disease list for the following 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;

1.4 "contracted network service provider" – a service provider who is contracted to Prime Cure to provide healthcare services to members and their registered dependants. (The Scheme shall provide members with an electronic list containing the addresses of the contracted network service providers, and shall update the list from time to time);

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

1.6 "Healthcare Centre" – a facility operated by, or on behalf of Prime Cure. (The Scheme shall provide the member with an electronic list containing the addresses of the Healthcare Centres and shall up-date the list from time to time);

1.7 "medicine formulary" – a list of medicines preferred by Prime Cure;

1.8 "Prime Cure" – a healthcare company registered as Prime Cure Health (Pty) Ltd, which provides healthcare services at Healthcare Centres and through contracted network service providers and is the Scheme's contracted DSP;

1.9 "Prime Cure agreed tariff" – the cost of a healthcare service, as negotiated and agreed between Prime Cure and a particular service provider;

1.10 "Prime Cure practitioner" – a medical practitioner who practices at a Healthcare Centre; and

1.11 "Single Exit Price" (SEP) – the price of a specific drug, determined annually by the Department of Health.

## 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 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 hospital treatment of all medical conditions;

3.2 Disease /Condition Management Programme – a programme which incorporates evidenced clinical protocols for containing costs and/or on-going review and monitoring of patients with a defined medical condition.

Specific Disease/Condition Management Programmes, which have been adopted by the Scheme are the Prime Cure HIV/AIDS Management Programme and the Prime Cure Oncology Management Programme, Chronic Condition Management;

3.3 If the Scheme has adopted a management programme for a particular condition, the benefit in respect of such condition is subject to pre-authorisation and registration with the relevant management programme.

## 4 Pre-Authorisation

Where a benefit is subject to pre-authorisation, a beneficiary must obtain authorisation from Prime Cure prior to obtaining the relevant health service to which the benefit relates.

Unless otherwise stated, a beneficiary who fails to obtain such

prior authorisation for a PMB condition will, except in the case of a medical emergency condition, be liable for a 30% co-payment. A member who fails to obtain such prior authorisation will, in the case of a non-PMB, be held liable for the full cost of the services rendered.

## 5 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.

### 5.1 PRESCRIBED MINIMUM BENEFITS

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 pre-authorised and obtained from a –

5.1.1 public hospital; or

5.1.2 a Prime Cure DSP.

A co-payment will be imposed if a beneficiary voluntarily obtains such services from a provider other than a public hospital or a 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 a 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 provider other than a public hospital or a DSP.

A co-payment as contemplated above will also be imposed in those instances where a beneficiary voluntarily declines a medicine formulary drug and chooses to use another drug instead.

## 5.2 ALCOHOL AND DRUG DEPENDANCY

Subject to PMB regulations, pre-authorisation by Prime Cure and the DSP, a beneficiary is entitled to the following:

### 5.2.1 Hospitalisation

Subject to the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff with the DSP, or the actual cost, if lower, for hospitalisation for alcohol or drug dependency, per annum, subject to PMB regulations.

### 5.2.2 Professional Services Out of Hospital

Subject to PMB regulations and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff with the DSP, or the actual cost, if lower, if provided at a DSP, unless involuntarily obtained from a non-DSP.

## 5.3 AMBULANCE SERVICES

Subject to pre-authorisation by Prime Cure, a beneficiary is entitled to 100% of the Prime Cure agreed tariff or the actual cost, if lower, of emergency transport and other ambulance services, provided such service is obtained from a contracted network service provider, unless involuntarily obtained from a non-DSP or in the case of a medical emergency condition. In such events, a member must notify Prime Cure the following day of the emergency event. In the event of the voluntary use of a non-DSP provider, a beneficiary will be liable for a 30% co-payment.

A member will be required to pay the full cost of a non-medically justifiable use of an ambulance service.

## 5.4 AUXILIARY HEALTH SERVICES

5.4.1 Subject to pre-authorisation, and referral by a Prime Cure practitioner or contracted network service provider, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, limited collectively to the out of hospital allied services listed below, to a sub-limit of **R2 905** per family per annum and a maximum limit of **R1 935** per beneficiary -

5.4.1.1 audiology;

5.4.1.2 dietician services;

5.4.1.3 clinical psychology;

5.4.1.4 speech and occupational therapy;

5.4.1.5 podiatry services;

5.4.1.6 physiotherapy; and

5.4.1.7 social services.

