



**SASOLMED
ANNEXURE D**

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ANNEXURE D

(With effect from 1 January 2024)

(Unless otherwise stated below)

To be read in conjunction with Annexure B and C

1. WAITING PERIODS

1.1 The Scheme 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 scheme 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; and

1.1.2 a condition specific waiting period of up to 12 months (nine months for pregnancy).

1.2 The Scheme 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 scheme 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 (nine months for pregnancy), except in respect of any treatment or diagnostic procedures covered within the Prescribed Minimum Benefits; and

1.2.2 in respect of any person contemplated in this subparagraph, where the previous medical scheme had imposed a general or condition specific waiting period, and



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such waiting period had not expired at the time of termination, a general or condition specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

1.3 The Scheme 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 scheme 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 scheme, 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; and

1.4.1.2 an employer changing or terminating the medical scheme 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 scheme to which an application is made for such transfer to occur at the beginning of the financial year.



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Where the former medical scheme 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 Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme;

- 1.4.2** a beneficiary who changes from one benefit option to another within the scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied; or
- 1.4.3** a child dependant born during the period of membership, provided the member registers such child as a dependant within thirty (30) days in terms of main Rule 7.1.3; or
- 1.4.4** a foster child or newly adopted child, provided the member registers such child as a dependant within ninety (90) days in terms of main Rule 7.1.4.

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, with due regard to Prescribed Minimum Benefit (PMB) Regulations.



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3. TERRITORIAL APPLICATION

Subject to the provisions of the main Rules, the benefits available in terms of the Rules shall be provided within the borders of the Republic of South Africa. In the event of a member or his dependant incurring unforeseen medical expenses outside the borders of South Africa and for which another party is not liable, benefits shall be as per paragraphs 16.4 to 16.4.6 of the main Rules, and subject to any further provisions, limitations and exclusions contained in Annexures A to D.

4. REQUIREMENTS OF MANAGED HEALTHCARE PROGRAMMES

- 4.1** Pre-authorisation is required before services in respect of hospitalisation, specialised radiology and other services stated in Annexure B as being subject to prior authorisation, qualify for benefits.
- 4.2** When the Scheme's relevant Managed Healthcare Organisation grants a pre/post-authorisation, 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 expressions "subject to the relevant managed healthcare programme" and "subject to pre-authorisation", are used, when applied to hospitalisation or admission to a sub-acute facility, day clinic or unattached operating theatre, physical rehabilitation hospital, rehabilitation centers or hospice, it shall imply that an authorisation granted for admission and care covers all recognised services associated with that admission, except for specialised radiology services, which shall require an additional authorisation



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independent of the hospital authorisation or other authorisation concerned.

Services which are subject to the Hospital Benefit Management Programme but not associated with admission to a hospital or sub-acute facility, day clinic or unattached operating theatre, physical rehabilitation hospital, rehabilitation centers or hospice, require applications to be made for each and every eligible service as indicated in Annexure B.

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

- 4.4** The granting of a pre-authorisation and/ or post authorisation is confirmation that the proposed clinical procedure or treatment complies or complied with the clinical and funding protocols but is not a guarantee of benefits.
- 4.5** Payment of benefits for a clinical procedure or treatment in respect of which a pre/post-authorisation is granted, is subject to:
 - 4.5.1** the Rules of the Scheme;
 - 4.5.2** qualification for and availability of benefits at the time of submitting a claim;
 - 4.5.3** submission of such information as may be reasonably required by the relevant managed healthcare programme;



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- 4.5.4** the clinical procedure or treatment, length of stay and level or care, where applicable, not exceeding 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, unless clinically motivated and authorised;
- 4.5.6** with the exception of an emergency medical condition, and with due regard to the PMB regulations, if application for a pre-authorisation is not made or is refused for a clinical procedure or treatment, on clinical grounds and/or in accordance with Scheme Rules and/or managed healthcare protocols, no benefits are payable;
- 4.5.7** in an emergency, pre-authorisation must be applied for within two (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 is 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 Scheme to perform its duties. Specifically, the Scheme may require particulars of diagnosis, clinical investigations, procedures and treatment by the attending medical practitioner of the



