ANNEXURE B:
GOLD ASCEND PLAN
BENEFITS
Effective 1 January 2022

SECTION 1: ENTITLEMENT TO BENEFITS, DEFINITIONS, AND CONDITIONS APPLICABLE

A. ENTITLEMENT TO BENEFITS

Subject to the provisions of Rule 6 and Rule 12 and to the conditions stipulated in section C of this Annexure and set out in Annexure C, members and their registered dependents are entitled to the benefits as stipulated in this annexure.

1. General

Benefits are pro-rated subject to the month in which the member joins the Scheme. The payment of benefits shall be subject to -

1.1. The provisions of Rule 6.3 and Rule 12 are applicable to all continuation members.

1.2. The conditions as stipulated in preamble C of this Annexure are applicable to all members.

1.3. The following waiting periods shall be imposed, subject to the provisions of the Act and Rule 8.4:

1.3.1. General waiting period: 3 months

1.3.2. Pre-existing conditions: 12 months

B. DEFINITIONS

All definitions applicable to this Option are reflected in the Rules.

C. CONDITIONS APPLICABLE

1. Where specifically indicated in this Annexure that a member's entitlement to benefits shall be subject to such healthcare management programme the member shall be obliged to furnish any information required by the Scheme to perform its duties.
2. Specifically, in the case of the Hospital Benefit Management Programme, the Scheme may require of diagnosis, clinical investigations, procedures and treatment by the attending medical practitioner of the beneficiary prior to and during admission of the beneficiary to hospital.
    2.1. Hospital stays are subject to Case Management protocols.
3. All hospital admissions must be authorised. A co-payment of R1 500 will be applied if authorisation was not obtained prior to admission. This co-payment will be waived in the event of an emergency.
4. Hospital stay is subject to Case Management protocols.
    4.1. Frail care is not a covered benefit.
5. Day procedures and minor procedures are only payable at Day Hospital or doctors' rooms.
    5.1. Where a day procedure is done at a place outside the Day Hospital, it will be payable up to the cost of the day hospital, unless no day hospital is available.
    5.2. Where a minor procedure is done at a place outside the doctors' rooms it will be payable up to the cost of the doctors' rooms.
6. Payment of specialist visits are subject to referral by a GP, except for:
    6.1. Follow-up visits
    6.2. Emergencies
    6.3. Gynaecologist visits
    6.4. Paediatrician visits for babies up to the age of 12 months
7. Back and Neck Preventative Programme:
    7.1. Authorisation for spinal surgery for the treatment of chronic back and/or neck pain are subject to managed care protocols.

7.2. Managed care may request adherence to conservative clinical treatment prior to authorising surgery

SECTION 2: SCHEDULE OF BENEFITS

1. OUT OF HOSPITAL BENEFITS

Prescribed Minimum Benefits (PMB):

In accordance with the Medical Schemes Act, costs will be covered related to the diagnosis, treatment and care of the following conditions as updated by the Council for Medical Schemes (https://www.medicalschemes.com):

i. medical emergencies,
ii. chronic conditions as listed in the Chronic Disease List (CDL),
iii. and medical conditions listed in the Diagnosis Treatment Pairs (DTPs),.

This definition shall apply whenever "PMB applicable" appears in the definition of benefits below. Managed care clinical protocols and designated service provider (DSP) networks are applicable.

1.1. DAY-TO-DAY BENEFITS

1.1.1. The following benefits are covered subject to day-to-day benefit limitations: General Practitioners, Specialists (excludes Psychiatrists), Physiotherapists, Radiologists, Pathologists and Acute Medicines

	Limit
Member without dependents	R6 556
Member with one dependent	R9 709
Member with two dependents	R11 362
Member with three dependents	R12 993
Member with four dependents	R14 645
Member with five dependents	R16 287
Member with six or more dependents	R17 918

1.2. GENERAL PRACTITIONERS

1.2.1. 100% Sizwe Hosmed rates for visits by general practitioners in the supplier's room or patient's home, subject to the stipulated number of GP visits.

