BMW EMPLOYEES MEDICAL AID SOCIETY

ANNEXURE D

(With effect from 1 January 2022)
(Unless otherwise stated below)
(To be read in conjunction with Annexures B and C).

1. WAITING PERIODS

1.1 The Society may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical Society for a period of at least 90 days preceding the date of application:

1.1.1 a general waiting period of up to three months;

1.1.2 a condition specific waiting period of up to 12 months.

1.2 The Society may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical Society for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application:

1.2.1 a condition specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the Prescribed Minimum Benefits;

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1.2.2 in respect of any person contemplated in this sub-paragraph, where the previous medical Society had imposed a general or condition specific waiting period, and such waiting period had not expired at the time of termination, general or condition specific waiting period for the unexpired duration of such waiting period imposed by the former medical Society.

1.3 The Society may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical Society for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a general waiting period of up to three months, except in respect of any treatment or diagnostic procedures covered within the Prescribed Minimum Benefits.

1.4 No waiting period may be imposed on:

1.4.1 a person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical Society, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of:

1.4.1.1 change of employment;

1.4.1.2 an employer changing or terminating the medical Society of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must have been

furnished to the Society to which an application is made for such transfer to occur at the beginning of the financial year;

Where the former medical Society had imposed a general or condition specific waiting period in respect of persons referred to in this rule, and such waiting period had not expired at the time of termination of membership, the Society may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical Society.

1.4.2 a beneficiary who changes from one benefit option to another within the Society unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;

1.4.3 a child dependant born during the period of membership.

2. PROPORTIONATE ADJUSTMENT OF BENEFITS

For a beneficiary admitted during the course of a financial year the maximum benefits available to such member shall be adjusted in proportion to the period of membership from the admission date to the end of the financial year; provided that there shall be no adjustment in respect of optometry, maternity, HIV and Prescribed Minimum Benefit entitlements and provided further that there shall be no reduction in limits per case.

3. TERRITORIAL APPLICATION

Subject to the provision of the main rules, the benefits available in terms of these rules shall be provided for at the rate equivalent to the Society Rate for services obtained outside of the borders of the Republic of South Africa and at the discretion of the Board of Trustees. The Society shall not be required to make special arrangements to obtain foreign services or medicines for special conditions and this includes harvesting and transportation of organs and tissue for transplant and any medicines or medical services of any kind available only outside the Republic of South Africa. A member requiring assistance for himself or a beneficiary with regard to potential healthcare costs incurred while travelling in foreign countries, must make separate provision for such insurance.

4. REQUIREMENTS OF MANAGED HEALTHCARE PROGRAMMES

4.1 A pre-authorisation is required before services in respect of hospitalisation benefits. A pre-authorisation reference number is a number allocated by the Society's managed healthcare organisation.

4.2 When the Society's relevant managed healthcare organisation grants a pre-authorisation reference number, it may, if deemed appropriate, also authorise the proposed clinical procedure or treatment to be performed in a medical practitioner's consulting rooms, instead of in a hospital, in which case the same benefit will apply as if the clinical procedure or treatment had been performed in hospital.

4.3 Whenever the expression "subject to the relevant managed healthcare programme", is used, when applied to hospitalisation in

a hospital or admission to a sub-acute facility, day clinic, or unattached operating theatre, physical rehabilitation hospital rehabilitation centres or hospice, it shall imply that approval which is granted for admission and care covers all recognised services associated with that admission except for specialised radiology.

Services which are subject to the hospital benefit management programme but not associated with admission to a hospital sub-acute facility, day clinic, or unattached operating theatre, physical rehabilitation hospital, rehabilitation centres or hospice requires application to be made for each and every eligible service, as indicated in Annexure B.

A request for prior-authorisation shall be made, except in case of an emergency, to the relevant managed healthcare programme at least 48 hours before a beneficiary is admitted to a hospital or a sub-acute facility, day clinic, unattached operating theatre, physical rehabilitation hospital, rehabilitation centres or hospice before a beneficiary receives a relevant health service at such institution.

4.4 The granting of a pre-authorisation reference number is confirmation that the proposed clinical procedure or treatment complies with the clinical and funding protocols and is not a guarantee that benefits will be paid.

