Bonitas

BONITAS MEDICAL FUND ANNEXURE D

2018

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1 WAITING PERIODS

1.1 The Fund 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.

1.2 The Fund 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, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;

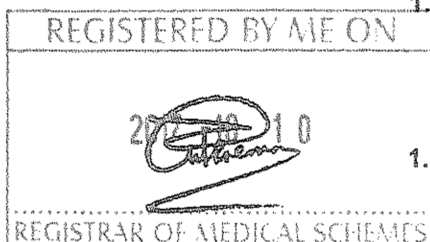
1.2.2 in respect of any person contemplated in this sub-paragraph, where the previous medical scheme had imposed a general or condition specific waiting period, and such waiting period had not expired at the time of termination, a general or condition specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

1.3 The Fund 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; or



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.

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

1.4.3 A beneficiary who changes from one benefit option to another within the Fund unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;

1.4.4 a child dependant born during the period of membership.

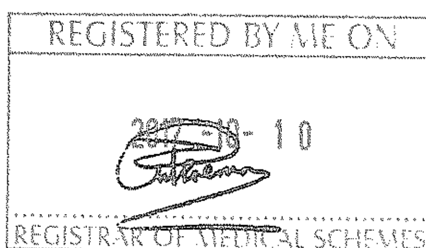
2. PROPORTIONATE ADJUSTMENT OF BENEFITS

For a beneficiary admitted during the course of a financial year the threshold level and 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, provided that there shall be no adjustment in respect of hearing aids, optometry, maternity and Prescribed Minimum Benefit entitlements and provided further that there shall be no reduction in limits per case.

3. TERRITORIAL APPLICATION

3.1 Subject to the provisions of the main rules, and any benefit which specifically affords a member an extra-territorial or international benefit (and subject to such terms and conditions as may be applicable to the accessing of such extra-territorial or international benefit) the benefits available in terms of these rules shall be provided only within the borders of the Republic of South Africa. The Fund shall not be required to make special arrangements to obtain foreign services or medicines for special conditions and this includes harvesting and transportation of organs and tissue for transplant and any medicines or medical services of any kind available only outside the Republic of South Africa. A member requiring assistance for himself or a beneficiary with regard to potential healthcare costs incurred while travelling in foreign countries, must make separate provision for such insurance.

3.2 Should any member be entitled to access any benefit in terms of the registered rules and benefit options outside the borders of the Republic of South Africa, then the Fund, retains the right, subject to compliance with any law or regulation as may be applicable, to reimburse the member or pay the service provider directly for services which may be rendered to the member in terms of such a benefit.



4. REQUIREMENTS OF MANAGED HEALTHCARE PROGRAMMES

4.1 A pre-authorisation reference number (PAR) is required before services in respect of hospitalisation and specialised radiology qualify for benefits. A pre-authorisation reference number is a number allocated by the Fund's managed healthcare organisation.

4.2 When the Fund's relevant managed healthcare organisation grants a pre-authorisation reference number, 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.

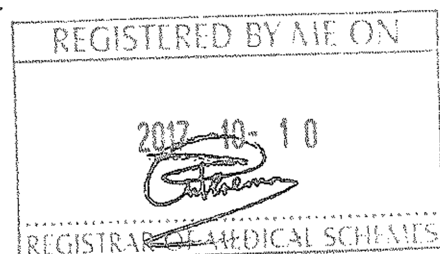
4.3 Whenever the expression "subject to the relevant managed healthcare programme", is used, when applied to hospitalisation in a hospital or admission to a sub-acute facility, day clinic, or unattached operating theatre, physical rehabilitation hospital or rehabilitation centers or hospice it shall imply that approval which is granted for admission and care covers all recognized services associated with that admission except for specialised radiology services.

Services which are subject to the hospital benefit management programme but not associated with admission to a hospital, sub-acute facility, day clinic, or unattached operating theatre, physical rehabilitation hospital or rehabilitation centers requires application to be made for each and every eligible service as indicated in Annexure B.

