PLUS OPTION BENEFITS
(Effective 1 January 2025)

DEFINITIONS

The **Scheme Rate** is defined as the rate at which claims will be reimbursed, as approved by the Board of Trustees.

Designated Service Provider ('DSP') is defined as a network of providers appointed by the Scheme as preferred providers to provide Members with diagnosis, treatment and care in respect of one or more PMB conditions.

The Scheme's Designated Service Providers are:

- The Centre for Diabetes and Endocrinology ('CDE') is a DSP who provide complete out of hospital care to Beneficiaries with Diabetes Mellitus.
- The Independent Clinical Oncology Network ('ICON') is a DSP for the provision of oncology services
- ER24 for emergency medical transportation

Preferred Provider is defined as a network of health care providers, appointed by the Scheme, to provide members with health care services.

The Scheme's Preferred Providers are :

- The Momentum Pharmacy Network
- The Momentum Specialist Network
- The Opticlear Network of Optometrists

The **Agreed rate** is defined as the fee for any health care service, as determined by the Board of Trustees following negotiations with a network of service providers.

The **Medicine Reference Price ('MRP')** is the maximum price that the Scheme will pay for specific categories of medicines for which generic product(s) exist.

Dispensing fee is the maximum fee, excluding VAT, which may be charged to evaluate a script, prepare the medication and advise the patient.

BENEFITS APPLICABLE TO THE PLUS OPTION

The Benefits applicable to the Plus Option, in terms of Rule 16, are as set out below.

Notwithstanding any other provisions in these Rules, the Scheme will provide all Members and Dependants with cover for the Prescribed Minimum Benefits at 100% of cost.

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 programme.

Dispensing fees will be reimbursed at the rate agreed with the Momentum Pharmacy Network. The difference between dispensing fees at a non-network and network pharmacy will be payable by the Member.

TABLE 1: HOSPITALISATION BENEFITS

The benefits in Table 1 are for hospitalisation and are unlimited.

In the event of hospitalisation, the Member is required to obtain compulsory Pre-authorisation. Failure to obtain authorisation at least 48 hours prior to being hospitalised, could result in a R1 000 co-payment per admission. A Member is not required to obtain Pre-authorisation for a hospital admission in the case of an emergency. However, in such instances, a Member must notify the Scheme's provider, Momentum Health Solutions (MHS), of the admission within 48 hours thereafter.

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
Statutory Prescribed Minimum Benefits (PMBs)	100% of Cost	Services rendered by State Hospitals or DSP unlimited; subject to Pre-authorisation and Managed Care Protocols.
Hospitalisation State hospitals Private hospitals (excluding rehabilitation)	 100% of UPFS or Cost whichever is the lower 100% of Agreed Rate	Benefits for admission to hospitals are subject to Managed Care Protocols and Pre-authorisation with the Scheme's Managed Care Provider at least 2 working days prior to admission or within 48 hours in the case of emergencies
Medicines dispensed in hospital and upon discharge from hospital	100% of SEP & Agreed Dispensing Fee	To take out medicines (TTOs) are limited to a 7day supply and are subject to medicine formulary
Alternatives to Hospitalisation · Step-down facilities · Hospice (ward fees and disposables) · Home Nursing	100% of Agreed Rate or 100% of Cost in the case of PMBs	Subject to PMB regulations, Pre-authorisation and Managed Care Protocols
Hospitalisation for Psychiatric Conditions/ Substance Abuse	100% of Agreed Rate	R82 300 **per beneficiary.** PMB admissions will accrue to this limit, but are not subject to this limit

