BMW EMPLOYEES MEDICAL AID SOCIETY

ANNEXURE C

(To be read in conjunction with Annexure B and D)

(Effective 1 January 2022)

1. PRESCRIBED MINIMUM BENEFITS

The Society will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the Society has been ineffective or would cause harm to a beneficiary, the Society will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

2. LIMITATION AND RESTRICTION OF BENEFITS

2.1 In cases of illness of a protracted nature, the Society shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Society may nominate in consultation with the attending practitioner.

2.2 The Society may require a second opinion in respect of proposed treatment or medicine which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Society and at the cost of the Society. In the event that the second opinion proposes different treatment or medication to the first, the Society may in its discretion require that the second opinion proposals be followed, unless in terms of the managed healthcare programme.

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2.3 Unless otherwise decided by the Society, 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.

2.4 If the Society or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols with due regard to the provision of Regulations 15(H) and 15(I).

2.5 If the Society does not have funding guidelines or protocols in respect of benefits for services and supplies as referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Society or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Society or its managed healthcare organisation may impose.

"Medically necessary" refers to services and supplies that meet all the following requirements:

2.5.1 they are required to restore normal function of an affected limb, organ, or system;

2.5.2 no alternative exists that has a better outcome, is more cost-effective, or has a lower risk;

2.5.3 they are accepted by the relevant service provider as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;

2.5.4 they are not rendered for the convenience of the relevant beneficiary or service provider;

2.5.5 outcome studies are available and acceptable to the Society in respect of such services or supplies.

2.6 The Society reserves the right not to pay for any new medical technology or, investigational procedures, interventions, new drugs or medicine as applied in clinical medicine, including new indications for existing medicines or technologies, unless the following clinical data relating to the above have been presented to and accepted by the Medical Advisory Committee and such data demonstrating their:

2.6.1 therapeutic role in clinical medicine;

2.6.2 cost-efficiency and affordability;

2.6.3 value relative to existing services or supplies;

2.6.4 role in drug therapy as established by the Society's managed healthcare organisation.

2.7 In the event that:

2.7.1 the treatment of an extended or chronic sickness condition becomes necessary;

2.7.2 a disease or a condition (including pregnancy) requires specialised or intensive treatment;

2.7.3 the treatment of any disease or condition becomes of a protracted nature or requires extended medication and such treatment is given in or by, a non-designated service provider, the case may be evaluated in terms of the relevant managed healthcare programme and having regard to the aforementioned diseases or conditions in question, the Society may require or advise:

2.7.3.1 the transfer and arrangements of that beneficiary to a public hospital or other designated service provider as arranged by the Society where appropriate care is available, with due regard to Regulation 8(3)(c);

2.7.3.2 the application of a limited drug formulary;

2.7.3.3 both such transfer and restricted drug formulary;
in order to conserve or maximize efficient utilisation of available benefits.

2.8 In the event that a decision has been taken in terms of paragraph 2.8 above, the following conditions shall apply:

2.8.1 in respect of non-Prescribed Minimum Benefit conditions, if the Society or its managed healthcare organisation should determine that any annual benefit limits, as set out in Annexure B, and available to the beneficiary receiving such treatment, are likely to be exceeded in the course of the year, the beneficiary may be advised to move to a public hospital or designated service provider or to accept a limited drug formulary, or both, in order to conserve available benefits.

In such designated service provider or public facility any costs incurred over and above the limit stipulated in Annexure B (excluding Prescribed Minimum Benefit conditions), shall be the member's responsibility. The member may elect on behalf of himself or his beneficiary, to remain in the private hospital, or remain on the full drug formulary available, or both, in which event the Society shall pay up to the benefit limit stipulated in Annexure B, whereafter the member shall be responsible for payment, direct to the private hospital, for any further treatment in such hospital, or for payment direct to the supplier for further medicine.

