ALLIANCE-MIDMED MEDICAL SCHEME

BENEFITS

(Effective 1 January 2026)

(unless otherwise stated below)

A ENTITLEMENT TO BENEFITS

Beneficiaries are entitled to the Prescribed Minimum Benefits and the benefits stipulated in paragraph B of this Annexure and Annexure D.

Entitlement to benefits is subject to the Rules, Annexure A to the Rules, Annexure A, Appendix 1 to the Rules, Annexure B to the Rules, Annexure B, Appendix 1 to the Rules, Annexure C to the Rules and Annexure D to the Rules and with specific references to paragraphs C and D of this Annexure.

A.1 GENERAL PROVISIONS

1. Where specifically indicated in this annexure that a Member's entitlement to benefits shall be subject to such Hospital and Major Benefit Management Programme, the Member shall be obliged to furnish any information required by the Scheme to perform its duties. Specifically, the Scheme 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.

2. Should a patient request admission to Hospital and has co-morbidities that may put him/ her at risk, the Scheme reserves the right to suggest/redirect the patient to a more appropriate facility.

3. The Scheme applies Managed Care principles and evidence-based policies and has a right to intervene on all (potential high risk/high costing) cases and request a second opinion if necessary.

4. Except in the case of an emergency, a request for pre-authorisation shall be made, at least 72 (seventy-two) hours prior to the intended admission date, to the hospital and Major Benefit Management Programme (medical scheme), before a beneficiary is admitted to a hospital or day clinic or before a beneficiary receives a relevant health service at such institution and hospital updates must be provided within 24 (twenty-four) hours, and every twenty-four hours thereafter while the beneficiary is in the Hospital or facility.

5. In the event of an emergency, the Scheme shall be notified of such emergency within one working day after admission to Hospital.

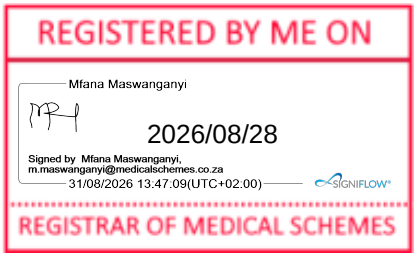
Should a request for pre-authorisation for a planned procedure not be made within 72 (seventy-two) hours or within 24 (twenty-four) fours in the event of an emergency, a R1 500 co-payment will apply.

6. Proportionate Adjustment of Benefits

For a Member admitted during a financial year, his/her maximum available benefits shall be adjusted in proportion to the period of Membership from the admission date to the end of the financial year. Optometry and hearing appliance benefits will be excluded from the proportional adjustment.

7. Territorial Application

7.1 Unless specifically stated otherwise, the benefits available in terms of these Rules shall be provided only within the borders of the Republic of South Africa. The Scheme 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 for transplant and any medicine or medical services of any kind available only outside the Republic of South Africa. A Member requiring assistance for himself or a Beneficiary about potential health care costs incurred while travelling in foreign countries, must make separate provision for such costs.



7.2 Benefits in respect of claims incurred outside the borders of the Republic of South Africa (Foreign Claims) are allowed in emergencies only and only where the applicable travel insurance policy does not make provision for such medical benefits. The Scheme will require a copy of the travel insurance policy/letter repudiating the foreign claim/s. The benefit payable will be subject to the same benefits that apply to services rendered locally and are subject to the same limits where applicable. Foreign claims will be processed and refunded to Members in South African Rand at the applicable exchange rates at the time of service, and only on the Member's return to South Africa.

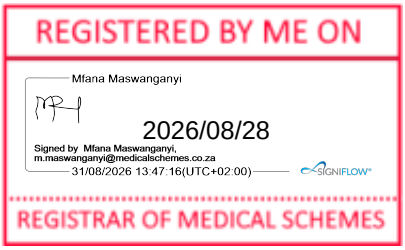
7.3 Emergency Condition means, in relation to a Beneficiary, the sudden and at the time, unexpected onset of an Accidental Injury or Illness during an insured journey that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the Beneficiary's life in serious jeopardy.

8. Authorisation

Where the Scheme or its Administrator (relevant healthcare management programme), or the Medical Advisor requires authorisation for a specific treatment or procedure, the Beneficiary or a person acting on his behalf must contact the Scheme, initially by telephone call to the relevant call centre, and thereafter by written communication delivered or emailed to confirm the authorisation requested or received. The Member or his Beneficiary is responsible for ensuring that communications reach the Scheme and for maintaining records of such communication. The Scheme will maintain records of communications that it received.

Where the Scheme requires pre-authorisation as per the Rules, the Scheme will provide a pre-authorisation for in-hospital services include in the initial pre-authorisation and any service provider what will provide services in the hospital must also obtain pre-authorisation for the services that they plan to render during the beneficiary's hospitalisation.

9. REQUIREMENTS OF HEALTHCARE MANAGEMENT PROGRAMMES



9.1 Where specifically indicated in this Annexure that a Member's entitlement to benefits shall be subject to such healthcare management programme as may be stipulated in paragraph 1, the Member shall be obliged to furnish any information required by the Scheme to perform its duties. Specifically, the Scheme may require particulars of diagnosis, clinical investigations, procedures, and treatment by the attending medical practitioner of the Beneficiary prior to, during and after admission of the Beneficiary to Hospital.

9.2 A request for pre-authorisation shall be made at least 72 hours (seventy-two hours) prior to a planned admission, except in case of an emergency, to the Hospital and Major Benefit Management Programme before a Beneficiary is admitted to a Hospital or day clinic or before a Beneficiary receives a relevant health service at such institution.

9.3 If authorisation is not obtained (except in the case of an emergency), or in case of failure to furnish such information or to grant permission for access to such information as may be required, the Member shall be liable for a payment of R1 500 per case; provided the Board may waive all or part of such payment on good cause shown by the Member.

9.4 In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission to Hospital failing which the payment as per clause 9.3 shall apply.