4.5 Payment of benefits for a clinical procedure or treatment in respect of which a pre-authorisation reference number is granted, is subject to:

4.5.1 the rules of the Society;

4.5.2 qualification for and availability of benefits;

4.5.3 submission of such information as is reasonably required by the relevant managed healthcare programme;

4.5.4 the clinical procedure or treatment does not exceed the authorisation;

4.5.5 approval by the relevant managed healthcare programme for any extension of an authorisation, failing which only the authorised portion of the clinical procedure or treatment will qualify for benefits;

4.5.6 with the exception of an emergency medical condition, if application for a pre-authorisation reference number is not made or is refused for a clinical procedure or treatment, benefits are payable subject to a R5 000 copayment;

4.5.7 in an emergency, a pre-authorisation reference number must be applied for within 2 business days after a clinical procedure was performed or treatment commenced;

4.5.8 the member or his beneficiary is responsible for ensuring that an appropriate authorisation and pre-authorisation reference number are obtained;

4.5.9 where a beneficiary's entitlement to benefits is subject to such managed healthcare programme as may be stipulated in paragraph 6, the beneficiary shall be obliged to furnish any information required by the Society to perform its duties. Specifically the Society may require particulars of diagnosis, clinical investigations, procedures and treatment by the attending medical practitioner of the beneficiary prior to admission of the beneficiary to hospital;

4.5.10 the Society or its managed healthcare organisation reserves a right to inquiry and/or intervention in the treatment of all members and their beneficiaries admitted into an intensive care unit where the treatment or care exceeds a reasonable time for any specific condition as identified by the Society. In addition, all treatment in an intensive care unit in excess of four (4) days is subject to specific inquiry and/or intervention;

4.5.11 in terms of specific re-imbursement contracts with private hospitals certain benefits for specific in-hospital services, drugs or devices might not be covered at all or partially covered or only covered under special circumstances. These benefits will be outlined in a list of non-covered and restricted benefits for in-hospital services divided into different categories, which will be reviewed quarterly and supplied to all hospitals;

4.5.12 if the health problems of beneficiaries are of such a nature that they qualify for admittance to the Society's Case Management Programme and/or Disease Management, the

Society or its managed healthcare organisation may enter such beneficiaries on such a programme;

5. FUNDING GUIDELINES AND PROTOCOLS

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 irrespective of other clinical guidelines, subject to Regulation 15(H) and 15(I).

A Protocol is a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways.

Protocols are developed on the basis of evidence-based medicine taking into account considerations of cost-effectiveness and affordability and may be updated from time to time, with reasonable notice, to reflect new indications, price changes, emerging scientific data and/ or appeals from stakeholders.

Specific protocols, where relevant, are available to a member or healthcare provider upon request, when the request is to provide clarity regarding a specific issue affecting a member or beneficiary undergoing treatment related to such protocols.

Where a protocol has proven to be ineffective, has caused or would cause harm to a member or beneficiary, appropriate exceptions shall be made

without penalty to that member or beneficiary, at the discretion of the Board.

6. SCHEDULE OF MANAGED HEALTHCARE PROGRAMMES

6.1 HIV Disease Management Programme

A programme adopted by the Society incorporating such clinical protocols as defined in relevant to perform disease management in order to contain costs at an appropriate level of care and for the ongoing review and monitoring of patients living with HIV infection and AIDS.

6.2 Ambulance Services

A programme adopted by the Scheme to provide ambulance services to beneficiaries as set out in the contract between the Scheme and its healthcare service provider.

6.3 Dental Management Programme

A programme adopted by the Society for the management of dental benefits as set out in the contract between the Society and its managed healthcare organisation.

6.4 Chronic Medicine Management Programme

A programme adopted by the Society for the prior authorisation and management of medicine claims against the chronic sickness medicine benefit in respect of diseases that qualify for reimbursement.

6.4.1 The chronic medicine management programme includes the chronic medicine formulary which includes the rules defined by the chronic medicine management programme against which applications for chronic medicines are adjudicated by applying the principles of clinical appropriateness, cost-effectiveness and affordability.

6.4.2 Chronic medicine is medicine that meets all of the following requirements:

6.4.2.1 it is prescribed by a medical practitioner for an uninterrupted period of at least three months;

6.4.2.2 it has been applied for in the manner, and at the frequency, prescribed by the Society;

6.4.2.3 it has been registered for indication.

6.5 Hospital Management Programme

A programme adopted by the Society for the ongoing monitoring, by the Society or its managed healthcare organisation, of the treatment of a sickness condition of a beneficiary for a stipulated period. The monitoring shall include a sickness condition which might occur whilst the beneficiary is in a private hospital, sub acute facility, unattached operating theatre or day clinic, physical rehabilitation hospital, rehabilitation centre or hospice a sickness condition for which the beneficiary was admitted in the first instance and which may extend beyond the period of hospitalisation.

The hospital management programme includes the case management programme which is a programme whereby clinically indicated, appropriate and cost-effective healthcare, as an alternative to hospitalisation, or otherwise, is offered to beneficiaries with specific healthcare needs, on condition that the Society or the Society's managed healthcare organisation directs a beneficiary's participation in the programme or approves an application by a beneficiary for participation in the programme.