A co-payment must be reasonable and not add undue financial burden on members. Accordingly, the proposed 50% co-payment for voluntary use of a non-DSP has been deemed as too excessive and consequently rejected as unfair to members

A co-payment of ~~50%~~ of the Prime Cure agreed tariff for services will apply to those members who self-refer to a non-Prime Cure practitioner or contracted network service provider.

## 5.5 BLOOD TRANSFUSIONS

Subject to pre-authorisation, the annual family limit for hospitalisation and referral by a Prime Cure practitioner or contracted network service provider, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of blood transfusions and is limited to **R17 110** per family per annum, except in the case of PMB conditions.

## 5.6 CONSULTATIONS AND VISITS

### 5.6.1 Specialist Consultations and Visits Out of Hospital

Subject to PMB regulations, referral by a contracted network service provider and pre-authorisation prior to a specialist visit, a beneficiary is entitled to 100% of

the Prime Cure agreed tariff, or the actual cost, if lower, of consultations and procedures performed out of hospital by a designated specialist, according to a Prime Cure approved list of specialist codes and treatment protocols, subject to the following limitations:

5.6.1.1 Five consultations per family per year, inclusive of the cost of any prescribed medication, subject to a maximum of three per beneficiary, and limited to **R3 815** per family per annum for non-PMB visits;

5.6.1.2 Cost of involuntary use of a non-designated provider will be paid at the Prime Cure agreed tariff; and

5.6.1.3 Failure to obtain pre-authorisation will result in a 30% co-payment.

5.6.2 **General Practitioner Consultations and Visits Out of Hospital at a contracted network service provider**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost if lower, of consultations and procedures performed out of hospital, by general practitioners provided that the

service is obtained at a registered Healthcare Centre or at a contracted network service provider with the following limitations:

5.6.2.1 All visits after the 6th consultation per beneficiary per annum must be pre-authorised by the member or provider.

Failure to obtain authorisation for a consultation for a PMB condition will result in the member being held liable for a 30% co-payment. Failure to obtain authorisation for a non-PMB condition will result in the member being held liable for the full cost of the consultation.

5.6.2.2 Immunisation – Subject to Prime Cure protocols, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost if lower, of one flu vaccine per beneficiary per annum.

5.6.3 **General Practitioner Consultations and Visits Out of Hospital at a non-contracted network service provider**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of consultations and visits out of hospital received

from general medical practitioners, subject to authorisation to be obtained on or before the first working day after the event. This benefit is subject to a co-payment of 20% per visit and a limit of **R1 100** per consultation and/or visit, including related expenses, excluding facility fees.

The provider must be paid at point of service, thereafter, the beneficiary may claim the costs from Prime Cure. It is limited to one consultation/visit per beneficiary and limited to a maximum of two visits per family per annum.

5.6.4 General Practitioner Consultations and Visits Out of Hospital, excluding facility fees, in the case of an emergency are unlimited and without co-payment if the episode meets the requirements of the Prime Cure definition of a medical emergency condition. Authorisation must be obtained on or before the first working day after an event by the member or the provider.

5.6.5 **General Practitioner and Specialist Consultations and services In Hospital**

Subject to PMB regulations and pre-authorisation by Prime Cure and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of

the Prime Cure agreed tariff, or the actual cost, if lower, of consultations and visits in a public hospital or Prime Cure contracted private hospitals, by general practitioners, nurse practitioners and medical specialists.

5.6.6 **Allied Health Services in Hospital**

5.6.6.1 Subject to the annual family limit for hospitalisation, pre-authorisation, evidence-based protocols and case management, allied services in hospital for physiotherapy, dietetics, occupational therapy, speech therapy, podiatry and social workers are subject to the Allied Health Services in hospital sub-limit of **R8 320** per family per annum;

5.6.6.2 Benefits for non-PMB psychiatric conditions are limited to five days per admission in a public hospital psychiatric facility, subject to the annual family limit for hospitalisation, pre-authorisation, subject to the Allied Health Services sub-limit of **R8 320** per family per annum. Benefit for sleep therapy is excluded.

