ANNEXURE E

LA-HEALTH MAJOR MEDICAL BENEFIT
(MMB)

(A) GENERAL

1. Effective date

   The MMB shall with effect from 1 January 2005 be applicable to all the benefit options as per Annexure B1 – B5.

2. Annual Maximum

   No annual maximum is applicable to benefits provided in terms of this Annexure.

3. The benefits granted in terms of this Annexure is referred to in the Rules as the Major Medical Benefit (MMB).

4. The benefits offered in terms of this Annexure shall neither be available in respect of the Limitations and Exclusions in Annexure C nor in Appendix 1 to the LA KeyPlus option.

(B) PRESCRIBED MINIMUM BENEFITS

Members and their registered dependants are entitled to the prescribed minimum benefits (PMB). The cost of diagnosis, treatment and care of all PMB will be covered in full, i.e. without a co-payment and not subject to any maximums or exclusions stated in this Annexure but subject to waiting periods, if applicable, through Scheme DSP only and if involuntarily obtained from a non-DSP.

Diagnosis, treatment and care in a private hospital, of the sickness conditions prescribed in terms of the Regulations, excluding procedures/conditions specified in Schedule 1, hereof or diagnosis, treatment and care in a public hospital of sickness conditions not prescribed in terms of the Regulations, do not qualify for PMB, but qualify for additional benefits as stipulated by paragraph (C) below.

(C) ADDITIONAL BENEFITS

1. Hospitals

Subject to the provisions of paragraph D of this Annexure, benefits are granted for hospitalization, treatments and the associated clinical procedures and will be subject to a 20% co-payment if pre-authorisation is not obtained.

1.1 Private Hospitals

The use of Designated Service Providers (DSP) qualifies for benefits stipulated below. (The benefits for the use of Non-DSP are in accordance with the relevant Benefit Schedules).

1.1.1 Accommodation

Except where indicated to the contrary in the relevant Benefit Schedules 100% of the cost or LAHR for:

- accommodation in a general ward;
- accommodation in a private ward where medically necessary (e.g. as a result of a contagious disease);
- accommodation in an intensive care unit and/or high care ward;
- the use of the recovery room.

1.1.2 Operating theatre

Except where indicated to the contrary in the relevant Benefit Schedules 100% of theatre cost or LAHR, including the use of registered unattached theatres. In the case of after hours surgery, the normal tariff for the theatre will apply, unless in an emergency.

1.1.3 Medicine, material, hospital apparatus and out-patient treatment
Except where indicated to the contrary in the relevant Benefit Schedules 100% of the cost or LAHR / LAMR of disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used during stay in the hospital, including the cost of procedures and the use of hospital apparatus.

1.1.4 Internal Prostheses (Medical and surgical accessories)
Except where indicated to the contrary in the relevant Benefit Schedules, 100% of the cost or LAHR of medical and surgical accessories placed in the body as an internal supporting mechanism during an operation and/or which for functional medical reasons are implanted as a prosthesis to replace parts of the body.

2. Secondary facilities

The following benefits are payable in cases managed as part of a Case Management Program only, subject to the provisions of paragraph (D) of this Annexure:

2.1 100% of cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for sub-acute facilities, hospice, nursing services or practicing nurses and rehabilitation services.

2.2 Benefits for clinical procedures and treatment during stay in a secondary facility will be subject to the same Benefits that apply to hospitalization.

3. General Practitioners and Specialists

3.1 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for clinical procedures and operations, if pre-authorisation was obtained for hospitalization. In addition, 100% of the applicable tariff as per the benefit schedules of Annexure B for the following clinical procedures performed out of hospital (no pre-authorisation required for these):

3.1.1 Upper gastro-intestinal endoscopy;
3.1.2 Lower gastro-intestinal endoscopy (excluding sigmoidoscopy and anoscopy);
3.1.3 Laser tonsillectomy;
3.1.4 24 hour oesophageal pH studies;
3.1.5 Oesophageal motility.

Should the Scheme channel a clinical procedure or operation from hospital to the doctor's room (at the pre-authorisation stage), such procedure or operation will be covered by MMB.

3.2 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for apparatus used during surgical procedures and operations, if pre-authorisation was obtained for hospitalization.

3.3 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for anaesthetic, where the anaesthetic is administered during surgical procedures and operations, if a pre-authorisation was obtained for hospitalization.

3.4 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for visits after admission and during a patient's stay in hospital, if pre-authorisation was obtained for hospitalization.