1.2.2. The benefits are subject to availability of funds in the day-to-day benefit as in 1.1 above. PMB applicable.

	Number of visits
Member without dependents	6
Member with one dependent	9
Member with two dependents	12
Member with three dependents	14
Member with four dependents	15
Member with five dependents	16
Member with six or more dependents	17

1.2.3. One (1) extra visit per single member per annum is applicable for preventative care.

1.3. Covid Benefit

1.3.1. Covid benefit provides for the following:

1.3.2. Covid Vaccine as approved by SAPRA (South African Health Products Regulatory Authority)

1.3.3. Pathology – Covid test as approved by CMS regulation

1.3.4. In-Hospital treatment for Covid pneumonia

1.4. SPECIALISTS

1.4.1. 100% Sizwe Hosmed rates for visits to specialists, subject to the stipulated number of specialist visits below, except in cases of emergencies and PMBs.

1.4.2. Referral to the specialist by a GP is mandatory, unless

1.4.2.1. not possible as in the case of an unavailable GP,

1.4.2.2. in an emergency, or

1.4.2.3. a follow-up specialist visit after an initial GP referral.

1.4.3. Failure to get the required GP referral will result in the Scheme paying an equivalent of the Scheme GP rate. The benefits are subject to availability of funds in the day-to-day limit as in 1.1 above.

1.4.4. Psychiatrists are excluded from this benefit and are covered under mental health.

	Number of visits
Member without dependents	2
Member with one dependent	6
Member with two dependents	7
Member with three dependents	8
Member with four dependents	9
Member with five dependents	10
Member with six or more dependents	11

1.5. PHYSIOTHERAPY

1.5.1. 100% Sizwe Hosmed rates subject to the limit set out in day-to-day benefits above. PMB applicable.

1.6. RADIOLOGY AND RADIOGRAPHY

1.6.1. **General radiology**

1.6.1.1. 100% Sizwe Hosmed rates for general diagnostic radiology subject to managed care protocols. PMB applicable.

1.6.1.2. Tests related to oncology for registered beneficiaries are covered as part the Oncology Management Programme.

1.6.2. **Specialised radiology**

1.6.2.1. MRI, CAT scan, Angiogram subject to an overall combined limit of R21 575 per family per annum.

1.6.3. **Interventional radiology**

1.6.3.1. (refer to paragraph 2.11.3)

1.7. PATHOLOGY

1.7.1. 100% Sizwe Hosmed rates for blood and histology tests as well as other pathology tests performed by a GP, medical specialist or the medical technician and private nurse practitioner. PMB applicable

1.7.2. Pathology tests related to oncology and HIV/AIDS for registered beneficiaries are covered as part the Disease Management Programme.

1.8. ACUTE MEDICINE

1.8.1. The acute medicine benefit, including Pharmacy Advised Therapy (PAT), has the following sub-limits within the overall day-day benefit:

	Limit
Member without dependents	R2 047
Member with one dependent	R3 689
Member with two dependents	R4 105
Member with three dependents	R4 652
Member with four dependents	R4 783
Member with five dependents	R5 046
Member with six or more dependents	R5 462

1.8.2. This benefit is subject to the conditions stipulated below:

1.8.2.1. The Pharmaceutical Benefit Management Programme;

1.8.2.1.1. Reimbursement is at 100% Single Exit Price (SEP) plus

a) the dispensing fee as per the Department of Health's latest gazetted Dispensing Regulations; or

b) the tariff negotiated with the service provider;

1.8.2.2. Medicine must be prescribed by a person legally entitled to prescribe; and

1.8.2.3. Medicine used during an in-hospital event is excluded from this benefit.

1.9. MATERNITY AND INFERTILITY

1.9.1. Antenatal consultations

1.9.1.1. 100% Sizwe Hosmed rates for antenatal consultations, limited to nine (9) midwife, GP or Specialist antenatal visits per pregnancy, in addition to the regular GP benefits as stated in rule 1.2 above,

1.9.1.2. Two (2) specialist obstetrician visits per pregnancy, subject to referral by the midwife or GP in addition to the regular specialist benefit as in 1.4.

1.9.2. Pregnancy scan and tests

1.9.2.1. 100% Sizwe Hosmed rates for pregnancy scans and the following pregnancy-related tests subject to registration on the maternity benefit management program:

1.9.2.1.1. Two (2) Haemoglobin Measurement tests,

1.9.2.1.2. one (1) Blood Grouping test,

1.9.2.1.3. one (1) VDRL test for Syphilis and

1.9.2.1.4. Two (2) HIV blood tests over and above the regular Pathology benefits in rule 1.7

1.9.2.1.5. Twelve (12) urine analysis tests

1.9.2.1.6. One (1) Full blood count (FBC) test

1.9.2.1.7. Vitamins worth R114 paid from day to day benefit

1.9.2.1.8. Two (2) 2D scans per pregnancy – this excludes the diagnostic sonar.

1.9.3. **Infertility**

1.9.3.1. Covered in accordance with Code 902 M of the PMB Regulations.

1.9.3.1.1. All investigations for an infertility condition will be covered in a DSP hospital and in accordance with the policies of the relevant Public Authorities.