6.6 Optometry Management Programme

The programme adopted by the Society for the management of optometry benefits by the Society or its managed healthcare organisation.

6.7 Routine Medicine Management Programme

The programme adopted by the Society for the management of claims by the Society or its managed healthcare organisation in respect of routine medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability.

The routine medicine management programme includes the routine medicine management programme formulary which contains the rules adopted by the Society for the management of claims in respect of routine medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability.

The routine medicine management programme furthermore includes the Medicine Exclusion List, which does not apply to Prescribed Minimum Benefit related conditions. This list refers to the product exclusions collated by the contracted routine medicine benefit management programme, based on scientific evidence and independent expert opinion. Products may be listed for the following reasons:

6.7.1 place in therapy is not well-established;

6.7.2 benefit is not clinically significant;

6.7.3 non-drug therapy is the mainstay of therapy;

6.7.4 product is too expensive relative to its clinical value;

6.7.5 chronic medicines that only qualify for reimbursement if strict financial and clinical prior authorisation criteria are met;

6.7.6 newly registered product under review by a scientific committee;

6.7.7 cheaper alternative drugs are available;

6.7.8 product is misused and alternatives are available.

6.8 Pathology Management Programme

The programme adopted by the Society for the management of pathology benefits by the Society or its managed healthcare organisation.

6.9 Oncology Management Programme

The oncology programme has been specifically designed to assist members diagnosed with malignant diseases.

7. PRESCRIBED MINIMUM BENEFITS

COVER FOR PRESCRIBED MINIMUM BENEFITS

Type	Designated Service Provider (“DSP”)	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
Chronic Disease List (“CDL”) – Out-of-Hospital Consultations	All specialists who have agreed to charge the Premier Rate.	The Scheme shall pay the costs of PMB’s in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate or and any amount the provider charges above the Scheme Rate.

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
	GPs: Any GP participating in the GP Network.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL – Diagnosis	**Cases Requiring Specialists:** All specialists who have agreed to charge the Premier Rate. **GPs:** Any GP participating in the GP Network.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket in full. This is subject to the member making application to the Scheme.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket up to 80% of the Scheme Rate. This is subject to the member making application to the Scheme The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL – Medicine	The DSP is a defined list of contracted pharmacies and/or providers.	For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the chronic drug amount as specified per plan	The Scheme may, at its discretion, impose a co-payment and pay up to a maximum of 80% of the Scheme Medication Rate for a drug listed on the formulary or, up to 80% of the Scheme Medication Rate of the chronic drug amount, as specified per

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
		and subject to the Scheme Medication Rate. This is subject to Regulations 15H(c) and 15I(c).	plan, for drugs not listed on the formulary. This is subject to Regulations 15H(c) and 15I(c). Where the pharmacy and/or provider charges more than the Scheme Medication Rate, an additional co-payment may apply.
	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
	Any provider charging the Scheme Rate.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
CDL – Pathology	**GP's:** Any GP participating in the GP Network.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained for a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
CDL – Radiology	**Cases Requiring Specialists:** All specialists who have	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
	agreed to charge the Premier Rate, and/or any specialist working in a State hospital contracted with the Scheme. Subject to Regulation 8 (3) (a) (b).	services obtained for a DSP.	20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
Diagnostic Treatment Pairs PMBs ("DTPMB") – Out-of-Hospital Consultations	Any provider that has contracted with the Scheme in respect of member's chosen plan and where it is appropriate for such diagnosis to be made by the provider.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket in full. This is subject to the member making application to the Scheme.	The Scheme shall pay healthcare treatment, subject to Scheme's diagnostic basket up to 80% of the Scheme Rate. This is subject to the member making application to the Scheme The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	GP's: Any GP participating in the GP Network	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained for a DSP.	Where a member voluntarily uses a non-DSP we pay at 80% of the Scheme Rate or the health plan entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.

