

Schedule of benefits 2010

SUBJECT TO THE PROVISIONS OF THESE RULES, MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS:

(UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
	STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER APPENDIX 1	100% of cost	No limit	1. Services to be rendered by Designated Service Providers (DSP). 2. For purposes of prescribed minimum benefits, designated service providers are Medi-Clinic and/or State / Public Hospitals and Chronicare.
	ALL MEDICAL BENEFITS		Overall annual limit: R1,300,000 ppa	1. The overall annual limit is not pro rated where the date of admission to membership occurs during the financial year. 2. Sub-limits as defined in this Annexure may be pro rated, i.e. calculated from the date of admission to membership to the end of the financial year. 3. Once the overall annual limit and/or sub-limits are reached, only the diagnosis, treatment and care costs of the prescribed minimum benefit conditions will be paid in full.
1. HOSPITALISATION AND RELATED BENEFITS				
<p>All hospitalisation requires pre-authorisation from the Scheme's designated agent or hospital DSP.</p> <ol style="list-style-type: none"> 1. Authorisation shall be obtained from the Scheme's designated agent or hospital DSP before a Beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which the Member will be liable for a co-payment of 20% of the cost of the hospital account, up to maximum of R1,000, except for Prescribed Minimum Benefits. This is in addition to any co-payment in terms of note 4 below. 2. In the event of an emergency, the Scheme shall be notified of such emergency within one working day after admission. 3. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 4. Unless the Beneficiary is deemed to have involuntarily obtained a service from a provider other than a DSP, a Member will be liable for a co-payment of 10% of the cost of the non-DSP hospital account, up to a maximum of R10,000, if a non-DSP provider is used. A Beneficiary will be deemed to have involuntarily obtained a service from a non-DSP provider, – <ol style="list-style-type: none"> 4.1 if the service was not available from the DSP or could not be provided without unreasonable delay; 4.2 if there was no DSP within 25 kilometers of the Beneficiary's ordinary place of residence; or 4.3 in the case of an emergency as defined in the Medical Schemes Act. <p>Except in the case of note 4.3, pre-authorisation shall be obtained by a Member prior to obtaining a service from a non-DSP provider in terms of this Rule, to enable the Scheme to confirm that the circumstances contemplated above are applicable. Where a beneficiary has been admitted to hospital due to an emergency and where there is a DSP within 25 kilometers of their residence, the patient must be transferred to a DSP hospital, provided the DSP has the appropriate facilities, as soon as stabilised. Should this transfer not take place, a co-payment as contemplated in 4 above will be applied.</p> 5. If the choice of a provider or a change of provider would result in a reduction of the quality of care or an overall increase in the cost of care, special authorisation may be sought at the time of pre-authorisation for treatment at a non-DSP, without a co-payment. 6. The 10% co-payment referred to in note 4. above will not apply in respect of hospital accommodation at Contracted Providers. 				