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

4.4 The granting of a pre-authorisation reference number is confirmation that the proposed clinical procedure or treatment complies with the clinical and funding protocols and is not a guarantee that benefit will be paid.

4.5 Payment of benefits for a clinical procedure or treatment in respect of which a pre-authorisation reference number is granted, is subject to:



4.5.1 the rules of the Fund;

4.5.2 qualification for and availability of benefits;

4.5.3 submission of such information as is reasonably required by the relevant managed healthcare programme;

4.5.4 the clinical procedure or treatment does not exceed the authorisation;

4.5.5 approval by the relevant managed healthcare programme for any extension of an authorisation, failing which only the authorized portion of the clinical procedure or treatment will qualify for benefits;

4.5.6 with the exception of an emergency medical condition, if application for a pre-authorisation reference number is not made or is refused for a non – PMB clinical procedure or treatment, no benefits will be paid, except on BonCap where a late pre-authorization penalty will apply;

4.5.7 in an emergency, a pre-authorisation reference number must be applied for within 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 and pre-authorisation reference number are obtained;

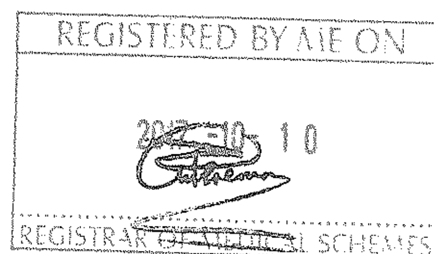
4.5.9 where a beneficiary's entitlement to benefits is subject to such managed healthcare programme as may be stipulated in paragraph 6, the beneficiary shall be obliged to furnish any information required by the Fund to perform its duties. Specifically the Fund may require particulars of diagnosis, clinical investigations, procedures and treatment by the attending medical practitioner of the beneficiary prior to admission of the beneficiary to hospital;

4.5.10 the Fund or its managed healthcare organisation reserves a 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 Fund. In addition, all treatment in an intensive care unit in excess of 4 days is subject to specific inquiry and/or intervention;

4.5.11 in terms of specific re-imbursement contracts with private hospitals certain benefits for specific in-hospital services, drugs or devices might not be covered at all or partially covered or only covered under special circumstances. These benefits will be outlined in a list of non-covered and restricted benefits for in-hospital services divided into different categories, which will be reviewed quarterly and supplied to all hospitals;

4.5.12 if the health problems of beneficiaries are of such a nature that they qualify for admittance to the Fund's Case Management Programme and/or Disease Management, the Fund or its managed healthcare organisation may enter such beneficiaries on such a programme;

4.5.13 the member or beneficiary is responsible for ensuring that the scheme is notified if said member or beneficiary is enrolled in a clinical trial.



5. FUNDING GUIDELINES AND PROTOCOLS

If the Fund or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of other clinical guidelines, subject to Regulation 15(H) and 15(I).

6. SCHEDULE OF MANAGED HEALTHCARE PROGRAMMES

6.1 HIV Infection Management (Aid for AIDS) Programme

A programme adopted by the Fund incorporating such clinical protocols as defined in relevant annexures to the contract between the Fund 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 Ambulance Services

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

6.3 Dental Management Programme

A programme adopted by the Fund for the management of dental benefits as set out in the contract between the Fund and its managed healthcare organisation.

6.4 Chronic Medicine Management Programme

A programme adopted by the Fund for the prior authorisation and management of medicine claims against the chronic sickness medicine benefit in respect of diseases that qualify for reimbursement.

6.4.1 The chronic medicine management programme includes the chronic medicine formulary and other rules defined by the chronic medicine management programme against which applications for the funding of chronic medicines are adjudicated. These rules apply the principles of clinical appropriateness, cost-effectiveness and affordability and aim to achieve the best clinical outcomes.