10. SCHEDULE OF HEALTH MANAGEMENT PROGRAMMES

10.1 HIV Management Programme

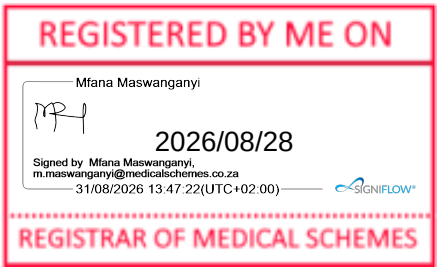
10.2 Ambulance Services Management

10.3 Chronic Disease Management Programme

10.4 Hospital and Major Benefits Management Programme

10.5 Pharmaceutical Benefit Management

10.6 Oncology Management Programme



10.7 Maternity Management Programme

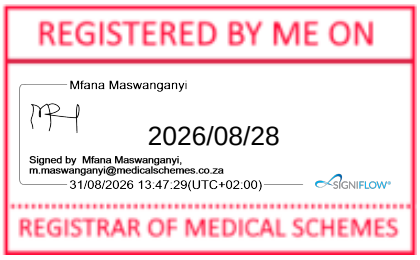
10.8 Mental Wellness Programme

10.9 Lifestyle Benefit Programme

B **BENEFITS (Paid from Major Medical Pool (MMP) unless otherwise stipulated)**

B(a) Where no restriction or limit allocation of the benefit is indicated, the benefit is unlimited, subject to B(b).

B(b) There is no overall annual limit.



B(c) Dependant categories are:

M0 - Member without dependants

M1 - Member with one dependant

M2 - Member with two dependants

M3 - Member with three dependants

M4+ - Member with four or more dependants

B(d) Except where indicated differently, all benefit limits are per annum.

B1. **Alcohol and Drug Dependency**

Subject to the Hospital and Major Benefit Management Programme and Mental Wellness Programme:

100% of the lower of the cost or Alliance-Midmed rate for all services when treatment has been authorised at the Preferred Service Provider.

Pre-authorisation required.

B2. **Emergency and Ambulance services**

Subject to the Ambulance Services Management Programme:

B2.1 100% of the lower of the cost or Alliance-Midmed rate per Beneficiary if authorised by the Preferred Service Provider for ambulance services dispatched by the Life Midmed Hospital in Middelburg and Life Cosmos Hospital in Emalahleni.

Pre-authorisation required for non-emergency cases dispatched by Life Midmed and Life Cosmos Hospitals.

B2.2 100% of the lower of the cost or Alliance-Midmed rate per Beneficiary in the case of an emergency.

B2.3 Benefit limited to R5 083 per beneficiary per annum applies for use of a non-preferred provider.

B3. Appliances (Subject to an overall combined limit of R12 814 per beneficiary per annum for in and out of Hospital appliances)

B3.1 In Hospital

Subject to the Hospital and Major Benefit Management Programme:

100% of the lower of the cost or Alliance-Midmed rate for general medical and surgical appliances.

Authorisation required for any appliance in excess of R2000. (Including wheelchairs).

B3.2 Out of Hospital

Appliances in excess of R2000 require authorisation.

100% of the lower of the cost or Alliance-Midmed rate for general medical and surgical appliances.

A separate benefit applies to hearing aids which is restricted to a 36-month cycle.

B3.2.1 Subject to the Chronic Disease Management Programme and Pharmaceutical Benefit Management Programme: 100% of the lower of the cost or Alliance-Midmed rate for the following medical and surgical appliances: -

- Nebulisers;
- Glucometers;
- Peak Flow meters; and
- Disposable materials; used to monitor and treat diabetes.

B3.2.2 Subject to the Hospital and Major Benefit Management Programme and Pharmaceutical Benefit Management Programme:

100% of the lower of the cost or Alliance-Midmed rate for: -

- Oxygen;
- Cylinders;
- Concentrators;
- Home ventilators and attachments; and
- Humidifiers (Humidifiers OH will be funded if prescribed by a health professional);
- CPAP machines

B3.2.3 One hearing aid unit per beneficiary per ear, every three years, based on the date of service that falls after the start of the 2020 benefit year.

Benefit limited to **R12 766** per unit every three years.

R594 co-payment per unit, if not issued by a preferred provider.

Subject to benefit limits as per the benefit schedule, pre-authorisation and the provision of a recommendation and report by and ENT Specialist and/or an audiologist and 3 (three) written quotations, of which one is to be obtained from the nominated ENT Specialist / Preferred Service Provider.

B4. **Blood, blood equivalents and blood products**

Subject to the Hospital and Major Benefit Management Programme:

B4.1 100% of the lower of the cost or Alliance-Midmed rate for blood and blood products. Benefit limited to **R28 870** per Member family per annum.

B4.2 100% of the lower of the cost or Alliance-Midmed rate for blood equivalents. Pre-authorisation required for costs exceeding **R27 605**, subject to PMB.

B5. **Consultations and visits** – Subject to financial and quantity limits. Combined limit with consultations specified in Rule B12 – Mental Health.

These consults apply to General Practitioners, Specialists and Nurse Practitioners only.

B5.1 In Hospital

B5.1.1 General Practitioners

100% of the lower of the cost or Alliance-Midmed rate for consultations and visits by General Practitioners.

Benefit limited to R613 per GP consultation.

B5.1.2 Specialist (including Psychiatrist)

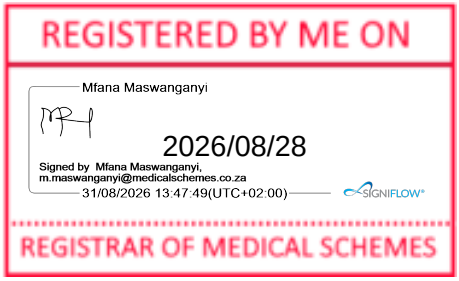
150% of the lower of the cost or Alliance-Midmed rate for consultations and visits by Specialist.

Specialist consultation fees available to members from the call centre.