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
1.1	PRIVATE & STATE/PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES & DAY CLINICS 1. Accommodation in a general ward, high care ward and intensive care unit. 2. Theatre fees. 3. Medicines, materials and hospital equipment. 4. Visits by medical practitioners. 5. Nursing services and all other non- psychiatric in-hospital services. 6. Confinement and midwives.	100% of Agreed Tariff at DSP or Contracted Provider or 90% of Agreed Tariff at other providers 100% of Agreed Tariff at DSP or Contracted Provider or 90% of Agreed Tariff at other providers 100% of cost (TTO limited to 7 days) at DSP or Contracted Provider or 90% of Agreed Tariff at other providers 100% of cost up to a maximum of 3 times RPL 100% of Agreed Tariff at DSP or Contracted Provider or 90% of Agreed Tariff at other providers 100% of Agreed Tariff at DSP or Contracted Provider or 90% of Agreed Tariff at other providers	Included in the R890,000 pfpa limit for hospitalisation Included in the R890,000 pfpa limit for hospitalisation Included in the R890,000 pfpa limit for hospitalisation	1. Subject to pre-authorisation by the Scheme's designated agent or hospital DSP. 2. Hospital accommodation, theatre fees, medicines and materials in hospital and hospital equipment are subject to an annual limit of R890,000 pfpa. 3. Benefit is not pro rated if member joins during benefit year.
1.2	SURGICAL PROCEDURES All in-hospital services, namely operations, procedures and consultations.	100% of cost up to a maximum of 3 times RPL		1. Subject to pre-authorisation by the Scheme's designated agent or hospital DSP. 2. Excludes dental implants, unless indicated as an essential part of another pre-authorised dental procedure. 3. Includes Elective Orthognatic Surgery and Maxillo Facial Surgery.
1.3	IN-HOSPITAL PSYCHIATRIC TREATMENT 1. Accommodation. 2. Medicines, materials and hospital equipment. 3. Visits by medical practitioners.	100% of UPFS or 100% of RPL 100% of cost (TTO limited to 7 days) 100% of RPL	Limited to 21 days pbpa	1. Includes treatment for substance abuse. 2. Benefit is not pro rated if member joins during benefit year. 3. Includes treatment on a day patient basis, in lieu of hospitalisation, subject to pre-authorisation. 4. Where the treatment is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
1.4	SUB-ACUTE FACILITIES / ALTERNATIVES TO HOSPITALISATION: 1. Step-down Nursing Facilities. 2. Private Nursing (in lieu of hospitalisation). 3. Hospice. 4. Post hospitalisation benefit (in lieu of hospitalisation). 5. Cardiac Rehabilitation Benefit (following hospitalisation / post discharge)	100% of RPL or Agreed Tariff at DSP or Contracted Provider, whichever is applicable 100% of RPL 100% of RPL 100% of RPL, or cost where no RPL exists 100% of RPL at Accredited Providers.	R12,960 pfpa 90 days per diagnosis 6 months per cardiac event. Subject to hospitalisation limit of R890,000 pfpa	1. Excludes frail care facilities. 2. Subject to pre-authorization by the Scheme's designated agent. 3. Post hospitalisation and/or cardiac rehabilitation benefit must be in accordance with an authorised treatment plan. 4. The Scheme's designated agent will liaise with the case manager of the hospital and the treating doctor to assess the appropriateness of step-down transfer of certain Beneficiaries. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge such as cardiac rehabilitation programme at an accredited provider, rehabilitation facilities, sub-acute facilities or home nursing in accordance with the Beneficiary's clinical motivation from doctors and case managers. 5. Benefit is not pro rated if member joins during benefit year. 6. The Cardiac Rehabilitation benefit provides for an initial 3-month intensive rehabilitation benefit followed by a 3-month continuing care benefit.
1.5	RADIOLOGY. Basic - All X-rays Ultrasounds Advanced - MRI & CT Scans - Scopes (Diagnostics) - Angiography	PMB: 100% of cost Non – PMB: 100% of RPL for both in and out of hospital Non – PMB 100% of RPL for both in and out of hospital Non – PMB: 100% of RPL for both in and out of hospital	R715 pbpa Subject to Pre-Authorisation	1. The Scheme's designated agent must authorise MRI, CAT Scans, Scopes and Angiography, except in emergencies. 2. In the event of an emergency, the Scheme's designated agent shall be notified on the first working day following the procedure. 3. In respect of PMB conditions, radiology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost. 4. Excludes PET-scans unless authorised as part of a member's Oncology Programme or where it is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent. 5. Where the service is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.
1.6	PATHOLOGY and MEDICAL TECHNOLOGY	PMB: 100% of cost Non-PMB: 80% of Agreed Tariff out of hospital 100% of Agreed Tariff in hospital		1. In respect of PMB conditions, pathology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost.
1.7	ORGAN TRANSPLANTS	PMB: 100% of cost Non-PMB: 100% of Agreed Tariff at DSP or contracted Provider	R108,000 pfpa	1. The Scheme will pay for both the cost of harvesting the organ from the donor as well as transplanting it into the recipient if both the donor and the recipient are members of the Society. Where the donor is a member of the Scheme and the recipient is not, the costs of harvesting the organ from the donor will not be covered by the Scheme. 2. Subject to pre-authorization. 3. Benefit includes anti-rejection medication, but excludes hospitalisation and related costs, which are covered under the hospitalisation benefit in 1.1 above. 4. Benefit is not pro rated if member joins during benefit year.

