

BENEFITS
(Effective 1 January 2008)

The Scheme Rate is determined by, and equal to, the 2008 National Health Reference Price List (NHRPL).

PART 1

CORE BENEFITS

The Core Benefits in terms of Rule 16 are as set out in Tables B.1 and B.2 below. Notwithstanding any other provisions in these Rules the Scheme will provide, in the state hospital facilities and at a designated service provider, all members and dependants with cover for the prescribed minimum benefits at 100% of the cost. The Scheme's designated service providers are the Preferred Provider Network Hospitals for all in-hospital procedures and the Centre for Diabetes and Endocrinology (CDE) for in and out-of-hospital treatment in respect of diabetes.

Voluntary treatment for all elective procedures other than diabetic related procedures rendered at an institution other than the Preferred Provider Network Hospitals appointed by the Scheme, shall be paid at the agreed tariff, subject to a co-payment of R1 000 payable by the member. In the event of emergencies, this ruling would not be applicable for the duration of stabilising the patient, thereafter the member must be transferred to a Preferred Provider Network Hospital. In respect of diabetes, voluntary treatment at a provider other than CDE will be covered at 70% of the Scheme Rate if a member is not registered on the CDE Managed Care program.

The benefits in Table B.1 are for hospitalisation, and are subject to an Overall Annual Limit of R1 000 000 for a Member Family and R500 000 for a beneficiary.

In the event of hospitalisation, the member is required to obtain compulsory pre-authorisation. Failure to obtain authorisation at least 48 hrs prior to being hospitalised, will result in an excess payable by the member of R1 000 per admission. A member is not required to obtain pre-authorisation for hospital admission in the case of an emergency. However, in such instance, a member must notify the Scheme's provider of the admission within 48 hours thereafter.

Overall Annual Limit

The Overall Annual Limit applies to all benefits paid from Scheme funds. No benefits are payable by the Scheme after depletion of the Overall Annual Limit, except for Statutory Prescribed Minimum Benefits (PMBs), which continue to be covered after the specified sub-limits and Overall Annual Limit are exhausted.

Table B.1 Hospitalisation Benefits

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
Statutory Prescribed Minimum Benefits (PMBs)	100% of cost	In & out of hospital procedures & treatment rendered by Public Hospital or Designated Service Provider unlimited as per Regulations, and subject to pre-authorisation.
Private hospitals (excluding rehabilitation) Ward & Theatre Fees	100% of agreed tariff	Included in overall annual limit Benefits for admission to private hospitals are subject to pre-authorisation and utilisation of the Preferred Provider Network hospitals appointed by the Scheme. In the event that non-Preferred Provider Network hospitals are voluntarily utilised, a co-payment of R1 000 will be payable by the member directly to the hospital.
Provincial hospitals	100% of UPFS or cost whichever is the lower	
Medicines dispensed in hospital and upon discharge from hospital	100% of SEP & agreed dispensing fee subject to Maximum Medical Aid Price (MMAP)	To take out medication (TTOs) limited to 7 days supply
Approved secondary /step-down facilities	100% of agreed tariff	
General Practitioner and Specialist Procedures and consultations, including confinements in hospitals Confinements will be subject to pre-authorisation at 36 weeks of pregnancy	150% of Scheme rate	Included in overall annual limit
Blood transfusions and Technician services	100% of Scheme rate	Included in overall annual limit
Radiology and Pathology in & out of hospital	100% of Scheme rate or agreed tariff	Included in overall annual limit

Renal dialysis	100% of Scheme rate	Subject to overall annual limit
ISOS Emergency Rescue Services Only	100% of cost	Subject to overall annual limit and ISOS protocols
Surgical/Internal prostheses Subject to pre-authorisation and the Hospital Risk Management program	100% of cost per item as per surgical prosthesis schedule below*	R25,000 per beneficiary Both specified and non-specified items are limited to a total benefit of R25 000 per beneficiary per year, unless the individual limit detailed in the schedule below is higher than R25 000.
Hospitalisation for psychiatric conditions/substance abuse	100% of agreed tariff	R32,000 per beneficiary
Maxillo - facial surgery (excluding special dentistry)	100% of Scheme rate	Included in overall annual limit
Organ transplants (hospitalisation and surgery)	100% of Scheme rate	Subject to overall annual limit
Oncology treatment (in & out of hospital treatment and medication & materials) Subject to pre-authorisation with Qualsa's Oncology Management Programme.	100% of Scheme rate	R300,000 per beneficiary

