

ANNEXURE B1

WOOLTRU HEALTHCARE FUND

CORE OPTION

SCHEDULE OF BENEFITS

With effect from 1 January 2009

With due regard to PMB's which will be paid at 100% of the cost – unlimited

1. OPTIONS

When a Member joins the Scheme he must select the Option he wishes to join. If the Member has selected the Core Option, then the Scheme will provide to the Member and his Dependants the benefits as detailed in this schedule.

2. PRIMARY HEALTHCARE BENEFITS

The Scheme will provide primary healthcare benefits as detailed in this schedule at 100% of the Agreed Tariff at the Designated Service Provider.

The details with regard to the Designated Service Provider shall be communicated in writing to Members by the Scheme. Members must select a primary healthcare provider from the Designated Service Provider network list provided by the Scheme at the beginning of each year, or at the time of joining the Scheme, for the provision of primary healthcare services as listed in this schedule of benefits.

2.1 Acute Medication

Acute medication according to the fixed formulary of the Designated Service Provider.

(Acute medication for the purpose of this paragraph means any medicine used for the treatment of diseases or conditions that require a short course of medicine treatment).

2.2 Chronic Medication

Chronic medication according to the fixed formulary of the Designated Service Provider.

(Chronic medication for the purpose of this paragraph means any medicines, which have been classified to be used for the treatment of chronic illnesses as determined by the Scheme and which include Prescribed Minimum Benefits). These benefits are subject to pre-authorisation by the Designated Service Provider.

2.3 Pathology and Radiology

Pathology and radiology services on referral by the Designated Service Provider. Benefits in respect of these services are restricted to the Designated Service Provider's lists of primary care investigations.

2.4 Consultations

a) General Practitioner

General practitioner consultations, via the Designated Service Provider network, including the prescribing or dispensing of acute medication, and the performing of minor procedures as per the Designated Service Provider's list.

b) Specialists

Pre-authorized out-of-hospital specialist consultations referred by the Designated Service Provider, including medication and procedures and any associated investigations.

2.5 Dentistry

Conservative dentistry at the Designated Service Provider in terms of the schedule below.

Advanced/Specialised dentistry (including implants, orthodontics and dentures) is not covered by the Core Option.

2.6 Optical

Optical benefits via the Designated Service Provider in terms of the schedule below.

2.7 Preventative Treatment

Benefits are limited to cholesterol screening, pap smears, glucose test, HIV test, mammogram, glaucoma and prostate screening, via the Designated Service Provider, in terms of the schedule below.

2.8 Emergency Treatment and Out of Area Visits

Benefits at any doctor or emergency unit (excluding facility fee), will be covered for after-hours bona fide emergencies when the Designated Service Provider is not available, or when the Beneficiary is out of town, subject to the schedule below.

3. BENEFITS FOR HOSPITALISATION AND OTHER MAJOR MEDICAL SERVICES

Notwithstanding any other provisions in these rules, the Scheme will provide Members and their Dependants with cover at 100% of the National Scheme Tariff (NST) as per the agreement with the Designated Service Provider, in respect of hospitalisation and other major medical services as contained in this Annexure.

3.1 Annual Hospital Benefit

Notwithstanding any provisions to the contrary, as contained in the schedule below, all benefits in respect of hospitalisation and other major medical services will be unlimited at 100% of the Agreed Tariff at the Designated Service Provider.

3.2 Pre-authorisation

Pre-authorisation must be obtained at least 2 working days before admission to hospital. In emergency cases the Designated Service Provider must be notified of the event within 48 hours of admission to the hospital.

No benefits will be granted for hospitalisation, treatments and associated clinical procedures if the Designated Service Provider has denied authorisation.

In respect of any hospitalisation for which pre-authorisation has not been obtained, or pre-authorisation has been obtained later than as stipulated above members will be subject to the difference between NST and actual costs charged for all other associated costs.

3.3 In-Hospital Benefits

3.3.1 Provincial and State Hospitals

a) Ward Fees

100% of the Uniform Patient Fee Schedule or NST or Agreed Tariff, whichever applies, at the rate for a general ward.

b) Theatre Fees, High Care Units, Drugs and Materials

100% of the Uniform Patient Fee Schedule or NST or Agreed Tariff, whichever applies, for theatres, intensive care units, high care wards, ward and theatre drugs, dressings and materials.

