



SASOLMED

ANNEXURE C

(With effect from 1 January 2024)

To be read in conjunction with Annexures B and D

1. PRESCRIBED MINIMUM BENEFITS

The Scheme 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. The Scheme will employ appropriate interventions aimed at improving the efficiency and effectiveness of healthcare provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies. [(Regulation 8(3)]

Where a managed healthcare protocol or a formulary drug preferred by the Scheme, but excluding the PMB algorithm as defined in the Regulation has been ineffective or would cause harm to a beneficiary, the Scheme 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 Scheme shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Scheme may nominate in consultation with the attending practitioner.

2.2 The Scheme 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 Scheme and at the cost of the Scheme. If the second opinion proposes different treatment or medicine to the first,



the Scheme may in its discretion require that the second opinion proposals be followed unless in terms of the managed healthcare programme.

- 2.3** Unless otherwise decided by the Scheme, 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 Scheme 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 Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its Managed Healthcare Organisation acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its Managed Healthcare Organisation may impose.

'Medically necessary' refers to services or 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 or provided for the convenience of the relevant beneficiary or service provider;
- 2.5.5** outcome studies are available and acceptable to the Scheme in respect of such services or supplies; and
- 2.5.6** they are not rendered or provided because of personal choice or preference of the relevant beneficiary or service



provider, while other medically appropriate, more cost-effective alternatives exist.

2.6. The Scheme 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; and
- 2.6.4** role in drug therapy as established by the Scheme's Managed Healthcare Organisation.

2.7 Subject to Regulation 15H(c) and Regulation 15I(c), 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; and
- 2.7.3** the treatment of any disease or condition becomes of a protracted nature or requires extended medicine 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 Scheme may require or advise:

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

2.7.3.2 the application of a limited drug formulary; and



2.7.3.3 both such transfer and restricted drug formulary; in order to conserve or maximise 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 Benefits conditions, if the Scheme 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 Scheme 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 Scheme (or contacted Managed Healthcare Organisation on behalf of the Scheme) may from time to time contract with or credential specific provider groups (networks) as determined by the Scheme in order to ensure cost effective and appropriate care.

3. BENEFITS EXCLUDED INsofar AS THESE ARE NOT PRESCRIBED UNDER THE PRESCRIBED MINIMUM BENEFITS



3.1 General exclusions

Unless otherwise decided by the Scheme (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 Scheme:

- 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 and necessary based on current practice, evidence-based medicine, cost effectiveness and affordability;
- 3.1.4** all costs in respect of injuries or conditions wilfully 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 and is generally considered to be inherently dangerous, except for Prescribed Minimum Benefits;
- 3.1.5** all costs for medicines for the treatment of chronic conditions not on the list of diseases covered, except for 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; and

3.1.6 all costs related to back-up power supply for the home including, but not limited to, inverters, generators, uninterrupted power supply (UPS) systems and batteries, including the hire, purchase and maintenance thereof.

3.2 Exclusions and indemnity in regard to third party claims

3.2.1 It is recorded that the relationship between the Scheme and its members shall at all times be deemed to be one of the utmost good faith.

The member therefore acknowledges and agrees that, notwithstanding anything to the contrary, or not specifically set out in the rules or Annexures of the Scheme, the member is under a duty of care to disclose all and any information or matters to the Scheme, which may in any manner impact upon or affect a decision or discretion which vests in the Scheme, concerning such member or his/her claim.

3.2.2 The Scheme shall effect payment of any claims, for both Prescribed and non-Prescribed Minimum Benefit conditions incurred by the member, arising from the actions or omissions of any other third party; Should any amounts so paid by the Scheme be deemed significant and recoverable by the Scheme and the member has not provided proof of taking legal action to recover such amounts to the satisfaction of the Scheme within three (3) months from commencement date of treatment, the Scheme may take steps to recover such amounts on the member's behalf and in the member's name and the member shall sign all documents, including an indemnity form for the Scheme to be directly reimbursed their portion of the claim from third parties concerned, required for such process; Should the member take timeous legal action to recover from a liable



third party or should the Scheme decide not to take such action on behalf of the member, the Scheme will be entitled to request the member to complete an indemnity form, for the Scheme to be directly reimbursed their portion of the claim, from third parties concerned. In such an event, the member, shall:

- 3.2.2.1** be liable to repay to the Scheme all amounts in respect of medical costs paid by the Scheme and recovered by or on behalf of the member from the party responsible to compensate such member, free of any legal costs or deductions that may have been incurred in the recovery of such amount;
- 3.2.2.2** ensure that, prior to the settlement of any claim instituted against such other party, all the amounts set out above and paid by the Scheme, are included in such claim and form part of any settlement amount, whether globular or separately;
- 3.2.2.3** disclose to the Scheme, alternatively, instruct his/her legal representative to disclose to the Scheme, the full extent of any compensation awarded in respect of past and future medical expenses;
- 3.2.2.4** sign all documentation as may be required by the Scheme to obtain copies of all such information not in the Scheme's possession, relating to the member's medical accounts and records from the relevant practitioners and/or medical institutions;
- 3.2.2.5** either personally or through his/her legal representative keep the Scheme informed, whether called upon by the Scheme to do so or not, as to the ongoing progress of his/her claim;



3.2.2.6 indemnify the Scheme against all amounts paid by the Scheme in terms of paragraph 3.2.2.1, such indemnity to be in the form required by the Scheme and to be furnished to the Scheme within three months from commencement of treatment, in default of which the member shall be liable for reimbursing the Scheme any non-PMB claims which the Scheme may recover from the member through the usual process; and

3.2.2.7 in the event the member is unjustly enriched in terms of any claims or costs funded by the Scheme, the Scheme may have the right to reverse costs incurred and/or institute action to recover costs arising from the actions or omissions of any other party.

3.2.3 Should a member's claim referred to in paragraph 3.2.2 against the party liable for his/her injuries not be successful, alternatively, only be partially successful, then in such event the member shall be entitled to such benefits (also considering recoveries made under paragraph 3.2.2.6) or portion of benefits (also considering recoveries made under paragraph 3.2.2.6) in respect of which his/her claim has been unsuccessful as would have applied, should no claim have been possible *ab initio*, irrespective of the lapse of time.

3.3 Exclusions in regard to non-registered service providers

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

- 3.3.1** persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
- 3.3.2** any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law.

3.4 Specific exclusions

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

3.4.1 Alternative Health Practitioners

All services not listed in paragraph D1 of Annexure B:

3.4.1.1 Aromatherapy;

3.4.1.2 Ayurvedics;

3.4.1.3 Herbalists;

3.4.1.4 Iridology;

3.4.1.5 Phytotherapy;

3.4.1.6 Reflexology; and

3.4.1.7 Therapeutic massage therapy (masseurs).



3.4.2 Ambulance services

Services not authorised or included in the preferred provider contract subject to Regulation 8(3), and services rendered outside the borders of South Africa.

3.4.3 Appliances, external accessories and orthotics

3.4.3.1 appliances, devices and procedures not scientifically proven or clinically appropriate, including back-up power supply for the home as per paragraph 3.1.6;

3.4.3.2 back rests and chair seats;

3.4.3.3 bandages and dressings (except medicated dressings or bandages applied after a procedure);

3.4.3.4 beds, mattresses, pillows and overlays;

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

3.4.3.6 electric toothbrushes;

3.4.3.7 humidifiers;

3.4.3.8 ionizers and air purifiers;

3.4.3.9 orthopaedic shoes, inserts, levellers and boots, unless specifically authorised and/or PMB;



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

3.4.3.11 stethoscopes; and

3.4.3.12 oxygen hire or purchase, unless authorised.

3.4.4

Blood, blood equivalents and blood products

3.4.4.1 Erythropoietin, unless approved by the relevant managed healthcare programme; and

3.4.4.2 Hemopure (bovine blood) unless in an emergency where there is no human blood or blood products available for acutely anaemic patients and specifically authorised by the relevant managed healthcare programme.

3.4.5

Dentistry

3.4.5.1 Orthodontic treatment for dependants 21 years and older;

3.4.5.2 periodontal plastic procedures for cosmetic reasons;

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

3.4.5.4 general anaesthetics, conscious analgo sedation and hospitalisation for dental work, except in the case of patients 8 years or younger or with bony impaction of the third molars; and

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

3.4.6

Hospitalisation

3.4.6.1 Accommodation and services provided in a geriatric hospital, old age home, or similar institution, unless



specifically authorised by the relevant managed healthcare programme.