1.10. ADDITIONAL OUT OF HOSPITAL BENEFITS

1.10.1. **Private Nurse**

1.10.1.1. Subject to benefits at Sizwe Hosmed Private Nurse rates and Pre-Authorisation.

1.10.1.2. Frail care is not a covered benefit.

1.10.1.3. Limit per year per family – R5 243

1.10.1.4. PMB applicable

1.11. AUXILIARY SERVICES

1.11.1. Limited to speech therapy, podiatry, occupational therapy, social workers, dietetics, audiology, homeopathy, clinical technologists, educational psychologists, biokineticists and registered counsellors, subject to the limits as stated below:

1.11.2. 100% Sizwe Hosmed rates with the following annual limits per family:

1.11.2.1. Member: R1 171

1.11.2.2. Member with one or more dependent: R1 882

1.11.3. PMB applicable

1.12. CHIROPRACTORS

1.12.1. Payable at 100% Sizwe Hosmed rates up to a limit of R1 161 per beneficiary per annum

1.13. CHRONIC MEDICINES

1.13.1. Subject to the conditions stipulated below:

1.13.1.1. Benefits are limited to PMB chronic conditions, subject to pre-authorisation, registration on the chronic disease programme, formulary and clinical protocols;

1.13.1.2. The Pharmaceutical Benefit Management Programme;

1.13.1.3. Reimbursement is at 100% SEP plus the dispensing fee as per the Department of Health's latest gazetted Dispensing Regulations or as per negotiated tariff with the preferred service provider;

1.13.1.4. Medicine must be prescribed by a person legally entitled to prescribe;

1.13.1.5. Medicine used during an in-hospital event is excluded from this benefit;

1.13.1.6. Members should use Sizwe Hosmed preferred providers to avoid co-payment co-payments or limits; and

1.13.1.7. Where there is a generic equivalent, the chronic medicine benefit shall not exceed the maximum retail price of the generic equivalent.

1.14. APPLIANCES

1.14.1. 100% Sizwe Hosmed rates with the following annual limit per family:

1.14.1.1. Member: R1 171

1.14.1.2. Member with one or more dependent: R1 882

1.14.2. Includes procurement towards the following devices and appliances:

1.14.2.1. Nebulizer,

1.14.2.2. Glucometer,

1.14.2.3. Insulin pump,

1.14.2.4. Morphine pump

1.14.2.5. C-PAP machine and

1.14.2.6. other clinically appropriate unspecified appliances items.

1.14.3. Any appliance is payable only once per annum, subject to the limits as stipulated above.

1.14.4. The cost of C-PAP machines is payable from this benefit, subject to fulfilment of clinical criteria and procurement protocols

1.14.5. Prescribed Minimum Benefits: All items are payable at cost with no co-payment or deductibles, subject to pre-authorisation, minimum benefit package, preferred provider network and Managed Care clinical protocols.

1.15. MENTAL HEALTH

1.15.1. Limited to Psychiatrists, and Clinical and Counselling Psychologists relating to mental health. Benefit excludes services covered under the auxiliary benefit.

1.15.2. 100% Sizwe Hosmed rates subject to annual limit of R 5 977 per family.

1.15.3. All consultations in doctors' rooms are paid at 100% Sizwe Hosmed rates subject to the mental health limit.

1.15.4. Prescribed Minimum Benefits: All items are payable at cost with no co-payment or deductibles, subject to minimum benefit package, preferred provider network and Managed Care clinical protocols.