Except for immuno-suppressants referred to in paragraph 3.3.13 of this schedule, medicine dispensed by the hospital for use after discharge is limited to a period of five days only.

3.3.2 Private Hospitals

a) Ward Fees

100% of the Agreed Tariff for accommodation in a general ward.

b) Theatre Fees, High Care Units, Drugs and Materials

100% of the Agreed Tariff for theatres, intensive care units, high care wards, ward and theatre drugs, dressings and materials.

Except for immuno-suppressants referred to in paragraph 3.3.13 of this schedule, medicine dispensed by the hospital for use after discharge is limited to a period of five days only.

c) Unattached Theatre Units

100% of NST or Agreed Tariff for theatres, drugs, dressings, materials and recovery bed provided the theatre is registered with the Department of Health.

Except for immuno-suppressants referred to in paragraph 3.3.13 of this schedule, medicine dispensed by the hospital for use after discharge is limited to a period of five days only.

3.3.3 Procedures performed at Out-Patient Departments or Emergency Rooms of Provincial, State or Private Hospitals

- a) 100% of the Uniform Patient Fee Schedule, NST, or Agreed Tariff in respect of the facility charge, theatres, drugs, dressings, materials and the recovery bed where the facilities are used to perform a procedure, provided that pre-authorisation has been granted by the Designated Service Provider

Except for immuno-suppressants referred to in paragraph 3.3.13 of this schedule, medicine dispensed by the hospital for use after discharge is limited to a period of five days only.

3.3.4 Maternity Benefits

- a) The benefit entitlement applicable to hospitalisation as detailed above will apply in respect of confinements.
- b) The services of a mid-wife during and after confinement qualify for benefits in terms of this paragraph only where hospital services are not used, and provided that pre-authorisation has been obtained from the Designated Service Provider.

3.3.5 General Practitioner benefits associated with hospitalisation

100% of the Designated Service Provider's Agreed Tariff in respect of consultations, operations and procedures performed in hospital.

3.3.6 Specialist benefits associated with hospitalisation

100% of the Designated Service Provider's Agreed Tariff in respect of consultations, operations and procedures performed in hospital.

3.3.7 Pathology

100% of the Designated Service Provider's Agreed Tariff for pathology in hospital.

3.3.8 Radiology (including MRI, CT Scans, Computer Tomography & Radio-Isotope Studies)

100% of the Designated Service Provider's Agreed Tariff for radiology in hospital.

Benefits are subject to pre-authorisation by the Scheme or by the Designated Service Provider .

Where pre-authorisation is not obtained, no benefit will be available.

3.3.9 Maxillo-facial & Oral Surgery

Wisdom teeth extraction or facial trauma will be covered under this benefit at 100% of the Designated Service Provider's Agreed Tariff subject to motivation and pre-authorisation by the Scheme or by the Designated Service provider

3.3.10 Blood Transfusions and Transportation of Blood / Blood Products

100% of the Agreed Tariff in respect of blood transfusions and transport, (i.e. the cost of material, apparatus and operator's fees).

3.3.11 Ambulance Services

100% of the cost of emergency ambulance transport services to the nearest hospital, or inter-hospital transfers in an emergency, subject to the services being authorised by the Designated Service Provider.

No benefits will be paid for unauthorised use of non-Designated Service Providers.

3.3.12 Internal Prosthesis

100% of the Agreed Tariff for internal prostheses, including external fixators and colostomy kits, and appliances placed in the body as an internal adjuvant during an operation subject to the schedule below.

3.3.13 Organ Transplants

100% of the Agreed Tariff, subject to pre-authorisation by the Scheme or by the Designated Service Provider provided that:

- a) Benefits in respect of organ and patient preparation will be at the Agreed Tariff.
- b) Benefits in respect of immuno-suppressant and other medication dispensed by the hospital during hospitalisation and upon discharge from hospital will be covered at 100% of the cost.
- c) Donor costs in respect of an organ transplant will not be covered by the Scheme unless the recipient is a Beneficiary of the Scheme. If the donor is not a Beneficiary of the Scheme, the benefit limits applicable to the recipient, (who must be a Beneficiary of the Scheme), will apply jointly to the recipient and the donor.

3.3.14 Dialysis

100% of the Agreed Tariff subject to pre-authorisation by the Scheme or the Designated Service Provider.

3.3.15 Medical and Surgical Appliances

Clinical motivation is required in respect of medical and surgical appliances and benefits are subject to the terms, conditions and protocols of the Scheme's agreement with the Designated Service Provider.