5.6.7 **Nurse Practitioner Consultation at a Pharmacy Wellness Clinic**

A beneficiary is entitled to 100% of the Prime

Cure agreed tariff, for consultations with a nurse practitioner for minor illness at a Prime Cure contracted Network Pharmacy Wellness Clinic, limited to a maximum of **R290** per visit and **R580** per family per annum.

5.7 **DENTAL**

5.7.1 **Conservative Dentistry**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff of the following out of hospital dental procedures performed by a general dental practitioner at a Healthcare Centre or by a contracted network service provider, subject to Prime Cure dental protocols and limited to one consultation per beneficiary per annum if clinically appropriate:

One consultation for a full mouth examination per beneficiary per annum – subject to list of benefit codes

5.7.1.1 Primary extractions subject to pre-authorisation where four or more extractions are required, except in the case of an emergency; Extractions (Only if clinically necessary). Pre-authorisation required for 5 or more extractions.

5.7.1.2 Three composite (white) or amalgam fillings and pre-authorisation required for four or more restorations;

Pre-authorisation required for 4 or more

restorations or 5 or more Composite fillings (only anterior covered).

5.7.1.3 Composite fillings for anterior teeth only to a maximum of four fillings where-after pre-authorisation needs to be obtained;

5.7.1.4 Two sets of x-rays. Additional x-rays to a maximum of four require pre-authorisation;

5.7.1.5 Emergency root canal treatment;

5.7.1.6 Examination and treatment of emergency pain and sepsis;

5.7.1.7 One preventative treatment per beneficiary per annum inclusive of fluoride treatment, cleaning, scaling and polishing. Authorisation needed for children over the age of 12; and

5.7.1.8 Dental emergency out of network visits are limited to one event per beneficiary per year to cover emergency pain management, sepsis and extractions paid at the Prime Cure tariff.

5.7.2 **Specialised Dentistry – no benefits except for:**

5.7.2.1 Dentures. A family is entitled to 80% of the Prime Cure agreed tariff of one set of acrylic dentures per family every 24 months for members over the age of 21 when provided by a general dental practitioner at a Healthcare Centre or by a contracted network service provider. The balance of 20% shall be the co-payment and shall be paid to the dentist at the time of placing an order for dentures.

5.7.3 **Dental Hospitalisation**

Subject to the annual family limit for hospitalisation and pre-authorisation by Prime Cure, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of hospital admissions, when provided by a public hospital or a Prime Cure contracted private hospital, for the following dental and surgical procedures:

5.7.3.1 Children under seven years;

5.7.3.2 Impacted 3rd molars subject to PMB regulations; and

5.7.3.3 Trauma.

5.7.4 **Dental Medication – Acute**

5.7.4.1 Limited to the Prime Cure formulary;

5.7.4.2 Prescribed and dispensed by an approved Prime Cure designated service provider.

5.8 **HIV/AIDS (subject to Rule 5.1.2)**

Subject to registration on the Prime Cure HIV/AIDS Management Programme, a beneficiary is entitled to:

5.8.1 **Services Out of Hospital**

5.8.1.1 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of services relating to the treatment or management of HIV/AIDS at a Prime Cure DSP; and

5.8.1.2 Prescribed medicines in accordance with the Prime Cure medicine formulary for the treatment of HIV/AIDS.

Should a beneficiary elect not to participate in the Prime Cure HIV/AIDS Management Programme, benefits detailed in Rules 5.8.1, 5.8.2 and 5.11.3.1 below, will be subject to Rule 5.1 above.

5.8.2 **Services In Hospital**

5.8.2.1 Subject to Rule 5.1 and admission to a DSP

hospital only, subject to registration on the HIV/AIDS programme.

## 5.9 HOSPITILISATION

### 5.9.1 General

Subject to a limit of **R173 000** per family per annum and subject to a private hospital sub limit of **R75 000** per family per annum, a beneficiary is entitled to 100% of the Prime Cure agreed tariff as negotiated between Prime Cure and the service provider concerned, in respect of all services received in public hospitals or Prime Cure contracted private hospitals. Such services must, however, be referred by a Prime Cure practitioner or contracted network service provider or be provided by a contracted network service provider.

### 5.9.2 Referral and Pre-authorisation

All hospital admissions are subject to referral by a Prime Cure practitioner and to pre-authorisation by Prime Cure, except in the case of an admission for a medical emergency condition.