3.5 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for radiology and pathological services rendered during a patient's stay in hospital, if pre-authorisation was obtained for hospitalization.

3.6 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for MRI-scans, computer tomography, bone density scans and radio-isotope studies, irrespective of whether treatment was done during and/or not during hospitalization.

3.7 Maxillo-facial and oral surgery

3.7.1. The conditions listed below will be covered at 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for the services rendered during a patient's stay in-hospital, if pre-authorisation was obtained for hospitalisation:

- **Severe life threatening infections** in the mouth, face and neck area. The infection manifests itself by acute symptoms of sufficient severity that the absence of immediate hospital admission with medical and surgical intervention could result in serious jeopardy to the person's health. This definition specifically excludes procedures such as Apicectomy.

- **Jaw / TM joint replacements** referring to surgical reconstruction to the Temporomandibular joint (the joint that connects the lower jaw to the scull)

- **Cancer related surgery** done to remove cancer of the oral cavity and will include reconstruction surgery of the bone as part of the cancer related surgery. (This will not include periodontal soft tissue procedures, orthodontics and placement of dental implants and superstructures, crowns, bridges or dentures to replace lost teeth or previous dental restorative appliances and restorations.)

- **Trauma** defined as acute sudden unforeseen physical trauma / injury of the facial bones and oral tissues (both soft and hard), which manifests itself by acute symptoms of sufficient severity that the absence of hospital admission with surgical intervention at least within the first 24 hours thereafter could result in serious jeopardy to the person's health or serious impairment to bodily functions.

- **Severe trauma** related surgery will include surgery done within the initial trauma admission as well as admission related to post-traumatic reconstruction surgery of the bone. (This will not include periodontal soft tissue procedures, orthodontics and placement of dental implants and superstructures, crowns, bridges or dentures to replace lost teeth or previous dental restorative appliances and restoration related surgery.)

- **Surgical removal of permanent teeth.**

- **Orthognatic surgery.**

- **Cleft lip and palate repairs**

4. Auxiliary Services

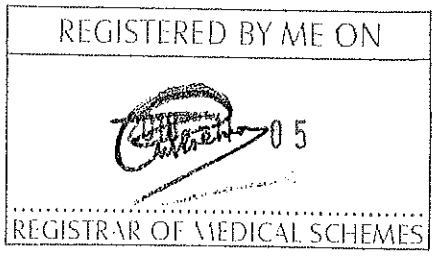
These services are supplementary to hospital care and qualify for benefits if rendered during hospitalisation and/or case management.

4.1 100 % of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for services rendered during a patient's stay in hospital, if pre-authorisation was obtained for hospitalization.

4.2 100 % of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for approved step down services rendered outside of hospital, if the treatment forms part of case management. Subject to pre-authorisation and case management.

4.3 Blood transfusions

100% of the cost of blood transfusions (i.e. the cost of the blood products and/or equivalents, apparatus and the operator's fee) (Note: Bone marrow transplants are not covered under this section but under organ transplants).



5. Special Clauses

5.1 Maternity Benefits

Covered services are as per the relevant benefit schedules in Annexure B. Confinement benefits are as per paragraphs 1 and 3 of this Annexure but subject to pre-authorisation.

5.2 Organ transplants and Bone Marrow transplants (including immunosuppressant drugs)

100 % of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules in respect of bone marrow transplants, organ transplants will only be allowed if the treatment forms part of the PMB or a Case Management Program (and occurs within South

Africa). The costs involved in harvesting the organ, bone marrow or stem cells, determining compatibility and disease markers, local registry costs (but specifically excluding foreign registries), and transport of the harvested organ for use by a beneficiary of the Scheme are all covered by the Scheme but only when all of the above donor costs are incurred within the borders of South Africa and in the cases where the donor's costs are not payable by a third party.

Donor costs will be covered by the Scheme if the donor is a beneficiary of the Scheme and the recipient is not, unless such donor costs are covered by any other party.

5.3 **Acute/Chronic Dialysis**

100% of the cost up to LAHR paid from MMB, subject to approval of treatment plan, at National Renal Care Facilities. If non-DSP is used voluntarily, the claim is paid as the agreed LA Health Rate. PMB's paid at cost.

5.4 **Oncology**

Apart from the benefits as in paragraphs 1 and 3 of this Annexure, benefits for treatment and services rendered outside a hospital are covered at the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules but subject to the condition that the treatment is subject to authorization and/or approval and the treatment meeting the Scheme's clinical criteria and protocols. Also subject to review by an external panel of specialists. Subject to generic substitution and cost-effective therapeutic equivalent substitution, where applicable. Tests and scans prior to positive diagnosis of cancer are not covered, except for those covered under paragraph 3.6 above and tests and scans leading to the determination of the diagnosis as a PMB.