1.16. PREVENTATIVE CARE

1.16.1. **Wellness consultations:**

1.16.1.1. Subject to a family limit of R1 161 per annum

1.16.2. **Preventative Care Screening:**

1.16.2.1. Family benefit of up to one (1) test per beneficiary per annum

1.16.2.2. Subject to a family limit of R 2 332 per annum

1.16.2.3. Includes the following tests:

1.16.2.4. Blood sugar, Cholesterol, Blood pressure, Body Mass Index, HIV screening test.

1.16.2.5. One (1) screening test per beneficiary per annum.

1.16.2.6. One (1) consultation visit in doctors' rooms.

1.16.2.7. Limited to R 295 per beneficiary per annum at a Preferred Provider facility.

1.16.3. **Other screening tests**

1.16.3.1. Cover limited to the following tests:

1.16.3.2. Females: Mammogram every 2 years for women above age 40 years, Pap smear every 2 years for women above 21 years.

1.16.3.3. Males above 40 years: Prostate Specific Antigen (PSA) test

1.16.4. **Female Contraceptives**

1.16.4.1. Contraceptive limit of R3 021 per family per annum subject to Managed Care Protocols and formulary.

1.16.5. **Vaccinations**

1.16.5.1. Flu Vaccine

1.16.5.2. Pneumococcal Vaccine

1.16.5.3. Human Papilloma Virus (HPV) vaccine

1.16.5.4. Immunisation for children six (6) years and younger, immunization permitted will be in line with those provided by the Department of Health, subject to family wellness screening family limit

1.17. OPTICAL

1.17.1. All sub-limits and rules specified are subject to Optical Benefit Management Programme and benefit limits specified for materials.

1.17.1.1. One (1) set of spectacle lenses and one (1) set of frames, or one (1) set of contact lenses per beneficiary every two (2) years.

1.17.1.2. Each beneficiary must choose either spectacles or contact lenses once every two (2) years.

1.17.1.3. Eye test: one (1) test per beneficiary per 24 months.

1.17.2. **Spectacles, lenses and frames**

1.17.2.1. 100% Sizwe Hosmed rates determined by the Board of Trustees for spectacles and lenses prescribed or supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner.

1.17.3. **Visual examination**

1.17.3.1. If undertaken by a registered optometrist, shall be based on the Sizwe Hosmed rates. The benefit shall be 100% of the Sizwe Hosmed rate at the Scheme's preferred provider network and shall be limited to one (1) eye test per beneficiary per 24 months.

1.17.4. **Frames**

1.17.4.1. Limited to one (1) pair per beneficiary per 24-month period within the combined benefit. The difference, where applicable, is payable by the member directly to the supplier.

1.17.4.2. The benefit is limited to one (1) pair of spectacles per beneficiary per 24-month period, except where two (2) spectacles are approved by the Fund in place of a pair of spectacles with bifocal or multi focal lenses, after clinical motivation by a registered optometrist to the Fund.

1.17.4.3. The benefit is limited to the negotiated tariff with the provider for glass lenses.

1.17.4.4. The benefit for bifocal or multi focal lenses shall be limited to the cost of 65 millimetre and bifocal lenses with a reading segment of 28 millimetres.

1.17.4.5. All add-ons: Generic add on tints up to 35% and generic add on coatings (hard coatings and anti-reflex coatings) up to the benefit limit

1.17.4.6. Sunglasses and repairs to spectacles are excluded from the benefit.

1.17.4.7. Benefits shall not be granted for spectacles if a beneficiary has already received a benefit for contact lenses until twenty-four months has lapsed since the last claim.

1.17.4.8. Each claim for lenses/ frames must be submitted together with the lens prescription.

1.17.5. **Contact lenses**

1.17.5.1. Benefit payable and subject to the specified benefit limits described below.

1.17.5.2. 100% of the Scheme rate of clear contact lenses if prescribed by a registered optometrist, or supplementary optical practitioner in accordance with the approved tariff for these service providers. Provided that (clinically approved where member cannot wear spectacles):

1.17.5.3. The application by a member be motivated by a recommendation from a registered optometrist that contact lenses are clinically essential as determined by the lens prescription on clinical/medical grounds and approved by the Fund.

1.17.5.4. The benefit sub limit is limited to

1.17.5.4.1. one (1) pair of permanent contact lenses per beneficiary per 24-month period, or

1.17.5.4.2. 24 pairs of monthly disposable contact lenses per beneficiary per 24-month cycle.

1.17.5.4.3. Additional benefits may be approved on medical/clinical grounds if approved by the Fund.

1.17.5.5. In cases where contact lenses are not clinically essential and worn at the election of the member, the benefit shall be limited to the equivalent of two (2) single vision glass lenses of 65 mm and a sphere of two (2) dioptres plus the benefit amount of the frame, plus the cost of a refraction as a combined benefit.