2.9 The Society reserves the right not to pay for procedures performed by non-recognised providers

Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or need access to certain infrastructure for quality outcomes. Where such procedures have been identified by the

Society's contracted managed healthcare service provider, recognized providers are those who have been acknowledged by meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed care provider and/or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

3. BENEFITS EXCLUDED INSOFAR AS THESE ARE NOT PRESCRIBED UNDER THE PRESCRIBED MINIMIUM BENEFITS

3.1 General exclusions

Unless otherwise decided by the Society (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme), expenses incurred in connection with any of the following will not be paid by the Society:

3.1.1 all costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure B, for the benefits to which the member is entitled in terms of the rules;

3.1.2 all costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease;

3.1.3 all costs for healthcare services if, in the opinion of the medical or dental adviser, such healthcare services are not appropriate or necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost;

3.1.4 all costs in respect of injuries or conditions willfully self-inflicted or injuries sustained while voluntarily participating in a riot, civil commotion, war, invasion, act of foreign enemy, hostilities whether war is declared or not, and civil war; or injuries arising from professional sport, speed contests and speed trials or any other recreational activity which is:

- not commonly recognised as a sport;
- involves uncontrolled competition, unusual skill or violent activity;

is generally considered to be inherently dangerous, unless Prescribed Minimum Benefits.

3.1.5 all costs for medicines for the treatment of chronic conditions not on the list of diseases covered, with the exception of medicines for the treatment of an excluded chronic condition which the Chronic Medicine Programme has specifically determined should be treated to achieve overall cost effective treatment of the beneficiary;

3.2 Exclusions in regard to non-registered service providers

The Society shall not pay the costs for services rendered by:

3.2.1 persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

3.2.2 any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law.

3.3 Specific exclusions

All costs for services rendered in respect of the following, unless specifically authorised by the Society.

3.3.1 Alternative Health Practitioners

All services not listed in paragraph D1 of Annexure B:

3.3.1.1 Acupuncture;

3.3.1.2 Aromatherapy;

3.3.1.3 Ayurvedics;

3.3.1.4 Herbalists;

3.3.1.5 Iridology;

3.3.1.6 Osteopathy;

3.3.1.7 Phytotherapy;

3.3.1.8 Reflexology;

3.3.1.9 Therapeutic Massage Therapy (Masseurs).

3.3.2 Ambulance Services

This benefit is only available for the transportation of acutely ill patients, and subject to approval by the Society's preferred provider. In instances where a member's clinical condition and/or injury is of such nature that authorisation cannot be obtained or advise on the DSP or preferred provider cannot be *obtained.*

3.3.3 Appliances, external accessories and orthotics

3.3.3.1 appliances, devices and procedures not scientifically proven or appropriate;

3.3.3.2 back rests and chair seats;

3.3.3 bandages and dressings (except medicated dressings or dressing applied during a procedure or treatment);

3.3.3.4 beds, mattresses, pillows and overlays;

3.3.3.5 cardiac assist devices – e.g. Berlin Heart;

3.3.3.6 diagnostic kits, agents and appliances unless otherwise stated except for diabetic accessories;

3.3.3.7 electric tooth brushes;

3.3.3.8 humidifiers;

3.3.3.9 ionizers and air purifiers;

3.3.3.10 orthopaedic shoes and boots, unless specifically authorised;

3.3.3.11 pain relieving machines, e.g. TENS and APS;

3.3.3.12 stethoscopes and sphygmomanometers (blood pressure monitors);

3.3.3.13 oxygen hire or purchase, unless authorised.

3.3.4 Dentistry

3.3.4.1 orthodontic treatment over the age of 21 years;

3.3.4.2 periodontal plastic procedures for cosmetic reasons;

3.3.4.3 dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable;

3.3.4.4 general anaesthetics, conscious analog sedation and hospitalisation for dental work, except in the case of patients under the age of 8 years or with bony impaction of the third molars;

3.3.4.5 all general anaesthetics and conscious analog sedation in the practitioner's rooms, unless pre-authorised.

3.3.5 Hospitalisation

3.3.5.1 For non-PMB treatment, if application for a pre-authorisation for a clinical procedure, treatment or specialised radiology is not made or is refused, the Society may apply a co-payment (refer to paragraphs 4.5.6 and 4.5.7 of Annexure D);

3.3.5.2 accommodation and services provided in a geriatric hospital, old age home, frail care facility or similar institution (unless specifically provided for in Annexure B).

3.3.6 Infertility

3.3.6.1 Medical and surgical treatment which is not included in the Prescribed Minimum Benefits in the Regulations to the Medical Schemes Act 131 of 1998, Annexure A, paragraph 9, Code 902M, including:

- Assisted Reproductive Technology (ART);
- In-vitro fertilization (IVF);
- Gamete Intrafallopian tube transfer (GIFT);
- Zygote Intrafallopian tube transfer (ZIFT);
- Intracytoplasmic sperm injection (ICSI);

3.3.6.2 vasovasostomy (reversal of vasectomy);

3.3.6.3 salpingostomy for reversal of tubal ligation.