3.4.7 Infertility

3.4.7.1 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);

3.4.7.2 vasovasostomy (reversal of vasectomy); and

3.4.7.3 salpingostomy for reversal of tubal ligation.

3.4.8 Maternity

3.4.8.1 3D and 4D scans; and

3.4.8.2 2D scans more than 2, unless motivated for an appropriate medical condition.

3.4.9 Medicine and injection material

3.4.9.1 anabolic steroids and immunostimulants, unless Prescribed Minimum Benefits;

3.4.9.2 contraceptives: implants, parenteral, foams and IUCD's injectables, patches, vaginal rings when used for skin conditions excluding oral contraceptives authorised by the relevant managed healthcare programme and compliant with relevant protocols or provided for in other benefits;



- 3.4.9.3** cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen (except for albinism prescribed by a Dermatologist which will be paid from the Chronic Medicine Benefits) 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;
- 3.4.9.4** erectile dysfunction and loss of libido medical treatment unless authorised by the relevant managed healthcare programme and compliant with the relevant protocol;
- 3.4.9.5** patented and nutritional supplements including baby food and special milk preparations unless for malabsorptive disorders and if registered by 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;
- 3.4.9.6** injection and infusion material, except for out-patient parenteral (OPAT) treatment and diabetes;
- 3.4.9.7** the following medicines, unless they form part of the public sector and chronic disease list protocols and are authorised by the relevant managed healthcare programme:
- 3.4.9.7.1** maintenance Rituximab or other monoclonal antibodies in the first line



setting for haematological malignancies;

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

3.4.9.7.3 protein C inhibitors such as Xigris, for septic shock and septicemia; and

3.4.9.7.4 any specialised drugs as defined by the managed healthcare 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 malignancies, unless deemed cost-effective for the specific setting, compared to standard therapy (excluding specialized drugs) as defined in established and generally accepted treatment protocols;

3.4.9.8 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);

3.4.9.9 medicines defined as exclusions by the relevant managed healthcare programme. A list showing the relevant exclusions are available to all members and Healthcare Service Providers, updated monthly, on the website;

3.4.9.10 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;

- 3.4.9.11** any new chemotherapeutic drug that has not convincingly demonstrated a survival advantage of more than three (3) months in advanced or metastatic solid organ malignant tumours;
- 3.4.9.12** medicines not authorised by the relevant managed healthcare programme;
- 3.4.9.13** patent medicines, household remedies and proprietary preparations and preparations not otherwise classified;
- 3.4.9.14** slimming preparations for the treatment and prevention of obesity;
- 3.4.9.15** smoking cessation and anti-smoking preparations unless pre-authorised by the relevant managed healthcare programme;
- 3.4.9.16** benefits for clinical trials unless pre-authorised by the relevant managed healthcare programme;
- 3.4.9.17** diagnostic agents, unless pre-authorised by the relevant managed healthcare programme;
- 3.4.9.18** growth hormones, unless pre-authorised by the relevant managed healthcare programme;
- 3.4.9.19** immunoglobulins and immune stimulants, oral and parenteral, unless pre-authorised by the relevant managed healthcare programme;
- 3.4.9.20** Erythropoietin, unless pre-authorised by the relevant managed healthcare programme;
- 3.4.9.21** medicines used specifically to treat alcohol and drug addiction, unless Prescribed Minimum Benefits; and



3.4.9.22 vitamin supplements, unless on prescription for a diagnosed physiological condition or used as pregnancy supplements and, where applicable, pre-authorised by the relevant managed healthcare programme.

3.4.10 Mental health

3.4.10.1 Sleep therapy.

3.4.11 Non-surgical procedures and tests

3.4.11.1 Epilation – excluding ophthalmology; and

3.4.11.2 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.