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
General Practitioner Procedures and Consultations	140% of Scheme Rate	Unlimited
Specialist Procedures and Consultations	100% of the Agreed Rate at a Preferred Provider Specialist and 140% of Scheme Rate at a non-preferred provider. Co-payments may apply at a non-preferred provider	Unlimited
Confinements	100% of Agreed Rate at a Preferred Provider and 140% of Scheme Rate at a non-preferred provider. Co-payments may apply at a non-preferred provider	Unlimited Subject to Pre-authorisation by 36 weeks of pregnancy
Blood transfusions and Technician Services	100% of Scheme Rate or Agreed Rate	Unlimited
Radiology and Pathology in hospital	100% of Scheme Rate or Agreed Rate	Unlimited
Renal dialysis	100% of Scheme Rate or Agreed Rate unless a	Subject to Pre-authorisation and Managed Care Protocols

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
	PMB, in which case 100% of cost	
ER24 (Emergency Medical Services Only)	100% of Agreed Rate	Subject to ER24 Pre-authorisation and Protocols
Internal prostheses	100% of Agreed Rate per item as per surgical prosthesis schedule below*	Subject to pre-authorisation and managed care protocols.
Maxillo-Facial Surgery (excluding Specialised Dentistry)	100% of Scheme Rate	Subject to Pre-authorisation and Managed Care Protocols
Organ Transplants (Hospitalisation and Surgery)	100% of Agreed Rate at a Preferred Provider and 140% of Scheme Rate at a non-Preferred Provider. Co-payments may apply at a non-Preferred Provider	Subject to pre-authorisation and managed care protocols
Oncology Treatment (including all in & out-of-hospital treatment and medication & materials)	100% of Agreed Rate at a Preferred Provider and 140% of Scheme Rate at a non-Preferred Provider. Co-payments may apply at a non-Preferred Provider	R710 000 **per beneficiary.** Subject to Pre-authorisation and registration on the Oncology Management Programme and ICON protocols
Specialised Radiology (MRI and CT scans)	100% of Agreed	Subject to Pre-

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
	Rate, unless a PMB, in which case 100% of cost	authorisation. PMB scans – unlimited. Non-PMB scans - limited to 2 **per family** per year, subject to R500 co-payment.
Home Oxygen - daily continuous use of oxygen for a chronic ailment.	100% of Agreed Rate, unless a PMB, in which case 100% of cost	Subject to Pre-authorisation, Managed Care Protocols and pre-approval by the Scheme's Medical Advisor.
HIV/AIDS	100% of Cost	Subject to registration on the HIV/AIDS Management Programme. Treatment within PMB Protocols at DSP is unlimited.
Outpatient surgical procedures (List of procedures below**)	100% of the Agreed Rate at a Preferred Provider Specialist and 150% of Scheme Rate at a non-Preferred Provider. Co-payments may apply at a non-Preferred Provider	Subject to Pre-authorisation and Managed Care Protocols
External surgical appliances prescribed as part of a hospital event e.g. crutches, moonboots, walkers etc.	100% of Scheme Rate	Subject to Pre-authorisation and Managed Care Protocols
Speech therapy, Physiotherapy, Audiology,	100% of Scheme	Subject to Pre-

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
Occupational Therapy as part of a hospital event or resulting from a hospital event for a period of 6 weeks post-discharge.	Rate	authorisation and Managed Care Protocols
Out-of-hospital Psychiatric Consultations (PMB conditions only)	100% of Agreed Rate at a Preferred Provider and 150% of Scheme Rate at a non-Preferred Provider Co-payments may apply at a non-Preferred Provider	Only PMB conditions will be paid from Insured benefits. Subject to registration on the Mental Wellness Programme, in which case an appropriate care plan based on clinical protocols will be issued.

***SURGICAL PROSTHESIS SCHEDULE**

This schedule lists surgical prostheses and appliances (excluding dental implants) placed in the body as internal fixtures during an operation.