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beneficiary prior to admission of the beneficiary to hospital;

- 4.5.10** the Scheme or its Managed Healthcare Organisation reserves the 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 Scheme. In addition, all treatment in an intensive care unit in excess of four (4) days may be subject to specific inquiry and/or intervention;
- 4.5.11** if the health problems of beneficiaries are of such a nature that they qualify for admittance to the Scheme's Case Management Programme and/or Active Disease Risk Management Programme, the Scheme or its Managed Healthcare Organisation may enter such beneficiaries on such a programme;
- 4.5.12** the member or beneficiary is responsible for ensuring the Scheme is notified, if enrolled in any form of clinical trial; and
- 4.5.13** the Scheme or its contracted Managed Healthcare Organisation may from time to time contract with or pilot with credentialed specific provider groups (networks) or centers of excellence as determined by the Scheme in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits (as set out in Annexures B and D). The Scheme reserves the right not to fund or to



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partially fund, or to impose a co-payment for, services acquired outside of these networks provided reasonable steps are taken by the Scheme to ensure access to the network and that the member is aware of the need to use such a network for the provision of medical care. The application of these Rules will be subject to Prescribed Minimum Benefit (PMB) Regulations.

5. FUNDING GUIDELINES AND PROTOCOLS

If the Scheme or its Managed Healthcare Organisation has funding guidelines, protocols or formularies in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies that are within the applicable funding guidelines, protocols and formularies, irrespective of other clinical guidelines, subject to Regulation 15(H) and 15(I) and PMB Regulations.

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.

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 and/or the Managed Healthcare Organisation appointed by the Scheme.



6. SCHEDULE OF MANAGED HEALTHCARE PROGRAMMES

6.1 HIV/Aids Management Programme

A programme adopted by the Scheme incorporating such clinical protocols as defined in relevant annexures to the contract between the Scheme and its Managed Healthcare Organisation and contracted 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 Emergency Evacuation and Ambulance Services

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

6.3 Chronic Medicine Management Programme

A programme adopted by the Scheme for the prior authorisation and management of medicine claims against the chronic medicine benefit in respect of diseases that qualify for reimbursement in terms of paragraphs 6.4.3 and 7.12 below.

6.3.1 The Chronic Medicine Management Programme may include the use of formularies and other managed healthcare protocols against which applications for funding of chronic medicines are adjudicated. These protocols, where applicable, shall apply the principles of clinical appropriateness, cost-effectiveness and affordability and aim



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to achieve the best clinical outcomes for the beneficiary concerned.

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

6.3.2.1 it is prescribed by a medical practitioner for an uninterrupted period of at least three months for a condition appearing on the lists as per paragraphs 6.3.3 and 7.12; and

6.3.2.2 it has been applied for in the manner, and at the frequency, prescribed by the Scheme; and

6.3.2.3 it has been registered for the prescribed indication; and

6.3.2.4 it has been authorised in line with the clinical and funding protocols adopted by the Chronic Medicine Management Programme, and where applicable, subject to PMB Regulations.

6.3.3 The following chronic diseases, in addition to the chronic diseases referred to in paragraph 7.12, qualify for benefits in terms of the Scheme's Chronic Medicine Management Programme:

Diseases marked with * are possible Prescribed Minimum Benefit conditions; where a PMB condition has been validated and authorised as a PMB, the funding of associated claims will be as for PMBs, subject to PMB Regulations and paragraph 7 below:

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- 1) Acne
- 2) Allergic dermatitis
- 3) Allergic rhinitis
- 4) Alzheimer's Disease
- 5) *Anaphylaxis
- 6) *Angio-edema
- 7) Ankylosing spondylitis
- 8) Anorexia nervosa
- 9) Aplastic anaemia
- 10) Attention deficit disorder – for children 6 – 18 years,
unless clinically motivated
- 11) *Auto-immune disorders
- 12) Barrett's oesophagitis
- 13) Behavioural disorders
- 14) *Benign Prostatic Hypertrophy
- 15) Blood / haematological disorders (including nutrient-
deficiency and chronic anaemias)
- 16) Bulimia
- 17) Cerebral palsy
- 18) Chronic infections (unrelated to HIV infection)
- 19) Chronic organic pain syndromes
- 20) Cluster headaches
- 21) Connective tissue disorders (including Beuchet's
Syndrome)
- 22) Discoid Lupus Erythematosus, Polychondritis,
Polymialgia, Rheumatica, Polymyositis, Systemic
Sclerosis, Wegener's Granulomatosis
- 23) Cryoglobinaemia
- 24) Cystic fibrosis
- 25) Depression



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- 26) Major Depression
- 27) Dermatomyositis
- 28) Dystonias
- 29) Eczema
- 30) *Endocarditis
- 31) *Endocrine disorders (including pituitary, thyroid, parathyroid, ovarian, testicular and adrenal dysfunction but specifically excluding male menopause)
- 32) *Endometriosis
- 33) Enuresis
- 34) Essential tremor
- 35) Gastro-oesophageal Reflux Disease (complicated)
- 36) Generalised Anxiety Disorder
- 37) Gout/Hyperuricaemia
- 38) Hepatitis B and C
- 39) *Hirsutism
- 40) Huntington's Chorea
- 41) *Iron Deficiency Anaemia
- 42) *Ischaemic Heart Disease/Angina
- 43) *Liver failure
- 44) Macular degeneration
- 45) Meniere's disease
- 46) *Menopause (female)/HRT
- 47) *Metabolic disorders
- 48) Migraine
- 49) Motor Neuron Disease
- 50) Muscular dystrophy
- 51) Myasthenia gravis
- 52) Narcolepsy



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REGISTRAR OF MEDICAL SCHEMES

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- 53) *Nephrotic Syndrome
- 54) *Neurogenic bladder
- 55) Obsessive Compulsive Disorder
- 56) Obstructive/Reflux Nephropathy
- 57) *Onychomycosis
- 58) *Ophthalmological disorders (including
keratoconjunctivitis sicca, but specifically excluding
allergic conjunctivitis)
- 59) Osteoarthritis
- 60) Osteopaenia
- 61) Osteoporosis
- 62) Paget's disease
- 63) *Pancreatic disease
- 64) Panic disorder
- 65) *Para/Quadriplegia
- 66) *Pemphigus
- 67) Peptic Ulcer Disease (including eradication therapy)
- 68) Peripheral neuropathy
- 69) *Peripheral Vascular Disease
- 70) Phobic disorders
- 71) Polyarteritis nodosa
- 72) *Polycystic Ovarian Disease
- 73) Post Bowel Surgery
- 74) Post-herpetic neuralgia
- 75) Post-traumatic Stress Disorder
- 76) Psoriasis
- 77) Psychotic disorders
- 78) *Pulmonary Hypertension
- 79) Pulmonary interstitial fibrosis
- 80) Pyelonephritis



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- 81) Raynaud's disease
- 82) Renal calculi
- 83) Rickets
- 84) Scleroderma
- 85) Seborrheic dermatitis
- 86) Sinusitis
- 87) Sjogren's Syndrome
- 88) Spasticity (unrelated to Stroke)
- 89) *Stroke
- 90) *Thromboangiitis Obliterans
- 91) *Thrombocytopaenic Purpura
- 92) Tic Disorder
- 93) Tourette's Syndrome
- 94) *Transient Ischaemic attacks
- 95) Trigeminal Neuralgia
- 96) *Tuberculosis
- 97) Urinary incontinence
- 98) Urticaria
- 99) *Valvular heart disease
- 100) *Venous thrombotic disorders
- 101) *Vitroretinal disorders
- 102) Zollinger-Ellison Syndrome

6.4 Hospital Benefit Management Programme

A programme adopted by the Scheme for the ongoing monitoring, by the Scheme 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



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hospital, rehabilitation center or hospice, and a sickness condition for which the beneficiary was admitted in the first instance, and which may extend beyond the period of hospitalisation.