B5.2 Out of Hospital (Subject to limits per family size)

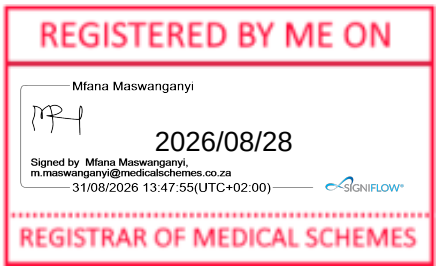
B5.2.1 General Practitioners

100% of the lower of the cost or Alliance-Midmed rate of **R631** for consultations and visits by General Practitioners in the service providers' rooms or patient's home or primary health care facility.
The following defined benefit limits applies per family size:
M0 – Limited to 6 per annum. Subject to an annual monetary limit up to **R3 650**.
M+1: Limited to 11 consults per Member Family per annum. Subject to an annual monetary limit up to **R6 594**.
M+2: Limited to 15 consults per Member Family per annum. Subject to an annual monetary limit up to **R9 009**.
M+3: Limited to 19 consults per Member Family per annum. Subject to an annual monetary limit up to **R11 728**.
M+4: Limited to 21 consults per Member Family per annum. Subject to an annual monetary limit up to **R12 613**.
M+5: Limited to 25 consults per Member Family per annum. Subject to an annual monetary limit up to **R15 015**.
M+6: Limited to 27 consults per Member Family per annum. Subject to an annual monetary limit up to **R16 215**



B5.2.2 The following minor procedures undertaken in a GP's room will be paid from the Major Medical Pool at an enhanced consultation rate of **R690** per procedure and a facilitation fee of **R439** per procedure: -

- Scars – minor procedures of similar magnitude
- Stitching of minor wounds – with or without local anaesthesia including normal after-care
- Skin: Removal of benign lesion by curetting first lesion
- Skin: Drainage of Subcutaneous abscess Onychia
- Skin: Removal of benign lesion by curetting – subsequent lesion
- Removal of foreign body
- Scars: minor procedures
- Skin: Treatment by Chemo-Cryotherapy
- Skin: Lesion by Chemo-Cryotherapy – subsequent lesion
- Skin: Lesion by Chemo-Cryotherapy – maximum event
- Deep Laceration involving limited muscle damage
- Skin: Drainage of major hand or foot infection
- Scars: Additional wounds stitched at same session (each)
- Lacerations scars: radical excision of nailbed
- Skin: Intralesional injection, single
- Scars: Repair by small skin graft
- Skin: Removal of foreign body – Chemo / Cryotherapy
- Skin: Removal of malignant lesions
- Chemo-Cryotherapy – Benign lesions
- Repair of nail bed
- Scars: Excision of large benign tumour
- Hands: Remove Foreign Bodies requiring incision, under local anaesthetic
- Bursae & Ganglia: Excision, aspiration, or injection (no after care)
- Needle Biopsy – soft tissue
- Deep skin biopsy with anaesthetic suturing
- Bursae & Ganglia: Excision, small Bursa or Ganglion.



The first consultation will be paid at 100% of the enhanced consultation rate and subsequent consultations will be paid at 25% of the enhanced consultation rate. Consultations are limited to 3 (three) per annum.

B5.2.3 An enhanced consultation fee of R690 and a facilitation fee of R1 329 will be paid per procedure from the Major Medical Pool per male circumcision undertaken in the appropriately equipped General Practitioner's rooms.

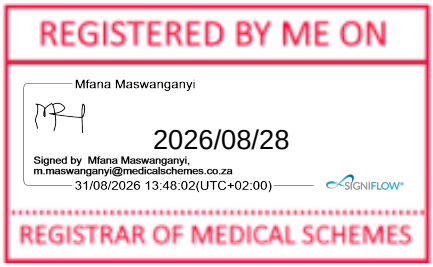
B5.2.4 **Medical Specialists (Subject to limits per family size)**

150% of the lower of the cost or Alliance-Midmed rate for consultations and visits by Medical Specialists. (See paragraph B12.2.2).

The first consultation in a calendar year to a Specialist will be at 250% of the Alliance-Midmed rate.

The following defined benefit limits per family size applies:
M0 – Limited to a max of 4 consults per Member Family per annum. Subject to an annual monetary limit up to R3 644.
M+1 – Limited to a max of 8 consults per Member Family per annum. Subject to an annual monetary limit up to R5 736.
M+2 – Limited to a max of 9 consults per Member Family per annum. Subject to an annual monetary limit up to R6 454.
M+3 – Limited to a max of 9 consults per Member Family per annum. Subject to an annual monetary limit up to R6 454.
M+4 – Limited to a max of 11 consults per Member Family per annum. Subject to an annual monetary limit up to R7 887.
M+5 – Limited to a max of 11 consults per Member Family per annum. Subject to an annual monetary limit up to R7 887.
M+6 – Limited to a max of 11 consults per Member Family per annum. Subject to an annual monetary limit up to R7 887.

B6. **Dentistry**



All dental claims will be paid at the Alliance-Midmed rate and specialised dentistry treatment is subject to prior approval.

B6(a) Dental benefits are subject to managed care protocols and Managed Care Interventions which may include the requirement of treatment plans and/or radiographs prior to benefit application. Scheme exclusions apply to dental benefits. In the event of a dispute, the registered Rules of the Scheme prevail.

B6(b) Pre-authorisation is required for crowns, orthodontics, periodontics, and IV conscious sedation.

B6(c) Benefits for In Hospital dental and oral surgery are limited to beneficiaries up to age 12.

B6.1 Conservative Dentistry

Treatment	Benefit	Co-Payment
Consultations	Limited to 2 consultations per Beneficiary per year	
X-rays: Intra-oral	Limited to 4 x-rays per Beneficiary per annum	
X-rays: Extra-oral	Limited to 1 per Beneficiary in a 3-year period	
Oral Hygiene	Limited to 2 scale and polish treatments per Beneficiary per annum Benefit for fissure sealants limited to beneficiaries younger than 16 years of age Benefit for fluoride limited to beneficiaries from age 5 and younger than 13 years of age	
Fillings	Limited to once per tooth in 720 days.	
Root Canal Therapy and Extractions	Subject to Managed Care Protocols	
Plastic Dentures and associated Laboratory costs	Limited to 1 set of plastic dentures (an upper and lower) per Beneficiary in a 4-year period.	5%