1.17.5.6. Benefits shall not be granted for contact lenses if a beneficiary has already received a pair of spectacles in a given twenty-four-month period.

1.17.5.7. Contact lens cleaning materials are excluded from benefits.

1.17.6. **Spectacles Lenses and frames limits**

1.17.6.1. 100% Sizwe Hosmed rates, as per the limits per beneficiary below:

Benefit Description	Limit per Beneficiary
Frames	R629
Single Focus Lenses	R202 per lens
Bi-focal Lenses	R438 per lens
Multi-focal lenses	R438 per lens
Contact Lenses	R1 387

1.18. DENTAL

Dentistry benefits are subject to a Dental Benefit Management Programme. Benefits are subject to managed care protocols and managed care interventions which may include the requirement of treatment plans and/or radiographs prior to benefit application. Fund exclusions apply to dental benefits. Refer to Annexure C for a detailed list of Fund exclusions.

Radiology and pathology are subject to the conditions and limits stipulated hereunder and in paragraphs 2.11 and 2.12 respectively.

1.18.1. **Conservative dentistry**

1.18.1.1. 100% Sizwe Hosmed rates subject to managed care protocols for the following benefits:

1.18.1.2. Consultations: two (2) annual check-ups per beneficiary (once in six (6) months)

1.18.1.3. X-rays

1.18.1.3.1. Intra-oral: subject to managed care protocols

1.18.1.3.2. Extra-oral: one (1) per beneficiary in a three (3) year period

1.18.1.4. Oral hygiene: two (2) annual scale and polish treatments per beneficiary (once in 6 months)

1.18.1.4.1. Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age

1.18.1.4.2. Benefit for fluoride is limited to beneficiaries from age 5 and younger than 13 years of age.

1.18.1.5. Fillings: once per tooth in 720 days

1.18.1.6. Extractions

1.18.1.7. Root canal treatment: subject to managed care protocols. Excluding wisdom teeth (3rd molars) and primary (milk) teeth.

1.18.1.8. Plastic dentures and associated laboratory costs:

1.18.1.8.1. One (1) set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a four (4) year period

1.18.2. **Specialised dentistry**

1.18.2.1. 100% Sizwe Hosmed rates, subject to pre-authorisation (where indicated) and managed care protocols. If authorisation is obtained after the procedure or treatment has been done, a 20% co-payment will apply to all related claims.

1.18.2.1.1. Partial metal frame dentures and associated laboratory costs: No benefit

1.18.2.1.2. Crowns and bridges and associated laboratory costs: No benefit

1.18.2.1.3. Implants and associated laboratory costs: No benefit

1.18.2.1.4. Orthodontics and associated laboratory costs: No benefit

1.18.2.1.5. Periodontics:

a) 100% Sizwe Hosmed rates; subject to registration on the Periodontal Programme
b) Limited to conservative, non-surgical therapy only (root planning)
c) Surgical periodontics: No benefit

1.18.2.1.6. Maxillofacial surgery and oral pathology in the dental chair:

a) 100% Sizwe Hosmed rates, subject to managed care protocols
b) Benefit for Temporo-mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments.
c) The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis.

1.18.3. **Dental Hospitalisation (General Anaesthetic)**

1.18.3.1. In-hospital treatment:

1.18.3.1.1. A co-payment of R1 000 per hospital admission applies, if a member opts to go to a day clinic (discipline 76/77) instead of a hospital (discipline 57/58), subject to the availability of a day clinic in his demographic area.

1.18.3.1.2. Pre-authorisation is required, subject to managed care protocols.

1.18.3.1.3. Subject to a DSP hospital network and the stated conditions apply (refer to point C of this annexure).

1.18.3.1.4. No funding will be granted without authorisation except in the case of an emergency. If authorisation is obtained after the procedure has been done, a

20% co-payment will be applied to the hospital account.

1.18.3.1.5. General anaesthetic benefits are available for children under the age of five (5) years for extensive dental treatment.

1.18.3.1.6. General anaesthetic benefits are available for the removal of impacted teeth.

1.18.3.1.7. Laughing gas (Nitrous Oxide) in dental rooms:

a) 100% Sizwe Hosmed rates, subject to managed care protocols.

