

**WOOLTRU HEALTHCARE FUND**

**PLUS 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 Plus Option, then the Scheme will provide to the Member and his Dependents the benefits as detailed in this schedule.

**2. PRIMARY HEALTHCARE BENEFITS**

The Scheme will provide primary healthcare benefits as contained in this Annexure

**2.1 Acute Medication**

Acute medication: subject to the limits in terms of the schedule below.

(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 Managed Healthcare Organisation formulary and subject to the limits in terms of the schedule below.

(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 Managed Healthcare Organisation.

## **2.3 Pathology and Radiology**

Pathology and radiology: subject to the limits in terms of the schedule below.

## **2.4 Consultations**

General practitioner and specialist consultations will be paid subject to the limits in terms of the schedule below.

## **2.5 Dentistry**

Preventative (scale and polish) and conservative dentistry which includes consultations, fillings, extractions, plastic dentures and other procedures provided by dental practitioners subject to the limits in terms of the schedule below.

Specialised/Advanced dentistry (dental implants) is subject to the limits in terms of the schedule below.

## **2.6 Optical**

Optical benefits include; eye examination, frames, spectacle lenses and contact lenses, which are subject to the limits in terms of the schedule below.

No benefit is provided for sunglasses.

## **2.7 Preventative Tests**

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

## **2.8 Over the Counter Medicine (OTC)**

100% of Single Exit Price, subject to relevant medicine pricing legislation, where the Member requests medicine for any self-diagnosed illnesses in terms of the schedule below.

## **2.9 Associated Health Services**

Associated health services provided by practitioners registered with HPCSA (eg: chiropractors, homeopaths, naturopaths) in terms of the schedule below.

## **2.10 Auxiliary Services rendered out of hospital**

Auxiliary services provided out of hospital by practitioners registered with HPCSA (eg: clinical psychology, speech therapy, audiology, occupational therapy, podiatry, orthoptics, dietetics, biokinetics and physiotherapy), in terms of the schedule below.

No benefit will be payable in respect of social workers, vocational guidance, child guidance, marriage guidance, school therapy or attendance at remedial education schools or clinics.

## **2.11 Primary healthcare benefits provided outside Southern Africa**

Any claims for healthcare services rendered outside the borders of South Africa will be subject to the same benefits, sub-limits and exclusions that apply to the relevant healthcare services in South Africa in terms of the schedule below, with

the exception of hospitalisation which is not covered, provided that:

- a) the benefit entitlement will not exceed the rate and applicable tariff for the equivalent healthcare service in South Africa;
- b) where the cost of the claim is lower than the applicable tariff, benefits will be paid at cost;
- c) medicine claims will be paid at cost, limited to the amount payable in terms of relevant South African medicine pricing legislation;
- d) members must pay the healthcare provider directly and then submit a claim to the Scheme;
- e) claims will be refunded in South African Rands;
- f) the currency conversion as at the date of service will apply;
- g) qualifying services that cannot be linked to a fixed tariff amount, will be limited to 50% of the cost of the account;
- h) no benefit will be provided in respect of ambulance or other emergency transportation outside the borders of the RSA.

### **3. BENEFITS FOR HOSPITALISATION AND OTHER MAJOR MEDICAL SERVICES**

The Scheme will provide Members and their Dependents with cover for 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, subject to pre-authorisation via the Managed Healthcare Organisation.

## **3.2 Pre-authorisation**

Pre-authorisation must be obtained at least 2 working days before admission to hospital. In emergency cases the Managed Healthcare Organisation 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 Managed Healthcare Organisation 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.

Where a Beneficiary elects to receive treatment in hospital from a non Designated Service Provider general practitioner or specialist, the Member 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 NRPL 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 Managed Healthcare Organisation .

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 Managed Healthcare Organisation.

#### **3.3.5 General Practitioner benefits associated with hospitalisation**

100% of Agreed Tariff in respect of consultations, operations and procedures performed in hospital. .

#### **3.3.6 Specialist benefits associated with hospitalisation**

100% of Agreed Tariff in respect of consultations, operations and procedures performed in hospital. .