The Hospital Benefit Management Programme includes a case management 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 Scheme or the Scheme's Managed Healthcare Organisation directs a beneficiary's participation in the programme or approves an application by a beneficiary for participation in the programme.

6.5 Acute Medicine Management Programme

A programme adopted by the Scheme for the management of claims by the Scheme or its Managed Healthcare Organisation in respect of acute medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability.

The acute medicine management programme furthermore includes the application of medicine reference pricing and medicine exclusions based on scientific evidence and independent expert opinion. Medicine exclusions may be applied for various reasons, including, but not limited to, the following:

- 6.5.1** place in therapy is not well-established;
- 6.5.2** clinical benefit offered by product is not significant;
- 6.5.3** product is too expensive relative to its clinical value;



6.7 Oncology Management Programme

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

6.8 Back and Neck Rehabilitation Programme

A programme adopted by the Scheme for the conservative management of beneficiaries identified with back and neck conditions.

6.9 Mental Health Programme

A programme adopted by the Scheme for beneficiaries with certain mental health conditions and substance abuse disorders, and which aims to improve the quality and integration of mental healthcare that these beneficiaries receive. Parallel to healthcare provider decision support, it uses specialised mental health managed care interventions to promote effective self-care by beneficiaries suffering from moderate to severe mental illness, to lower total healthcare costs in the medium and long term.

6.10 Weight Management Programme

A programme adopted by the Scheme for beneficiaries who are overweight and require expert advice.

6.11 Virtual Care Consultations Programme

A programme adopted by the Scheme where members can consult with a network of nurses and doctors.

6.12 Maternity Management Programme



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A programme adopted by the Scheme for beneficiaries who are pregnant and require support during pregnancy and confinement in hospital, including post-confinement parenting advice.

7. PRESCRIBED MINIMUM BENEFITS

- 7.1** Members and their registered dependants shall be entitled to Prescribed Minimum Benefits for relevant health services, as per Regulation 8 and Annexure A to the Regulations published in terms of the Act, and in accordance with the Scheme's managed healthcare programmes and protocols, and the Rules of the Scheme.
- 7.2** Prescribed Minimum Benefits are not subject to annual benefit limits, except as may be prescribed by Regulation and further outlined in Annexure C to these Rules. Where benefit limits in terms of the Rules have been exceeded, continued benefits shall apply for Prescribed Minimum Benefits, subject to PMB Regulations.
- 7.3** For all Prescribed Minimum Benefit conditions, the benefits available at Designated Service Providers (DSPs) and non-DSPs are as stipulated in paragraphs 7.5 to 7.13 below, subject to PMB Regulations.
- 7.4 Designation of Service Providers for Prescribed Minimum Benefit Conditions**

The Scheme designates the service providers listed in paragraph 7.13 below, for the delivery of Prescribed Minimum Benefits to its beneficiaries, subject to the provisions of Annexure B to the Rules, and PMB Regulations.

For the purpose of the Rules, 'Designated Service Provider' or "DSP" shall mean a healthcare provider or group of providers selected by



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the Scheme as the preferred provider or providers for the diagnosis, treatment and care, including medicine, of Prescribed Minimum Benefit conditions and services. In the case of non-PMB conditions and services, the term 'DSP' shall refer to preferred provider arrangements, and the associated benefits shall be as for non-PMB conditions, subject to the stated benefits and limitations as per Annexure B.

7.5 Prescribed Minimum Benefits obtained from Designated Service Providers

100% of cost and/or negotiated rate, which will not be less than the fee charged by the State, in respect of diagnosis, treatment and care of Prescribed Minimum Benefit conditions if those services are obtained from a Designated Service Provider.