3.3.16 External Prostheses

Written motivation is required in respect of external prostheses, which must be received by the Designated Service Provider at least 72 hours before the request for pre-authorisation. Benefits are subject to the terms, conditions and protocols of the Scheme's agreement with the Designated Service Provider.

3.3.17 Nursing Services and Frail Care

a) Nursing Services in Lieu of Hospitalisation

100% of Agreed Tariff subject to:

- clinical motivation,
- pre-authorisation by the Designated Service Provider,
- case management by the Designated Service Provider.

Benefits will be limited as per the schedule below (Combined limit with frail care).

b) Frail Care

100% of the Agreed Tariff in respect of a chronically ill Beneficiary in a registered nursing home or hospital or registered frail care facility, as specified in the schedule below. (Combined limit with private nursing).

This benefit will be subject to approval and case management by or on behalf of the Designated Service Provider. . Members may claim either for nursing services or frail care facilities but not both, where such services are provided simultaneously.

3.3.18 Auxiliary Services rendered in hospital

Benefits in respect of clinical psychology, speech therapy, occupational therapy, and physiotherapy at 100% of the Agreed Tariff for treatments and consultations if pre-authorised by the Designated Service Provider. No benefit will be payable in respect of audiology, podiatry, orthoptics, dietetics, biokinetics, social workers, vocational guidance, child guidance, marriage guidance, school therapy or attendance at remedial education schools or clinics.

3.3.19 Specialised Radiology and diagnostic endoscopic procedures in lieu of hospitalisation.

100% of Agreed Tariff subject to:

- clinical motivation,
- pre-authorisation by the Designated Service Provider,
- case management by the Designated Service Provider.

4. HIV/AIDS

Benefits in respect of HIV/AIDS will be provided for Beneficiaries joining the HIV/AIDS programme of the Designated Service Provider. Benefits will be provided in terms of the contract with the Designated Service Provider.

5. STATUTORY PRESCRIBED MINIMUM BENEFITS (PMB)

5.1 Prescribed Minimum Benefits provided by a State facility

Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the cost of Prescribed Minimum Benefits obtained in a State facility, without limitation. If Prescribed Minimum Benefit hospitalisation services are voluntarily obtained outside a State facility, the benefits payable by the Scheme shall be limited to the Uniform Patient Fee Schedule for that service, and any difference between the fee charged and the Uniform Patient Fee Schedule tariff, shall be a co-payment payable by the Member.

5.1 Diagnostic tests for an unconfirmed PMB diagnosis

Where diagnostic tests and examinations are performed but do not result in confirmation of a PMB diagnosis, (except for an emergency medical condition), such diagnostic tests or examinations will not be considered to be Prescribed Minimum Benefits.

5.2 Prescribed Minimum Benefits for Chronic Conditions

This Option covers the full negotiated tariff for services rendered in respect of the Prescribed Minimum Benefits. Such services include diagnosis, medical management and medication, where rendered by the Designated Service Provider, to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions. Services provided are subject to Annexure F, rule 7 and 8.

General Practitioner services will be restricted to the Designated Service Provider for the provision of primary healthcare benefits. If the relevant PMB services are not available through the Designated Service Provider, an alternative provider or specialist may be consulted with prior approval from

the Designated Service Provider, except in the case of an emergency where prior approval is not required.

Where a PMB includes medication, the Scheme shall pay 100% of the cost of that medication, without limit, subject to relevant medicine pricing legislation, irrespective of where the medicine is obtained, provided that the medicine is dispensed by a healthcare practitioner licensed to do so in terms of relevant legislation and:

- the medication is included on the Designated Service Provider's formulary;
or
- the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition (i.e. involuntary use of a non-formulary drug); and
- pre-authorisation is obtained from the Designated Service Provider.

If the Scheme's formulary includes a drug that is clinically appropriate and effective for the treatment of a PMB condition suffered by a Beneficiary, and that Beneficiary knowingly declines the formulary drug and opts to use another drug instead, the benefit payable by the Scheme with regard to that PMB drug will be limited to the Single Exit Price and the difference will be a co-payment payable by the Member at point of service.

5.3 Pre-authorisation for PMB's

Members are required to obtain pre-authorisation for Prescribed Minimum Benefits from the Designated Service Provider..

