ANNEXURE B: BENEFIT ENTITLEMENT

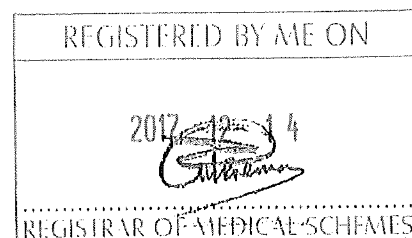
Subject to the provisions of the Main Rules, the benefits available to a member in respect of himself and his registered dependants are set out below. Provided that nothing contained in these Rules shall be interpreted as imposing a limitation on the reimbursement of any minimum benefit, the following conditions will apply unless otherwise indicated.

Notwithstanding anything to the contrary herein contained, the prescribed minimum benefits will be paid to a maximum of the higher of 100% of UPFS for procedures performed by provincial facilities or the Scheme's Designated Service Provider (DSP), or 100% of the Scheme Rate in a private hospital where the beneficiary voluntarily obtains a benefit from another service provider and will accumulate to available limits first. Where a prescribed minimum benefit procedure is obtained in a private hospital involuntarily such procedure will be paid to a maximum of 100% of cost.

1. INTRODUCTION TO BENEFITS

1.1. The benefits payable by the Scheme are the health care service benefits provided for in the option chosen by the member in terms of rule 17 of the main body of the rules and in terms of the provisions of this schedule.

2. DEFINITIONS



In this schedule:

2.1. "an accident" is an unforeseen event and has an ascertainable date, time and place;

2.2. "emergency room" means those healthcare services that take place in a casualty unit / emergency room which do not result in an admission to the hospital.

2.3. "hospital" means any institution established or registered in terms of any law as a private or governmental hospital, maternity home, nursing home or similar institution where nursing is practiced, or any other private or governmental institution where surgical or other medical activities are performed, wherein accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy and shall be deemed to include a day clinic, but not:

2.3.1. a facility which has as its primary function the provision of remedial, rehabilitative or convalescent care; or

2.3.2. a home for the aged; or

2.3.3. a long term nursing facility; or

2.3.4. a rest home; or

2.3.5. any facility that has not been issued with a registration number by the Board of Healthcare Funders

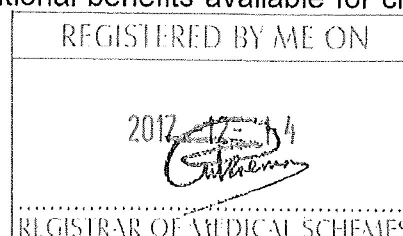
2.4. "total medical Scheme contribution" means the sum of the contribution towards health care cover, and non-healthcare expenses.

2.5. "UPFS" means Uniform Patient Fee Schedule;

2.6. "the main body of the rules" means the documents headed "Rules of the Malcor Medical Aid Scheme" to which this schedule is an annexure;

2.7. words and phrases shall have the same meaning as those ascribed to them in rule 4 of the main body of rules, unless the context clearly indicates otherwise.

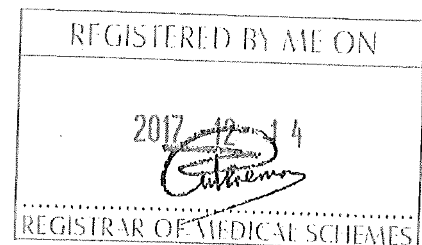
2.8. "Acute medication" shall mean all prescribed medication, other than those for which a member has additional benefits available for chronic medication.



2.9. "Over-the-Counter medication" shall mean all scheduled 0, 1 and 2 medication obtainable without a prescription, provided that it is purchased at a service provider who has been duly registered to supply such medication.

2.10. "Chronic Medication" shall mean a course of prescribed medication required in respect of the Prescribed Minimum Benefit ailments as set out in Appendix 1 of these Rules.

3. CHRONIC ILLNESS BENEFITS



Out-of-hospital benefits

3.1. Choice of benefits

3.1.1. A member shall subject to 2.10 be entitled, upon completing a separate chronic illness benefit application form and submitting same to the Scheme, to chronic illness benefits in terms of the benefit tables of the option selected, except for PMB conditions.

3.2. Basis

3.2.1. The calculation of the amount payable by the Scheme in respect of chronic illness benefits must be based on:

3.2.1.1. the Malcor Rate in respect of the relevant health care services (or a percentage of such tariff); and/or

3.2.1.2. a fixed amount per health care service rendered as shown in the benefit tables.

3.3. Scheme's liability

3.3.1. The Scheme's liability shall:

3.3.1.1. only commence once the member and / or his dependants have been clinically diagnosed as suffering from a chronic illness condition and the member has met the Scheme's required clinical criteria; and

3.3.1.2. be limited in each financial year in terms of the relevant sections of the benefit table and will also be subject to the provisions of the Act and its Regulations.

3.3.2. The determination of whether a member and his dependants is entitled to Chronic Illness Benefits shall be based on:

3.3.2.1. the clinical diagnosis of the prescribing medical practitioner or a specialist specified by the Medical Panel appointed by the Scheme; and

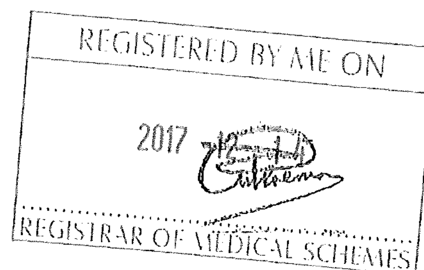
3.3.2.2. the opinion of the Medical Panel of the Scheme or the appropriate organisation approved by the Scheme;

3.3.2.3. in terms of the relevant section of the benefit table.