Type	Designated Service Provider (“DSP”)	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
DTPMB – Diagnosis	All specialists who have agreed to charge the Premier Rate, GPs participating in the GP Network and/or any specialist working in a State hospital contracted with the Scheme. Subject to Regulation 8 (3) (a) (b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained for a DSP.	Where a member voluntarily uses a non-DSP we pay at 80% of the Scheme Rate or the health plan entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
DTPMB – In-Hospital Consultations	The DSP is a defined list of contracted pharmacies and/or providers.	For drugs on the Scheme’s formulary, the Scheme will pay in full up to a maximum of the Scheme Medication Rate. Payment is subject to Regulations 15H(c) and 15I(c).	The Scheme may, at its discretion, impose a co-payment and pay up to a maximum of 80% of the Scheme Medication Rate. This is subject to Regulations 15H(c) and 15I(c). Where the pharmacy and/or provider charges more than the Scheme Medication Rate, an additional co-payment may apply.
	A defined list of providers that has contracted with the Scheme, which includes all specialists who have agreed to charge the Premier Rate or GPs participating in the GP Network	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
DTPMB – Medicine	Any provider charging the Scheme Rate.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
	Any Scheme Network Hospital and /or the State hospitals contracted with the Scheme. Subject to Regulation 8 (3) (a) (b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Where a member voluntarily uses a non-DSP we pay up to a maximum of 80% of the Scheme Rate/ agreed rate or the health plan entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate/ agreed rate and any amount the provider charges above the Scheme Rate.
	Drug and Alcohol abuse facilities: Any facility and or provider contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP equivalent to a maximum of 21 days in-hospital or 15 consultations out-of - hospital.	The Scheme may, at its discretion, impose a co-payment and pay up to 80% the Scheme Rate/ agreed rate or the health plan entitlement equivalent to a maximum of 21 days in-hospital or 15 consultations out-of -hospital.
DTPMB – Pathology	**All other conditions:** Any hospital with psychiatric ward and is contracted with the	The Scheme shall pay the costs of PMBs in full subject to the rate contracted with the hospital for a	Where a member voluntarily uses a non-DSP we pay up to a maximum of 80% of the Scheme Rate Health/ agreed rate or the health plan

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
	Scheme, subject to the condition meeting clinical entry criteria and the Scheme's baskets of care.	psychiatric ward / facility, subject to the condition meeting clinical entry criteria and the Scheme's baskets of care.	entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate/ agreed rate and any amount the provider charges above the Scheme Rate.
DTPMB– Radiology	Hospice and any other compassionate care facility	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme may, at its discretion, impose a co-payment and pay up to the maximum of 80% the Scheme Rate/agreed rate or the health plan entitlement subject to available benefits.
DTPMB – Hospital Admissions	**Specialists:** All specialists who have agreed to charge the Premier Rate, GPs participating in the GP Network and/or any specialist working in a State hospital contracted with the Scheme. Subject to Regulation 8 (3) (a) (b).	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
DTPMB – Mental Illness	**GPs:** Any Scheme network GP who is a SAOC member.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	A defined list of providers that has contracted with	The Scheme shall pay the costs of PMBs in	Up to a maximum of 80% of the Scheme Rate.

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
	the Scheme.	full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	
DTPMB – Terminal Care facilities	Any provider charging the Scheme Rate.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
Oncology - Out-of-Hospital Treatment	Any GP participating in the GP Network.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
	Cases Requiring Specialists: All specialists who have agreed to charge the Premier Rate.	The Scheme shall pay the costs of PMB's in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate and any amount the provider charges above the Scheme Rate.
Oncology – Pathology	A defined list of providers that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.

Type	Designated Service Provider (“DSP”)	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
Oncology– Radiology	Any provider charging the Scheme Rate.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
HIV – Out-of-Hospital Consultations	The DSP is a defined list of contracted pharmacies and or providers.	For drugs on the Scheme’s formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the chronic drug amount as specified per plan and subject to the Scheme Medication Rate. This is subject to Regulations 15H(c) and 15I(c).	The Scheme may, at its discretion, impose a co-payment and pay up to a maximum of 80% of the Scheme Medication Rate for drug a listed on the formulary or up to 80% of the Scheme Medication Rate of the chronic drug amount, as specified per plan, for drugs not listed on the formulary. This is subject to Regulations 15H(c) and 15I(c). Where the pharmacy and/or provider charges more than the Scheme Medication Rate, an additional co-payment may apply.
	Any vendor that has contracted with the Scheme.	The Scheme shall pay the costs of PMBs in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate.
HIV – Pathology	Contracted provider, applicable to member’s plan, in respect of our chronic renal dialysis	The Scheme shall pay the costs of PMB’s in full for involuntary use of non-DSP and up to	Up to a maximum of 80% of the Scheme Rate/ agreed rate or the health plan entitlement subject to available benefits.

