SIZWE MEDICAL FUND

PRIMARY CARE PLAN

ANNEXURE B: PRIMARY CARE

BENEFITS

(Effective 1 January 2019)

A. *ENTITLEMENT TO BENEFITS*

Subject to the provisions of Rule 6 and Rule 12 and to the conditions stipulated in preamble C of this Annexure and paragraph one of Annexure C, members and their registered dependants are entitled to the benefits as stipulated in paragraphs 1 to 4.

1. General

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:

General waiting period: 3 months

Pre-existing conditions:12 months

Benefits shall be pro-rated subject to the month in which the member joins the Scheme.

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. 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, except in cases of emergencies.
4. Voluntary admissions in hospitals that are not participating in the DSP will be subjected to a co-payment equal to the difference between the DSP and the non-DSP rates.
5. Day procedures and minor procedures are only payable at a Day Hospital or doctors' rooms. Where a day procedure is done at a place outside the Day Hospital, it will be payable up to the rates of the Day hospital, unless no day hospital is available. Where a minor procedure is done outside the doctors' rooms it will be payable up to the rate of the doctors' rooms.

Payment of specialist visits are subject to referral by a GP, with the exception of :

- Follow-up visits
- Emergencies
- Gynaecologist visits
- Paediatrician visits for babies up to the age of 12 months

SIZWE MEDICAL FUND

PRIMARY CARE PLAN

OUT OF HOSPITAL BENEFITS

1.1 DAY-TO-DAY BENEFITS

The following services are covered subject to specified day-to-day benefits: General Practitioners, Specialists (excluding Psychiatrists), Physiotherapy, Radiology, Pathology and Acute Medicines.

	Specified Benefit
Member without dependants	R 5 990
Member with one dependant	R 8 870
Member with two dependants	R 10 380
Member with three dependants	R 11 870
Member with four dependants	R 13 380
Member with five dependants	R 14 880
Member with six or more dependants	R 16 370

1.1.1. General Practitioners (GP)

100% Sizwe rates for visits by general practitioners in the supplier's room or patient's home, subject to the stipulated number of GP visits. The benefits are subject to availability of funds in the day-to-day **benefit** as in 1.1 above.

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

One (1) extra visit per single member per annum for preventative care

1.1.2 SPECIALISTS

100% Sizwe rates for visits to specialists, subject to the stipulated number of specialist visits below, except in cases of emergencies and PMBs. Referral to the specialist by a GP is mandatory, unless not possible as in the case of an unavailable GP, in an emergency (refer to definition of medical emergency) or a follow-up specialist visit after an initial GP referral. 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.

Psychiatrists are EXCLUDED from this benefit and are covered under mental health.

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

Prescribed Minimum Benefits: All consultations and visits are payable at cost with no co-payment or deductibles, subject to PMBs, provider network and Managed Care clinical protocols.

1.1.3 PHYSIOTHERAPY

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

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

1.1.4 RADIOLOGY AND RADIOGRAPHY

General Radiology

100% Sizwe rates for general diagnostic radiology subject to managed care protocols.

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

Specialised radiology

MRI/CAT scan/Angiogram subject to an overall combined limit of R 19 710 per family per annum.

Interventional radiology

(refer to paragraph 2.11)

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

1.1.5 PATHOLOGY

100% Sizwe 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.

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

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

1.1.6 ACUTE MEDICINE

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

	Limit
Member without dependants	R 1 870
Member with one dependant	R 3 370
Member with two dependants	R 3 750
Member with three dependants	R 4 250
Member with four dependants	R 4 370
Member with five dependants	R 4 610
Member with six or more dependants	R 4 990

This benefit is subject to the conditions stipulated below:

a. The Pharmaceutical Benefit Management Programme;
b. Reimbursement is at 100% SEP plus the dispensing fee as per the Department of Health's 2015 Dispensing Regulations or as per the Sizwe tariff as negotiated with the service provider;
c. Medicine must be prescribed by a person legally entitled to prescribe; and
d. Medicine used during an in-hospital event is excluded from this benefit.

1.1.7 MATERNITY AND INFERTILITY

1.1.7.1 Antenatal consultations

100% Sizwe 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 1.1.1 above, if the patient is registered for the maternity benefit management program within 24 weeks of falling pregnant.