In such an event, a member must notify Prime Cure within 24 hours after the emergency or the first working day after the admission. Elective procedures need authorisation before the event. In the event that no authorisation for non-emergency procedures was obtained, a member will be required to pay a

co-payment of **R2 000** per admission.

5.9.3 **Ward fees**

Subject to PMB regulations and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, as negotiated between Prime Cure and the hospital concerned subject to case management, for:

5.9.3.1 general ward fees;

5.9.3.2 high care and intensive care unit fees.

5.9.4 **Ward and Theatre Drugs and Appliances**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, as negotiated between Prime Cure and the hospital concerned, for ward and theatre drugs and appliances that are prescribed and used while the beneficiary is hospitalised, subject to PMB regulations, case management and the following limits –

5.9.4.1 In the case of prescribed drugs, the Prime Cure agreed tariff for such drugs and the annual family limit for hospitalisation;

5.9.4.2 Internal surgical prosthesis sub-limit of **R30 000** per family per annum subject to

the annual family limit for hospitalisation and pre-authorisation; and

5.9.4.3 In the case of "To Take Out" (TTO) medicine, a limit of seven days' supply is allowed on discharge, subject to the annual family limit for hospitalisation and Prime Cure medicine formulary.

5.9.5 **Theatre Fees and Material**

Subject to the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, as negotiated between Prime Cure and the hospital concerned, for theatre fees, labour ward charges, dressings and materials used in theatre, subject to case management.

5.10 **MATERNITY (subject to PMB regulations)**

All maternity related costs are subject to the annual family limit for hospitalisation.

5.10.1 **Ante-natal Consultations and Post-natal Care at a contracted network service provider out of hospital**

A beneficiary is entitled to a 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of ante- and post-natal consultations and visits performed out of hospital, by general practitioners or nursing

practitioners, provided that the service is obtained at a registered Healthcare Centre or a contracted network service provider.

5.10.2 **Specialist Ante-natal Consultations and Post-natal Care out of hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of ante- and post-natal consultations and visits performed out of hospital, by a specialist subject to a maximum of two visits per family per annum and two, 2 dimensional ultrasound scans per pregnancy subject to referral by a Prime Cure practitioner.

Should the beneficiary voluntarily use a non-designated provider, a co-payment equal to the difference between the Prime Cure agreed tariff of the DSP and the tariff of the non-DSP, will apply.

Failure to obtain pre-authorisation will result in a 30% co-payment.

5.10.3 **Confinement in Hospital**

Subject to authorisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff as negotiated between Prime Cure and the service provider concerned, in respect of all services received in a

public facility or Prime Cure DSP only. Such services must, however be referred by a Prime Cure practitioner or contracted network service provider or be provided by a contracted network service provider.

5.11 **MEDICINES**

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

5.11.1 **Acute Medication**

Subject to the medicine formulary list, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of acute medication and injection material, provided that such medication or material is supplied by a Healthcare Centre or contracted network service provider. The medication must be prescribed by a Prime Cure practitioner, dentist or nursing sister at a Healthcare Centre, or by a contracted network service provider.

5.11.2 **Pharmacist Advised Therapy (PAT)**

Subject to the Prime Cure formulary a beneficiary may obtain medicines from a Prime Cure accredited network service provider/DSP pharmacy, without a doctor's prescription. The benefit in respect of the cost of such medicines is limited to **R105** per

prescription, and a maximum of three prescriptions per beneficiary and **R315** per annum.

5.11.3 **Chronic Medication**

5.11.3.1 **PMB Conditions**

Where a PMB condition includes chronic medication, a beneficiary will be entitled to 100% of the medicine formulary provided the beneficiary is registered on the condition management programme and the medication is prescribed by a Prime Cure practitioner and obtained from a DSP and pre-authorised by Prime Cure.

A beneficiary will also be entitled to 100% of the Prime Cure price of the medicine if involuntarily obtained from a provider other than a DSP; and

5.11.3.2 if voluntarily obtained, the member makes a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the drug been obtained from a DSP or where the member had knowingly used a non-formulary drug.

5.11.3.3 **Non-PMB Conditions**

No benefit.