3.3.7 Maternity

3.3.7.1 3D and 4D scans;

3.3.7.2 2D scans in excess of 2, unless motivated for an appropriate medical condition;

3.3.7.3 antenatal classes/exercises.

3.3.8 Medicine and injection material

3.3.8.1 Anabolic steroids and immunostimulants, unless Prescribed Minimum Benefits;

3.3.8.2 contraceptives, oral, parenteral, foams, IUCD's and when used for skin conditions;

3.3.8.3 cosmetic preparations, emollients, moisturizers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and suntanning preparations, medicated shampoos and conditioners, except for the treatment of lice, scabies and other microbial infections and coal tar products for the treatment of psoriasis;

3.3.8.4 erectile dysfunction and loss of libido medical treatment;

3.3.8.5 patented and nutritional supplements including baby food and special milk preparations unless for malabsorptive disorders and if registered on the relevant managed healthcare programme or for mother to child transmission (MTCT) prophylaxis and if registered on the relevant managed healthcare programme or when used during an authorised hospital admission, subject to the relevant managed healthcare programme;

3.3.8.6 injection and infusion material, except for out patient parenteral treatment (OPAT) and diabetes;

3.3.8.7 the following medicines, unless they form part of the public sector protocols, Prescribed Minimum Benefits and are authorised by the relevant managed healthcare programme:

3.3.8.7.1 Maintenance rituximab or other monoclonal antibodies in the first-line setting for haematological malignancies;

3.3.8.7.2 liposomal amphotericin B for fungal infections, subject to Prescribed Minimum Benefits;

3.3.8.7.3 trastuzumab for the treatment of HER2-positive early breast cancer that exceeds the dose and duration of the 9

(nine) week regimen as used in the FinHer protocol;

3.3.8.7.4 any specialised drugs as defined by the managed care company (e.g. biologicals, tyrosine kinase inhibitors) that have not convincingly demonstrated a median overall survival advantage of more than 3 (three) months in locally advanced or metastatic solid organ malignant tumours, unless deemed cost-effective for the specific setting, compared to standard therapy (excluding specialised drugs) as defined in established and generally accepted treatment protocols, for example sorafenib for hepatocellular carcinoma, bevacizumab for colorectal and metastatic breast cancer;

3.3.8.7.5 Carmustine wafers for the treatment of malignant gliomas;

3.3.8.7.6 Any new chemotherapeutic drug that has not convincingly demonstrated a survival advantage of more than 3 months in advanced or metastatic solid organ malignant tumors, unless pre-authorised by the contracted managed healthcare service provider as a cost-

effective alternative to standard chemotherapy;

3.3.8.7.7 Temozolomide (Temodal ®);

3.3.8.8 medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines (except for schedule 0, 1 and 2 medicines supplied by a registered pharmacist);

3.3.8.9 medicines for intestinal flora;

3.3.8.10 medicines defined as exclusions by the relevant managed healthcare programme;

3.3.8.11 medicines and chemotherapeutic agents not approved by the Medicine Control Council unless Section 21 approval is obtained and pre-authorised by the relevant managed healthcare programme;

3.3.8.12 medicines not authorised by the relevant managed healthcare programme;

3.3.8.13 new medicines that have not been reviewed by the relevant managed healthcare programme;

3.3.8.14 patent medicines, household remedies and proprietary preparations and preparations not otherwise classified;

3.3.8.15 slimming preparations for obesity;

3.3.8.16 smoking cessation and anti-smoking preparations, unless pre-authorised by the relevant managed healthcare programme;

3.3.8.17 tonics, evening primrose oil, fish liver oils;

3.3.8.18 all benefits for clinical trials unless pre-authorised by the relevant managed healthcare programme;

3.3.8.19 diagnostic agents, unless authorised;

3.3.8.20 growth hormones, unless pre-authorised;

3.3.8.21 immunoglobulins and immune stimulants, oral and parenteral, unless pre-authorised;

3.3.8.22 medicines used specifically to treat alcohol and drug addiction, unless Prescribed Minimum Benefits.