6. ANNUAL BENEFIT SCHEDULES

PRIMARY HEALTHCARE BENEFITS Sub-Limits apply to certain benefits as specified below Pro-rata allocation of benefits will apply in respect of Beneficiaries joining during the year	
Prescribed Acute Medicine	100% of Agreed Tariff or Single Exit Price plus legislated professional fee (where applicable) Medicine must be clinically appropriate and dispensed or prescribed by the Designated Service Provider Doctor/Dentist in accordance with the Designated Service Provider Acute/Dental Medicine Formulary
Chronic Medicine Non PMB	Pre-authorisation via the Designated Service Provider or automatic via the Designated Service Provider auto-chronic list R7 000 per Beneficiary per annum via the Designated Service Provider and in accordance with the Designated Service Provider formulary
Pathology & Radiology out of hospital	100% at Agreed Tariff subject to defined lists. Tests must be clinically appropriate and must be requested by the Designated Service Provider Doctor
General Practitioners Out of hospital	Benefits for clinically appropriate consultations at the Designated Service Provider Network Doctor Includes basic Primary Care and Pre-and Post Natal Care (including 2 ultrasound scans for pregnancy)
Specialists Out of hospital (subject to pre-authorisation)	Benefits are subject to pre-authorisation by the Designated Service Provider. Limited to: Single Member: R 940 per year Family: R1 290 per year The above limits include the cost of consultation, medication, procedures and any special investigations, such as radiology and pathology, related to the authorised out of hospital specialist visit
Basic Dentistry out of hospital	Basic dentistry (out of hospital only) through the Designated Service Provider Dentist Limited to a specific list of Designated Service Provider procedure dentistry codes (Includes consultations, primary extractions, fillings, and scaling and polishing), but excludes dentures and fluoride. No benefit for basic dentistry in hospital
Optical Benefits	
Frames, Lenses, Contact Lenses	One pair of clear standard mono-or bifocal lenses plus standard frame per Beneficiary per 24 months at the Designated Service Provider contracted optometrist No benefit for contact lenses
Eye Tests	One examination per Beneficiary per 24 months at the Designated Service Provider optometrist

PRIMARYHEALTHCARE BENEFITS

Sub-Limits apply to certain benefits as specified below
Pro-rata allocation of benefits will apply in respect of Beneficiaries joining during the year

Preventative Treatment	TEST	TARIFF CODE	LIMITED TO
	Cholesterol screening	4027	One per adult every two years
	HCG (Glucose) test	4050	One per adult every two years
	Mammogram	34100	One per female (over 40 years) every two years or annually where clinically indicated (family history)
	Pap smear	4566	One per adult female every year
	HIV test	3932	One per beneficiary per annum
	Glaucoma screening	3014	One screening per adult (over 40 years) every two years
	Prostate screening	4519	One screening per male (over 50 years) every year
	Preventative screening tests as per benefit schedule through the Designated Service Provider Doctor Network.		
Out of Area Benefit and Emergency visits	Limited to 3 Visits per family per annum Limited to R1100 per annum, (including, related investigation, procedures and/or medication)		
Over the Counter Medicine	No benefit		
Auxiliary Services out of hospital	No benefit		
Chiropractor, Homeopath, Naturopath	No benefit		
ECG Tests	Benefits for clinically appropriate indications via the Designated Service Provider Doctor Network.		
Pre-and- Post natal Care, including sonar's	Benefits through the Designated Service Provider Doctor Network according to the defined list of codes		

HOSPITALISATION AND OTHER MAJOR MEDICAL SERVICES

Sub-Limits apply to certain benefits as specified below
Pro-rata allocation of benefits will apply in respect of Beneficiaries joining during the year