B6.2 Specialised Dentistry

Treatment	Benefit	Co-Payment

Partial Metal Frame Dentures and associated Laboratory costs	Limited to 2 partial metal frames (an upper and lower) per Beneficiary in a 5-year period. Pre-authorisation is required	10%
Crown and Bridge and associated Laboratory costs	Limited to 3 crowns per Member Family per year and one per tooth in a 5-year period A treatment plan and X-rays may be requested. The benefit is subject to managed care protocols. Covered at 90% of the SDBR. A pontic on a second molar where the third molar is a crown retainer, is subject to managed care protocols.	10%
Implants	No Benefit	
Orthodontics	Limited to 2 family Members per year and individuals from age 9 and younger than 18 years of age Pre-authorisation required	10%
Periodontics and associated Laboratory costs	Pre-authorisation is required. Subject to Managed Care Protocols and limited to conservative, non-surgical therapy only. Benefit will only be applied to members registered on the Periodontal Programme. Pre-authorisation required	10%
Maxillo-Facial Surgery in the dental chair	Subject to Managed Care Protocols	10%
Temporo-mandibular Joint (TMJ) therapy	Limited to non-surgical interventions/ treatments. Pre-authorisation required	10%
Oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours)	Treatment costs will only be covered if supported by a laboratory report that confirms diagnosis. Pre-authorisation required.	10%

B6.3 Anaesthetic

Treatment	**Benefit**	**Co-Payment**
Hospitalisation (general anaesthetic)	Limited to beneficiaries up to age 12.	
Laughing gas in dental rooms	Subject to Managed Care protocols	
IV conscious sedation in rooms	Subject to Managed Care protocols	

	Pre-authorisation required Benefit limited to extensive dental treatment	

B7. Hospitalisation

In Hospital (in-patient care) including private and public hospitals, registered unattached operating theatres, day clinics and sub-acute facilities – pre-authorisation required

This paragraph expressly excludes the benefit for hospitalisation arising out of Maternity (see paragraph B10.1), Mental Illness (see paragraph B12.1), and Refractive Surgery (see paragraph B14.2).

In the event of a PMB condition, or a protracted, or intensive or specialised treatment in a private hospital, if the sub-limit for alternatives to hospitalisation and rehabilitation as stipulated in paragraph B7.3 is unlikely to cover the full costs of treatment in the private sector, the Hospital and Major Benefit Management Programme may transfer the Beneficiary to a public hospital or other preferred provider where appropriate care is available. In this event no hospital benefit limit shall apply; or

The Member may elect to remain in the private hospital, in which event the Member shall be responsible for payment of an amount estimated to be equal to the difference in cost between the public hospital or preferred provider facility and the private hospital. Such estimate shall be determined by the Scheme in its sole discretion. If a Beneficiary is transferred to a public hospital or preferred provider facility, such Beneficiary shall only be entitled to the services that are normally available at that public hospital or facility.

In a case of non-PMB conditions the Scheme shall pay up to the benefit limit for alternatives to hospitalisation and rehabilitation as stipulated in paragraph B7.3. Any costs incurred over and above the stipulated benefit shall be the Member's responsibility irrespective of where the treatment was procured.

Subject to the Hospital and Major Benefit Management Programme:

B7.1.1 100% of the lower of the cost or Alliance-Midmed rate for accommodation in a general ward, high care ward and intensive care unit.

B7.1.2 100% of the lower of the cost or Alliance-Midmed rate for theatre fees.

B7.1.3 100% of the lower of the cost or Alliance-Midmed rate for materials, use of hospital equipment and the transport of blood.

B7.1.4 100% of the lower of the cost or Alliance-Midmed rate for injection material, disposable instruments or devices and disposable endoscopic instruments in accordance with the fee structure negotiated by the hospital and the Scheme.

B7.1.5 In respect of medicines legally prescribed: 100% of MRP
Medicines given to a patient to take home shall be limited to a maximum of seven days.

B7.2 Out-patient care

B7.2.1 100% of the lower of the cost or Alliance-Midmed rate for out-patient services and materials, subject to a co-payment of R50 per out-patient visit. No co-payment will apply should the patient be subsequently hospitalised or if the treating doctor classifies that outpatient visit as a medical emergency.

B7.2.2 In respect of legally prescribed medicines and injection materials: 100% of MRP.

B7.3 Alternatives to hospitalisation (subject to benefit limits)
Subject to the Hospital and Major Benefit Management Programme:
Benefit limited to R62 978 per Member family per annum.

B7.3.1 The Scheme will, at its sole discretion and as deemed appropriate, pay up to 100% of the lower of the cost or Alliance-Midmed rate for all services rendered by sub-acute nursing facilities, frail care facilities, step-down nursing facilities, private nursing, rehabilitation centres, hospice, and home support centres, up to a maximum of 6 (six) months in any calendar year, subject to appropriate Managed Care Protocols.
Pre-authorisation required.

B7.4 Rehabilitation

Subject to the Hospital and Major Benefit Management Programme and authorised treatment plans:

100% of the lower of the cost or Alliance-Midmed rate for all services rendered by registered rehabilitation hospitals, sub-acute facilities, and centres if there is evidence of a prognosis for recovery and the patient can be rehabilitated.

B8. Immune deficiency related to HIV infection and AIDS

Subject to the HIV Management Programme, the Pharmaceutical Management Programme and the Chronic Disease Management Programme.

B8.1 Anti-retroviral medicines – Subject to Generic Reference Pricing

100% of the lower of the cost or Alliance-Midmed rate.

B8.2 Related medicines - Subject to Generic Reference Pricing.

100% of the lower of the cost or Alliance-Midmed rate.

B8.3 All other HIV/AIDS related services

Benefits for all other services shall be paid in full at the PSP.

B9. Infertility

Payable at the Public Sector rate and subject to PMB and the Hospital and Major Benefit Management Programme:

PMB benefits are payable at PMB rates. No benefit for the following:

- Assisted Reproduction Technology (ART) including In-Vitro Fertilisation(IVF)
- Gamete Intrafallopian Tube Transfer
- Zygote Intrafallopian (Zift)
- Intractoplasmic Sperm Injections (ICSI)

B10. Maternity

B10.1 In Hospital – Pre-authorisation required

Subject to the Hospital and Major Benefit Management Programme, Maternity Management Programme and the HIV Management Programme:

B10.1.1 100% of the lower of the cost or Alliance-Midmed rate for accommodation, theatre fees, labour ward fees, dressings, materials and equipment.