5.11.3.4 **Medicine obtained on a specialist prescription**

Subject to the medicine formulary, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of medication prescribed by a specialist, provided that such medication or material is supplied by a Prime Cure Healthcare Centre or contracted pharmacy network service provider. Unless a PMB, the cost of such medication is subject to the specialist consultations and visits out of hospital limit.

5.12 **ONCOLOGY**

Subject to registration with the Prime Cure Oncology Programme, as well as his/her annual family limit for hospitalisation, unless a PMB condition, a beneficiary is entitled to 100% of the Prime Cure agreed tariff at a state facility, in respect of oncology services provided by a contracted network service provider subject to referral by a Prime Cure practitioner or contracted network service provider.

5.13 **OPTICAL SERVICES**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff cost of the following conservative or basic optical service,

provided by an optometrist or optometric technician at a Healthcare Centre or a contracted network service provider -

5.13.1 Eye examinations – subject to a limit of one examination per beneficiary per annum; and

5.13.2 Spectacles that are un-tinted, subject to selected frames approved by Prime Cure and single vision or bi-focal lenses prescriptions as per Prime Cure clinical entry criteria and norms. This benefit is subject to a limit of one pair of spectacles per beneficiary every two years.

## 5.14 PATHOLOGY

### 5.14.1 Pathology Services Out of Hospital

A beneficiary is entitled to 100% of the Prime Cure negotiated cost for services rendered out-of-hospital provided such services are according to Prime Cure approved pathology codes and requested and provided by a Prime Cure practitioner, or a contracted network service provider.

### 5.14.2 Pathology Services In Hospital

Subject to PMB regulations and the annual family limit for hospitalisation and a sub-limit of **R19 700** per family for pathology, a beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in hospital, provided such services are according to Prime Cure approved pathology codes,

or the actual cost, if lower, of pathology services requested by a Prime Cure practitioner or contracted service provider and rendered at a DSP.

5.14.3 **Pathology Services In and Out of hospital for PMB Conditions**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in and out of hospital, provided such services are according to Prime Cure approved pathology codes of pathology services that are requested by a Prime Cure practitioner or contracted service provider.

5.15 **RADIOLOGY**

5.15.1 **Basic Radiological Services Out of hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff or services rendered out of hospital provided such services are according to Prime Cure approved radiology codes and requested and provided by a Prime Cure practitioner, or a contracted network service provider.

Basic radiology requested by a specialist will only be covered if the member was referred by a Prime Cure designated provider and authorisation was obtained for the specialist consultation.

5.15.2 **Basic Radiological Services In hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in hospital provided such services are according to Prime Cure approved radiology codes and requested and subject to the annual family limit for hospitalisation.

5.15.3 **Specialised Radiology In and Out of hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in and out of hospital, provided such services are according to Prime Cure approved specialised radiology codes that are requested by a Prime Cure practitioner or contracted network service provider, subject to a combined sub limit of **R19 700** per family per annum for in and out-of-hospital specialised radiology, inclusive of MRI's and CT scans, and the annual family limit for hospitalisation.

5.16 **RENAL DIALYSIS**

Subject to PMB regulations and pre-authorisation and registration with Prime Cure, and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the price of Prime Cure agreed tariff, or actual cost if lower, of services for Haemodialysis and Peritoneal Dialysis provided that such services are referred by a Prime Cure practitioner or contracted

network service provider subject to the Department of Health Guidelines and provided by a state facility.

5.17 **TRANSPLANTS**

Subject to pre-authorisation by Prime Cure, as well as the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of services relating to organ transplants, provided such services are referred by a Prime Cure practitioner or contracted network service provider and obtained in a public hospital subject to the Department of Health Guidelines and provided by a state facility.

5.18 **WELLNESS**

A beneficiary is entitled to 100% of the Scheme Reimbursement Rate (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 pharmacy as detailed on the Discovery website.

## 6. THIRD PARTY LIABILITY

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 clain against a third party, subject to 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.

**ANGLO MEDICAL SCHEME**
**ANNEXURE C**

# LIMITATION OF BENEFITS AND GENERAL EXCLUSIONS APPLICABLE TO STANDARD CARE, MANAGED CARE AND VALUE CARE PLANS

## EFFECTIVE 1 JANUARY 2022

The Scheme will pay in full, without co-payment, the cost of the diagnosis, treatment and care of PMB's. Where a medicine is limited to a protocol or a formulary and has been ineffective in the treatment of the condition, or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment.