#### **3.3.7 Pathology**

100% of Agreed Tariff for pathology in hospital.

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

100% of Agreed Tariff for radiology in hospital.

Benefits are subject to pre-authorisation by the Scheme or by the Managed Healthcare Organisation.

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 Agreed Tariff subject to motivation and pre-authorisation by the Scheme or by the Managed Healthcare Organisation

### **3.3.10 Blood Transfusions and Transportation of Blood / Blood Products**

100% of 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 Agreed Tariff in respect 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. Where pre-authorisation is not obtained, no benefit will be available.

### **3.3.12 Internal Prosthesis**

100% of 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 Agreed Tariff, subject to pre-authorisation by the Scheme or by the Managed Healthcare Organisation Scheme 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 Agreed Tariff subject to pre-authorisation by the Scheme or the Managed Healthcare Organisation.

### **3.3.15 Medical and Surgical Appliances**

100% of Agreed Tariff subject to pre-authorisation by the Managed Healthcare Organisation, and subject to the limits in terms of the schedule below.

Clinical motivation is required in respect of medical and surgical appliances.

### **3.3.16 External Prostheses**

100% of Agreed Tariff subject to pre-authorisation by the Managed Healthcare Organisation, and subject to the limits in terms of the schedule below.

Written motivation is required in respect of external prostheses, which must be received by the Managed Healthcare Organisation at least 72 hours before the request for pre-authorisation.

### **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 Managed Healthcare Organisation,
- case management by the Managed Healthcare Organisation.

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

#### **b) Frail Care**

100% of 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 Managed Healthcare Organisation. 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 Managed Healthcare Organisation. 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 Managed Healthcare Organisation,
- case management by the Managed Healthcare Organisation.

## **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, at 100% of cost. Benefits for unregistered beneficiaries will be subject to Annexure G, rules 4 & 6.

## **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 9.

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 Managed Healthcare Organisation, 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 Managed Healthcare Organisation 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 Managed Healthcare Organisation'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

<b>PRIMARY HEALTHCARE BENEFITS</b> Sub-Limits apply to certain benefits as specified below Pro-rata allocation of limited benefits will apply in respect of Beneficiaries joining the Scheme during the year Annual Medical Limit (AML): Member = R3 000 Member plus one = R5 800 Member plus family = R7 700	
<b>Prescribed Acute Medicine</b>	100% of Single Exit Price plus legislated professional fee Subject to Annual Medical Limit
<b>Chronic Medicine Non PMB</b>	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 Managed Healthcare Organisation formulary
<b>Pathology &amp; Radiology out of hospital</b>	100% of NST Subject to Annual Medical Limit
<b>General Practitioners Out of hospital</b>	100% of Cost for DSP provider 100% of NST for non-DSP provider Benefit subject to Annual Medical Limit.  The cost of a consultation with the DSP provider in excess of R100 will be deducted from the Annual Medical Limit. The cost of a consultation with a DSP provider listed in a Care Plan issued to the Member as contemplated in Annexure F will not be deducted from the Annual Medical Limit Consultations with the DSP provider will continue to be paid at R100 per consultation even after the Annual Medical Limit is exhausted. The cost of a consultation up to NST with a non-DSP provider will be deducted from the Annual Medical Limit.
<b>Specialists Out of hospital (subject to pre-authorisation)</b>	100% of Cost for DSP provider 100% of NST for non-DSP provider Benefit subject to Annual Medical Limit.  The cost of a consultation with the DSP provider authorised by the Managed Healthcare Organisation in excess of R150 will be deducted from the Annual Medical Limit. Consultations with the DSP provider authorised by the Managed Healthcare Organisation will continue to be paid at R150 per consultation even after the Annual Medical Limit is exhausted. The cost of a consultation up to NST with a non-DSP provider will be deducted from the Annual Medical Limit. The first R150 of the first gynaecologist consultation per year will not be deducted from the Annual Medical Limit
<b>Maternity Programme</b>	To qualify for these benefits, expectant mothers must enrol on the Wooltru Maternity Programme before their 16 <sup>th</sup> week of pregnancy. The benefits include: Two routine scans at 12 and 22 weeks (settled at NST) Two consultations with gynaecologist within 60 days of giving birth (settled at NST or R150 if Annual Medical Limit is exhausted) Two consultations with paediatrician within 60 days of giving birth (settled at NST or R150 if Annual Medical Limit is exhausted)