No co-payment will apply to the first R456,000 in respect of the LA-Comprehensive and LA Core Options and R228 000 in respect of LA Active and LA Focus Options of the benefit per person of approved oncology- related claims, after which all further claims will be subject to a 20% deductible per claim, per 12 month cycle, save for PMB's which are subject to SAOC Tier 1 regimens and baskets of care for supportive requirements.

The treatment of side effects of chemo- and radiotherapy will be covered subject to obtaining pre-authorisation.

Long-term chronic conditions that develop as a result of chemo- and radiotherapy will not be covered under this provision.

5.5 **PET scans**

100% of cost up to LAHR. Subject to authorization and/or approval and the treatment meeting the Scheme's clinical criteria. No co-payment will apply at the Scheme's Designated Service Provider. A deductible of R3,440 will apply per scan should a Designated Service Provider not be used. Oncology-related PET scans also accumulate to the first R456,000 in respect of the LA Comprehensive and LA Core Options and R228 000 in respect of LA Active and LA Focus Options of the benefit per beneficiary of approved oncology- related claims, per 12 month cycle. After all approved oncology- related claims have accumulated to an amount of R456,000 per person in respect of the LA Comprehensive and LA Core Options and R228 000 in respect of LA Active and LA Focus Options. All further PET scan claims will be subject to a 20% co-payment or R3,440 per scan, whichever is greater. Limited to a maximum of 4 scans per beneficiary per 12-month cycle. In instances where the condition is a PMB condition. payment of this benefit will be subject to PMB cover.

5.6 **Stem Cell Transplants**

100% of cost up to LAHR for Stem Cell Transplants. The Scheme will only pay for the procedure, the search for, and the sourcing of the stem cells in South Africa subject to authorization and/or approval and the treatment meeting the Scheme's clinical criteria. In instances where the condition is a PMB condition, payment of this benefit will be subject to PMB cover.

5.7 **Speciality Medicine and Technology Benefit (SMTP)**

100% of cost. Limited to R228,000 per beneficiary per annum. A co-payment of 20% of each claim applies to all non-PMB treatment.

5.8 **Ambulance service and emergency transport**

100% of the cost or LAHR except where indicated to the contrary in Annexures B1 – B5.

5.9 **Refractive surgery, breast reduction surgery (reduction Mammoplasty), protruding ears and keloids (and other scars that cause functional problems).**

Benefits as in paragraphs 1 and 3 of this Annexure, subject to the Scheme's clinical guidelines and pre-authorisation.

5.10 **Foreign claims**

Benefits in respect of foreign claims are granted in accordance with the benchmark determined by the Scheme for a similar treatment in RSA. Such benefits shall be paid in ZAR.

(D) PRE-AUTHORISATION

Access to the MMB shall be achieved by procurement on the part of the attending General Medical Practitioner/General Dental Practitioner/Specialist, or the relevant hospital or, as a last resort, the member/dependant, of pre-authorisation from the Scheme, except in the case of medical emergencies and/or life threatening situations where a system of post-confirmation as contemplated in paragraph 2 and 3(c) of Annexure B will apply.

1. Pre-authorisation is required for the services specified in this Annexure except as specified in paragraph C 3.1 herein, as well as any other procedures or treatment decided upon by the Scheme from time to time and provided for in the rules, and of which members will be informed.

2. When the Scheme grants pre-authorisation, it is merely a confirmation that the proposed clinical procedure or treatment is medically necessary.

3. Payment of benefits for a clinical procedure or treatment in respect of which pre-authorisation was granted, will always be subject to the:

    3.1 Rules of the Scheme – in particular any maximum, exclusions and waiting periods;

    3.2 Beneficiary qualifying for benefits – in particular the valid membership of the member, valid registration of any dependant, and fully paid contributions;

    3.3 Beneficiaries submitting such additional information regarding their conditions and the proposed clinical procedure or treatment, or obtaining such second opinions as the Scheme may reasonably request.

4. Conditions applicable to pre-authorisation:

    4.1 If a pre-authorisation is obtained and the clinical procedure or treatment does not exceed the authorisation, the clinical procedure or treatment qualifies for benefits.

    4.2 If a pre-authorisation is obtained and the authorisation is exceeded, benefits are paid only for the authorised clinical procedure or treatment. The excess costs are for the account of the member.