3.3.9 Mental health

3.3.9.1 Sleep therapy.

3.3.10 Non-surgical procedures and tests

3.3.10.1 Epilation – excluding opthalmology;

3.3.10.2 hyperbaric oxygen therapy except for anaerobic life threatening infections, Diagnosis Treatment Pairs

(DTP) 277S and specific conditions pre-authorised by the relevant managed healthcare programme.

3.3.10.3 Extracorporeal membrane oxygenation ("ECMO") for adults and non-neonates.

3.3.11 Optometry

3.3.11.1 Coloured and other cosmetic effect contact lenses, and contact lens accessories and solutions;

3.3.11.2 optical devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable;

3.3.11.3 sunglasses, and repairs to spectacle frames.

3.3.12 Organs and Haemopoietic Stem Cell (Bone Marrow) Transplants and Immunosuppressive Medication

3.3.12.1 Organs and haemopoietic stem cell (bone marrow) donations to any person other than to a member or dependant of a member on this Society.

3.3.13 Additional Medical Services (Allied Medical Professions)

3.3.13.1 Art therapy;

3.3.14 Physical Therapy (Physiotherapy, Chiropractors and Biokineticists)

3.3.14.1 X-rays performed by chiropractors;

3.3.14.2 chiropractor benefits in hospital.

3.3.15 Prostheses Internal and External

3.3.15.1 Custom-made hip arthroplasty for inflammatory and degenerative joint disease.

3.3.16 Radiology

3.3.16.1 MRI scans ordered by a general practitioner, unless there is no reasonable access to a specialist;

3.3.16.2 Positron Emission Tomography for screening, excluding PET scans for appropriate diagnosis, staging, the monitoring of response to treatment and investigation of residual tumor or suspected recurrence (restaging). Metastatic breast cancer;

3.3.16.3 bone densitometry performed by a general practitioner or specialist not included in the Society credentialed list;

3.3.16.4 CT colonography (virtual colonoscopy) for screening;

3.3.16.5 MDCT Coronary Angiography for screening;

3.3.16.6 if application for a pre-authorisation reference number (PAR) for specialised radiology procedures

is not made or is refused, benefits are payable as per to paragraphs 4.1, 4.5.6 and 4.5.7 of Annexure D;

3.3.16.7 all screening that has not been pre-authorised or is not in accordance with the Society's policies and protocols.

3.3.17 Surgical procedures

3.3.17.1 Abdominoplasties and the repair of divarication of the abdominal muscles;

3.3.17.2 bilateral gynaecomastia;

3.3.17.3 blepharoplasties, unless causing demonstrated functional visual impairment and pre-authorised;

3.3.17.4 breast augmentation;

3.3.17.5 breast reconstruction - unless mastectomy following cancer and pre-authorised;

3.3.17.6 breast reductions, unless medically necessary and pre-authorised;

3.3.17.7 erectile dysfunction surgical procedures;

3.3.17.8 gender re-alignment for personal reasons and not directly caused by or related to illness, accident or disease;

3.3.17.9 genioplasties as an isolated procedure;

3.3.17.10 keloid surgery, except following burns and for functional impairment;

3.3.17.11 obesity – surgical treatment with the exception of certain bariatric surgical procedures performed for life threatening morbid obesity by a multidisciplinary team in accordance with agreed protocol in credentialed centre of excellence when pre-authorised, but not including post-operative plastic and reconstructive surgery;

3.3.17.12 otoplasties;

3.3.17.13 pectus excavatum / carinatum;

3.3.17.14 **revision** of scars, except following burns and for functional impairment;

3.3.17.15 rhinoplasties for cosmetic purposes;

3.3.17.16 **uvula** palatal pharyngoplasty (UPPP and LAUP) for snoring;

3.3.17.17 all costs for cosmetic surgery performed over and above the codes authorised for admission;

3.3.17.18 Femoroacetabular Impingement (FAI) Reconstruction;

3.3.17.19. Laparoscopic unilateral primary inguinal hernia repair;

3.3.17.20 Percutaneous Valve Replacements, including Transcatheter Aortic Valve Implantation (TAVI);

3.4 Items not mentioned in Annexure B

3.4.1 Appointments which a beneficiary fails to keep;

3.4.2 autopsies;

3.4.3 cryo-storage of fetal stem cells and sperm;

3.4.4 holidays for recuperative purposes;

3.4.5 veterinary products.