ANNEXURE C

LIMITATION AND EXCLUSION OF BENEFITS

Preamble

1. The scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, the scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

2. The limitations and exclusions in the KeyPlus Option as listed in Appendix 1 to Annexure B5 must be read with this Annexure, where applicable.

A. Limitation of Benefits

1. The maximum benefits to which a member and his dependants are entitled to in any financial year, are limited as set out in Annexure B.

2. In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending practitioner, at the cost of the Scheme. In such cases, if such specialist`s advice is not acted upon, no further benefits will be allowed for that particular illness subject to evidence based managed care protocols/formularies, as provided for in Regulation 15.

3. Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month`s supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.

4. Where the cost of generic medicine exceeds the cost of the original (ethical) brand equivalent of such medicine, the Scheme's funding liability for such medicine shall not exceed the cost of the original (ethical) brand equivalent.

5. Except for benefits in respect of the PMB's, expenses for allowable benefits that are in excess of that which the member is entitled to in terms of the rules of the Scheme may be paid from a member's MSA but shall not accumulate to the AT.

6. Except for the circumstances contemplated in Rules 16.8, 16.9 and 16.10 (including all their respective sub-clauses) of the Main Body of the Rules, if any other party is liable for the cost incurred by the member for any past or future healthcare service and/or medical expense, the Scheme's liability towards the member or dependant, as the case may be, shall be limited in total to the difference between the amount which the member would be entitled to in terms of the Rules and the amount of the liability undertaken by such other party in respect of such healthcare service and/or medical expense. In this regard, where payment has been made by the Scheme to the member for such healthcare service and/or medical expense, the member or the other party concerned, shall reimburse the Scheme, or the Scheme shall be entitled to recover from the member:
   6.1 only from monies due and payable or paid by such party to the member in respect of such healthcare service and/or medical expense; and
   6.2 such reimbursement and/or recovery shall be applicable irrespective of the lapse of time since the Scheme funded, or the healthcare service and /or medical expense was incurred by the member.

7. In the event of any other party (including a manufacturer or supplier) being liable, whether in part or in full, for the cost incurred for the recall, replacement or repair of any defective product used or device/implant inserted in respect of a member or his dependant, the Scheme shall be entitled to be reimbursed or may recover from the other party concerned or the member, if payment has been made to the member by the other party concerned, the full cost of the product used or the cost associated with the initial insertion of the device/implant (including the cost of diagnostic work-up and follow-up interventions) incurred by the Scheme, provided that the quantum of the reimbursement or recovery may not exceed what was actually paid for by the Scheme in respect of such product, device or implant.

B. Exclusion of Benefits

Expenses incurred in connection with any of the following shall not be paid by the Scheme.

1. Any sickness condition that was specifically excluded from benefit during any applicable waiting periods when a member/dependant joined the Scheme.

2. All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules of the Scheme, taking into consideration that beneficiaries admitted during the year are entitled to benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

3. Costs for services rendered by:
   - 3.1 persons not registered in terms of appropriate legislation for whom registration is a prerequisite to render relevant health services; or
   - 3.2 any institution, nursing home or similar institution except a state or provincial hospital, not registered in terms of any law; or
   - 3.3 persons who have not been registered as a provider by the Board of Healthcare Funders

4. Health care services and/or claims received for medicine not registered, or approved for use in a specific instance by the Health Products Regulation Authority.

5. Healthcare services of an experimental, unproven nature, or those rendered by an unregistered provider.

6. Recuperative or convalescent holidays.

7. Search and rescue.

8. Travel and subsistence for members other than emergency transport provided by or via the Scheme's Designated Service Provider.

9. Healthcare services relating to any complications that may arise from any exclusion except insofar as these services are PMB-related.

10. Healthcare costs associated with a Prescribed Minimum Benefit, if such costs are incurred outside of the borders of South Africa.

11. All costs associated with medical reports, unless the report is requested by the Scheme.

12. All costs associated with medical examinations for life assurance, insurance, employment, lawsuits and similar purposes.