The items below are subject to the benefit limits indicated. **PMB conditions accrue to, but are not subject to, the limits below:**

PROSTHESIS	AMOUNT	LIMITATION
Partial hip replacement	R35 800	Only 1 joint, per beneficiary per year
Total hip replacement	R45 000	Only 1 joint, per beneficiary per year
Spinal fusion	R46 000	Per beneficiary per year
Cardiac stents	R45 000	Per beneficiary (maximum 3 per year)
Cardiac pacemakers	R101 000	Per beneficiary per year
Grafts	R28 500	Per graft per beneficiary per year
Cardiac valves	R69 500	Per valve per beneficiary per year
Artificial limb	R150 000	Per family per year
Artificial eyes	R28 300	Per family per year
Knee replacement	R35 000	Only 1 joint, per beneficiary per year
Shoulder replacement	R35 000	Per shoulder per beneficiary per year
All other claims for internal prosthesis, not specified above	R69 200	Per beneficiary per year

****OUT-OF-HOSPITAL SURGICAL PROCEDURES LIST**

The following procedures, if performed in a doctor's rooms, and subject to Pre-authorisation and Managed Care Protocols, are covered from the Insured Benefit. Anaesthetic costs, if applicable, are covered for local/regional anaesthetic and conscious sedation costs.

GASTRO-ENTEROLOGY

Gastroscopy and related procedures

Colonoscopy, Oesophagoscopy, Sigmoidoscopy and related procedures
R2 500 co-payment if these are performed in hospital without an approved clinical indication and Scheme approval.
Anaesthetic costs related to these scopes are limited to local or regional anaesthetic.
General anaesthetic costs are not covered

OPHTHALMOLOGY

Treatment of retina and choroids by cryotherapy
Pan-retineal photocoagulation in one sitting
Laser capsulotomy
Laser trabeculuplasty
Laser apparatus hire fee

Please note: Costs related to Lasik eye surgery are excluded from the benefits.

OTHER

Circumcision
Dental surgery (fillings and extractions for children under 7 years of age)

EMERGENCY ROOM TREATMENT

Emergency Treatment in a trauma or casualty facility of a hospital, and all associated costs, where such treatment was either due to an emergency or resulted in an admission into hospital will be paid at 100% of the Agreed Rate and / or 150% of Scheme Rate, where applicable, from the In-hospital benefit, unless a PMB, in which case it will be paid at 100% of cost
Where such treatment has prevented an admission into hospital and / or where such treatment could not be rendered in a doctor's consultation room, the trauma fee and all associated costs will be paid from the In-hospital benefits at 100% of the Agreed Rate and / or 150% of Scheme Rate where applicable and at 100% of cost in the event of a PMB.

TABLE 2: OUT-OF-HOSPITAL INSURED BENEFITS

OUT-OF-HOSPITAL PREVENTATIVE PROCEDURES	PAID FROM INSURED BENEFITS AT 100% OF SCHEME RATE
Flu vaccine injection	1 per beneficiary per year
Eye testing	1 test per eye per beneficiary every 2 years at an Opticlear Optometrist. Co-payments may apply at a non-Preferred Provider Optometrist Only the consultation fee, inclusive of tonometry, will be paid from Insured Benefits. Lenses, frames, etc. will be paid from available MSA.
Preventative Health Screenings, limited to: • Blood Pressure Measurements • Blood Glucose Screening (finger prick test) • Cholesterol Screening (finger prick test) • Body Mass Index	These screening tests are to be undertaken at any Pharmacy Network Providers, are subject to Scheme Protocols and limited to R370 per beneficiary per year.
Cholesterol tests	One of the following tariff codes will be allowed: • 4025 • 4026 • 4027 • 4028 • 4170
Pap Smears	. The following tariff code will be allowed: • 4566 • 4599
Prostate Specific Antigen (PSA) testing	The following tariff code will be allowed: • 4519

OUT-OF-HOSPITAL PREVENTATIVE PROCEDURES	PAID FROM INSURED BENEFITS AT 100% OF SCHEME RATE
Mammograms Beneficiary 40 years and older or clinically indicated (high risk members). Once every 2 years.	One of the following tariff codes will be allowed: • 3605 • 34100 • 34101
Pneumococcal Vaccine (Pneumovax only)	1 per beneficiary per year matching the following criteria: i. Over 65 years, or patients diagnosed with the following: - Cancer - Asthma - COPD - Cardiac failure; and - HIV
Bone Density scan (DEXA)	One per female beneficiary (over 65 years) every two years. One per male beneficiary (over 70 years) • 3604 • 39173 • 150120
Colorectal Screening	50 years and older or family history Faecal Occult blood annually • 4351

