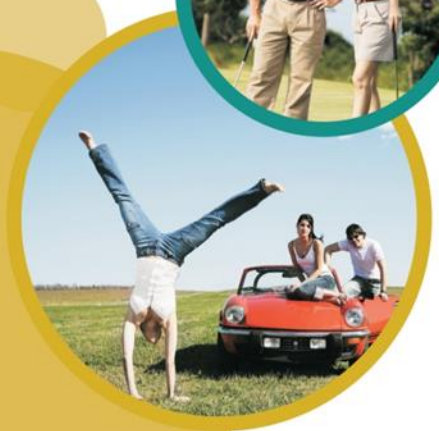
CAPE MEDICAL PLAN
We Care

HealthPact Premium 2023



Schedule 1

Cape Medical Plan Benefit Option

Benefits effective 1 January 2023

Health Pact Premium

The following are the benefits payable from **1 January 2023** subject to the general rules of Cape Medical Plan.

SECTION A: CLAIMS

1. Referral of Accounts

The Member hereby authorises Cape Medical Plan to scrutinise any medical account submitted to Cape Medical Plan on behalf of the member for payment for evidence of any breach of the rules of Health Professions Council of South Africa and, where such breach is found, if it is in the overall interests of the collective membership of Cape Medical Plan, for the account to be referred to the Health Professions Council of South Africa as a complaint against the provider of service concerned for a decision and determination of the validity of the complaint. Such accounts will be referred back to the supplier of service and the affected member for correction as per Section 59(2) and (3) and Regulation 6 of the Medical Schemes Act.

If the scheme and the supplier cannot agree on the account it will be referred to HPCSA and their decision will be accepted by the scheme and the account will be processed for payment as per Section 59 and Regulation 6.

2. Agreement with Service Providers

If a Member agrees to any fee with a medical service provider that is in excess of the Cape Medical Plan tariff, the Member shall be responsible for such excess, unless it is a Prescribed Minimum Benefit service involuntarily obtained.

SECTION B: MATTERS RELATING TO BENEFITS GENERALLY

3. Prescribed Minimum Benefits

All Prescribed Minimum Benefit services will be unlimited and paid in accordance with the Prescribed Minimum Benefit Regulations if services are obtained from a DSP or involuntarily obtained from a non-DSP, subject to rule 17.9 and 17.10.

3.1 As per the Prescribed Minimum Benefit Code of Conduct – Part V – the process followed by Cape Medical Plan will be as follows:

3.1.1 Cape Medical Plan will capture all submitted ICD10 diagnostic codes which must be recorded on the claim in order to assess and verify the status of a claim in terms of Prescribed Minimum Benefits.

3.1.2 Should the code submitted be insufficient to clearly show the claim is genuinely that of a Prescribed

Minimum Benefit additional information including but not limited to the following will be requested.

a) The setting (eg. Hospital or not)
b) The nature and severity of the condition or injury
c) The procedure or treatment required
d) The drugs used
e) Co-morbidities
f) The age and gender of the patient
g) Pathology or radiology results
h) Response to previous therapy
i) The hospital discharge summary (when applicable)

Before further assessment will take place.

3.2 Where diagnostics, treatment, medication or any necessary internal prosthetic devices is required as a Prescribed Minimum Benefit, the level of treatment described in the published Cape Medical Plan protocols (which comply with regulation 15 and all relevant Prescribed Minimum Benefit legislation) and formularies shall apply. In the absence of any published Cape Medical Plan protocol or formulary, the Cape Medical Plan medical advisory committee shall determine diagnostics, treatment, medication or any necessary internal prosthetic devices that comply with published and accredited clinical protocols and do not extend beyond what is necessary to result in generally accepted treatment levels.

3.3 Any medical treatment that extends beyond the levels of treatment described in the published Cape Medical Plan protocols and formularies subject to the provisions of Prescribed Minimum Benefit regulations, as determined by the Cape Medical Plan medical advisory committee ("the prescribed levels"), shall be paid in accordance with the prescribed levels and may result in a co-payment, and will be managed in accordance with Regulation 15 H and 15 I and all relevant Prescribed Minimum Benefit legislation.