    4.3 If a clinical procedure or treatment is undergone after a pre-authorisation has been refused, no benefits are payable.

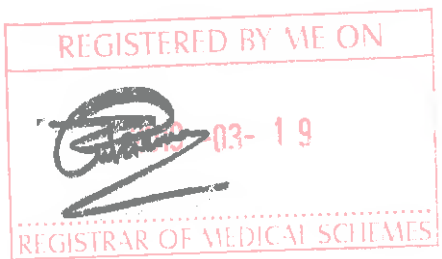
(E) CASE MANAGEMENT PROGRAM

1. If the health problems of beneficiaries are of such a nature that they qualify for admittance to the Scheme's Case or Disease Management Program, the Scheme may enter such beneficiaries on such a program – either on request of a beneficiary, or by referral by the member's treating General Practitioner or Specialist, or automatically.

2. If the Scheme uses a Case or Disease Management Program, the Scheme may, in its sole discretion grant amounts in excess of the benefits specified and which are not subject to the exclusions, provided it falls within the treatment plan of the case manager.

3. Notwithstanding the entitlement to benefits, if a beneficiary refuses participation in a Case or Disease Management Program, the Scheme may, subject to PMB, limit further benefits insofar as they are related to the specific complaint, or only pay benefits for a lower level of service.

4. Notwithstanding the entitlement to benefits, if a Beneficiary does not co-operate with the relevant Case or Disease Management Program, the Scheme may, subject to PMB, limit further benefits insofar as it is related to the specific condition.



Schedule 1

CLINICAL GUIDELINES AS DETERMINED BY LA-HEALTH:

1. **Breast Reduction Surgery:**

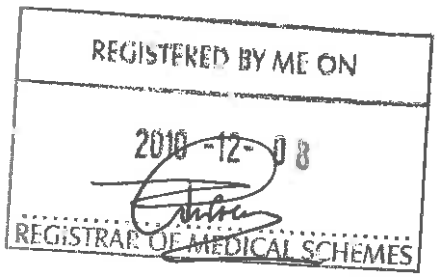
   Criteria -

- Overall mass of patient must not exceed a body mass index of 27.
- Bra size must be D or bigger.
- Sternal notch to nipple length must be 28 cms or more.
- Estimated amount of breast tissue to be removed must be more than 500 grams per side.
- Acceptable photos must accompany request.
- Orthopaedic report re. backache etc is optional.
- Post menopausal and adolescent women to be evaluated by a medical practitioner.
- Psychological and emotional reasons are not acceptable.

2. **LASIK Procedures:**

   Criteria -

   - Myopia > 3,0 diopter.
   - Astigmatism > 2,5 diopter.
   - Spherical equavalent > 4,0
   - Same *criteria* applies for re-do's.
   - PHAKIC-IOL - not acceptable.



3. **GYNECOMASTIA**

   Criteria -

   - Only young adults after puberty (18 to 22 years)
   - Acceptable photos must accompany request.
   - Full clinical motivation by attending doctor.
   - Cosmetic reasons are not acceptable.

4. **BLEPHAROPLASTY**

Criteria -

- Only when the visual fields are affected.
- Ophthalmologist's evaluation if the request comes from a plastic surgeon.
- Acceptable photos must accompany request.

5. **OTOPLASTY** (Bat ears).

Criteria -

- Only children under the age of 12 years.
- Clinical motivation by a medical practitioner.
- Acceptable photos must accompany request.

6. **TOTAL NOSE RECONSTRUCTION**

Criteria -

- Only code 1085 is covered in cases where the bony and/or cartilaginous structure of the nose is distorted.
- Acceptable photos must accompany the request.
- Full clinical motivation from the ENT- or plastic surgeon.
- Second opinion is required.

7. **CIRCUMCISION**

Criteria -

- Full clinical motivation required.

8. **SCARRING** (Keloids)

Criteria -

- Clinically motivated by a medical practitioner as part of the treatment process relating to the cause of the scarring.
- Only for functional reasons.

9. LASER TONSILLECTOMY

Criteria -

- In doctor's rooms as an office procedure.
- No cover under general anaesthetic in hospital.

10. BREAST RECONSTRUCTION AFTER MASTECTOMY

- Benefits are allowed in respect of reconstructive surgery after mastectomy for proven breast cancer. Benefits will be paid once only for full reconstruction by whichever method, as well as for reduction surgery on the unaffected side for symmetry, where indicated, as per motivation. Only complications of a true medical nature will be considered for benefits and not failed cosmesis.

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