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	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
1.8	KIDNEY DIALYSIS	100% of RPL		1. Subject to pre-authorisation.
1.9	BLOOD TRANSFUSIONS	100% of cost		1. Includes the cost of blood, blood equivalents, blood products and the transport of blood. 2. Subject to pre-authorisation.
1.10	PROSTHESES External and Internal.	100% of Agreed Tariff at DSP or Contracted Provider or 90% of cost at other Providers	R13,600 pbpa, except for the following prostheses which shall be limited as stated: Hip Replacements: - Bilateral Total R40,000 - Total Hip R22,700 - Partial Hip R12,650 - Revision Hip R43,300 Knee Replacements: - Without Patella R25,200 - With Patella R28,500 - Bilateral Knee R50,500 - Revision Knee R43,800 Shoulder Replacements: - Total Shoulder R30,200 - Bilateral Shoulder R38,300 Spinal Fusion: - Level 1 (without cage) R13,800 - Level 1 (with cage) R26,100 - Level 2 (without cage) R18,350 - Level 2 (with 1 cage) R29,200 - Level 2 (with 2 cages) R42,800 Artificial Limbs: - Below the knee R13,200 - Above the knee R22,000 Artificial Eyes R13,200 Finger Joint Prosthesis R3,250 Pacemakers: - With leads R27,400 - Biventricular R44,900 Intra Cardiac Device R150,100 Cardiac Valves, each R20,700 Cardiac Stents with Delivery System, each R14,900 (maximum 3 pa) Drug Eluting Stents, each (maximum 3 pa) R18,600 Aortic Aneurism Repair Grafts R87,700 Cochlear Implant R137,200 Multiple external and internal prostheses are subject to a joint overall limit of R49,200 pbpa.	1. External: Eyes and limbs, e.g. legs and arms. 2. Internal: Appliances placed in the body to replace body parts during an operation with the exception of dental implants. 3. Subject to pre-authorisation by Scheme's designated agent or hospital DSP. 4. Benefit is not pro rated if member joins during benefit year. 5. Where the prosthesis is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the procedure.

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	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
1.11	AMBULANCE SERVICES (Road and Air)	100% of cost at preferred provider except for in case of emergency		<ol style="list-style-type: none"> Such transport is to be certified by a medical practitioner as being essential. Subject to authorisation from Scheme's preferred provider (ER24). Failure to obtain authorisation will render the Member liable for all of the costs incurred.
2. PRESCRIBED MEDICINE AND INJECTION MATERIAL:				
2.1	SELF-MEDICATION	100% of cost or 80% of cost, as per the acute medication benefit	R130 per ailment, subject to the acute medication limits	<ol style="list-style-type: none"> See Annexure D to the Scheme's Rules for details of the self-medication benefit.
2.2	ACUTE MEDICATION Acute sickness conditions.	100% of cost up to R800 per beneficiary, thereafter 80% of cost	Limits: M R2,960 M + 1 R4,630 M + 2 R5,230 M + 3 + R5,760	<ol style="list-style-type: none"> Prescribed by a person legally entitled to prescribe. Subject to QMP. Benefit is pro rated if member joins during benefit year.
2.3	NON-PMB CHRONIC MEDICATION Chronic sickness conditions.	100% of Agreed Tariff at DSP Single exit price plus the lower of the dispensing fee, as set out in medicine pricing regulations or that agreed with DSP, at non-DSP.	Limit: R20,200 pbpa subject to Appendix I	<ol style="list-style-type: none"> Includes daily continuous use of oxygen for a chronic ailment excluding the cylinder which is provided for in benefit 3.3 below; subject to pre-authorisation. Prescribed by a person legally entitled to prescribe. Medication in respect of PMB conditions is subject to the Care Plan, Formulary and QMP and Appendix 1. Medication in respect of a condition that is not included in the PMB list of conditions is subject to pre-authorisation on MRM and QMP and Appendix 1. Where the Formulary indicates clinically appropriate and effective medicines for a PMB condition and the member knowingly declines the formulary medicine and opts to use another medicine instead the member will be liable for 25% of the cost of the medication. Once the limit is reached, only medication in respect of PMB chronic conditions will be paid in full according to the Careplan, Formulary and QMP. Benefit is pro rated if member joins during benefit year.