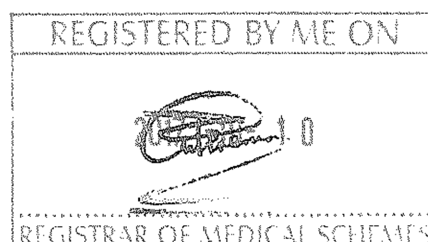
6.4.2 Chronic medicine is medicine that meets all of the following requirements:

6.4.2.1 it is prescribed by a medical practitioner for an uninterrupted period of at least three months; and

6.4.2.2 for a condition appearing on the list referred to in paragraph 6.4.3; and

6.4.2.3 it has been applied for in the manner, and at the frequency, prescribed by the Fund; and

6.4.2.4 it has been registered for indication.



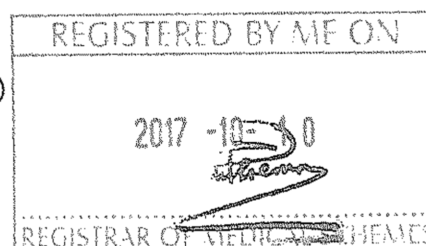
6.4.3 The following chronic diseases, in addition to the chronic diseases referred to in paragraph 7.11.2 qualify in terms of the Fund's Chronic Medicine Programme:

BONCOMPREHENSIVE OPTION

1. Acne
2. Allergic Rhinitis
3. Alzheimer disease (early onset)
4. Ankylosing Spondylitis
5. Anorexia Nervosa
6. Attention Deficit Disorder (in children 5 - 18 years old)
7. Behcet's Disease
8. Barrett's Oesophagus
9. Bulimia Nervosa
10. Cystic Fibrosis
11. Dermatitis
12. Dermatomyositis
13. Depression
14. Eczema
15. Gastro-Oesaphageal Reflux (GORD)
16. Generalized Anxiety Disorder
17. Gout
18. Huntington's Disease
19. Hyperthyroidism
20. Myaesthenia Gravis
21. Narcolepsy
22. Neuropathies
23. Obsessive Compulsive Disorder
24. Osteoporosis
25. Paget's Disease
26. Panic Disorder
27. Polyarteritis Nodosa
28. Post-Traumatic Stress Syndrome
29. Psoriatic Arthritis
30. Pulmonary Interstitial Fibrosis
31. Systemic Sclerosis
32. Tourette's Syndrome
33. Zollinger-Ellison Syndrome

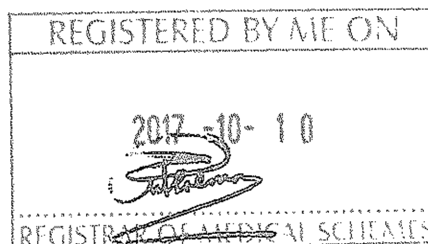
STANDARD AND STANDARD SELECT OPTIONS

1. Acne
2. Allergic Rhinitis
3. Ankylosing Spondylitis
4. Generalized Anxiety Disorder
5. Attention Deficit Disorder (in children 5 - 18 years old)
6. Barrett's Oesophagus
7. Behcet's Disease
8. Dermatitis
9. Depression
10. Eczema
11. Gastro-Oesaphageal Reflux (GORD)
12. Gout
13. Narcolepsy
14. Obsessive Compulsive Disorder
15. Panic Disorder
16. Post-Traumatic Stress Syndrome
17. Tourette's Syndrome
18. Zollinger-Ellison Syndrome



BONCLASSIC

1. Alzheimer disease (early onset)
2. Ankylosing Spondylitis
3. Attention Deficit Disorder (in children 5 - 18 years old)
4. Benign Prostatic Hypertrophy
5. Barrett's Oesophagus
6. Depression
7. Eczema
8. Gastro-Oesaphageal Reflux (GORD)
9. Generalized Anxiety Disorder
10. Gout
11. Obsessive Compulsive Disorder
12. Osteoporosis
13. Paget's Disease
14. Panic Disorder
15. Polyarteritis Nodosa
16. Post-Traumatic Stress Syndrome
17. Pulmonary Interstitial Fibrosis
18. Scleroderma
19. Tourette's Syndrome
20. Zollinger-Ellison Syndrome



BONCOMPLETE

1. Allergic Rhinitis (in children up to 21 years)
2. Attention Deficit Disorder (in children 5 - 18 years old)
3. Allergic Dermatitis / Eczema (in children up to 21 years)
4. Acne (in children up to 21 years)

BonSave, Primary, BonEssential, BonFit, Hospital Standard, Hospital Plus and BonCap options only cover the Prescribed Chronic Disease List (CDL).