***SURGICAL PROSTHESIS SCHEDULE**

Prosthesis	Amount	Limitation
Partial hip replacement	R14,000	Per beneficiary per year
Total hip replacement	R30,000	Per beneficiary per year
Spinal fusion	R32,000	Per beneficiary per year
Cardiac stents	R15,000	Per beneficiary (maximum 3 per year)
Cardiac pacemakers	R39,000	Per beneficiary per year
Grafts	R26,000	Per graft per beneficiary per year
Cardiac valves	R27,000	Per valve per beneficiary per year
Artificial limb	R22,000	Per family per year
Artificial eyes	R11,000	Per family per year
Knee replacement	R28,000	Per beneficiary per year
Shoulder replacement	R32,000	Per shoulder per family per year
All other surgical prostheses claims	R25,000	Per beneficiary per year

PART 1 (Continued)**CORE BENEFITS**

Table B.1 Continued

Specialised radiology (MRI and CT scans) 100% of Scheme rate	Subject to overall annual limit and pre- authorisation
HIV/AIDS	Subject to Prescribed Minimum Benefit protocols
Outpatient surgical procedures (List of procedures below) 150% of Scheme rate	Subject to the overall annual limit

The following procedures, if performed in a doctor's rooms, do not require pre-authorization and are covered from the overall annual limit. Anaesthetic costs, if applicable, are only covered for local/regional anaesthetic or, at most, conscious sedation. General anaesthetic costs are not covered for procedures performed in a doctor's rooms except in respect of PMBs.

GASTRO-ENTEROLOGY

Gastroscopy
Oesophagoscopy
Colonoscopy
Cystoscopy
Direct laryngoscopy
Bronchoscopy

OPHTHALMOLOGY

Treatment of retina and choroids by cryotherapy
Pan retinal photocoagulation in one sitting
Laser capsulotomy
Laser trabeculoplasty
Laser apparatus hire fee

Out of hospital preventative procedures	Subject to overall annual limit 100% Scheme rate
Dental check up/oral hygienist	1 visit per beneficiary per year
Flu vaccine injection	1 per beneficiary per year
Eye testing	1 test per beneficiary per year
Cholesterol tests	No limit on number of tests
Pap Smears	No limit on number of procedures
Mammograms	No limit on number of procedures

The benefits in Table B.2 are for treatment of chronic conditions, and are subject to an annual limit of R76,000 for a member family and R37,000 for a beneficiary unless in respect of Prescribed Minimum Benefits.

Table B.2 Chronic Condition Benefits including PMB Diagnosis and Treatment Pairs (DTPs) and Chronic Disease List (CDL) conditions

CHRONIC CONDITIONS	BENEFIT AMOUNT	ANNUAL LIMIT
<p>Drug treatment for any of the following:</p> <p>All chronic conditions covered subject to registration on the Scheme's Medicine Risk Management programme, except in respect of Diabetes types 1 & 2.</p> <p>Diabetes cover will be subject to registration with and protocols of the Centre for Diabetes & Endocrinology (CDE)</p> <p>25 PMB Conditions:</p> <p>Addison's disease, Asthma, Bipolar mood disorder, Bronchiectasis, Cardiac failure, Cardiomyopathy disease, Chronic renal failure, Coronary artery disease, Chronic obstructive pulmonary disorder, Crohn's disease, Dysrhythmias, Epilepsy, Glaucoma, Haemophilia, Hyperlipidaemia, Hypertension, Hypothyroidism, Multiple sclerosis, Parkinson's disease, Rheumatoid arthritis, Schizophrenia, Systemic lupus erythematosus, Ulcerative colitis, Antiretroviral therapy, *Diabetes Insipidus, *Diabetes Mellitus Type 1 & 2</p>	<p>100% of SEP plus agreed dispensing fee.(MMAP will apply)</p> <p>100% of cost if provided through CDE. 70% of SEP plus agreed dispensing fee if not registered on CDE.</p>	<p>Accrues to the chronic condition limit</p> <p>PMB conditions are covered at 100% of cost unlimited subject to the use of the Scheme's DSPs.</p> <p>The Scheme's PMB DTP & CDL programme offers benefits in accordance with approved Care Plans in respect of the diagnosis, treatment and care for such conditions. If medicines are voluntarily obtained from a provider other than the Scheme's DSP, co-payments could be applied.</p>