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	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
3. PRIMARY CARE:				
3.1	PREVENTATIVE OUT-OF- HOSPITAL PROCEDURES 1. Blood Pressure Measurements 2. Blood Glucose Screening 3. Cholesterol Screening 4. Body Mass Index	100 % of cost	R100 pbpa	1. Only screening tests to be paid from this benefit
3.2	SPECIALIST AND GENERAL PRACTITIONER SERVICES: 1. Consultations and visits (out of hospital). 2. All other services unless stated otherwise in this Annexure.	PMB: 100% of RPL Non-PMB: 100% of RPL for first 4 consultations pbpa, thereafter 80% of RPL	PMB: Unlimited Non-PMB Limits: M R3,960 M + 1 R5,290 M + 2 R6,610 M + 3 + R7,940	1. Consultations in respect of a PMB condition are subject to the Care Plan and Appendix 1. 1. Includes consultations out of hospital (including, but not limited to chiropractor, homeopath, biokineticist, ante-natal visits and midwifery, osteopaths, naturopaths, dietitians, podiatrists, chiropodists, ayurvedic and traditional healers, therapeutic massage therapists and outpatient facilities; subject to registration with the HPCSA and AHPCSA). 2. Once the limit is reached, only consultations in respect of PMB chronic conditions will be paid in full. 3. Where the service is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. Benefit is pro rated if member joins during benefit year.
3.3	AUXILIARY SERVICES 1. Audiology. 2. Audiometry. 3. Occupational therapy. 4. Speech therapy. 5. Orthoptic Services.	80% of RPL	R4,100 pfpa	1. Only treatment / procedures to be paid from this benefit. 2. Consultations are to be paid in accordance with benefits defined in 3.1. 3. Where the service is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. Benefit is pro rated if member joins during benefit year.
3.4	APPLIANCES AND CONSUMABLES RELATING TO CHRONIC DISEASE AND / OR MEDICAL CONDITIONS: 1. Wheelchairs, Crutches, Braces, Walking Frames and similar equipment. 2. Appliances relating to Chronic Disease and Medical Conditions, eg. Oxygen Cylinders and Nebulisers (includes either hire or purchase). 3. Consumables relating to Chronic Disease and Medical Conditions, eg. Colostomy kits and other incontinence materials / equipment. 4. Diabetic Consumables and Appliances, including needles, strips & glucometers.	100% of cost 100% of cost 100% of cost 100% of cost	R6,600 pbpa R6,600 pbpa R12,950 pbpa R2,600 pbpa	1. Excludes: <ul style="list-style-type: none"> • daily continuous use of oxygen, which is included under the chronic medication benefit in 2.3 above. • hearing aids, which are provided for in a separate benefit under 3.4 below. 2. Benefit is pro rated if member joins during benefit year. 3. Where the appliance or consumable is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. All benefits, except for nebulisers, are subject to pre-authorisation.