<b>PRIMARYHEALTHCARE BENEFITS</b>			
Sub-Limits apply to certain benefits as specified below Pro-rata allocation of limited benefits will apply in respect of Beneficiaries joining the Scheme during the year Annual Medical Limit (AML): Member = R3 000 Member plus one = R5 800 Member plus family = R7 700			
<b>Basic Dentistry out of hospital</b>	100% of NST Subject to Annual Medical Limit The first R100 of the first dental consultation for each beneficiary each year will not be deducted from the Annual Medical Limit. No benefit for basic dentistry in hospital		
<b>Specialised Dentistry out of hospital</b>	100% of NST Subject to Annual Medical Limit		
<b>Optical Benefits</b>	Frames, Lenses, Contact Lenses Eye Tests		
	100% of NST Subject to Annual Medical Limit 100% of NST Subject to Annual Medical Limit The first R100 of the first eye test for each beneficiary each year will not be deducted from the Annual Medical Limit.		
<b>Preventative Treatment</b>	<b>TEST</b>	<b>TARIFF CODE</b>	<b>LIMITED TO</b>
	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 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
	The cost of the test will not be deducted from the Annual Medical Limit.		
<b>Over the Counter Medicine</b>	100% of Agreed Tariff or Single Exit Price Subject to Annual Medical Limit		
<b>Associated Health Services (Chiropractor, Homeopath, Naturopath)</b>	100% of NST Subject to Annual Medical Limit		
<b>Auxiliary Services out of hospital</b>	100% of NST Subject to Annual Medical Limit		

**PRIMARYHEALTHCARE BENEFITS**

Sub-Limits apply to certain benefits as specified below

Pro-rata allocation of limited benefits will apply in respect of Beneficiaries joining the Scheme during the year

Annual Medical Limit (AML):

Member = R3 000

Member plus one = R5 800

Member plus family = R7 700

<b>Primary Healthcare provided outside Southern Africa</b>	Refer to paragraph 2.11 of this Annexure
<b>ECG Tests</b>	100% of NST Subject to Annual Medical Limit
<b>Pre-and- Post natal Care, including sonar's</b>	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 limited benefits will apply in respect of Beneficiaries joining the Scheme during the year

<b>Hospitalisation</b>	<b>Subject to pre-authorisation by Managed Healthcare Organisation</b>
Provincial/State Hospitals	100% of Uniform Patient Fee Schedule NST or Agreed Tariff, whichever is applicable
Private Hospitals	100% of Agreed Tariff.
<b>To take out Medicine</b> (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)
<b>Confinements</b>	100% of Agreed Tariff via the Designated Service Provider
<b>General Practitioner services in hospital</b>	100% of Agreed Tariff via the Designated Service Provider subject to authorisation by the Managed Healthcare Organisation. 100% of NST for unauthorised use of the Designated Service Provider. 100% of NST for use of a provider who is not a Designated Service Provider.
<b>Specialist services in hospital</b>	100% of Agreed Tariff via the Designated Service Provider subject to authorisation by the Managed Healthcare Organisation. 100% of NST for unauthorised use of the Designated Service Provider. 100% of NST for use of a provider who is not a Designated Service Provider.
<b>Pathology in hospital</b>	100% of Agreed Tariff via the Designated Service Provider
<b>Radiology (including MRI, CT scans, Computer Tomography &amp; Radio-Isotope Studies)</b>	100% of the Agreed Tariff via the Designated Service Provider Subject to pre-authorisation
<b>Maxillo-facial and Oral Surgery</b>	Extraction of wisdom teeth or facial trauma Subject to pre-authorisation.
<b>Blood Transfusions</b>	100% of Agreed Tariff via the Designated Service Provider
<b>Transportation of Blood and Blood Products</b>	100% of Agreed Tariff via the Designated Service Provider
<b>Ambulance Services</b>	100% of cost via the Designated Service Provider Where pre-authorisation is not obtained, no benefit will be available
<b>Internal Prosthesis</b>	Limited to R33 000 per beneficiary per annum Subject to pre-authorisation