B10.1.2 In respect of legally prescribed medicines: 100% of MRP:

Medicines given to a patient to take home shall be limited to a maximum of seven days' supply.

B10.1.3 **200%** of the lower of the cost or Alliance-Midmed rate for consultations and the delivery by a General Practitioner or Medical Specialist or Midwife.

B10.2 **Out of Hospital (Subject to registration on the Maternity Management Programme. Pre-authorisation required)**

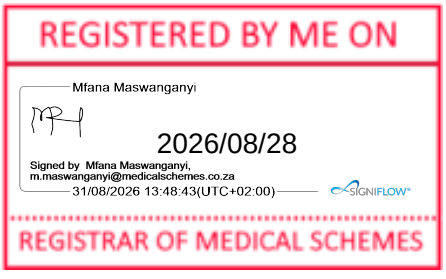
B10.2.1 100% of the lower of the cost or Alliance-Midmed rate for pregnancy related tests and pregnancy scans (a maximum of three (3) 2D pregnancy scans per normal pregnancy).

B10.2.1 100% of the lower of the cost or Alliance-Midmed rate plus the negotiated professional charge for registered medicines, dressings and materials supplied by a Midwife.

B10.2.3 150% of the lower of the cost or Alliance-Midmed rate for consultations and visits by a General Practitioner, Medical Specialist or Midwife.

The following consultation benefit limits apply:

- One consultation per month in the first 6 months.
- Two consultations per month in months 7 and 8.
- One consultation per week in month 9.



B10.2.4 100% of the lower of the cost or Alliance-Midmed rate for post-natal care by a Midwife.

B10.2.5 100% of the lower of the cost or Alliance-Midmed rate for services at a registered birthing unit.

B11. Medicines and injection material (Subject to MRP and Scheme Negotiated Dispensing Fee. Formularies and Generic Reference Pricing may apply.)

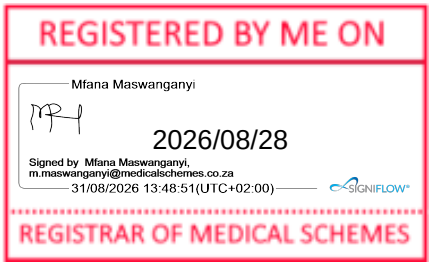
This paragraph expressly excludes medicines in respect of alternative health care services, (see paragraph B22.2), in-hospital medicines (see paragraph B7.1.5), anti-retroviral drugs (see paragraph B8.1) organ transplants (see paragraph B15) and oncology (see paragraph B16).

B11.1 Acute medication (Subject to PMBs and limits defined per family size) Subject to pharmaceutical benefit management programme.

In respect of legally prescribed medication: 100% of MRP.

The following defined benefit limits per family size per annum applies:

M0 – R7 355
M1 – R13 432
M2 – R15 605
M3 – R18 082
M4 – R20 385
M5 – R21 226
M6 – R23 541



This paragraph excludes prescriptions supplied for use in a hospital but includes, without a pre-payment to the supplier, a maximum of seven days' supply for in-patients on discharge from hospital.

B11.2 Pharmacy Advised Therapy

In respect of Schedules 1 and 2 medicines advised and dispensed by a pharmacist: 100% of MRP

Benefit limited to R2 618 per Member Family per annum.

Limited to **R218** per purchase and to 12 purchases per Member Family per annum.

B11.3 Extended/Chronic medication (Subject to PMBs and limits per family size)

Subject to the Pharmaceutical Benefit Management Programme and Chronic Disease Management Programme which may also include treatment plans for PMB conditions including 270 Diagnostic treatment pairs (DTP's).

In respect of legally prescribed extended medication: 100% of MRP

The following defined benefit limits per family size per annum applies:
M0 – R27 318
M+ - R57 141

B12. Mental Health (Subject to Scheme Mental Health Programme)

Subject to PMB, the Hospital and Major Benefit Management Programme and Mental Wellness Programme and to a maximum of three days' Hospitalisation allowed for patients admitted by a General Practitioner or Specialist per annum, thereafter a treatment plan with a confirmed diagnosis from a Psychiatrist and authorisation from the Hospital and Major Benefit Management Programme will be required:

B12.1 In Hospital (Pre-authorisation required. Sub-limits apply for non-preferred service providers).

Benefit limited to R65 582 per Member Family per annum at a non-Preferred Service Provider facility.
100% of Alliance-Midmed rate for PMB related services at a Preferred Service Provider facility.

B12.1.1 100% of the lower of the cost or Alliance-Midmed rate for accommodation in a general ward within a specialised psychiatric unit with the appropriate qualified staff and staff to patient ratio.

B12.1.2 100% of the lower of the cost or Alliance-Midmed rate for Electro-Convulsive treatment fees, limited to 12 treatments per annum.

B12.1.3 100% of the lower of the cost or Alliance-Midmed rate for materials and hospital equipment.

B12.1.4 100% of the lower of the cost or Alliance-Midmed rate for consultations and visits by General Practitioners.

B12.1.5 150% of the lower of the cost or Alliance-Midmed rate for consultations and visits by Medical Specialists.

B12.1.6 100% of the lower of the cost or Alliance-Midmed rate for procedures prescribed by General Practitioners, and Psychiatrists

B12.2 **Out of Hospital (Subject to a confirmed diagnosis by a suitably qualified Psychiatric Specialist and available benefit limits noted in B12.1)**

B12.2.1 100% of the lower of the cost or Alliance-Midmed rate for consultations and visits by General Practitioners, Clinical Psychologists and Social Workers.

B12.2.2 150% of the lower of the cost or Alliance-Midmed rate for consultations and visits by Medical Specialists.

B12.2.3 100% of the lower of the cost or Alliance-Midmed rate for procedures by General Practitioners, Psychiatrists or at the supplier's rooms or in any facility or at any place other than a registered hospital or day clinic with theatre facilities included.