1.18.3.1.8. IV conscious sedation in rooms:

a) 100% Sizwe Hosmed rates, subject to pre-authorisation and managed care protocols.

b) Limited to extensive dental treatment

1.19. HEARING AIDS

1.19.1. 100% of Sizwe Hosmed rate, subject to an annual limit of R8 658 per family

1.19.2. One (1) hearing unit (one per ear) per beneficiary every four (4) years from date of acquisition, subject to pre-authorisation.

1.20. ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS)

1.20.1. Refer to paragraph 2.15

1.21. AMBULANCE SERVICES

1.21.1. 100% of Cost as authorised by the contracted service provider.

1.21.2. Authorisation for emergency transportation should be obtained within 24 hours.

1.21.3. If services are not pre-authorised through the preferred provider, claims will not qualify for payment.

1.22. NON-MOTORISED WHEELCHAIRS

1.22.1. 100% Sizwe Hosmed rates with the following annual limit per family.

1.22.1.1. Member with or without dependents: R2 167

1.22.2. Any wheelchair is payable only once every 4 years, subject to the limits as stipulated above.

1.22.3. Prescribed Minimum Benefits: All items are payable at 100% cost with no co-payment or deductibles, subject to minimum benefit package, preferred provider network and Managed Care clinical protocols.

2. IN-HOSPITAL BENEFITS

2.1. HOSPITALISATION FOR PRESCRIBED MINIMUM BENEFITS

2.1.1. PMBs consist of the provision of the diagnosis, treatment and care costs of:

2.1.1.1. The Diagnostic and Treatment Pairs and

2.1.1.2. Any emergency medical condition

2.1.2. The level of health care provided in the state sector shall be used as the benchmark when determining PMB level of care.

2.1.3. The interpretation of the PMBs shall follow the predominant Public Hospital practice, as outlined in the relevant provincial or national public hospital clinical protocols, where these exist.

2.1.4. PMBs are subject to Pre-authorisation, Minimum Benefit Package, Designated Service Providers (DSP) and Treatment Protocols;

2.1.5. PMBs are covered in accordance with the provisions of Regulations 8 of the Medical Schemes Act;

2.2. APPLICABLE CONDITIONS

2.2.1. Hospitalisation Benefits are subject to pre-authorisation; A co-payment of R1 500 is applicable if no authorization is obtained prior to admission except for emergencies

2.2.2. 100% of negotiated tariff for accommodation in general ward, high care ward and intensive care unit;

2.2.3. 100% of negotiated tariff for theatre fees;

2.2.4. 100% of negotiated tariff for medicines, materials and hospital equipment and the transport of blood;

2.2.5. Medicines given to a patient to take home limited to a supply of seven (7) days;

2.2.6. Overall hospital benefit includes rehabilitation and sub-acute care

2.3. ANNUAL LIMITS

2.3.1. **Private Hospitals**

2.3.1.1. 100% Sizwe Hosmed rate for inpatient services, materials and medicines at negotiated tariffs. Subject to pre-authorisation managed care rules, formulary and clinical protocols.

2.3.2. **Private Hospitals: Out-Patient Care**

2.3.2.1. 100% Sizwe Hosmed rates for out-patient services, materials and medicines at negotiated tariffs.

2.3.3. **Alternatives to Hospitalisation**

2.3.3.1. Subject to the Hospital Benefit Management Programme and the Disease Management Programme.

2.3.3.2. 100% Sizwe Hosmed rates for all services rendered at registered step-down facilities, nursing facilities.

2.3.3.3. Hospice at 100% of cost.

2.3.3.4. 100% Sizwe Hosmed rates for services rendered under Home Care in lieu of Hospitalisation subject to Managed Care protocols and preferred provider arrangements

2.4. IN- HOSPITAL GENERAL PRACTITIONERS

2.4.1. Subject to the Hospital Benefit Management Programme.

2.4.2. 100% Sizwe Hosmed rates for consultations and visits by General practitioners in hospital.

2.5. IN – HOSPITAL MEDICAL SPECIALISTS

2.5.1. Subject to the Hospital Benefit Management Programme.

2.5.2. 100% Sizwe Hosmed rates for consultations and visits by medical specialists in hospital.