## 1 Limitation of Benefits

1.1 The maximum benefits to which a member and his/her registered dependants shall be entitled, in any financial year, shall be limited as set out in Annexures B1, B2 and B3.

1.2 In addition, the following general limitations of benefits shall apply to all benefit options:

1.2.1 Where a beneficiary has a health condition of a protracted nature, the Board shall have the right to insist upon the beneficiary consulting a specialist whom the Board may nominate in consultation with the attending practitioner. In such cases, if the specialist's advice is not acted upon, benefits will be limited to the minimum prescribed benefits for that condition.

1.2.2 Unless a different quantity is prescribed as a minimum benefit in the Act, or unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for

every such prescription or repeat thereof.

1.2.3 A member or registered dependant who is admitted during the course of a financial year shall be entitled to the benefits set out in Annexures B1, B2 and B3. The maximum benefits to which he/she shall be entitled will be adjusted in proportion to the period of membership, which will be calculated from the date of admission to the end of that financial year.

## 2 Excluded benefits

2.1 Unless otherwise decided by the Board, subject to the PMBs and with the exception of medicines approved and authorised in terms of a Scheme protocol or disease management programme, the following costs incurred by a beneficiary will not be paid by the Scheme. Subject to the availability of a positive carry over savings balance in a member's PMSA and Scheme approval, a beneficiary is entitled to recover the costs of the following excluded benefits from his / her positive savings -

2.1.1 bariatric surgery and related costs incurred for the treatment of obesity;

2.1.2 operations, medicines, treatments and procedures for cosmetic purposes, including, but not limited to, breast augmentations, breast reductions, blepharoplasties, abdominoplasties, rhinoplasties, and bat-ear corrections; or for any other reasons not directly caused by or related to an illness, accident or disease;

2.1.3 general anaesthetic and hospitalisation for dental work, except in the case of trauma, patients under the age of seven years and impacted third molars;

2.1.4 *in vitro* fertilisation, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, surrogate parenting, donor semen and related costs including collection and preparation, and amniocenteses which are not medically necessary;

2.1.5 medicines used specifically to treat infertility, except in the case of PMBs;

2.1.6 single and multivitamin preparations, vitamin combinations, geriatric vitamins and mineral supplements except where clinically indicated in managed care protocols; and

2.1.7 sex transformation operations and for reversal of voluntary sterilisation.

2.2 The following cost incurred by a member or a registered dependant shall not be paid by the Scheme and may not be funded from a member's PMSA, positive or otherwise –

2.2.1 charges for appointments which a member or registered dependant fails to keep;

2.2.2 interest and/or legal fees relating to overdue medical accounts;

2.2.3 holidays for recuperative purposes, tests for medical insurance and executive medical examinations/fitness;

2.2.4 provider and member travelling expenses, including social transfers and repatriation, incurred in the diagnosis or treatment of a health condition, excluding emergency ambulance transportation;

2.2.5 all costs for services rendered -

2.2.5.1 by persons not registered in terms of any law;

2.2.5.2 by any institution, except a public hospital, which is not registered as a private hospital, unattached theatre or day clinic;

2.2.5.3 by any institution not licensed in terms of the Mental Health Act of 1973;

2.2.5.4 resulting in any claim covered by any existing third-party health or travel insurance, other than the Scheme;

2.2.5.5 resulting in an international claim that does not provide the detail set out in Regulation 5 of the Regulations, contained in “Annexure D” to the Scheme Rules, with the exception of providing the South African regulatory coding requirements; and

2.2.5.6 an international claim submitted in a foreign language.