7.6 Prescribed Minimum Benefits voluntarily obtained from other providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition from a provider other than a Designated Service Provider, the percentage benefit payable by the Scheme shall be as stated in Annexure B of these Rules, and any difference between the amount charged and the benefit provided by the Scheme, shall be a co-payment, payable by the member, subject to PMB Regulations.

7.7 Prescribed Minimum Benefits involuntarily obtained from other providers

7.7.1 If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition from a provider other than a Designated Service Provider, the



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medical scheme shall pay 100% of cost in relation to those Prescribed Minimum Benefits, subject to PMB Regulations.

7.7.2 For the purposes of paragraph 7.7.1, a beneficiary shall be deemed to have involuntarily obtained a service from a provider other than a Designated Service Provider if –

7.7.2.1 the service was not available from the Designated Service Provider or would not be provided without unreasonable delay;

7.7.2.2 immediate medical or surgical treatment for a Prescribed Minimum Benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a Designated Service Provider; and

7.7.2.3 there was no Designated Service Provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

7.7.3 Except in case of an emergency medical condition, prior authorisation shall be obtained by a member before involuntarily obtaining a service from a provider other than a Designated Service Provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 7.7.2 are applicable.

7.8 Medicine for Prescribed Minimum Benefit Conditions

7.8.1 Where a Prescribed Minimum Benefit includes medicine, the Scheme shall pay 100% of the cost or the negotiated rate,



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which will not be less than the fee charged by the State, for the medicine, if:

- 7.8.1.1** the medicine is obtained from a Designated Service Provider, or is involuntarily obtained from a provider other than the Designated Service Provider;
- 7.8.1.2** the medicine is included on the applicable formulary in use by the Scheme, or the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition; and
- 7.8.1.3** the cost of the medicine is within the applicable formulary reference price or other applicable medicine reference price adopted by the Scheme.

7.8.2 Where a Prescribed Minimum Benefit includes medicine, and the medicine is voluntarily obtained from a provider other than the Designated Service Provider; or if the applicable formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead; the percentage benefit payable by the Scheme shall be as stated in Annexure B and any difference between the amount charged and the benefit payable by the Scheme shall be a co-payment payable by the member, subject to PMB Regulations.

7.9 Prescribed Minimum Benefits obtained from a public hospital and/or a registered public health dispensing unit



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Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the fee charged by the State, in respect of Prescribed Minimum Benefits, including medicine, obtained in a public hospital or from a registered public health dispensing unit, without limitation.

7.10 Diagnostic tests for an unconfirmed Prescribed Minimum Benefit diagnosis

Where diagnostic tests and examinations are performed in respect of a suspected PMB diagnosis but do not result in confirmation of a PMB diagnosis, such diagnostic tests or examinations are considered to form part of the Prescribed Minimum Benefits up to the point that a non-PMB diagnosis is confirmed, subject to the provision of a clinical motivation and authorisation by the Scheme's Managed Healthcare Organisation, and PMB Regulations.

7.11 Co-payments

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

7.12 Specified Prescribed Minimum Benefit Chronic conditions covered by the Scheme

The following specified Prescribed Minimum Benefit Chronic Disease List (CDL) conditions are covered by the Scheme, subject to registration on the Scheme's Chronic Medicine Management Programme, the application of clinical and funding protocols such as the utilisation of DSPs, medicine formularies and medicine reference pricing, and further subject to PMB Regulations and the stipulations of this paragraph 7 to the Rules:



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- 1) Addison's disease
- 2) Asthma
- 3) Bi-Polar Mood Disorder
- 4) Bronchiectasis
- 5) Cardiac failure
- 6) Cardiomyopathy
- 7) Chronic renal disease
- 8) Chronic obstructive pulmonary disease
- 9) Coronary artery disease
- 10) Crohn's disease
- 11) Diabetes insipidus
- 12) Diabetes mellitus type 1 and 2
- 13) Dysrhythmias
- 14) Epilepsy
- 15) Glaucoma
- 16) Haemophilia
- 17) HIV
- 18) Hyperlipidaemia
- 19) Hypertension
- 20) Hypothyroidism
- 21) Multiple sclerosis
- 22) Parkinson's disease
- 23) Rheumatoid arthritis
- 24) Schizophrenia
- 25) Systemic lupus erythematosus
- 26) Ulcerative colitis

7.13 Designation of Service Providers by the Scheme



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The Scheme selects the following Designated Service Providers (DSPs) for the delivery of Prescribed Minimum Benefits and other stated services / treatment to beneficiaries of the Scheme. In the case of non-PMB services and treatment, preferred provider arrangements may apply, subject to the Scheme's normal benefits, limits and conditions as stated in Annexure B to the Rules:

7.13.1 ER24 - for the provision of emergency evacuation and ambulance services to beneficiaries of the Scheme;

7.13.2 All public (provincial hospitals) plus all Mediclinic, Life Healthcare, NHN, Netcare and a number of independent private hospitals and/or clinics - for the provision of hospitalisation and hospital-based services to beneficiaries of the Scheme;

7.13.3 Ampath, Lancet, Pathcare (including Vermaak) and other independent laboratories selected by the Scheme - for the provision of pathology services to beneficiaries of the Scheme;

7.13.4 A Comprehensive Network of GPs and Pharmacies as communicated to members from time to time for the provision of out of hospital GP consultations (acute and chronic) and chronic medicine - in respect of members (and their registered dependants) who have chosen the Comprehensive Network as their Chronic Network Option in terms of Annexures A and B of the Rules;

7.13.5 A Restricted Network of GPs (Premier Plus Network) and Pharmacies as communicated to members from time to time for the provision of out of hospital GP consultations (acute and chronic) and chronic medicine - in respect of



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members (and their registered dependants) who have chosen the Restricted Network Option as their Chronic Network DSP in terms of Annexures A and B to the Rules;

7.13.6 Designated service providers as communicated to beneficiaries registered on the Scheme's oncology management programme from time to time - for the provision of authorised oncology medicines and consumables;

7.13.7 All registered specialists – in respect of specialist services, and subject to referral from a GP, where applicable, where no other Designated Service Provider has been selected by the Scheme in terms of these Rules or the managed healthcare programmes adopted by the Scheme;

7.13.8 All other registered practitioners – in respect of qualifying services where no other Designated Service Provider has been adopted by the Scheme in terms of these Rules or the managed healthcare programmes adopted by the Scheme;

7.13.9 Documentation Based Care (DBC) - for the provision conservative back and neck rehabilitation programme to beneficiaries of the Scheme;

7.13.10 Biokineticist who are registered with the Biokineticist Association of South Africa (BASA) – for the provision of a weight management programme to beneficiaries of the Scheme;

7.13.11 Radiology – any provider charging the Scheme tariff.



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- 7.13.12 Mental health drug and alcohol abuse facilities** – any accredited facility and or provider contracted with the Scheme;
- 7.13.13 All other mental health treatment** – Any provider accredited and/or contracted with the Scheme and/or a defined list of hospitals with a psychiatric ward and is contracted with the Scheme;
- 7.13.14 Major hip and knee joint replacements** – A defined list of hospitals and providers that have contracted with the Scheme;
- 7.13.15 Spinal surgery** – A defined list of hospitals and providers that has contracted with the Scheme;
- 7.13.16 Preferred providers for appliances and prosthesis, as communicated to members from time to time** - for the provision of internal and external prostheses and devices authorised by the Scheme's Managed Healthcare Organisation in terms of Annexure B;
- 7.13.17 Terminal care facilities** – Hospice and any other compassionate care facilities; and
- 7.13.18 Renal care** – Contracted providers, applicable to the member's option, in respect of chronic renal dialysis network and/or the State.

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