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	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
3.5	ACUTE MEDICAL AND SURGICAL APPLIANCES	80% of cost	R4,450 pfpa	<ol style="list-style-type: none"> 1. This benefit is for appliances of an acute nature. 2. Prescribed by a person legally entitled to prescribe. 3. Examples of acute appliances, include, but are not limited to braces, slings, splints and corsets; cervical collars; thermo-moulded shoes and post-operative sandals, including bunionectomy Arco-pedico shoes; air casts; pressure garments; compression hose; cushions; mastectomy breast prosthesis; TED compression stockings; the hiring of sleep apnoea monitors for infants; and the hiring of wheelchairs, walking frames, crutches, traction equipment, toilet and bath raisers and bath swivel stools.
3.6	HEARING AIDS Includes repairs to hearing aids.	100% of cost	R6,480 pb per cycle	<ol style="list-style-type: none"> 1. Where the hearing aid is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the purchase of the hearing aid. 2. "Cycle" shall mean a 2 year cycle: 2009/2010.
3.7	PSYCHOLOGICAL and PSYCHIATRIC TREATMENT	PMB: 100% of RPL Non-PMB: 80% of RPL	R4,450 pfpa	<ol style="list-style-type: none"> 1. Consultations in respect of a PMB condition are subject to the Care Plan and Appendix 1. 2. Once the limit is reached, only consultations and services in respect of PMB conditions will be paid in full. 3. Where the service is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. Benefit is pro rated if member joins during benefit year.
3.8	CLINICAL and TECHNICAL TECHNOLOGISTS 1. In-hospital services. 2. Out of hospital services.	100% of cost to a maximum of 3 times RPL 80% of RPL		<ol style="list-style-type: none"> 1. All in-hospital services are subject to pre-authorisation.
3.9	DENTAL SERVICES 1. Conservative and Restorative Dentistry (includes plastic dentures and extractions under conscious sedation). 2. Special dentistry (Including metal base dentures). 3. Implants.	80% of RPL or Agreed Tariff	R12,520 pfpa limited to R6,260 pbpa	<ol style="list-style-type: none"> 1. All orthodontic services are subject to prior approval. Where the service is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. This is subject to a combined family limit of R12,520 per annum. 2. General anesthetic and hospitalisation for conservative dental work excluded except in the case of trauma and impacted 3rd molars. 3. In-hospital Dentistry subject to pre-authorisation by Scheme's designated agent or hospital DSP. 4. Benefit is pro rated if member joins during benefit year.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
3.10	PHYSIOTHERAPY	PMB: 100% of RPL Non-PMB: 80% of RPL	R4,430 pfpa limited to R1,540 pbpa	<ol style="list-style-type: none"> 1. Physiotherapy in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 1. 2. Once the limit is reached, only the costs for physiotherapy in respect of the diagnosis, treatment and care costs for a PMB condition will be paid in full. 3. Benefit is pro rated if member joins during benefit year.
3.11	TRAVELLING EXPENSES	80% of cost	R650 pfpa	<ol style="list-style-type: none"> 1. Costs unavoidably incurred in the seeking of urgent or emergency medical treatment. 2. In other cases, the benefit amount may be granted at the discretion of the Board, upon application. 3. Benefit is pro rated if member joins during benefit year.
3.12	<p>OPTICAL SERVICES</p> <ol style="list-style-type: none"> 1. Comprehensive Consultation (inclusive of Tonometry (glaucoma) screening and visual screening). <p>Plus</p> <ol style="list-style-type: none"> 2. Spectacles <ol style="list-style-type: none"> 2.1 Lenses 2.2 Frames and/or Prescription Lens enhancements <p>Or</p> <ol style="list-style-type: none"> 3. Contact lenses in lieu of spectacles 4. Refractive Surgery. 	<p>100% of cost if obtained from PPN</p> <p>100% of cost for one pair of clear single vision spectacle lenses of any prescription including charges for extra lenses and prismatic correction when obtained from PPN pb per cycle</p> <p>Or</p> <p>100% of cost for one pair of clear AQUITY bifocal spectacle lenses of any prescription when obtained from PPN pb per cycle</p> <p>100% of cost in and out of network</p> <p>100% of cost in and out of network</p> <p>Benefits provided for under hospitalisation</p>	<p>One pb per cycle</p> <p>Consultations outside the network will be limited to a maximum of R400 pb per cycle.</p> <p>One pair of clear single vision spectacle lenses limited to R120 per lens when obtained outside of Network pb per cycle</p> <p>One pair of clear bifocal or multifocal spectacle lenses, limited to R250 per lens when obtained outside of Network pb per cycle</p> <p>Limited to R600 pb per cycle</p> <p>Limited to R840 pb per cycle</p>	<ol style="list-style-type: none"> 1. "Cycle" shall mean a 2 year cycle: 2009/2010. 2. Preferred Provider Network (PPN) is the Scheme's Designated Service Provider for providing optical care to its members. 3. All out-of-network care will be subject to the following maximum limits: <ul style="list-style-type: none"> • Spectacles with single vision lenses: R840 • Spectacles with bifocal or multifocal lenses: R1,100 • Contact lenses: R840 • Consultation: R400 <p>Where the maximum frame entitlement of R600 is not utilized at a PPN provider, the balance may be used for prescription lens enhancements.</p> 4. Refractive eye surgery is provided for under the hospitalisation benefit and subject to pre-authorisation and guidelines laid down by the Scheme's designated agent. 5. A list of PPN affiliated optometrists may be obtained from the Society's website.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
4. GENERAL				
4.1	HIV/AIDS AND RELATED ILLNESSES	100% of Single Exit Price (SEP) plus the lower of the agreed or regulated dispensing fee at DSP 100% of Agreed Tariff at DSP Contracted Provider or 90% of cost at other providers	In respect of pathology, medication and consultations. In respect of hospitalisation and related services.	1. Medicine and hospital pre-authorisation is required. 2. Registration and compliance with the HIV/Aids Programme is required and use of DSP is required. Failing which a co-payment for the diagnosis, treatment and care costs will apply. 3. Subject to Appendix I. 4. Post Exposure Prophylactics: Members will be covered for 28 days on Triple Therapy.
4.2	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above	Subject to Prescribed Minimum Benefits and Appendix I	1. Subject to pre-authorisation. 2. Where the treatment is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.
4.3	INFERTILITY	Prescribed Minimum Benefits only		1. Prescribed minimum benefits will be paid in respect of services obtained in the DSP and from State/Public Hospitals.
4.4	ONCOLOGY PROGRAMME/ CHEMOTHERAPY AND RADIOTHERAPY	100% of Agreed Tariff	Limit: R350,000 pbpa, subject to Prescribed Minimum Benefits and Appendix 1.	1. Subject to pre-authorisation and registration on the programme. 2. These benefits apply to in and out of hospital chemotherapy and radiotherapy. 3. Medication to treat side effects of chemotherapy and radiotherapy are to be paid from this benefit. 4. Not subject to chronic medication limits. 5. Includes all treatment in terms of the care plans. 6. Consultations are subject to authorised treatment plans and not the limits set out in benefit 3.1 above. 7. Where the treatment is deemed to be clinically appropriate and medically necessary by the Scheme's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.