Two (2) specialist obstetrician visits per pregnancy, subject to referral by the GP or midwife in addition to the regular specialist benefit as in 1.1.2.

1.1.7.2 Pregnancy scan and tests

100% Sizwe rates for pregnancy scans and the following pregnancy-related tests subject to registration on the maternity benefit management program within 24 weeks of falling pregnant:

- Two (2) Haemoglobin Measurement tests,
- one (1) Blood Grouping test,
- one (1) VDRL test for Syphilis and
- Two (2) HIV blood tests over and above the regular Pathology benefits in rule 1.1.5
- Twelve (12) urine analysis tests
- One (1) Full blood count (FBC) test
- Vitamins worth R100 paid from day to day benefit

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

1.1.7.3 Infertility

Covered in accordance with Code 902 M of the PMB Regulations, in a State facility.

1.2 ADDITIONAL OUT OF HOSPITAL BENEFITS

1.2.1 PRIVATE NURSE

Limit per year per family – R 4 790 at Sizwe rates (pre- authorisation is required)

Frail care is not included in this benefit.

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

1.2.2 AUXILIARY SERVICES

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:

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

Member	: R 1 070
Member with one or more dependant	: R 1 720

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

1.2.3 CHIROPRACTORS

Payable at 100% Sizwe rates up to a limit of R 1 060 per beneficiary per annum

1.2.4 CHRONIC MEDICINES

Subject to the conditions stipulated below:

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

ii. The Pharmaceutical Benefit Management Programme;
iii. Reimbursement is at 100% SEP plus the dispensing fee as per the Department of Health's 2015 Dispensing Regulations or as per negotiated tariff with the preferred service provider;
iv. Medicine must be prescribed by a person legally entitled to prescribe;
v. Medicine used during an in-hospital event is excluded from this benefit;
vi. Members should use Sizwe preferred providers to avoid co-payment co-payments or limits; and
vii. Where there is a generic equivalent, the chronic medicine benefit shall not exceed the maximum retail price of the generic equivalent.

1.2.5 APPLIANCES

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

Member	: R 1 070
Member with one or more dependant	: R 1 720

Includes procurement towards the following devices and appliances: Nebulizer, Glucometer, Insulin pump, Morphine pump and other clinically appropriate unspecified appliances items. Any appliance is payable only once per annum, subject to the limits as stipulated above.
The cost of C-PAP machines is payable from this benefit, subject to fulfilment of clinical criteria and procurement protocols

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.

1.2.6 MENTAL HEALTH

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

100% Sizwe rates subject to annual limit of R 5 460 per family.

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

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.

1.2.7 PREVENTATIVE CARE

1.2.7.1 Wellness consultations:

Subject to a family limit of R 1 060 per annum

1.2.7.2 Preventative Care Screening:

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

Subject to a family limit of R 2 130 per annum

Includes the following tests:
Blood sugar, Cholesterol, Blood pressure, Body Mass Index and HIV testing.

One (1) screening test per beneficiary per annum.

One (1) consultation visit in doctors' rooms.

Limited to R 270 per beneficiary per annum at a Preferred Provider facility.

1.2.7.3 Other screening tests

Cover limited to the following tests:
Females: Mammogram every 2 years for women above age 40 years, Pap smear every 2 years for women above 21 years.

Males above 40 years: Prostate antigen test

1.2.7.4 Female Contraceptives

Contraceptive limit of R 2 760 per family per annum subject to Managed Care Protocols and formulary.

1.2.7.5 Vaccinations

- Flu Vaccine
- Pneumococcal Vaccine
- Human Papilloma Virus (HPV) vaccine
- Immunisation for children six (6) years and younger, immunisation permitted will be in line with those provided by the Department of Health ,subject to family wellness screening family limit

1.2.8 OPTICAL

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

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.

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

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

1.2.8.1 Spectacles, lenses and frames

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

1.2.8.2 Visual examination

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

1.2.8.3 Frames

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.

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.

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

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.

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

Sunglasses and repairs to spectacles are excluded from the benefit.

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.

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

1.2.8.4 Contact lenses

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

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

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.

The benefit sub limit is limited to one (1) pair of permanent contact lenses per beneficiary per 24-month period, or 12 pairs of monthly disposable contact lenses per beneficiary per annum. Additional benefits may be approved on medical/clinical grounds if approved by the Fund.