6.5 Hospital Management Programme

A programme adopted by the Fund for the ongoing monitoring, by the Fund 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 hospital, rehabilitation centre or hospice for which the beneficiary was admitted in the first instance and which may extend beyond the period of hospitalisation.

The hospital management programme includes the case management programme which is a 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 Fund or the Fund's managed healthcare organisation directs a beneficiary's participation in the programme or approves an application by a beneficiary for participation in the programme.

6.6 Optometry Management Programme

The programme adopted by the Fund for the management of optometry benefits by the Fund or its managed healthcare organisation

6.7 Routine Medicine Management Programme

The programme adopted by the Fund for the management of claims by the Fund or its managed healthcare organisation in respect of routine medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability.

The routine medicine management programme includes the routine medicine management programme formulary which contains the rules adopted by the Fund for the management of claims in respect of routine medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability.

The routine medicine management programme furthermore includes the Medicine Exclusion List. This list refers to the product exclusions collated by the contracted routine medicine benefit management programme, based on scientific evidence and independent expert opinion. Products may be listed for the following reasons:

6.7.1 place in therapy is not well-established;

6.7.2 benefit is not clinically significant;

6.7.3 non-drug therapy is the mainstay of therapy;

6.7.4 product is too expensive relative to its clinical value;

6.7.5 chronic medicines that only qualify for reimbursement if strict financial and clinical prior authorisation criteria are met;

6.7.6 newly registered product under review by a scientific committee;

6.7.7 cheaper alternative drugs are available;

6.7.8 product is misused and alternatives are available.

6.8 Pathology Management Programme

The programme adopted by the Fund for the management of pathology benefits by the Fund or its managed healthcare organisation.

6.9 Oncology Management Programme

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

6.10 Active Disease Risk Management

A coordinated system of health care interventions aimed at beneficiaries with chronic diseases with the emphasis being placed on the prevention of exacerbation and or complications utilising evidence based protocols and formularies. Essential components include the risk stratification of the beneficiary population so that interventions can be targeted; coordination of care, services and interventions; education and coaching with a focus on behaviour modification and self-management; and the ongoing monitoring of outcomes (quality, clinical and financial). The service may extend (but is not limited) to beneficiaries who fall within the following groups:

- High risk beneficiaries as identified through data analytics
- Emerging risk beneficiaries as identified through data analytics
- Beneficiaries with mental illness
- Diabetics
- Beneficiaries with chronic back and neck pain
- Beneficiaries with cardiovascular disease
- Beneficiaries who meet criteria for assistance with weight management

6.11 Specialist Referral Management

A programme adopted by the Fund, for all beneficiaries of the Fund, for the co-ordination of care whereby specialist referrals will need to be obtained through a family practioner, prior to consultation with a specialist. Failure to obtain referral authorization prior to consultation with a specialist, will result in non-payment of claims except for the exceptions listed in Annexure B.

7. PRESCRIBED MINIMUM BENEFITS

This section includes the membership benefits that relate to PMBs and non-PMB benefits and service entitlements.

Members and their registered dependants shall be entitled to prescribed minimum benefits for relevant health services, and each case shall be assessed individually with reference to Regulation 8 and Annexure A to the Regulations published in terms of the Act and the scheme's healthcare programmes and protocols.

7.1 Prescribed minimum benefits will be paid at cost and or the negotiated rate for medical specialists within the specialist network.

7.2 For all prescribed minimum benefits conditions, the benefits are available at 100% of the cost in State (public hospitals or clinics) or other designated service provider (DSP) facilities and /or medicine in accordance with a drug formulary issued by the relevant managed healthcare programme.