3.4. Payment of claims

The Scheme shall pay the claims in respect of chronic illness benefits in accordance with rule 18 of the main body of the rules.

4. HOSPITALISATION



4.1. Choice of benefits

A member shall be entitled to benefits in terms of the benefit tables to the Schedule of the option selected.

4.2. **Basis**

4.2.1. The calculation of the amount payable by the Scheme in respect of the hospital benefits may in accordance with the Rules, be based on:

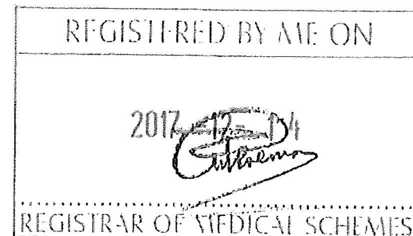
4.2.2. the cost of the relevant health care services (or a percentage of such cost); and/or

4.2.3. the applicable tariff in respect of the relevant health care services (or a percentage of such tariff); and/or

4.2.4. a fixed amount per health care service rendered as shown in the benefit tables and/or

4.2.5. a global fee and/or

4.2.6. a per diem payment.



4.3. **Limit of Scheme's liability**

4.3.1. The Scheme's liability in respect of hospital benefits shall be limited in each financial year to the amount, expressed in Rands, applicable in terms of the relevant section of the benefit table.

4.4. **Payment of claims**

The Scheme shall pay the claims in respect of the hospital benefits in accordance with rule 18 of the main body of the rules.

4.5. General provisions

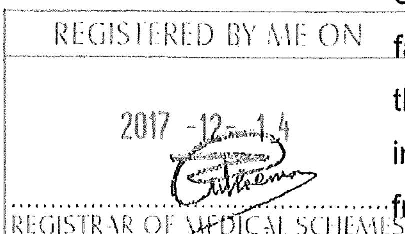
4.5.1. All scheduled hospital admissions are subject to pre-authorisation by the Scheme's case managers prior to the admission. Authorisation for unscheduled admissions or emergencies not obtained prior to the admission must be obtained within three days following such admission. Failure to obtain pre-authorisation for hospital admissions will result in a 25% co-payment.

4.5.2. The Board reserves the right to exclude benefits in respect of services which in its or its hospital case managers' opinion do not necessitate hospitalisation.

4.5.3. Benefits for intensive care units and high care wards are subject to a prior approval by the Scheme's hospital case managers.

4.5.4. Provided the initial hospitalisation was pre-certified, pathology, radiology, X-rays, psychology, physiotherapy and occupational therapy provided in hospital will be paid as part of Overall Hospital Benefit. Pre- and post-hospitalisation care shall be paid as part of the day-to-day expenses.

4.5.5. Pre-authorisation for in-patient admission will only be considered for conservative dentistry performed under general anaesthetic on persons who are 12 years or younger. All other dental related cases requiring surgery or conservative dentistry and that do not fall into the surgical class of Tariffs, will have to be motivated by the attending dental practitioner. Such motivated cases would include those for simple extractions and are subject to approval from the Scheme's dental advisor.

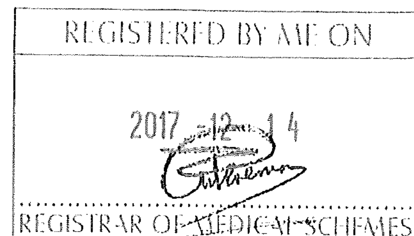


4.5.6. Private ward rates will only be paid if the stay in a private ward has been certified by a medical practitioner as essential because

the patient poses a risk to other patients and the case has been pre-certified. In the absence of such certification, general ward rates will apply.

4.5.7. Benefits in respect of any pre-authorised day procedures such as gastroscopy and colonoscopy or any pre-authorised specialised procedures that, in the Scheme's hospital case managers' opinion can safely be performed in a service provider's rooms, registered day-clinic or out-patient facility, may be paid as part of the Overall Hospital

4.5.8. Benefit.



5. ORGAN TRANSPLANTS

5.1. Where the recipient of the organ is a beneficiary of the Scheme, benefits will be paid for the supply and transportation of the organ needed for the transplant, as well as hospital accommodation and surgically related services and procedures, subject to the prior approval of the hospital case managers and managed care protocols. Benefits in respect of any services related to the organ donor will be covered at cost if obtained at a Designated Service Provider or the State, subject to the predominant PMB and managed care protocols.

5.2. Where the donor of the organ is a beneficiary of the Scheme and the recipient is not a beneficiary of the Scheme, no benefit is provided.

6. AUXILIARY AND PARAMEDICAL SERVICES

6.1. These services shall only be paid for if rendered by a registered supplier of any paramedical and auxiliary services on the instructions of a medical practitioner.

6.2. Nursing services provided other than in hospital shall only be available if authorised by a case manager.

6.3. Frail care services shall only be paid for if certified by a medical practitioner that such care is essential rather than hospitalisation and such services are provided through a registered frail care centre.

7. ALL-INCLUSIVE MAXIMUM

7.1. Notwithstanding any other provision in the Rules and Regulations, benefits granted according to the provisions of the Rules and Regulations are subject to an all-inclusive maximum as set out in the table of benefits, per member or family during any financial year subject to the prescribed minimum benefits.

8. MISCELLANEOUS CONDITIONS

8.1. Unless otherwise indicated, benefits shall be paid at the Malcor Rate.

8.2. All benefits and sub-limits are subject to the overall annual limits.

8.3. Unless otherwise indicated, all limits refer to the limit available per member family.