2.2.6 all costs for health care services -

2.2.6.1 which, in the opinion of the Scheme's Medical Advisor are not evidence based or are inappropriate or unnecessary in the diagnosis or treatment of a health condition;

2.2.6.2 for experimental, investigative or unproved services, treatments, devices, appliances and pharmacological regimes;

2.2.6.3 related to paternal DNA testing and investigations, including genetic testing for familial cancers;

2.2.6.4 for organ donations to any person other than to a member or registered dependant of a member;

2.2.6.5 for the use of gold in dentures or the cost of gold as an alternative to non-precious metal in crowns, inlays and bridges;

2.2.6.6 for optical devices which are not regarded by the South African Optometric Association as clinically essential or clinically desirable;

2.2.6.7 related to contact lens preparations;

2.2.6.8 related to the purchase of unregistered and off-label medications, unless authorised in respect of the Medicines and Related Substance Control Act 101 of 1965 and pre-authorised according to Scheme protocol, and proprietary preparations;

2.2.6.9 related to the purchase of prescription medicines not prescribed by a medical practitioner or other person who is legally entitled to prescribe medicine, except for medicines purchased in accordance with the pharmacist advised therapy (PAT) benefit, reflected in Annexures B1 and B2;

2.2.6.10 related to anabolic steroids, aphrodisiacs, tonics and homemade medicines;

2.2.6.11 related to the treatment of slimming products used to treat or prevent obesity, subject to medicine prescribed for bariatric surgery under Rule 2.2.1;

2.2.6.12 related to bandages and dressings;

2.2.6.13 related to the general food/nutritional supplements, including all baby food and milk supplements, except where clinically indicated in managed care protocols;

2.2.6.14 related to soaps, shampoos, cosmetic preparations medicated or otherwise; emollients, moisturisers, sunscreens and other similar topical applications;

2.2.6.15 related to preparations not easily classified or without NAPPI codes; and

2.2.6.16 for frail care for Standard Care Plan members.

**3. Specific limitations of benefits and general exclusions applicable to the Value Care Plan inclusive of the aforementioned points**

3.1 all services not obtained through a Prime Cure designated service provider, or referrals not pre-authorised, or not provided in terms of the Prime Cure protocol subject to PMB;

3.2 facility fees;

3.3 the following medicines are specifically excluded from cover in respect of CDL conditions -

3.3.1 Erythropoietin (unless the beneficiary is eligible for renal transplantation);

3.3.2 Infliximab and related biologics for inflammatory bowel disease and rheumatoid arthritis;

3.3.3 interferon's;

3.3.4 immunoglobulin's for chronic use;

3.3.5 medicines classified as biologicals; and

3.3.6 unregistered and off-label medications unless preauthorised.

3.4 iron chelating agents;

3.5 off formulary medication as prescribed by a specialist;

3.6 PET scan procedures not used in accordance with the Scheme, PMB and the State protocol;

3.7 medical, surgical or other appliances unless PMB;

3.8 deep brain stimulator devices for Parkinson's disease or epilepsy;

3.9 implant devices for pain management;

3.10 polysomnogram and CPAP titrations;

3.11 recuperative treatments;

3.12 frail care treatment;

3.13 private nursing care;

3.14 dental extractions for non-medical purposes;

3.15 all costs related to radial keratotomy and eximer laser keratectomy;

3.16 contact lenses and preparations;

3.17 consultations relating to impotence, infertility (except PMB), libido problems or sexual dysfunction;

3.18 injury or illness that occur beyond the borders of the republic of South-Africa;

3.19 extreme and professional sport and wilful self-inflicted injury unless a PMB; and

3.20 reconstructive surgery, port wine stains, keloid scars (not impairing function), surgery relating to obesity, blepharoplasty, nasal reconstruction and hair removal.

**ANGLO MEDICAL SCHEME**
**ANNEXURE D**

## COPY OF REGULATION 5 OF THE MEDICAL SCHEMES ACT

5 **Accounts by suppliers of services**

The account or statement contemplated in section 59(1) of the Act must contain the following -

5.1 the surname and initials of the member;

5.2 the surname, first name and other initials, if any, of the patient;

5.3 the name of the medical scheme concerned;

5.4 the membership number of the member;

5.5 the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;

5.6 the relevant diagnostic and such other item code numbers that relate to such relevant health service;

5.7 the date on which each relevant health service was rendered;

5.8 the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of

and net amount payable by the member in respect of the medicine;

5.9 where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;

5.10 where mention is made in such account or statement of the use of a theatre -

5.10.1 the name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation;

5.10.2 the name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation; and

5.10.3 all procedures carried out together with the relevant item code number contemplated in paragraph (f); and

5.11 in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating -

5.11.1 the expected total amount in respect of the treatment;

5.11.2 the expected duration of the treatment;

5.11.3 the initial amount payable; and the monthly amount payable.