3.4 The Member authorises Cape Medical Plan to obtain all clinical notes, treatment plans, investigation results, diagnostic results and other information Cape Medical Plan reasonably considers necessary to support the conclusion, identification and treatment interventions of any diagnosis of a Prescribed Minimum Benefit condition from the practitioner making the diagnosis for the purposes as set out in 3.3 above, before authorisation. Refusal or failure to submit the required information will result in a delay in authorisation.

3.5 In the event of medical emergencies, the Member authorises Cape Medical Plan to obtain all clinical notes, treatment plans, investigation results, diagnostic results and other information Cape Medical Plan reasonably considers necessary to assess the reasonableness of treatment in terms of 3.1 to 3.4 above. Refusal or failure to submit the required information may result in a referral of the account to the Health Professions Council of South Africa.

4. Pre-Authorisation or Pre-approved

4.1 With the exception of medical emergencies, all of the procedures which are marked in these rules with the abbreviation **["Pre-Auth"]** must be fully pre-authorised before the procedure is performed.

4.2 In the event of a medical emergency, full pre-authorisation must be given for any ongoing admission, treatment or other hospital based interventions once the patient has been brought to the point of being clinically stabilised. No payment from Cape Medical Plan funds will be made without such pre-authorisation being given except for Prescribed Minimum Benefits.

4.3 Any medical treatment that extends beyond the levels of treatment described in the published Cape Medical Plan protocols and formularies as determined by the Cape Medical Plan medical advisory committee ("the prescribed levels") shall be paid in accordance with the prescribed levels and may result in a co-payment and will be managed in accordance with Prescribed Minimum Benefit regulations.

4.4 The Member authorises Cape Medical Plan to obtain all clinical notes, treatment plans, investigation results, diagnostic results and other information Cape Medical Plan reasonably considers necessary to support the conclusion, identification and treatment interventions of any diagnosis of a Prescribed Minimum Benefit condition from the practitioner making the diagnosis for the purposes as set out in 4.3 above, before authorisation. Refusal or failure to submit the required information will result in a delay in authorisation.

SECTION C: SPECIFIC BENEFITS

5. Hospital Cover

THE FOLLOWING SPECIFIC BENEFITS ARE AVAILABLE IN HOSPITAL

5.1 **Ward fees, Intensive Care Unit, Specialised Intensive Care Units, High Care, operating theatres, unattached operating theatres and Day Hospitals**

["Pre-Auth"] 100% of cost to a maximum of 100% of the CMP tariff, or the agreed preferred provider tariff, whichever is applicable, for accommodation in a General Ward. If fees are in excess of the Cape Medical Plan tariff, but are for services obtained at a designated service provider for Prescribed Minimum Benefits payment will be made from insured benefits and will be managed in accordance with the Prescribed Minimum Benefit regulations.
Unattached operating theatres and clinics may be nominated for the performance of procedures that do not necessitate hospitalisation.

5.2 **Prescribed Medicines and Materials in Hospital ["Pre-Auth"]**

5.2.1 Cape Medical Plan will pay up to the published Single Exit Price, or the agreed preferred provider tariff or the pre-authorised price or tariff, whichever is applicable, for approved materials used while hospitalised. If fees are in excess of the Cape Medical Plan tariff, but are for services obtained at a designated service provider for Prescribed

Minimum Benefits payment will be made from insured benefits and will be managed in accordance with the Prescribed Minimum Benefit regulations.

5.2.2 With respect to devices, quotations from the manufacturer or admitting hospital shall be required at pre-authorisation. Where Cape Medical Plan can demonstrate the existence of a similar more cost-effective device, the member will be liable for the difference in cost.

5.2.3 Cape Medical Plan will pay up to a maximum of the Single Exit Price for approved medicines prescribed, dispensed and used while hospitalised.