7.3 Contracted Service Providers: Designated Service Providers and Preferred Providers

The Fund designates the following service providers for the delivery of benefits to its beneficiaries:

7.3.1 for the provision of diagnosis, treatment and care in respect to one or more conditions:

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REGISTRAR OF MEDICAL SCHEMES

- all licensed private hospitals on BonComprehensive, BonClassic, Hospital Plus, BonComplete, Standard, BonSave, Primary, Hospital Standard and BonEssential options, except specific facilities that may be contractually excluded and that will incur a 30% co-payment.
- contracted hospital networks on the BonCap, BonFit and Standard Select Options;

7.3.2 The following registered dispensing units for the provision of medicine to members of the Fund:

- Pharmacy Direct for the dispensing of medicine authorised by the contracted HIV/AIDS disease management programme except on BonComprehensive;

- Pharmacy Direct for the dispensing of chronic medicine, organ transplant medicine, medicine for members on renal dialysis and chronic specialised drugs, except on BonComprehensive; or such additional or other designated service providers or medicine benefits nominated by the Fund.

- Pharmacy Direct for the dispensing of authorised chronic medicine for all beneficiaries on the contracted Diabetes disease management programme, except on BonComprehensive;

- Pharmacy Direct for the dispensing of prescribed contraception for all eligible beneficiaries.

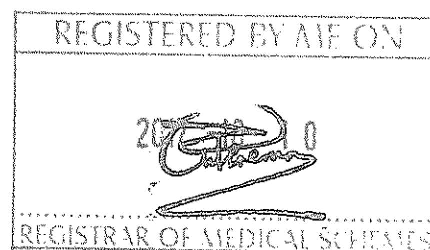
7.3.3 The designated service provider for the disease management of HIV/AIDS for BonCap and or such additional or other designated service providers nominated by the Fund;

7.3.4 All contracted general practitioners for the provision of healthcare services, except on BonComprehensive, BonClassic, BonComplete, BonSave, BonFit, BonEssential, Hospital Standard and Hospital Plus;

7.3.5 ER24 for emergency medical transport and international cover;

7.3.6 All contracted specialist practitioners for the provision of healthcare services, except on BonComprehensive, Hospital Plus and BonCap;
The Specialist Network includes, but is not limited to, the following specialists

- Dermatology
- Obstetrics and Gynaecology
- Pulmonology
- Specialist Medicine
- Gastroenterology
- Neurology
- Cardiology
- Psychiatry
- Neurosurgery
- Ophthalmology
- Orthopaedics
- Otorhinolaryngology (ENT)
- Rheumatology
- Paediatrics
- Plastic and reconstructive Surgery
- Surgery
- Cardio Thoracic Surgery
- Urology



7.3.7 Independent Clinical Oncology Network ('ICON'), appointed by the scheme as the designated service provider for the provision of oncology services for Prescribed Minimum Benefits on all options. In addition, ICON is a preferred provider for the provision of all oncology services. Furthermore, ICON doctors are part of the Specialist Network and form part of this DSP. This excludes paediatric chemotherapy and acute haematology. The Standard protocols apply for all options other than BonComprehensive;

Scheme to make alternative arrangements for these services with other providers

7.3.8 Improved Clinical Pathway Services (ICPS) and JointCare for hip and knee replacement surgery as the designated service provider on Standard Select; ICPS and JointCare for hip and knee replacement surgery as the preferred provider on BonClassic, BonComplete, Standard and Hospital Plus;

7.3.9 Designated service providers for chronic renal dialysis on all options.

7.3.10 Denis as the contracted service provider for dentistry on all options except BonEssential;

7.3.11 IsoLeso for Optometry on all options except on BonFit, BonSave, BonComprehensive and BonComplete.

7.3.12 Preferred Provider Negotiators (PPN) for Optometry on BonComplete.

7.3.13 Documentation Based Care (DBC) and Workability for conservative back and neck rehabilitation on all options except BonCap.

7.3.14 Preferred supplier agreements for appliances and prostheses as specified in Annexure B paragraphs D3.1.1 and D20.1.