3.4.12 Optometry

3.4.12.1 Cosmetic enhancements to spectacle lenses or contact lenses;

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

3.4.12.3 sunglasses except where albinism is present; and

3.4.12.4 Diagnostic Procedures: Sports Vision evaluations, screening and training.

3.4.13 Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication

3.4.13.1 Organs and haemopoietic stem cell (bone marrow) donations to any person other than to a member or dependant of a member on this Scheme, unless Prescribed Minimum Benefit of the donor member or the donor beneficiary after harvesting.

3.4.14 Additional health services**3.4.14.1** Art therapy; and**3.4.14.2** Music Therapy.**3.4.15 Pathology and Medical Technology****3.4.15.1** Gene Sequencing unless related to oncology.**3.4.16 Physical therapy (physiotherapy, chiropractics and biokinetics)****3.4.16.1** X-rays performed by chiropractors; and**3.4.16.2** Chiropractors services rendered in hospital.**3.4.17 Prostheses internal and external****3.4.17.1** Custom-made hip arthroplasty for inflammatory and degenerative joint disease unless authorised by the relevant managed healthcare programme.**3.4.18 Radiology and radiography****3.4.18.1** MRI scans ordered by a general practitioner unless there is no reasonable access to a specialist;**3.4.18.2** bone densitometry performed by a general practitioner;**3.4.18.3** Positron Emission Tomography for screening unless specifically authorised by the relevant Managed Healthcare Organisation;**3.4.18.4** CT colonography (virtual colonoscopy) for screening; and**3.4.18.5** MDCT Coronary Angiography for screening.**3.4.19 Surgical procedures****3.4.19.1** abdominoplasties and the repair of divarication of the abdominal muscles;**3.4.19.2** bilateral gynaecomastia;

REGISTERED BY ME ON


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 REGISTRAR OF MEDICAL SCHEMES

- 3.4.19.3** blepharoplasties, unless causing demonstrated functional visual impairment and pre-authorised;
- 3.4.19.4** breast augmentation, unless medically necessary and pre-authorised;
- 3.4.19.5** breast reconstruction, unless mastectomy following cancer and pre-authorised;
- 3.4.19.6** breast reductions, unless medically necessary and pre-authorised;
- 3.4.19.7** erectile dysfunction surgical procedures;
- 3.4.19.8** gender re-assignment for cosmetic effect;
- 3.4.19.9** obesity – surgical treatment except for certain bariatric surgical procedures performed for life threatening morbid obesity by a multidisciplinary team in accordance with agreed protocol in a credentialed centre of excellence when pre-authorised but not including any postoperative plastic and reconstructive surgery;
- 3.4.19.10** otoplasties;
- 3.4.19.11** revision of scars and keloids except for functional impairment;
- 3.4.19.12** rhinoplasties for cosmetic purposes;
- 3.4.19.13** [Deletion effective 1 January 2023];
- 3.4.19.14** uvulo palatal pharyngoplasty (UPPP and LAUP) for snoring;
- 3.4.19.15** genioplasties as an isolated procedure;
- 3.4.19.16** all costs for cosmetic surgery performed over and above the codes authorised for admission;
- 3.4.19.17** Balloon Sinuplasty; and
- 3.4.19.18** spinal surgery if a beneficiary has not been for an assessment to Document Based Care except in the case of emergencies.

3.5 Items not mentioned in Annexure B or above:

- 3.5.1** appointments which a beneficiary fails to keep;
- 3.5.2** autopsies;
- 3.5.3** cryo-storage of foetal stemcells and sperm;
- 3.5.4** holidays for recuperative purposes;
- 3.5.5** travelling expenses;
- 3.5.6** veterinary products;
- 3.5.7** accommodation in spa's, health resorts and places of rest even if prescribed by a treating provider;
- 3.5.8** reports, examinations and tests requested for any of the following:
- 1) emigration;
 - 2) immigration;
 - 3) visas;
 - 4) insurance policies;
 - 5) permits;
 - 6) pilot and driving licenses;
 - 7) employment,
 - 8) enrolments to colleges, schools and universities,
 - 9) court medical reports,
 - 10) fitness examinations and tests,
 - 11) adoption of children; and
 - 12) retirement because of ill health;
- 3.5.9** any costs relating to search and rescue; and
- 3.5.10** repatriation of a member or his beneficiaries unless specified in the ambulance contract with the Scheme for services rendered within the borders of South Africa.



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