5.3 **Out-patient Services – Casualty rooms and ER**

Does not fall under the category of hospital cover and is accordingly payable only in accordance with the category listed in paragraph 7.1 below.

5.4 **Hospitalisation / Institutionalisation for approved treatment of mental illness, alcoholism and drug addiction**

5.4.1 **["Pre-Auth"]** Limited to Prescribed Minimum Benefits only;

5.4.2 With respect to substance and alcohol abuse, Cape Medical Plan shall pay up to the agreed tariff at the designated service provider and if a non-

designated provider is voluntarily used, this may result in a co-payment by the member, as per rule 18.9.

6. Maternity and Confinement

THE FOLLOWING BENEFITS ARE AVAILABLE FOR MATERNITY AND CONFINEMENT

6.1 Maternity up to Hospitalisation or Birth

Cape Medical Plan must be notified as soon as pregnancy has been diagnosed, where after Cape Medical Plan shall pay 100% of cost to a maximum of 200% of CMP tariff for ante-natal consultations (including the consultation where pregnancy is diagnosed) and foetal scans, limited to R2 669 per member family per financial year.

6.2 Confinement (Birth or Delivery) ["Pre-Auth"]

6.2.1 100% of cost to a maximum of 200% of the CMP tariff; unless Prescribed Minimum Benefit code 52N is properly applicable to the case in which instance the benefit will be paid at cost.

6.2.2 Caesarean sections will be covered only if medically necessary; otherwise payment for a vaginal delivery will be made provided Prescribed Minimum Benefit code 52N applies to the case.

6.2.3 In order to reduce complications at the birth Cape Medical Plan will apply managed health care

interventions from 8 weeks until the birth. Cape Medical Plan will request relevant reports from treating doctors.

7. Practitioners

THE FOLLOWING BENEFITS ARE AVAILABLE FOR SERVICES PROVIDED BY MEDICAL PRACTITIONERS FOR NON PRESCRIBED MINIMUM BENEFIT HEALTHCARE.

7.1 **HPCSA Registered General Medical Practitioners** *(GP or Family doctor)*

7.1.1 **["Pre-Auth"]** Consultations and operations necessitating hospitalisation will be paid at 100% of cost to a maximum of 200% of the CMP tariff subject to authorisation and approval.

7.1.2 Consultations, procedures and operations out of hospital – 100% of cost to a maximum of 100% of CMP tariff provided that consultations shall be limited to one per beneficiary per financial year. Any necessary consultations for Prescribed Minimum Benefit conditions are available in addition to this limit. Benefit option rule 3 will be applied to all such claims.

7.2 **HPCSA Registered Medical Specialists and practicing as:**

Anaesthetists
Dermatologists

Gynaecologists
Paediatric Cardiologists
Paediatric Surgeons
Cardio Thoracic Surgeons
General Surgeons
Neurologists
Neurosurgeons
Otorhinolaryngologists (Ear, Nose & Throat)
Urologists
Clinical Haemotologists
Gastroenterologists
Nuclear Medicine Practitioners
Ophthalmologists
Orthopaedic Surgeons
Physicians
Plastic & Reconstructive Surgeons
Pulmonologists

Any beneficiary consulting a specialist needs to furnish Cape Medical Plan with a clinically appropriate medical report from their referring general practitioner.

7.2.1 **["Pre-Auth"]** Consultations and operations necessitating hospitalisation 100% of cost to a maximum of 200% of the CMP tariff;

7.2.2 Consultations and treatment out of hospital are only for Prescribed Minimum Benefits in which case benefit option rule 3 applies.