Hospitalisation	Subject to pre-authorisation by Preferred Provider
Provincial/State Hospitals	100% of Uniform Patient Fee Schedule or NST, whichever is applicable
Private Hospitals	100% of Agreed Tariff via the Designated Service Provider
To take out Medicine (medicine on discharge from hospital)	Limited to 5 days, except for immuno –suppressant drugs dispensed by the hospital for use after discharge (see Organ Transplants)
Confinements	100% of Agreed Tariff via the Designated Service Provider Members must join the Designated Service Provider’s Maternity Programme to qualify for benefits
General Practitioner services in hospital	100% of Agreed Tariff Via Designated Service Provider
Specialist services in hospital	100% of Agreed Tariff Via Designated Service Provider
Pathology in hospital	100% of Agreed Tariff Via Designated Service Provider
Radiology (including MRI, CT scans, Computer Tomography & Radio-Isotope Studies)	100% of the Agreed Tariff via the Designated Service Provider Subject to pre-authorisation
Maxillo-facial and Oral Surgery	Extraction of wisdom teeth or facial trauma Subject to pre-authorisation. Via Designated Service Provider
Blood Transfusions	100% of Agreed Tariff via Designated Service Provider
Transportation of Blood and Blood Products	100% of Agreed Tariff via Designated Service Provider
Ambulance Services	100% of cost via Designated Service Provider No benefits will be paid for unauthorised use of non-designated service providers.
Internal Prosthesis	Limited to R33 000 per beneficiary per annum via the Designated Service Provider Subject to pre-authorisation.

HOSPITALISATION AND OTHER MAJOR MEDICAL SERVICES	
Sub-Limits apply to certain benefits as specified below Pro-rata allocation of benefits will apply in respect of Beneficiaries joining during the year	
Organ Transplants Hospitalisation Organ and Patient Preparation Immuno-suppressant drugs dispensed in hospital Immuno-suppressant drugs dispensed by the hospital to take out for use after discharge Subsequent supplies of immuno-suppressant drugs (subject to pre-authorisation)	Subject to Designated Service Provider case management and networks. Benefit unlimited but subject to pre-authorisation
Dialysis	100% of Agreed Tariff via Designated Service Provider
Medical and Surgical Appliances	Subject to clinical motivation and approval by the Designated Service Provider.
External Prosthesis (including hearing aids and hearing aid repairs)	Subject to written motivation and terms, conditions and protocols of the Designated Service Provider.
Private Nursing in lieu of hospitalisation & /or Frail Care	100% of Agreed Tariff, via the Designated Service Provider and limited to R 2 500 per Beneficiary per month Subject to motivation by Designated Service Provider approval.
Auxiliary Services in hospital (subject to pre-authorisation)	100% of Agreed Tariff via the Designated Service Provider Benefits only payable if the services are directly related to an authorised admission
Specialised Radiology and diagnostic endoscopic procedures in lieu of hospitalisation	100% of Agreed Tariff via the Designated Service Provider
Dental Procedures in hospital	No benefit
International Cover	No benefit
Refractive Surgery	No benefit
Specialised Dentistry in and out of hospital	No benefit
Psychiatric Treatment in hospital	No benefit, except for Statutory Prescribed Minimum Benefits
Oncology, Radiotherapy & Chemotherapy in and out of hospital	Limited to Statutory Prescribed Minimum Benefits

HIV/AIDS	
Sub-limits apply to certain benefits as specified below Pro-rata allocation of benefits will apply in respect of Beneficiaries joining during the year	
HIV/AIDS	Subject to enrolment and conditions of the Scheme's HIV/AIDS Programme via the Designated Service Provider.
STATUTORY PRESCRIBED MINIMUM BENEFITS	
Hospitalisation for Statutory Prescribed Minimum Benefits	100% of agreed Designated Service Provider tariff or Uniform Patient Fee Schedule, cost unlimited
Subject to pre-authorisation from Designated Service Provider	Hospitalisation restricted to State/Provincial hospital or other appropriate facility as determined by the Designated Service Provider.
Chronic Medicine for 26 Chronic Disease List Conditions (CDL)	100% of Single Exit Price (SEP) plus agreed professional fee
Subject to pre-authorisation by Designated Service Provider	Benefits are paid as follows: <ul style="list-style-type: none"> • 100% of SEP plus agreed professional fee. Benefit unlimited, if authorized as per the Designated Service Provider formulary or for involuntary use of non-formulary drugs. • For voluntary use of non-formulary drugs, co-payment to be paid by Member at point of sale.
Diagnosis, Treatment and Care for 26 Chronic Disease List Conditions (CDL)	100% of diagnosis, treatment and care costs for the 26 CDL conditions, as per statutory requirements. Benefits are unlimited. Subject to Designated Service Provider Treatment Protocols
Benefits subject to pre-authorisation and Designated Service Provider Treatment Protocols (Care Plans)	Members are restricted to the Designated Service Provider Network of general practitioners and specialists for management of the 26 CDL conditions. If the relevant health services are not available through the Designated Service Provider, an alternative general practitioner or specialist may be consulted with the prior approval of the Designated Service Provider.