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.

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.

Contact lens cleaning materials are excluded from benefits.

1.2.8.5 Spectacles Lenses and frames limits

100% Sizwe rates, as per the annual limits per beneficiary below:

Benefit Description	Limit per Beneficiary
Frames	R 550
Single Focus Lenses	R 185 per lens
Bi-focal Lenses	R 400 per lens
Multi-focal lenses	R 400 per lens
Contact Lenses	R 1 270

1.2.9 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.

1.2.9.1 Conservative dentistry

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

- Consultations: two (2) annual check-ups per beneficiary (once in six (6) months)
- X-rays (intra-oral): subject to managed care protocols
  - Extra-oral: one (1) per beneficiary in a three (3) year period
- Oral hygiene: two (2) annual scale and polish treatments per beneficiary (once in 6 months)
  - Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age
  - Benefit for fluoride is limited to beneficiaries from age 5 and younger than

13 years of age.

- Fillings: once per tooth in 365 days
- Extractions
- Root canal treatment: subject to managed care protocols. Excluding wisdom teeth (3rd molars) and primary (milk) teeth.
- Plastic dentures and associated laboratory costs:
  - One (1) set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a four (4) year period, subject to pre-authorisation.

1.2.9.2 Specialised dentistry

100% Sizwe 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.

- Partial metal frame dentures and associated laboratory costs: No benefit
- Crowns and bridges and associated laboratory costs: No benefit
- Implants and associated laboratory costs: No benefit
- Orthodontics and associated laboratory costs: No benefit
- Periodontics:
  - 100% Sizwe rates; subject to registration on the Periodontal Programme
  - Limited to conservative, non-surgical therapy only (root planning)
  - Surgical periodontics: No benefit
- Maxillo facial surgery and oral pathology in the dental chair:
  - 100% Sizwe rates, subject to managed care protocols
  - Benefit for Temporo-mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments.
  - 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.

1.2.9.3 Dental hospitalisation (general anaesthetic)

In-hospital treatment:

A co-payment of R1 500 per hospital admission applies.

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

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

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.

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

Laughing gas (Nitrous Oxide) in dental rooms:

100% Sizwe rates, subject to managed care protocols.

IV conscious sedation in rooms:

- 100% Sizwe rates, subject to pre-authorisation and managed care protocols.
- Limited to extensive dental treatment

1.2.10 HEARING AIDS

100% of Sizwe rate, subject to an annual limit of R 7 910 per family.

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

1.2.11 ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS)

(Refer to paragraph 2.15)

1.2.12 AMBULANCE SERVICES

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

Authorisation for emergency transportation should be obtained within 24 hours.

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

1.2.13 NON-MOTORISED WHEELCHAIRS

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

Member with or without dependants: R 1 980

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

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 APPLICABLE CONDITIONS

100% of Sizwe DSP rates for accommodation in general ward, high care ward and intensive care unit.

100% of Sizwe DSP rates for theatre fees.

100% of Sizwe DSP rates or negotiated tariff for medicines, materials and hospital equipment and the transport of blood.

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

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

2.2 ANNUAL LIMITS

2.2.1 Private/ Public Hospitals

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

2.2.2 Private and Public hospitals: out-patient care

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

2.2.3 Alternatives to hospitalisation

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

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

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

2.3 HOSPITALISATION FOR PRESCRIBED MINIMUM BENEFITS

The prescribed minimum benefits consist of the provision of the diagnosis, treatment and care costs of:

a) The Diagnostic and Treatment Pairs and
b) Any emergency medical condition

The level of healthcare provided in the State sector shall be used as the benchmark when determining PMB level of care. The interpretation of PMBs shall follow the predominant public hospital practice, as outlined in the relevant provincial or national public hospital clinic protocols, where these exist.

PMBs are not subject to annual benefit limits, except for such limits as may be prescribed in terms of the regulations. PMBs are subject to pre-authorisation, minimum benefit package, designated service providers and treatment protocols. PMBs are covered in full without any co-payment or deductibles subject to the provisions of Regulation 8.

Voluntary use of non-DSP hospitals and failure to secure pre-authorisation prior to hospitalisation will result in a co-payment except where the DSP hospital or specialized care is not readily available and in case of emergencies. The co-payment will be equivalent to the difference between the DSP and the non-DSP facility rates. Where there is no DSP facility or relevant specialized facility, Sizwe Medical Fund will pay in full at cost (as charged).