2.6. IN – HOSPITAL AUXILIARY SERVICES AND PHYSIOTHERAPY

2.6.1. **Auxiliary Services:**

2.6.1.1. 100% Sizwe Hosmed rates subject to pre–authorisation and PMBs

2.6.1.2. Limited to the following: dieticians, speech therapy, occupational therapy and clinical technology.

2.6.2. **Physiotherapy:**

2.6.2.1. 100% Sizwe Hosmed rates – subject to pre-authorisation, managed care rules and clinical protocols.

2.7. MATERNITY

2.7.1. **Hospitalisation (Private Hospitals)**

2.7.1.1. Subject to the Hospital Benefit Management Programme, Disease Management Programme and to the conditions and annual limits as stipulated.

2.7.1.2. 100% of cost for accommodation at general ward rates, theatre fees, labour ward fees, drugs, dressings, medicines and materials in a private or provincial hospital; and for drugs, dressings, medicines and materials supplied by a midwife.

2.7.2. **Delivery**

2.7.2.1. 100% of cost for the delivery by a general practitioner, medical specialist or midwife and materials supplied.

2.7.3. **Post-Natal Services and Midwifery**

2.7.3.1. Subject to the Hospital or Maternity Benefit Management programmes and to the Disease Management Programme.

2.7.3.2. 100% Sizwe Hosmed rates for post-natal care by a midwife or as an alternative to hospitalisation.

2.8. BLOOD TRANSFUSION AND BLOOD REPLACEMENT PRODUCTS:

2.8.1. 100% of the cost of blood transfusions and blood replacement products, limited to PMBs.

2.9. PROSTHESIS

2.9.1. Subject to pre-authorisation, treatment protocols, DSPs and PMBs.

2.9.2. Applies to both surgical and non-surgical prostheses.

2.9.3. 100% Sizwe Hosmed rates subject to pre-authorisation, treatment protocols and PMBs.

2.9.4. Annual limit of R29 565 per family for both surgical and non-surgical prostheses.

2.9.5. **Internal Prosthesis**

2.9.5.1. Subject to benefit limit unless PMB:

2.9.5.1.1. Pacemakers;

2.9.5.1.2. Defibrillators;

2.9.5.1.3. Spinal fusion – only one (1) spine level per beneficiary; Should more than one (1) spinal level be required, approval will be granted subject to managed care protocols.

2.9.5.1.4. Cardiac stents – three (3) stents per family per annum;

2.9.5.1.5. Vascular stents – two (2) stents per family per annum;

2.9.5.1.6. Grafts;

2.9.5.1.7. Joints – hip and knee (partial and total) - only one (1) joint per beneficiary per annum;

2.9.5.1.8. Other clinically appropriate unspecified prosthetic items

2.9.6. **EXTERNAL PROSTHESIS**

2.9.6.1. Subject to benefit limit unless PMB

2.9.6.1.1. Artificial limb;

2.9.6.1.2. Breast;

2.9.6.1.3. Ocular;

2.9.6.1.4. Taylor Spatial frame;

2.9.6.1.5. External fixator;

2.9.6.1.6. Mesh;

2.9.6.1.7. Other clinically appropriate unspecified prosthetic items.

2.9.6.2. Prescribed Minimum Benefits: All items are payable at cost with no co-payment or deductibles, subject to minimum benefit package, preferred provider network and Managed Care clinical protocols.

2.10. ONCOLOGY

2.10.1. Oncology benefits subject to pre-authorisation, Prescribed Minimum Benefits and treatment protocols

2.10.2. 100% of the Sizwe Hosmed rate for consultations, visits, treatment, specialised radiology medication and 100% of the costs of materials used in radiotherapy and chemotherapy subject to Manged Care Protocols.

2.10.3. Benefit will pay at 80% of costs above R208 000 per beneficiary per year.

2.11. RADIOLOGY AND RADIOGRAPHY

2.11.1. **General Radiology**

2.11.1.1. has no in-hospital limit but is subject to clinical protocols

2.11.2. **Specialised Radiology:**

2.11.2.1. (MRI/CAT scan/Angiogram) subject to an overall combined in and out of hospital limit of R21 575 per family per annum, pre-authorisation and managed care protocols

2.11.3. **Interventional Radiology:**

2.11.3.1. Within hospital limit, subject to pre-authorisation and clinical protocols.

2.12. PATHOLOGY

2.12.1. Subject to the Hospital Benefit Management and Disease Management programmes.

2.12.2. 100% Sizwe Hosmed rates for tests performed by a general practitioner or medical specialist – benefit is payable from the annual Hospital benefits.