B13. **Non-surgical procedures and tests**

This paragraph expressly excludes psychiatry and psychology (see paragraph B13.2) and optometric examinations by registered optometrists (see paragraph D14).

B13.1 **In Hospital**

Subject to PMB and the Hospital and Major Benefit Management Programme:

B13.1.1 100% of the lower of the cost or Alliance-Midmed rate for all non-surgical procedures performed by a General Practitioner

B13.1.2 150% of the lower of the cost or Alliance-Midmed rate for all non-surgical procedures performed by a Medical Specialist.

B13.2 Out of Hospital (including treatment in practitioners' rooms) (Subject to limits per family size) (Pre-authorisation required)

The following defined benefit limits per family size per annum applies:
M0 – R7 091
M+ - R11 015

B13.2.1 100% of the lower of the cost or Alliance-Midmed rate for all non-surgical procedures performed by a General Practitioner.

B13.2.2 150% of the lower of the cost or Alliance-Midmed rate for all non-surgical procedures performed by a Medical Specialist.

B14. Optometry

Each Beneficiary is entitled to either Spectacles in a 24-month benefit cycle or Contact Lenses in a 12-month benefit cycle. Benefits are subject to Optical Managed Care protocols and Managed Care Interventions.

B14.1 Optometric examinations, Frames and Lenses

B14.1.1

	Scheme Benefit (Paid from Risk)	Additional Optical Savings Benefit (Paid from Positive Savings Only)
Consultation	100% of the cost for a Composite Consultation to a maximum of R762 of the refraction, a glaucoma screening, visual fields screening and biometrics eye evaluation.	Nil
Frames	A frame to the maximum value of	A frame to the maximum value of

	R2 529.		R3 892.	
Lenses	One pair of either	Single vision lenses to the value of R639 per pair.	One pair of either	Single Vision Lenses to the maximum value of R836 per pair.
		Bifocal lenses to the value of R1 940 per pair.		Bifocal lenses to the maximum value of R2 337 per pair.
		Multifocal lenses to the value of R2 494 per pair.		Multifocal lenses to the maximum value of R3 016 per pair.
Lens Enhancements	Lens enhancements to the value of R1 109		Lens enhancements to the value of R666	
OR				
Contact lenses (Annual Benefit)	A benefit to the value of R2 663.		A benefit to the value of R2 501.	

B14.1.2 The Optical Savings Benefit amounts may be accessed if the member has positive savings and to protect the benefit structure integrity, payments from positive savings will be limited to the amounts in the Additional Optical Savings Benefit Table. Optical claims from the Additional Optical Savings Benefit will be refunded to the member, based on a detailed account, containing all the costs of the transaction.

B14.2 Refractive surgery (Laser Keratotomy/Excimer Laser)

Subject to clinical criteria and the approval of the Medical Advisor: 150% of the lower of cost or Alliance-Midmed rate for services by Medical Specialists in respect of Members with a refractive error >4.5. If above criteria are not met, then benefit is subject to PMSA.

B14.2.1 100% of the lower of cost or Alliance-Midmed rate for hospitalisation.

B15. Organ transplants (Pre-authorisation required

Subject to PMBs and the prior approval by the Hospital and Major Benefit Management Programme:

B15.1 100% of the lower of the cost or Alliance-Midmed rate for the harvesting of the organ and transplantation thereof. Unless services at a PSP, a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the PSP been used.

B15.2 100% of the lower of the cost or Alliance-Midmed rate, plus the negotiated professional charge for post-operative anti-rejection medicines.

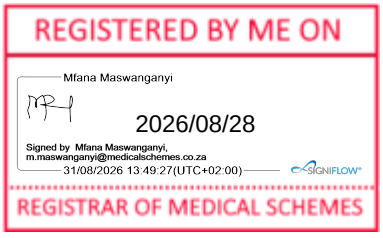
B16. Oncology – Subject to ONCOLOGY MANAGEMENT PROGRAMMES and Protocols; and an overall limit of **R662 786** per Beneficiary unless PMB Criteria are met

Subject to PMBs and the Hospital and Major Benefit Management Programme and the Pharmaceutical Benefit Management Programme:

B16.1 100% of the lower of the cost or Alliance-Midmed rate for consultations, visits and for treatment and materials used in Radiotherapy and Chemotherapy, during treatment and for proven oncology-related tests following active treatment to include the required pathology tests, in the discretion of the Medical Advisor.

B16.2 100% of MRP in respect of registered medicines used in Radiotherapy and Chemotherapy.

B16.3 100% of the lower of the cost or Alliance-Midmed rate for stem cell harvesting and transplantation including Chemotherapy, limited to Allogeneic and Autologous grafts derived from the South African Bone Marrow Registry



B17. **Pathology and Medical Technology**

B17.1 **In Hospital**

100% of the lower of the cost or Alliance-Midmed rate for all tests performed by a Pathologist or Medical Technologist.

B17.2 **Out of Hospital (Subject to limits per family size)**

100% of the lower of the cost or Alliance-Midmed rate for all tests performed by a Pathologist or Medical Technologist. Pathology tests will only be paid where the provider is duly accredited in terms of ISO15189, and a Pathologist signed off the test results. A 5% co-payment to the maximum of R64 applies if a non-preferred provider laboratory is used.

The following defined benefit limits per family size per annum applies:

M0 – R7 513

M+ - R11 670

B18. Physical therapy

B18.1 In Hospital (subject to pre-authorisation and managed care protocols).

100% of the lower of the cost or Alliance-Midmed rate for Physiotherapy and Biokinetics.

Benefit limited to R9 244 per Member family per annum.
No limit applies for treatment in intensive care.

B18.2 Out of Hospital

100% of the lower of the cost or Alliance-Midmed rate for Physiotherapy and Biokinetics.

Benefit limited to R5 373 per Member family per annum, subject to available positive member savings.