The following chronic conditions will also be covered in terms of PMBs at DSPs:

Addison's disease	Diabetes mellitus types 1 & 2
Epilepsy	Dysrhythmias
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Hyperlipidaemia	Hypertension
Cardiac failure	Hypothyroidism
Cardiomyopathy	Multiple sclerosis
Chronic obstructive pulmonary disease	Parkinson's disease
Chronic renal disease	Rheumatoid arthritis
Coronary artery disease	Schizophrenia

Crohn's disease	Systemic Lupus Erythematosus
Diabetes insipidus	Ulcerative colitis

2.4 IN- HOSPITAL GENERAL PRACTITIONERS

Subject to the Hospital Benefit Management Programme.

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

2.5 IN – HOSPITAL MEDICAL SPECIALISTS

Subject to the Hospital Benefit Management Programme.

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

2.6 IN – HOSPITAL AUXILIARY SERVICES AND PHYSIOTHERAPY

2.6.1 Auxiliary services:

100% Sizwe rates subject to pre–authorisation and PMBs

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

2.6.2 Physiotherapy:

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

2.7 MATERNITY

2.7.1 Hospitalisation (Public or private hospitals)

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

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

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

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

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

2.8 BLOOD TRANSFUSION AND BLOOD REPLACEMENT PRODUCTS:

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

2.9 PROSTHESIS

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

Applies to both surgical and non-surgical prostheses.

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

Annual limit of R 27 010 per family for both surgical and non-surgical prostheses.

2.9.1 Internal prosthesis

Subject to benefit limit unless PMB:

- Pacemakers;

- Defibrillators;
- Spinal fusion – only one spine level per beneficiary; Should more than one (1) spinal level be required , approval will be granted subject to managed care protocols.
- Cardiac stents – 3 unless PMB ;
- Vascular stents - 2 stents per family per annum;
- Grafts;
- Joints – hip and knee (partial and total) - only one joint per beneficiary per annum;
- Other clinically appropriate unspecified prosthetic items

2.9.2 External prosthesis

Subject to benefit limit unless PMB

- Artificial limb;
- Breast;
- Ocular;
- Taylor Spatial frame;
- External fixator;
- Mesh;
- Other clinically appropriate unspecified prosthetic items.

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

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

100% Sizwe rates for consultations, visits, treatment, medication, pathology tests and 100% of the cost of materials used in radiotherapy and chemotherapy

subject to the overall Oncology limit of R 151 690 per family from annual hospital benefits.

2.11 RADIOLOGY AND RADIOGRAPHY

General Radiology has no in-hospital limit but is subject to clinical protocols

Specialised Radiology: (MRI/CAT scan/Angiogram) subject to an overall combined in and out of hospital limit of R 19 710 per family per annum, pre-authorisation and managed care protocols

Interventional Radiology: Within hospital limit, subject to pre-authorisation and clinical protocols.

2.12 PATHOLOGY

Subject to the Hospital Benefit Management and Disease Management programmes. 100% Sizwe rates for tests performed by a general practitioner or medical specialist – benefit is payable from the annual Hospital benefits.

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

2.13 MENTAL HEALTH

2.13.1 Psychiatry hospitalisation

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.

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

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.

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

2.14. ORGAN TRANSPLANT AND RENAL DIALYSIS

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

2.14.1 Renal Dialysis

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

2.14.2 Organ transplant

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

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

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

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

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

2.15 ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS)

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 Medical Fund will apply the Fund's PMB hospitalisation rules as in 2.3.

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

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

3 SPECIFIC CLINICAL LIMITATIONS

a) The following procedures will only be covered in terms of PMBs, subject to clinical protocols:

- Advanced Laparoscopic surgery;
- Reconstructive Surgery;
- Joint Replacements e.g. hip /knee;
- Cardiac surgery which include cardiac stents;
- Spinal surgery;
- Breast Reconstructive Surgery.

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

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

d) 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.

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

*4.*EXCLUSIONS

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In addition to the exclusions listed in Annexure C, the following conditions are specifically excluded from benefits:

- Refractive surgery including Radial Keratotomy;
- Breast Reduction;
- Breast Augmentation;
- Keloids;
- Frail Care.

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