2.12.3. Pathology tests required for Acquired Immune Deficiency Syndrome fall within the limit as stipulated under Acquired Immune Deficiency Syndrome in section 2.15 as well as the HIV/AIDS Management Programme.

2.13. MENTAL HEALTH

2.13.1. **Psychiatry Hospitalisation**

2.13.1.1. Limited to 21 days per beneficiary per annum. This benefit includes psychiatrist consultations and six (6) in-hospital consultations by a clinical psychologist – subject to PMBs.

2.13.1.2. Limited to R1 700 per day to a maximum value of R35 700

2.13.1.3. Four (4) additional out- of- hospital visits / consultations in lieu of hospitalisation are allowed subject to managed care protocols

2.13.2. **Alcoholism, Drug Addiction, Narcotism**

2.13.2.1. PMBs are subject to pre-authorisation, minimum benefit package, at a DSP (where there are DSP arrangements in place) and treatment protocols. Where no DSP arrangements exist, any medical institution will serve as a provider for the above purpose.

2.13.2.2. Three (3) days withdrawal treatment at an appropriate facility, plus 21 days in-patient rehabilitation.

2.14. ORGAN TRANSPLANT AND RENAL DIALYSIS

2.14.1. Organ Transplant /Renal Dialysis treatment subject to PMBs. at DSPs.

2.14.2. **Renal Dialysis**

2.14.2.1. Benefit is restricted to the requirements set out in Prescribed Minimum Benefits. at Designated Service Providers.

2.14.3. **Organ Transplant**

2.14.3.1. 100% Sizwe Hosmed rates of organ transplantation, and cost of post-operative anti-rejection medicines required by the recipient.

2.14.3.2. Harvesting, transporting and donor fees are covered as part of PMBs, even if the donor is not a Sizwe Hosmed member.

2.14.3.3. Coverage for post-transplant complications beyond three months of surgery limited to the recipient.

2.14.3.4. Only donors and organs from within the Republic of South Africa will be covered.

2.14.3.5. Transplant PMBs subject to pre-authorisation, minimum benefit package, treatment protocols and DSPs.

2.15. ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS)

2.15.1. HIV/AIDS is a PMB benefit and is subject to a Disease Management Program that infected beneficiaries are encouraged to enrol for. In the event of hospitalisation for HIV/Aids, Sizwe Hosmed Medical Fund will apply the Fund's PMB hospitalisation rules as in 2.1.

2.15.2. Where there is no arrangement in place, Sizwe Hosmed will pay the cost in full, subject to treatment protocols for any accredited provider of the services.

2.15.3. Benefits include counselling, prescribed medication, pathology tests and relevant consultations.

3. SPECIFIC CLINICAL LIMITATIONS

3.1. The following procedures will only be covered in terms of PMBs at DSP facilities, subject to clinical protocols:
   3.1.1. Advanced Laparoscopic surgery;
   3.1.2. Reconstructive Surgery;
   3.1.3. Joint Replacements e.g. hip /knee;
   3.1.4. Cardiac surgery which include cardiac stents;
   3.1.5. Spinal surgery;
   3.1.6. Breast Reconstructive Surgery.

3.2. Minor procedures in doctors' rooms are only payable at a DSP or at a day hospital, subject to PMBs.

3.3. One (1) joint procedure (e.g. right hip joint) per beneficiary per annum covered, unless PMB.

3.4. One (1) spinal level (e.g. lumbar spine) covered per beneficiary per annum, unless PMB. Should more than one (1) spinal level be required, approval will be granted subject to managed care protocols.

3.5. One (1) cardiac stent covered per vessel per beneficiary.

4. EXCLUSIONS

4.1. In addition to the exclusions listed in Annexure C, attention is drawn to the following conditions specifically excluded from benefits on this plan:
   4.1.1. Refractive surgery including Radial Keratotomy;
   4.1.2. Breast Reduction (unless PMBs);
   4.1.3. Breast Augmentation (unless PMBs);
   4.1.4. Keloids;
   4.1.5. Frail Care.
   4.1.6. Specialised dentistry: crowns & bridges, implants, orthodontics and surgical periodontics
   4.1.7. Metal (chrome cobalt) base to full dentures
   4.1.8. Partial metal (chrome cobalt) frame dentures

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