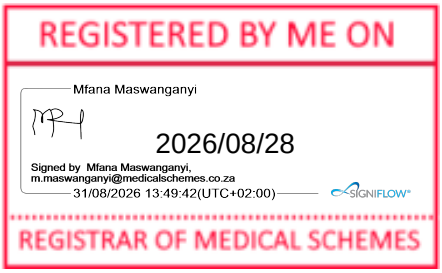
B19. Prosthesis (Pre-authorisation required) (Subject to sub-limits)

B19.1 Internal Prostheses (Subject to the Hospital and Major Benefit Management Programme and the following sub-limits): -

B19.1.1 Cardiac / Vascular Prostheses and Appliances

100% of the lower of the cost or Alliance-Midmed rate per Member Family per annum sub-limit, to include: -

- Stents (Cardiac, Peripheral and Aortic)
- Valves
- Pacemakers
- Implantable defibrillators



Benefit limited to R72 941 per Member family per annum.

B19.1.2 Joint Prostheses

Subject to failed conservative treatment and the Joint Replacement Protocol

100% of the lower of the cost or Alliance-Midmed rate, subject to a Member Family per annum sub-limit and a co-payment per joint, on joint replacements (hips, knees, shoulders, and elbows).

Benefit limited to **R62 001** per Family Member per annum. A **R5 876** co-payment per joint applies, if non-preferred is provider used.

Managed Care Protocols apply.

B19.1.3 Orthopaedic Prostheses and Appliances (Subject to failed conservative treatment, Risk Management and Managed Care Protocols)

100% of the lower of the cost or Alliance-Midmed rate, to include

- Spinal fixation devices (maximum 2 levels unless motivated)
- Fixation devices – non-spinal
- Implantable devices, disc prosthesis, Kyphoplasty
- Bone lengthening devices

Benefit limited to R72 941 per Member family per annum.

B19.1.4 Neuro Stimulators and Deep Brain Stimulators (Subject to per Member Family per annum sub-limit)

100% of the lower of the cost or Alliance-Midmed rate.

Benefit limited to R43 765 per Member family per annum.

B19.1.5 Internal Sphincters and Stimulators (Subject to per Member Family per annum sub-limit)

100% of the lower of the cost or Alliance-Midmed rate.

Benefit limited to R70 024 per Member family per annum.

B19.1.6 Intraocular lenses (Subject to per Member Family per annum sub-limit)

100% of the lower of the cost or Alliance-Midmed rate

Benefit limited to R4 842 per lens per Member family per annum.

B19.2 External Prostheses (not surgically implanted) (Subject to per Member Family per annum sub-limit)

100% of the lower of the cost or Alliance-Midmed rate.

Benefits limited to R56 176 per Member family per annum.

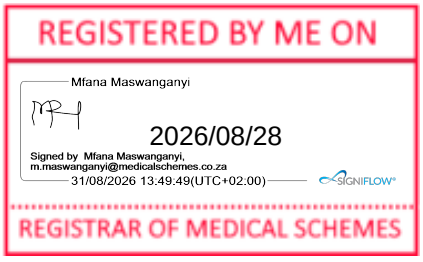
B20. Renal dialysis (acute and chronic)

Subject to PMBs and the Hospital and Major Benefit Management Programme:

100% of the lower of the cost or Alliance-Midmed rate for consultations, visits and all services and materials associated with the cost of Renal Dialysis.

B21. Radiology and radiography

B21.1 General radiology



B21.1.1 In Hospital (Subject to limits per family size)

100% of the lower of the cost or Alliance-Midmed rate for diagnostic radiology tests and scans.

The following defined benefit limits per family size per annum applies:

MO – R1 996

M1 – R3 118

M2 – R4 644

M3 – R5 841

B21.1.2 Out of Hospital (Subject to limits per family size)

100% of the lower of the cost or Alliance-Midmed rate for diagnostic radiology tests and scans.

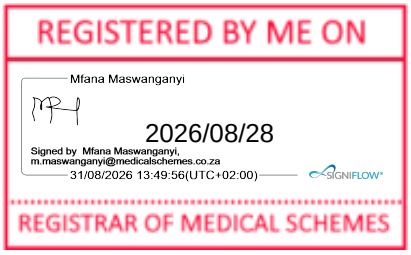
The following defined benefit limits per family size per annum applies:

MO – R1 996

M1 – R3 118

M2 – R4 644

M3 – R5 841



B21.2 Specialised radiology

B21.2.1 In Hospital (Subject to limits per family size)

Subject to the Hospital and Major Benefit Management Programme:

100% of the lower of the cost or Alliance-Midmed rate.

Benefit limited to R15 587 per Member family per annum.

B21.2.1.1 Subject to pre-authorisation for the following:

100% of the lower of the cost or Alliance-Midmed rate for:

- Coronary and Cerebral Angiography
- MRI scans (excluding MRI scans ordered by a General Practitioner)
- Nuclear imaging and Radio Isotope scans
- Neurological Interventional Radiological procedures
- MUGA scans
- Stealth station.

B21.2.1.2 All other specialised radiology

Subject to the Hospital and Major Benefit Management Programme

100% of the lower of cost or Alliance-Midmed rate with the following provisos:

- contrast and non-contrast brain scans will only be paid if ordered by a Specialist. However, in case of emergencies, that is, head injuries and strokes, only non-contrast scans will be paid for if ordered by a General Practitioner; (Emergency Room).
- sinus scans will only be paid if ordered by a Specialist

B21.2.2 Out of Hospital (Subject to limits per family size)

100% of the lower of the cost or Alliance-Midmed rate with the following provisos:

Benefit limited to R15 587 per Member Family per annum.

B21.2.2.1 Bone Densitometry scans when performed by a Specialist, and if preauthorised by the Hospital and Major Benefit Management Programme, except where the Bone Densitometry forms part of the Life Stages Benefit;

B21.2.2.2 Full sinus scans will only be paid if ordered by a Specialist; however, limited sinus scans will be paid for if ordered by a General Practitioner;

B21.2.2.3 Full body scans (MRI and CT) will be paid for if pre-authorised and subject to the Hospital and Major Benefit Management Programme.

B21.2.3 **Colonoscopy (In-hospital and out of hospital) (Subject to per beneficiary, per annum sub-limit)**

100% of the lower of the cost or Alliance-Midmed rate

Benefit limited to R7 040 per beneficiary per annum.