OUT-OF-HOSPITAL PREVENTATIVE PROCEDURES	PAID FROM INSURED BENEFITS AT 100% OF SCHEME RATE
	• 4352

OUT-OF-HOSPITAL MATERNITY BENEFITS	PAID FROM INSURED BENEFITS, SUBJECT TO REGISTRATION ON THE SCHEME'S MATERNITY PROGRAMME
GP Consultations	1 antenatal consultation per pregnancy at % of Scheme rate
Obstetrician / Gynaecologist Consultations	7 antenatal consultations per pregnancy at 200% of Scheme rate at a Preferred Provider and 155% of Scheme rate at a non-Preferred Provider. Co-payments may apply at a non-Preferred Provider
2D Ultrasounds	2 scans per pregnancy at 100% of Scheme rate or agreed tariff,
Routine blood tests for abnormalities	One of each of the following blood tests per beneficiary per pregnancy, with tariff codes as listed below • 4448 • 3755 • 3764 and 3765 • 3709 • 3932 and 4614 • 4050 • 3948 or 3949 • 4531 and 3942 • 4188

OUT-OF-HOSPITAL MATERNITY BENEFITS	PAID FROM INSURED BENEFITS, SUBJECT TO REGISTRATION ON THE SCHEME'S MATERNITY PROGRAMME
Antenatal Vitamins	Limited to R140 per month during pregnancy and 1 month post-delivery. Subject to pre-registration on the Maternity Programme.

TABLE 3: CHRONIC CONDITION BENEFITS INCLUDING PMB DIAGNOSIS AND TREATMENT PAIRS (DTPS) AND CHRONIC DISEASE LIST (CDL) CONDITIONS

The benefits in Table 3 are for the treatment of chronic conditions and are subject to an annual limit of **R165 200** for a member family and **R80 200** for a beneficiary, unless in respect of Prescribed Minimum Benefits.

CHRONIC CONDITIONS	BENEFIT AMOUNT	ANNUAL LIMIT
Drug treatment for any of the following:		
All chronic conditions covered, subject to registration on the Scheme's Medicine Risk Management programme and approval of treatment protocols, except in respect of Diabetes types 1 & 2.	100% of SEP plus Agreed Dispensing fee. (Subject to Medicine Reference Price List and use of a Momentum Pharmacy Network)	Accrues to the chronic condition limits of R80 200 per beneficiary or R165 200 per family
Diabetes cover will be subject to registration with and protocols of the Centre for Diabetes & Endocrinology (CDE)	100% of cost if provided through CDE. 70% of SEP plus Agreed Dispensing Fee if not provided through CDE. (Subject to Medicine Reference Price)	
PMB Conditions	Unlimited, subject to Care Plan Protocols and Formulary	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.

26 CDL conditions:

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.

Additional Chronic Conditions:

Allergic Rhinitis, Alzheimer's disease, Cystic Fibrosis, Depression, GORD (Gastro Oesophageal Reflux Disease), Gout, Myasthenia Gravis, Osteoarthritis, Osteoporosis, Peripheral Arteriosclerotic disease, Psoriasis, Scleroderma, Wilson's disease.

TABLE 4: BENEFITS PAYABLE FROM MEMBERS' MEDICAL SPENDING ACCOUNTS

The benefits in Table 4 below shall be paid from the Members' **Medical Spending Accounts (MSA),** as described in Rule 17.2, and are subject to the funds available in the MSA, except in respect of PMBs which will be paid from the Insured Benefits.