7.3 Paediatricians

7.3.1 Consultations, treatment and procedures other than as per 7.3.2 at 100% of cost to a maximum of 200% of the CMP tariff with a limit of R2 260 per minor beneficiary per financial year;

7.3.2 **["Pre-Auth"]** Procedures and operations necessitating hospitalisation are subject to 100% of cost to a maximum of 200% of the CMP tariff;

7.4 Radiologist ["Pre-Auth"]

7.4.1 In respect of the following procedures, 100% of cost to a maximum of 100% of the CMP tariff limited to R13 951 per beneficiary per financial year and subject to a co-payment of R1 500 per event except for Prescribed Minimum Benefits:

Angiograms
CT scans
Duplex Doppler Scans
Interventional Radiology
MRI scans
Nuclear Medical Investigations

7.4.2 For all radiology other than 7.4.1, 100% of cost for services where hospitalisation is necessitated. Benefit option rule 3 will be applied to all such claims.

7.4.3 Female beneficiaries over the age of 49 shall be entitled to a mammogram. The procedure will be paid at cost to a maximum of 100% of the CMP tariff limited to R1 797 per female beneficiary once every second financial year and subject to a co-payment of R300 per event except for Prescribed Minimum Benefits.

7.4.4 All beneficiaries over the age of 50 shall be entitled to a bone density scan. The procedure will be paid at cost to a maximum of 100% of the CMP tariff. Beneficiaries will be entitled to this benefit once every fifth financial year.

7.4.5 All outpatient radiology benefits other than 7.4.3 and 7.4.4 are only for Prescribed Minimum Benefits in which case benefit option rule 3 applies.

7.5 Pathology Service Providers

7.5.1 Pathology services must be rendered by SANAS accredited pathology providers, in which event Cape Medical Plan shall pay 100% of cost to a maximum of 100% of CMP tariff for services other than Prescribed Minimum Benefits in which case benefit option rule 3 applies, on condition the most cost effective and appropriate tests are selected.

7.5.2 In accordance with HPCSA regulations, pathology claims will be rejected and not paid if the tests were not requested by an appropriately registered medical practitioner for the purposes of reaching a

medical diagnosis, monitoring a declared existing medical condition and the necessary treatment of that condition.

7.5.3 Outpatient pathology will be covered from the insured benefit at the CMP tariff, subject to being requested by an appropriately registered medical practitioner, for services other than Prescribed Minimum Benefits in which case benefit option rule 3 applies.

7.6 For the above services 7.1 to 7.5 consultations for confirmed Prescribed Minimum Benefit conditions will be managed and paid for in accordance with rule 3.

7.7 **General and Specialised Dentistry (any use of Specialised dentistry is subject to referral from a General Dentist)**

7.7.1 **["Pre-Auth"]** This benefit shall be paid in accordance with the Prescribed Minimum Benefit Regulations in respect of Prescribed Minimum Benefits;

7.7.2 100% of cost to a maximum of 120% of the CMP tariff in respect of procedures and operations which would ordinarily require hospitalization on the basis that the procedure itself is impossible to perform outside of a hospital and, is not classified as a Prescribed Minimum Benefit (refer to benefit exclusion list 12.20; 12.21;12.22;12.23;12.24;12.26).

8. Specific Treatments

THE FOLLOWING BENEFITS ARE AVAILABLE FOR THE FOLLOWING TREATMENTS

8.1 Renal Dialysis

["Pre-Auth"] Payment will be at the amount determined by the Prescribed Minimum Benefit Regulations provided that the entry criteria for dialysis as per Prescribed Minimum Benefits are met, and that the treatment is provided by a designated service provider nominated by Cape Medical Plan.

8.2 Oncology

8.2.1 **["Pre-Auth"]** Provided the formularies and treatment protocols of Cape Medical Plan and the SAOC tier guidelines are applied in accordance with an agreed treatment plan. Payment will be at the amount determined by the Prescribed Minimum Benefit Regulations for services that qualify for treatment in terms of the Prescribed Minimum Benefits subject thereto further that treatment is performed by a nominated DSP. Where a nominated DSP is not available within a reasonable distance to the ordinary place of residence or employment treatment will be paid for in accordance with the Prescribed Minimum Benefit Regulations provided the formularies and treatment protocols of Cape Medical Plan are applied in

accordance with an agreed treatment plan, subject to rule 3.