7.4 Prescribed minimum benefits obtained from designated service providers

100% of negotiated cost in respect of diagnosis, treatment and care of prescribed minimum benefit conditions if those services are obtained from a designated service provider.

7.5 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 during the applicable waiting period or when benefits are exceeded from a provider other than a designated service provider, the member shall be required to pay the 40% co-payment on all options except on BonComprehensive.

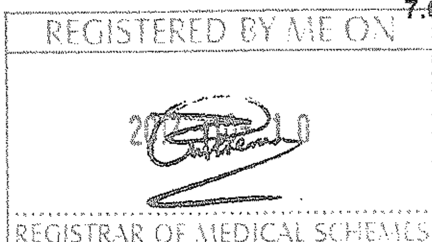
7.6 Prescribed minimum benefits involuntarily obtained from other providers

7.6.1 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 Fund shall pay 100% of the cost, in relation to those prescribed minimum benefits.

7.6.2 For the purposes of paragraph 7.6.1. a beneficiary shall be deemed to have involuntarily obtained a service from a provider other than a designated service provider if -

7.6.2.1 the service was not available from the designated service provider or would not be provided without unreasonable delay;

7.6.2.2 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; or



7.6.2.3 there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

7.6.3 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 Fund to confirm that the circumstances contemplated in paragraph 7.6.2 are applicable.

7.7 Medicine

7.7.1 Where a prescribed minimum benefit includes medicine, the Fund shall pay 100% of the cost of that medicine if that medicine is:

7.7.1.1 obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider;

7.7.1.2 included on the applicable formulary in use by the Fund; or

7.7.1.3 the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

7.7.1.4 All medicine paid as a prescribed minimum benefit is subject to the reimbursement limit, i.e Maximum Generic Price or Medicine Price list.

7.7.2 Where a prescribed minimum benefit includes medicine a co-payment of 40% of the cost of the medicine will apply, except on BonComprehensive, if

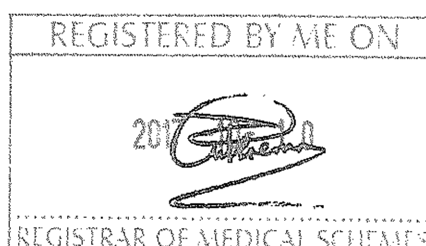
7.7.2.1 the medicine is voluntarily obtained from a provider other than a designated service provider; or

7.7.2.2 the 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;

7.7.2.3 during the applicable waiting period; or

7.7.2.4 when benefits are exceeded beyond what is prescribed in the Regulations to the Act 131 of 1998.

7.7.3 If non-formulary drugs are voluntarily obtained on BonComprehensive, benefits will be limited to the applicable limit or a co-payment of up to 40% of the total cost will be imposed.



7.8. Prescribed minimum benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these rules, the Fund shall pay 100% of the costs of prescribed minimum benefits obtained in a public hospital, without limitation.

7.9 Diagnostic tests for an unconfirmed prescribed minimum benefit diagnosis

Where diagnostic tests and examinations are performed but do not result in confirmation of a prescribed minimum benefits diagnosis, except for an emergency medical condition, such diagnostic tests or examinations are not considered to be a prescribed minimum benefit.

7.10 Co-payments

Co-payments in respect of the costs of prescribed minimum benefits may not be paid out of medical savings accounts.

7.11 Chronic conditions

7.11.1 The Scheme covers Prescribed Minimum Benefits at cost which includes the diagnosis, medical management and medicine to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions, and in DTP chronic conditions

7.11.2 Specified PMB Chronic Conditions

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REGISTRAR OF MEDICAL SCHEMES

- Addison's disease
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic renal disease
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative Colitis

8. INTERNATIONAL TRAVEL BENEFIT

8.1 A member and his dependants on all plans, except the BonCap benefit plan, are entitled to the International Travel Benefit (ITB) and specifically the benefits as set out in Annexure B depending on the benefit option selected.