GENERAL PRACTITIONERS, SPECIALISTS AND OTHER CONSULTATIONS OUT-OF-HOSPITAL	**BENEFIT**	**ANNUAL LIMIT**
General practitioners - consultations and out-of-hospital visits	150% of Scheme Rate	Subject to MSA balance
Hello Doctor General practitioner tele-health consultations	100% of Agreed Rate	Subject to MSA. Once MSA is depleted, 2 Hello Doctor consultations per family will be paid from Insured Benefits. This does not include any associated claims prescribed or referred

GENERAL PRACTITIONERS, SPECIALISTS AND OTHER CONSULTATIONS OUT-OF-HOSPITAL	BENEFIT	ANNUAL LIMIT
		by the HelloDoctor provider.
Specialists	100% of the Agreed Rate at a Preferred Provider Specialist and 155% of Scheme Rate at a non-Preferred Provider Specialist. Co-payments may apply at a non-Preferred Provider.	Subject to MSA balance
Physiotherapy services	100% of Scheme Rate	Subject to MSA balance
Auxiliary services - Speech therapy and audiology, occupational therapy, podiatry, homeopathy, naturopathy, chiroprators, etc(excluding X-rays and appliances	100% of Scheme Rate	Subject to MSA balance
Clinical Psychology (excluding educational counselling) Non-PMB services	150% of Scheme Rate	Subject to MSA

GENERAL PRACTITIONERS, SPECIALISTS AND OTHER CONSULTATIONS OUT-OF-HOSPITAL	BENEFIT	ANNUAL LIMIT
Psychiatric consultations Non-PMB services	100% of Agreed Rate at a Preferred Provider and 155% of Scheme Rate at a non-Preferred Provider. Co-payments may apply at a non-Preferred Provider	Subject to MSA balance

DENTISTRY	BENEFIT	ANNUAL LIMIT
Conservative Dentistry – fillings, extractions, X-rays and prophylaxis	100% of Scheme Rate	R2 900 per family per year from Insured Benefits, thereafter subject to MSA balance
Specialised Dentistry – orthodontic, periodontic, crowns, bridgework, dentures, dental implants and osseo-integration	150% of Scheme Rate	Subject to MSA balance

MEDICATION	BENEFIT	ANNUAL LIMIT
Acute Medicines prescribed by medical practitioners	100% of SEP & Agreed Dispensing Fee. Excludes administration fee	Subject to MSA balance
Pharmacy Advised Therapy (over the counter medication)	100% of SEP & Agreed	Subject to MSA balance and limited to R555 per

Homeopathic and Naturopathic medicines	Dispensing Fee. Excludes administration fee	beneficiary per day
OPTICAL	**BENEFIT**	**ANNUAL LIMIT**
Optometric tests (including all visual tests)	100% of Agreed Rate at the Preferred Provider Optometrist. Co-payment may apply at a non-Preferred Provider.	1 eye test per beneficiary every second year from insured benefit. The Opticlear Network of Optometrists is the Preferred Provider.
Spectacles: additional eye test, lenses (including contact lenses), frames and "readers"	100% of Agreed rate at the Preferred Provider Optometrist. Co-payments may apply at a non-Preferred Provider	Subject to MSA balance. The Opticlear Network of Optometrists is the Preferred Provider. If an additional optometric test is done within the two-year cycle, this additional eye test will be paid from MSA

RADIOLOGY AND PATHOLOGY	**BENEFIT**	**ANNUAL LIMIT**
Radiology out-of–hospital (excluding specialised radiology)	100% of Agreed Rate	Subject to MSA balance
Pathology out-of-hospital	100% of Agreed Rate	Subject to MSA balance

EXTERNAL APPLIANCES	**BENEFIT**	**ANNUAL LIMIT**
Hearing aids, orthopaedic boots, surgical collars, wheelchairs, nebulisers and oxygen equipment, etc.	100% of Cost, out-of-hospital	Subject to MSA balance
Stoma Therapy products	100% of Scheme Rate	Subject to Pre-authorisation and Managed Care Protocols

ALTERNATIVE SERVICES	BENEFIT	ANNUAL LIMIT
Step Down Facilities	100% of Scheme Rate	Subject to MSA balance