8.3 **Treatment in lieu of hospitalisation – Step-down facilities, Rehabilitation, when Hospitalisation is not clinically appropriate**

8.3.1 **["Pre-Auth"]** 100% of cost to a maximum of 100% of the CMP tariff for services that qualify for treatment and services provided by hospices, registered step down facilities and registered nurses, if treatment is in lieu of hospitalisation, with a limit of 15 days per beneficiary per financial year. A Prescribed Minimum Benefit will be managed in accordance with rule 3 and the Prescribed Minimum Benefit regulations.

8.4 **Endoscopic Procedures**

8.4.1 **["Pre-Auth"]** 100% of cost to a maximum of 200% of the CMP tariff if performed by a medical specialist qualified to perform the procedure provided that the following co-payments shall apply per laparoscope used during a procedure for non Prescribed Minimum Benefits:

Arthroscopies	R1 000
Appendicectomies	R1 000
Inguinal Hernia Repair	R1 000
Gynaecological procedures	R1 000
Urology procedures	R1 000
Umbilical Hernia Repairs	R1 000
Incisional Hernia Repairs	R1 000

Ventral Hernia Repairs	R1 000
Colectomy	R1 000
Colonoscopy	R1 000
Gastroscopy	R1 000
Hysteroscopy	R1 000
Sympathectomy	R1 000
Vaginal Hysterectomy	R1 000
Cystoscopy	R1 000

8.5 **Organ Transplants**

["Pre-Auth"] 100% of the CMP tariff if performed by a designated service provider in a facility nominated by Cape Medical Plan provided that the Prescribed Minimum Benefit conditions are met and subject to rule 3.

9. Other Services

THE FOLLOWING BENEFITS ARE AVAILABLE FOR THE FOLLOWING OTHER MEDICAL SERVICES

9.1 **Ambulance Services**

9.1.1 For medical emergencies that qualify as Prescribed Minimum Benefits, payment will be at the amount determined by the Prescribed Minimum Benefit Regulations for services provided by a registered ambulance service provider for the transportation of a patient on instruction by a registered medical practitioner (HPCSA) to the nearest appropriate medical facility within the borders of the Republic of South Africa when medically necessary. Prescribed

Minimum Benefits rule 3 of this benefit option applies.

["Pre-Auth"] For inter facility transfers, 100% of cost to a maximum of 100% of the CMP tariff for services provided by a registered ambulance service provider for the transportation of a patient on instruction by a registered medical practitioner (HPCSA).

9.2 **Blood Transfusion**

["Pre-Auth"] 100% of cost to a maximum of 100% of the CMP tariff. For Prescribed Minimum Benefits refer to rule 3.

10. Medicines and Prosthesis

THE FOLLOWING BENEFITS ARE AVAILABLE FOR MEDICINES AND PROSTHESIS

10.1 **Prosthesis**

10.1.1 **["Pre-Auth"]** Subject to 10.1.2 Cape Medical Plan shall pay 100% of the cost of the prosthesis or implant if introduced internally as an integral part of an operation limited to R51 145 per beneficiary per financial year subject thereto that, for the following prostheses the following sub-limits shall apply:

- Cardiac stents (including delivery system), per stent R15 980.

- Trans vaginal tape R10 923.
- The cost of patches utilised in incisional hernia repair is limited to R4 369.
- The cost of patches utilised in groin hernia repair is limited to R1 463.
- Pacemaker including leads R51 145.
- Joint Replacements R51 145.
  Should a bilateral same joint replacement be deemed clinically appropriate the prosthesis benefit will be R102 290 (Limited to hip and knee replacements that are part of the same procedure)
- Intra-ocular lenses are limited to R3 208 per lens.

10.1.2 Where a prosthesis is a Prescribed Minimum Benefit, rule 3 shall apply. Benefits shall be paid at the amount determined by the Prescribed Minimum Benefit Regulations.