8.2 Included in the member's ITB is cover:

8.2.1 for the usual, reasonable, costs of medical, surgical, dental (to sound natural teeth) and other treatment given in a hospital and by and on the authority of a member of the medical profession, as well as ambulance transportation, which occurs as a result of an accident or any emergency.

8.2.2 for 90 (ninety) days from date of departure from South Africa or until the member returns to South Africa, whichever occurs first;

8.2.3 for emergency transport to the nearest appropriate facility and / or repatriation to South Africa;

8.2.4 to enable the member to stabilize so that the member is able to return to South Africa. The member may be accompanied by medical staff, subject to approval. Should the member be capable of being repatriated and elects not to return to South Africa, all expenses incurred after the Fund's decision to repatriate shall be for the member's own account;

8.2.5 for situations where, if due to hospitalisation, the member is unable to return to South Africa within the 90 (ninety) day period, the period of cover will be extended for such period as is reasonable necessary to enable the member to return to South Africa up to a maximum of 90 (ninety) days from the date of admission to hospital;

8.3 The Fund's liability for healthcare services rendered out-of-hospital in respect of emergencies contemplated in clause 8 will also be subject to what is stated in 8.2.

8.4 Notwithstanding what is stated in clauses 8.2, 8.3 and Annexure B of the applicable Benefit Plans described in these Rules, and unless otherwise decided by the Fund, expenses incurred in connection with any of the following will not be paid by the Fund:

8.4.1 pregnancy or childbirth should medical complications or emergencies arise after the 24th (twenty fourth) week of pregnancy;

8.4.2 situations where a member is aware of a reason which could give rise to any claim;

8.4.3 situations where the member is traveling contrary to medical advice, or with the intention of obtaining medical treatment, or where a terminal prognosis has been given;

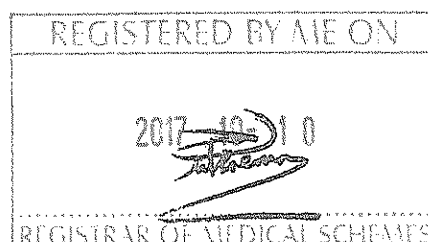
8.4.4 emergency treatment for conditions, and complications thereof, for which treatment or medical advice was received at any time during the thirty day period immediately preceding the date of departure from South Africa.

8.5 Nothing in this clause will be interpreted to preclude the application of the exclusions stated in Annexure C.

8.6 The calculation of the amount payable by the Fund in respect of emergency hospital benefits incurred outside South Africa as contemplated in clause 8.2 shall be based on the cost of claim and shall be based on the member's Benefit Plan choice.

8.7 The Fund's liability in respect of the ITB shall be limited in each financial year to the amount expressed in South African Rands applicable in terms of the relevant section of Annexure B.

8.8 Subject to what is stated in this clause 8, the Fund shall pay the claims in respect of the ITB in accordance with rule 15 of the main body of the Rules.



9. AFRICA BENEFIT

9.1 A member and his dependants are entitled to the Africa Benefit (AB) and specifically the benefits as set out in Annexure B depending on the benefit option selected.

9.2 A beneficiary shall be entitled to cover for the usual, reasonable, pre-authorised costs of medical, surgical, dental (to sound natural teeth) and other treatment given in a hospital situated in Africa and by and on the authority of a member of the medical profession, which the member elects to receive out of South Africa, provided that:

9.2.1 such treatment is routinely available in South Africa from a registered member of the medical profession;

9.2.2 subject to what is stated in this clause 9, the Fund shall pay the claims in respect of the AB in accordance with rule 15 of the main body of the Rules;

9.2.3 the Fund's liability shall not exceed the average global amount the Fund would in the ordinary course pay for such healthcare services given the Fund's claims experience in South Africa, subject to the beneficiary's benefit plan; and

9.2.4 Nothing in this clause will be interpreted to preclude the application of the exclusions stated in Annexure C.

9.3 The Fund's liability for healthcare services rendered out-of-hospital in Africa in respect of costs contemplated in clause 9 will also be subject to what is stated in 9.2.