13. Healthcare services that do not meet the Scheme's clinical protocols, provided that such protocols are in accordance with evidence-based medicine, taking into account considerations of cost-effectiveness and affordability and international and/or industry best practice.

14. Any and all costs related to claims fraudulently made and related to making material misrepresentation or non-disclosure of factual information.

15. Interest charges claimed by the member or healthcare provider, as the case may be, in respect of:

    15.1 late payment of claims caused by a delay in submission of claims or re-submission of corrected claims, or delays in the submission of statements, particulars or proof required in support of such claims;

    15.2 delays by a member in payment to a healthcare provider for services rendered in circumstances where the claim was submitted, processed and paid to the member in conformance with the Act and the Rules; or

15.3 delays in payment of a claim or part thereof, where the delay was occasioned as a result of an active complaint and/or dispute process initiated in terms of the Act or Rules.

16 Healthcare services relating to:

16.1 injuries sustained resulting from participation in a wilful and material violation of the law, except for those included under the PMBs;

16.2 injuries sustained resulting from wilful participation in war, terrorist activity, riot, civil commotion, rebellion or insurrection, except for those included under the PMBs.

17 Appointments which members or dependants of member fail to keep with a provider of service.

18 All costs for operations, medicine, treatment and procedures for:

18.1 Cosmetic purposes which shall, without limitation, be deemed to include health care services related to:

18.1.1 obesity, except PMB; or

18.1.2 hair removal; or

18.1.3 scars; or

18.1.4 nasal tip surgery; or

18.1.5 otoplasty for bat ears; or

18.1.6 keloids, except for functional impairment; or

18.1.7 Blepharoplasties (eyelid surgery); and

18.1.8 Portwine stains.

The Scheme shall, based on the clinical motivation received, decide whether a particular operation, treatment or procedure is cosmetic in nature, taking into consideration evidence-based studies that are based on cost-effectiveness and affordability.

18.2 Healthcare services related to gender reassignment.

18.3 The purchase of the following, unless prescribed by a person who is registered with a recognised professional body constituted in terms of an Act of Parliament:

18.3.1 applicators, toiletries and beauty preparations;

18.3.2 bandages, cotton wool and other consumable items;

18.3.3 patented foods, including baby foods;

18.3.4 vitamins, mineral supplements, tonics, stimulants slimming preparations and drugs as advertised to the public and healthcare providers;

18.3.5 household and biochemical remedies;

18.3.6 anabolic steroids;

18.3.7 aphrodisiacs;

18.3.8 anti-smoking preparations and devices;

18.3.9 sunscreen agents.

Unless otherwise decided by the Scheme, benefits in respect of medicines obtained under this clause, on a prescription, are limited to one month's supply (or to the nearest unbroken pack) for every prescription or repeat thereof.

18.4 Healthcare services relating to:

18.4.1 any complication that may arise from any exclusion listed in this annexure, except PMB; or

18.4.2 assisted reproductive therapy, including any work-up and complications thereof, other than those covered by the Prescribed Minimum Benefits (PBM); or

18.4.3 obesity, except PMB; or

18.4.4 acute and/or long term alcohol, drug or solvent abuse, except PMB; or

18.4.5 breast reductions or enlargements; or

18.4.6 Gynaecomastia; or

18.4.7 frail care; or

18.4.8 sclerotherapy, other than that approved by the Scheme for the treatment of varicose veins; or

18.4.9 synvisc intra-articular injections, except PMB; or

18.4.10 hyperbaric oxygen treatment, except PMB.

19. Osseo-integrated implants and implant-related procedures.

20. Accommodation in old-age homes or similar institutions, except where such has been approved by the Scheme as a recognised as a step-down facility.

21. All desensitization treatment and allergy tests unless motivated and funded from the member's MSA.

22. Any treatment, devices or therapy that are deemed to be alternative, or homeopathic for which cover is sought from the MMB, except where provision is therefore is made in the ATB or EDB.

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