10.2 **Chronic Medicines Benefit**

10.2.1 **["Pre-Auth"]** The Chronic Medicine Benefit is available subject to registration and adherence to the protocol of the appropriate disease management programme, subject to Regulations 15H and 15I.

10.2.2 The chronic diseases covered will be limited to the Chronic Disease List as stipulated in the Medical Schemes Act, as well as all qualifying DTP and Prescribed Minimum Benefit conditions.

- Addison's Disease
- Anti-coagulating therapy
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic Obstructive Pulmonary Disease
- Chronic Renal Disease
- Coronary Artery Disease
- Crohn's Disease
- Cushing's Disease
- Diabetes Insipidus
- Diabetes Mellitus Type 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis
- Multiple Sclerosis
- Parkinson's Disease
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis
- HIV

10.2.3 A formulary and reference price will apply. Prescribed Minimum Benefits will be paid as per the Prescribed Minimum Benefit Regulations provided rule 3 is complied with in full.

10.2.4 Cape Medical Plan will cover a dispensing fee at the negotiated tariff charged by the Cape Medical Plan designated service provider(s).

11. Sundry Benefits

THE FOLLOWING SUNDRY BENEFITS ARE AVAILABLE (subject to Prescribed Minimum Benefits)

11.1 **Biokineticists; Physiotherapists; Occupational Therapists; Speech Therapists and Dieticians ["Pre-Auth"]**

100% of cost to a maximum of 100% of the CMP tariff if approved as part of a treatment protocol, which necessitates the hospitalisation of the patient*.

SECTION D: BENEFITS EXCLUSIONS

12. Benefit Exclusions

The following are excluded from benefits under this option. 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

12.1 Surgery and other procedures for the purpose of correcting refractive errors including, but not limited to Excimer laser/Lasik procedure.

12.2 In-Vitro Fertilisation and non Prescribed Minimum Benefit Infertility treatment

12.3 Treatment relating to sexual dysfunction

12.4 Treatment for any cosmetic purposes including, but not limited to Abdominal Lipectomy and Liposuction

12.5 Psychology and Psychiatry treatment other than Prescribed Minimum Benefits

12.6 Any scar revision and associated treatments

12.7 Medical examinations for insurance, school, association, emigration, visa, employment or similar purposes

12.8 Any non-Prescribed Minimum Benefit treatment relating to substance abuse including, but not limited to alcohol

12.9 Treatment for Obesity including surgery

12.10 Sleep Studies

12.11 Breast reduction, Breast cosmetic surgery, including scar revision, breast augmentation and gynaecomastia. Non-diseased breast reconstruction, nipple reconstruction and

symmetry, unless authorised within PMB level of care criteria.

12.12 Any cosmetic surgery

12.13 Protective gear

12.14 Treatment of HIV/AIDS shall be limited to Prescribed Minimum Benefits

12.15 Hearing devices including cochlear implant devices, whether introduced internally or not, as well as the maintenance of these devices

12.16 Household medicinal remedies, contraceptives, patent medicines, non-ethical and all proprietary preparations including but not limited to vitamins, minerals, medical creams, soaps, shampoos, and laxatives

12.17 Blepharaplasties

12.18 Artificial and synthetic blood products

12.19 Experimental and unproven treatments, procedures, devices and unregistered medications as per the Medicine's Control Council including Section 21 medicines. This exclusion will not be applicable to any COVID-19 vaccine that is being used as part of the Vaccination plan in South Africa. It will not apply to any medication previously registered that is waiting for the Medicines Control Council to reregister it. The medication

must be used for the condition that it was initially registered for.