<b>HOSPITALISATION AND OTHER MAJOR MEDICAL SERVICES</b> Sub-Limits apply to certain benefits as specified below Pro-rata allocation of limited benefits will apply in respect of Beneficiaries joining the Scheme during the year	
<b>Organ Transplants</b>  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 Managed Healthcare Organisation case management. Benefit unlimited but subject to pre-authorisation
<b>Renal Dialysis</b>	100% of Agreed Tariff subject to pre-authorisation by the Designated Service Provider R100 000 for renal dialysis per beneficiary per annum
<b>Medical and Surgical Appliances</b>	Subject to clinical motivation and approval by the Managed Healthcare Organisation.
<b>External Prosthesis (including hearing aids and hearing aid repairs)</b>	Subject to written motivation and terms, conditions and protocols of the Managed Healthcare Organisation
<b>Private Nursing in lieu of hospitalisation &amp; /or Frail Care</b>	100% of Agreed Tariff, via the Designated Service Provider and limited to R 2 500 per Beneficiary per month Subject to motivation by treating medical practitioner and Managed Healthcare Organisation approval.
<b>Auxiliary Services in hospital (subject to pre-authorisation)</b>	100% of Agreed Tariff via Designated Service Provider  Benefits only payable if the services are directly related to an authorised admission
<b>Specialised Radiology and diagnostic endoscopic procedures in lieu of hospitalisation</b>	100% of Agreed Tariff via the Designated Service Provider
<b>Refractive Surgery</b>	100% of Agreed Tariff via the Designated Service Provider Subject to pre-authorisation
<b>Specialised Dentistry in hospital (Dental Implants)</b>	100% of Agreed Tariff via the Designated Service Provider Subject to pre-authorisation and limited to: R 8 090 per single Member per annum and; R17 300 per family per annum Via the Designated Service Provider
<b>Psychiatric Treatment in hospital</b>	100% of Agreed Tariff via the Designated Service Provider Subject to pre-authorisation and via the Designated Service Provider R24 200 per beneficiary per annum but limited to a maximum of R48400 per family per annum

<b>Oncology, Radiotherapy &amp; Chemotherapy in hospital</b>	100% of Agreed Tariff and subject to pre-authorisation
<b>HIV/AIDS</b> Sub-limits apply to certain benefits as specified below Pro-rata allocation of limited benefits will apply in respect of Beneficiaries joining the Scheme during the year	
<b>HIV/AIDS</b>	Subject to enrolment and conditions of the Scheme's HIV/AIDS Programme via the Designated Service Provider
<b>STATUTORY PRESCRIBED MINIMUM BENEFITS</b>	
<b>Hospitalisation for Statutory Prescribed Minimum Benefits</b>  Subject to pre-authorisation from Designated Service Provider	100% of the Designated Service Provider tariff or Uniform Patient Fee Schedule, cost unlimited  Hospitalisation restricted to State/Provincial hospital or other appropriate facility as determined by the Designated Service Provider.
<b>Chronic Medicine for 26 Chronic Disease List Conditions(CDL)</b>  Subject to pre-authorisation by Designated Service Provider	100% of Single Exit Price (SEP) plus agreed professional fee  Benefits are paid as follows: <ul style="list-style-type: none"> <li>• 100% of SEP plus legislated professional fee. Benefit unlimited, if authorized as per the Managed Healthcare Organisation formulary or for involuntary use of non-formulary drugs.</li> <li>• For voluntary use of non-formulary drugs, co-payment to be paid by Member at point of sale.</li> </ul>
<b>Diagnosis, Treatment and Care for 26 Chronic Disease List Conditions (CDL)</b>  Benefits subject to pre-authorisation and Designated Service Provider Treatment Protocols (Care Plans)	100% of diagnosis, treatment and care costs for the 26 CDL conditions, as per statutory requirements. Benefits are unlimited. Subject to Scheme Treatment Protocols  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 approval of the Managed Healthcare Organisation.