Benefits are not transferable from one financial year to another or from one category to another.

PMB conditions referred to in this Annexure are the minimum benefits which the Scheme must provide for it's members with regard to diagnosis and treatment of approximately 270 illness conditions (as stipulated in the Act) and the diagnosis, medical management and medication for 26 chronic disease conditions (listed below).

EXPLANATION OF PMB (CDL)

The diagnosis, treatment and care costs for relevant health care services rendered at DSPs will be paid in full for the Prescribed Minimum Benefits (PMB), Chronic Disease List Conditions (CDL). There are no limits on these services, provided these are within the Care Plans and obtained from the designated service provider (DSP), where applicable and subject to Appendix 1.

PMB Chronic Disease List:

Addison's Disease	Asthma
Bipolar Mood Disorder (not implemented as yet)	Bronchiectasis
Cardiac Failure	Cardiomyopathy
Chronic Renal Disease	Chronic Obstructive Pulmonary Disease
Coronary Artery Disease	Crohn's Disease
Diabetes Insipidus	Diabetes Mellitus Types 1 & 2
Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
Hyperlipidaemia	Hypertension
Hypothyroidism	Multiple Sclerosis
Parkinson's Disease	Rheumatoid Arthritis
Schizophrenia	Systemic Lupus Erythematosus
Ulcerative Colitis	HIV-Infedtion

The HIV/AIDS benefit provided will be in accordance with the National Antiretroviral Treatment Guidelines and the algorithms specified within the Prescribed Minimum Benefits for the treatment and management of HIV/AIDS

Key:

Agreed Tariff	= The tariff agreed between the Scheme and the service provider, whether designated or preferred provider.
Formulary	= A list of preferred medicines for the treatment of the 26 PMB (CDL) conditions. It includes original, branded and generic medicines and is administered by the Scheme's designated agent.
QMP	= Qualsa Maximum Price. The maximum price that the Society pays for medication, based on the cost of any original product.
PMB	= Prescribed Minimum Benefits as stipulated in the Regulations to the Medical Schemes Act.
RPL	= The Reference Price List published by the Department of Health. In the absence of the RPL being published by the Department of Health in a particular year, the Board may determine an appropriate rate of reimbursement for that particular year. In the absence of a published RPL tariff for 2010, RPL is defined as the RPL as determined by the Scheme for 2009 plus an 8% inflationary increase. In respect of claims from Namibian service providers, the RPL will be the NAMAF tariff.
TTO	= To-take-out Medicine – Medicine taken home after being hospitalised.
UPFS	= Uniform Patient Fee Structure (Tariff charged by State/Public Facilities).
pfpa	= per family per annum (family is defined as the member plus his/her registered dependants).
pbpa	= per beneficiary per annum.
PPN	= Preferred Provider Network – the Scheme's Designated Agent that provides Optical Care to the scheme's members.
MRM	= Medicine Risk Management Programme provided by the Scheme's Designated agent.
HPCSA	= Health Professions Council of South Africa.
AHPCSA	= Allied Health Professions Council of South Africa.
M	= Single Member.
M+	= Member with dependants.
Care Plan	= A list of services for the specific PMB CDL conditions, based upon protocols / guidelines as published by the Minister of Health. The services may include GP and Specialist consultations as well as pathology and other diagnostic services, such as radiology and physiotherapy.
DSP	= Designated Service Provider. A designated service provider is a provider that the Scheme has chosen as its preferred provider for specific services for the members of the Scheme.
Contracted Provider	= A service provider, other than a DSP, with whom the Scheme has negotiated a tariff for the provision of specific services for the members of the Scheme. As of 1 January 2006, the Scheme has contracted with Gatesville Medical Centre, Mitchells Plain Medical Centre and Bellville Medical Centre for the provision of hospital accommodation for members of the Scheme.