B21.2.4 **Gastroscopy (In-hospital and out of hospital) (Subject to per beneficiary, per annum sub-limit)**

100% of the lower of the cost or Alliance-Midmed rate

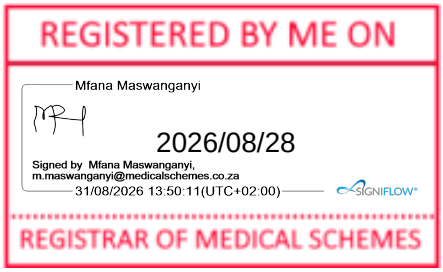
Benefit limited to R3 707 per beneficiary per annum.

B22. **Remedial & Other Therapies and Alternative Healthcare Practitioners**

B22.1 **General services (Subject to per family sub-limits)**

100% of the lower of the cost or Alliance-Midmed rate for services in respect of:

- Audiology
- Dietetics
- Hearing aid acoustics
- Occupational therapy
- Podiatry
- Speech therapy
- Social Workers (See Clause B12.2.1)



Provided that a treatment plan is approved where on-going treatment is required.

In-Hospital services subject to pre-authorisation.

In-Hospital benefits limited to R6 474 per Member family per annum

Out-of-Hospital benefits limited to R6 203 per Member family per annum

B22.2 Homeopathy, Naturopaths, Osteopaths, Chiropractics and Orthoptics (no in Hospital benefit – Subject to available funds in the Personal Medical Savings Account (PMSA) only)

B22.2.1 Consultations

100% of the lower of the cost or Alliance-Midmed rate subject to a co-payment of R10 per consult.

B22.2.2 Medicines

100% of MRP for registered homeopathic medicines prescribed by a registered homeopath.

B22.3 Autism Benefit - Subject to specified Managed Care Protocol.

B22.4 Attention Deficit Hyperactivity Disorder (ADHD) - Subject to specified Managed Care Protocol

B22.5 Nursing services: private nurse practitioners, agencies and home health care services

Subject to PMBs and the Hospital and Major Benefit Management Programme:

100% of the lower of the cost or Alliance-Midmed rate for consultations, assessments, procedures, nursing, excluding midwifery.

B22.6 100% of the lower of the cost or Alliance-Midmed rate for out-of-hospital wound care services, subject to a per Member Family per annum sub-limit.

Benefit limited to R15 350 per Member family per annum.

B23. Surgical procedures (Pre-authorisation required)

This paragraph expressly excludes services provided in respect of maternity (see paragraph B10) and organ transplants (see paragraph B15).

Subject to the Hospital and Major Benefit Management Programme:

B23.1 100% of the lower of the cost or Alliance-Midmed rate for surgical procedures performed by a General Practitioner.

B23.2 150% of the lower of the cost or Alliance-Midmed rate for surgical procedures performed by a Medical Specialist.

B24. Compulsory Childhood Immunisations (Subject to the Life Stages/Preventative Health Benefits)

Subject to PMBs and the benefits in the Life Stages Benefit category (LSB Category). The Scheme will pay 100% of the lower of the cost or Alliance-Midmed rate for immunisation at the MRP. Administered according to the Department of Health recommended immunisation programme for the first 12 years of life.

B24.1 Vaccines and Diagnostic Tests (Subject to the Life Stages/Preventative Health Benefits and Scheme Protocols)

Subject to benefit in the Life Stages Benefit category (LSB Category). The Scheme will pay 100% of the lower of the cost or Alliance-Midmed rate for such vaccines limited to the following vaccines, at the MRP: -

B24.1.1 Flu vaccine for all beneficiaries, once a year.

B24.1.2 Pneumococcal Vaccination, limited to Members 50 years and older.

Managed Care Protocols, Scheme criteria and risk assessment apply.

B24.1.3 Cervical Cancer vaccines, Cervarix and Gardasil, limited to females between the ages of 9 and 25 years, once per lifetime.

B24.1.4 Male and Female HPV vaccines, limited to beneficiaries between the ages of 9 and 14 years, limited to 3 vaccines per lifetime.

B24.2 Subject to benefit in the Life Stages Benefit category. (LSB Category). The Scheme will pay 100% of the lower of the cost or Alliance-Midmed rate for such tests limited to the following tests and subject to PMB

B24.2.1 Cholesterol test –Beneficiaries 25 years and older, once a year

B24.2.2 Prostate Antigen –Males 40 years and older, once a year.

B24.2.3 Blood sugar test – All beneficiaries, once a year
(Tariff Code 4050); Excluded: HbA1C

B24.2.4 Pap Smear –

i. 21 to 65 years – every three-years. Funded from Life Stages Benefit. Out of cycle tests funded from pathology benefit.
ii. 65+ years – every three years. Funded from pathology benefit.

HPV and Cytology pap smear:

i. Co-testing – 30+ years – every three years funded from Life Stages Benefit.
ii. Clinically motivated co-testing prior to age 30 – funded subject to Medical Advisor approval.

B24.2.5 Mammogram – Females 40 years and older, once a year (Earlier sonar surveillance by authorisation for high risk members).

B24.2.6 Bone Densitometry – Females 65 years and older; Males 70 years and older; once every three years

Managed Care Protocols, Scheme criteria and risk assessment apply.

B24.2.7 Infant Hearing Screening – New-born to 8 weeks, once only.

B24.2.8 Colorectal cancer screen (faecal occult blood test) - Beneficiaries 50 years and older, once per year.

B25. Trauma Benefit

When a beneficiary has been exposed to a traumatic event such as vehicle accidents, attacks, hijacking, child abuse, armed robbery, family violence and animal attacks, the Scheme will pay R3 215 per beneficiary per annum, without the need for pre-authorisation, for trauma services provided by a registered trauma counsellor. The medical treatment will be managed under the emergency and other benefit rules.

The benefit covers assistance, 24 hour 7 days a week, at the time of an event or incident, the evacuation of the injured and traumatized, and limited after care. It typically relates to vehicle accidents, assaults and attacks, hijacking, child abuse, house breaking, armed robbery, theft, family violence and animal attacks.