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
	and/or the State.	the agreed rate for services obtained from a DSP.	The co-payment, which the member is liable for is equal to 20% of the Scheme Rate/ agreed rate and any amount the provider charges above the Scheme Rate.
HIV –Radiology	Contracted provider, applicable to member's plan, in respect of our chronic renal dialysis and/or the State.	The Scheme shall pay the costs of PMB's in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Health/ agreed rate or the health plan entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate/ agreed rate and any amount the provider charges above the Scheme Health Rate.
HIV-Medication	**All other plans:** The DSP is a defined list of contracted pharmacies and or providers.	For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the chronic drug amount as specified per plan and subject to the Scheme Medication Rate. This is subject to Regulations 15H(c) and 15I(c).	The Scheme may, at its discretion, impose a co-payment and pay up to a maximum of 80% of the Scheme Medication Rate for drug a listed on the formulary or up to 80% of the Scheme Medication Rate of the chronic drug amount, as specified per plan, for drugs not listed on the formulary. This is subject to Regulations 15H(c) and 15I(c). Where the pharmacy and/or provider charges more than the Scheme Medication Rate, an additional co-payment may apply.
	Any vendor that has contracted with the	The Scheme shall pay the costs of PMBs in	Up to a maximum of 80% of the Scheme Rate.

Type	Designated Service Provider ("DSP")	Reimbursement Rate if the Beneficiary Uses the DSP or involuntarily uses a non-DSP	Reimbursement Rate if the Beneficiary Voluntarily Does Not Use the DSP
	Scheme.	full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	
HIV – VCT	Contracted provider, applicable to member's plan, in respect of our chronic renal dialysis and/or the State.	The Scheme shall pay the costs of PMB's in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Rate/ agreed rate or the health plan entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate/ agreed rate and any amount the provider charges above the Scheme Rate.
RENAL – Specifically as regard to Chronic Renal Dialysis, Pathology and Drugs	Contracted provider, applicable to member's plan, in respect of our chronic renal dialysis and/or the State.	The Scheme shall pay the costs of PMB's in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP.	Up to a maximum of 80% of the Scheme Health/ agreed rate or the health plan entitlement subject to available benefits. The co-payment, which the member is liable for is equal to 20% of the Scheme Rate/ agreed rate and any amount the provider charges above the Scheme Health Rate.

Notes:

1. For approved PMB conditions, all treatment codes and procedure codes must accord with the Scheme's baskets of care. The Scheme may have regard to Regulations 15H(c) and 15I(c).

2. "SAOC" means the South African Oncology Consortium.

3. No healthcare costs associated with a PMB will be paid if such costs are

incurred outside of the borders of South Africa.

4. The beneficiary must authorise all voluntary DTPMB hospital admissions, which admissions include but are not limited to Mental Illness admissions, HIV and Oncology admissions, within 48 hours of the required elective procedure / treatment. Failure to so authorise will entitle the Scheme to limit its liability to 70% of the Scheme Rate.

5. Where claims are paid in full, beneficiaries will not be required to make any payments not reimbursable by the Scheme.

7.1 Contracted and/ or Preferred Providers

The following contracted Preferred Providers:

7.1.1 Ambulance Service;

7.1.2 General Practitioner Network and Specialist Network and/or any specialists who have agreed to charge the Premier Rate

7.1.3 A defined list of Scheme Network Hospitals

7.2 Co-payments

Co-payments in respect of the costs of Prescribed Minimum Benefits may not be paid out of medical savings accounts.

7.3 Specified Prescribed Minimum Benefits chronic conditions

7.3.1 The Scheme covers Prescribed Minimum Benefits at cost as defined by the Act and/or negotiated tariffs, where such negotiations has been concluded with the Scheme which 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 conditions and relevant Prescribed Minimum Benefits conditions.

7.3.2Specified Prescribed Minimum Benefits conditions

Addison's disease

Asthma

Bronchiectasis

Bipolar mood disorder

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

7.3.3 Additional Disease List

Ankylosing Spondylitis
Behcet's Disease
Chronic Rhinitis
Churg-Strauss Disease
Corneal transplant
Cushing’s Disease*
Cystic Fibrosis*
Delusional Disorder
Dermatopolymyositis
Gastroesophageal
Generalised Anxiety Disorder
Huntington's Disease
Major Depression*
Motor Neuron Disease
Muscular Dystrophy and other inherited myopathies*
Myasthenia Gravis*
Obsessive Compulsive Disorder
Osteoporosis
Paget's Disease
Panic Disorder
Polyarteritis Nodosa
Post Traumatic Stress Disorder*
Psoriatic Arthritis
Pulmonary Interstitial Fibrosis
Sjogren’s Syndrome
Overlap Syndrome(mixed connective tissue disorder)
Systemic Sclerosis
Vasculitis associated with certain CIB covered diseases
Wegener's Granulomatosis*

All the conditions marked with a * on the additional disease list indicate that for these conditions, benefits will be provided for above the PMD DTP entitlement.