12.20 Dental implants

12.21 Orthodontic Treatment

12.22 Prosthodontic Treatment

12.23 Orthognathic Procedures

12.24 Periodontic Treatment

12.25 External devices including but not limited to crutches, commodes, nebulisers, pronator boots, bed pans, raised toilet seats, wheelchairs, CPAP machines

12.26 General Dentistry performed under general anaesthetics for beneficiaries over the age of 7 years old.

12.27 Mammaprint genetic testing and any other type of genetic testing

12.28 Educational therapy and Group therapy

12.29 Long-term nursing care (such as frail care nursing)

12.30 All treatment and costs incurred for which benefits are not specifically provided. Prescribed Minimum Benefits will be managed in accordance with Prescribed Minimum Benefit regulations and rule 3.

SECTION E: CONTRIBUTIONS

13. Monthly Contributions (Per Beneficiary)

	Insured
Principal member	**R2 842**
Adult Beneficiary	**R2 842**
Minor Beneficiary	**R501**

SECTION F: GENERAL

14. Designated Providers

14.1 For Chronic Medication Benefits as per 14.2 the designated service provider shall be the Clicks and Medipost group of pharmacies as well as any Western Cape and Gauteng State health facility, or other pharmacy that may be nominated by Cape Medical Plan.

14.2 For Chronic Renal Dialysis benefits as per 8.1, Oncology benefits as per 8.2, and Organ Transplants as per 8.5 the designated service provider shall be any Western Cape and Gauteng State health facility or alternative nominated private Sector facility if services are not available and accessible from State, or would not be provided without a degree of delay that would result in significant demonstrable deterioration or health risk to the beneficiaries.

15. The CMP Tariff

The CMP Tariff for **2023** shall be NHRPL 2006 plus **184.50%.**

16. Specific Benefit Payees

16.1 If the scheme and the supplier cannot agree on the account it will be referred to HPCSA and their decision will be accepted by the scheme and the account will be processed for payment as per section 59 and Regulation 6.

16.2 All benefits shall be paid to the member where the member requests that payment be made to the member.

16.3 Cape Medical Plan shall have no obligation to pay any service provider directly.

SECTION G: DEFINITIONS

17. In these benefit option rules, unless the context otherwise indicates the following terms and expressions shall have the meaning ascribed to them hereunder wherever they appear in the context:

17.1 "clinical advisory committee" – the medical advisor appointed by Cape Medical Plan from time to time and such expert advisors he may consult from time to time.

17.2 "disease management programme" - includes registering on the chronic meds programme and recording of health measurements.

17.3 "DSP" (Designated Service Provider) – any health care provider or group of providers selected by Cape Medical Plan as the preferred provider to provide to its members diagnosis, treatment and care in respect of specific treatments or services.

17.4 "HPCSA" – the Health Professionals Council of South Africa that exists in terms of the Health Professions Act, 1974 (Act 56 of 1974), as amended or any statutory body placed in its stead.

17.5 "medical emergency" - the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation, where if the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

17.6 "pre-authorise" or "pre-authorisation" or "pre-approve" - approval in writing (including e-mail or facsimile) and provision of a case management number from Cape Medical Plan prior to the event leading to the costs being incurred.

17.7 "SANAS" – the South African National Accreditation System established in terms of Section 21 of the Companies Act, 61 of 1973, registration number 1996/00354/08.

17.8 "SAOC" – the South African Oncology Consortium.

17.9 A co-payment is a certain amount of the cost of a medical procedure and or service provided to any member for which the member is held liable, as referred to in rule: 7.4.1, 8.4.1 and any other benefits that are paid in excess of CMP tariff or the agreed preferred provider tariff, or voluntarily obtained from a non DSP in the case of Prescribed Minimum Benefits. This amount is unless otherwise specified in these benefit option rules equal to the Rand amount difference of the CMP tariff and the supplier invoice cost.

17.10 52N – Prescribed Minimum Benefit Code
Applicable to Diagnosis of Pregnancy. Treatment – antenatal and obstetric care necessitating hospitalization including delivery.

17.11. "Clinically appropriate medical report" - a report that indicates why a beneficiary needs to see a specialist, what conservative treatment has been followed and what the beneficiary's recent medical history is

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