<p>Non-PMB conditions Allergic Rhinitis, Alzheimer's disease, Ancillary treatment, Auto-immune haemolytic anaemia, Cancer, Cerebral aneurysm, Conn's syndrome, Cushing's syndrome, Cystic fibrosis, Emphysema, Ischaemic heart disease, Macroglubolinaemia, Menopause, Myastenia gravis, Osteoarthritis, Osteoporosis, Paraplegia, Pemphigus, Peripheral arteriosclerotic disease, Psoriasis, Scleroderma, Waldenstrom's syndrome, Wilson's disease.</p>	<p>100% of SEP plus regulated dispensing fee (MMAP will apply)</p>	
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The benefits described in Table B.3 below shall be paid by deduction from **members' Medical Spending Accounts**, as described in Rule 16.2, and are subject to the funds available in the **members' Medical Spending Account (MSA)**, except in respect of PMBs.

Table B.3 Benefits Payable from members' Medical Spending Accounts

GENERAL PRACTITIONERS, SPECIALISTS AND PHYSIOTHERAPY OUT OF HOSPITAL	BENEFIT	ANNUAL LIMIT
General practitioners, specialists - consultations and visits outside of the hospital	150% of Scheme rate	Subject to MSA Balance
Physiotherapy services	100% of Scheme rate	Subject to MSA Balance
Circumcision procedures	150% of Scheme rate	Subject to MSA Balance
DENTISTRY	BENEFIT	ANNUAL LIMIT
Conservative – fillings, extractions, X-rays and prophylaxis	100% of Scheme rate	1 visit per beneficiary per year from insured benefit. Balance then subject to MSA
Special – orthodontic, periodontic, crowns, bridgework, dentures, dental implants and osseointegration	100% of Scheme rate	Subject to MSA Balance
PRESCRIBED MEDICINES	BENEFIT	ANNUAL LIMIT
Medicines prescribed by medical practitioners Subject to the MMAP	100% of SEP & agreed dispensing fee. Excludes administration fee	Subject to MSA Balance
Pharmacy Advised Therapy Homeopathic and Naturopathic medicines	100% of agreed tariff or SEP & agreed dispensing fee. Excludes administration fee	Subject to MSA Balance
OPTICAL	BENEFIT	ANNUAL LIMIT
Optometric tests (including all visual tests)	100% of agreed tariff	1 visit per beneficiary per year from insured benefit. Balance subject to MSA
Spectacles: lenses and frames including contact lenses and "readers"	100% of agreed tariff	Subject to MSA balance
EXTERNAL SURGICAL APPLIANCES	BENEFIT	ANNUAL LIMIT
Hearing aids, orthopaedic boots, surgical collars, wheelchairs, nebulisers and oxygen equipment, etc	100% of cost	Subject to MSA Balance

ALTERNATIVE SERVICES	BENEFIT	ANNUAL LIMIT
Homeopaths, naturopaths and chiropractors (excluding X-rays and appliances)	100% of Scheme rate	Subject to MSA balance
Private or home nursing	100% of Scheme rate	Subject to MSA balance
Clinical psychology) and psychiatric consultations (excluding educational counselling)	100% of Scheme rate	Subject to MSA balance
Speech therapy and audiology, occupational therapy, podiatry (excluding X-rays and appliances)	100% of Scheme rate	Subject to MSA balance
HOSPICE SERVICES	BENEFIT	ANNUAL LIMIT
Accommodation	100% of Cost	Subject to MSA Balance
Home care visits	100% of Cost	Subject to MSA Balance
Home visits by medical officer	100% of Cost	Subject to MSA Balance