FEDHEALTH MEDICAL SCHEME

ANNEXURE C

(With effect from 1 January 2017)
(To be read in conjunction with Annexure B and D)

1. PRESCRIBED MINIMUM BENEFITS

Notwithstanding the limitations and exclusions set out in this Annexure, beneficiaries shall be entitled to the Prescribed Minimum Benefits.

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

2. LIMITATION AND RESTRICTION OF BENEFITS

2.1 In cases of illness of a protracted nature, the Scheme shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Scheme may nominate in consultation with the attending practitioner.

2.2 The Scheme may require a second opinion in respect of proposed treatment or medicine which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme. In the event that the second opinion proposes different treatment or medicine to the first, the Scheme may in its discretion require that the second opinion proposals be followed, unless in terms of the managed healthcare programme.

2.3 For the Blue Door^{Plus} option, the Dynamic Saver option , in cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.

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

2.5 If the Scheme or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols with due regard to the provision of Regulations 15(H) and 15(I).

2.6 The Scheme reserves the right not to pay for any new medical technology or, investigational procedures, interventions, new drugs or medicine as applied in clinical medicine, including new indications for existing medicines or technologies, unless the following clinical data relating to the above have been presented to and accepted by the Medical Advisory Committee and such data demonstrating their:

2.6.1 therapeutic role in clinical medicine;

2.6.2 cost-efficiency and affordability;

2.6.3 value relative to existing services or supplies;

2.6.4 local indications, application and outcome studies;

2.6.5 role in drug therapy as established by the Scheme's managed healthcare organisation.

2.7 In the event that:

a) the treatment of an extended or chronic sickness condition becomes necessary;

b) a disease or a condition (including pregnancy) requires specialised or intensive treatment;

c) the treatment of any disease or condition becomes of a protracted nature or requires extended medicine and such treatment is given in or by a non-designated service provider,

the case may be evaluated in terms of the relevant managed healthcare programme and, having regard to the aforementioned diseases or conditions in question, the Scheme may require or advise:

2.7.1 the transfer of that beneficiary to a public hospital or other designated service provider as arranged by the Scheme where appropriate care is available with due regards to Regulation 8(3)(c);

2.7.2 the application of a limited drug formulary;

2.7.3 both such transfer and restricted drug formulary;

in order to conserve or maximise efficient utilisation of available benefits.

2.8 In the event that a decision has been taken in terms of paragraph 2.7 above, the following conditions shall apply:

2.8.1 in respect of Prescribed Minimum Benefits, no benefit limit shall apply provided treatment is given in or by a public hospital or designated service provider. If for any reason, the beneficiary voluntarily receives treatment in or by a non-designated service provider the beneficiary shall be required to pay 40% of the cost of such treatment.

2.8.2 in respect of non-Prescribed Minimum Benefit conditions, if the Scheme or its managed healthcare organisation should determine that any annual benefit limits, as set out in Annexure B, and available to the beneficiary receiving such treatment, are likely to be exceeded in the course of the year, the beneficiary may be advised to move to a public hospital or designated service provider or to accept a limited drug formulary, or both, in order to conserve available benefits. In such designated service provider or public facility any costs incurred over and above the limit stipulated in Annexure B (excluding Prescribed Minimum Benefit conditions), shall be the member's responsibility. The member may elect on behalf of himself or his beneficiary, to remain in the private hospital, or remain on the full drug formulary available, or both, in which event the Scheme shall pay 60% of the cost stipulated in Annexure B, thereafter the member shall be responsible for payment, direct to the private hospital, for any further treatment in such hospital, or for payment direct to the supplier for further medicine.

2.9 The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with, or pilot with credential specific provider groups (networks) or centres of excellence as determined by the Scheme in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits (as set out in Annexure D). The Scheme reserves the right not to fund or partially fund services acquired outside of these networks provided reasonable steps are taken by the Scheme to ensure access to the network, subject to Prescribed Minimum Benefits.

2.10 The scheme reserves the right not to pay for procedures performed by non-recognized providers (where applicable).

Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or need access to certain infrastructure for quality outcomes. Where such procedures have been identified by the scheme's managed care provider, recognized providers are those who have been acknowledged by meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed care provider and/or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

3. BENEFITS EXCLUDED INSOFAR AS THESE ARE NOT PRESCRIBED MINIMUM BENEFITS

3.1 General exclusions

Unless otherwise decided by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme), expenses incurred in connection with any of the following will not be paid by the Scheme:

3.1.1 all costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure B, for the benefits to which the member is entitled in terms of the rules;

3.1.2 all costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease;

3.1.3 all costs for healthcare services if, in the opinion of the medical or dental adviser, such healthcare services are not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost;

3.1.4 all costs in respect of injuries or conditions willfully self-inflicted or injuries sustained while voluntarily participating in a riot, civil commotion, war, invasion, act of foreign enemy, hostilities whether war is declared or not, and civil war, unless Prescribed Minimum Benefits;

3.1.5 all costs for medicines for the treatment of chronic conditions not on the list of diseases covered, with the exception of medicines for the treatment of an excluded chronic condition which the Chronic Medicine Programme has specifically determined should be treated to achieve overall cost effective treatment of the beneficiary;

3.2 Exclusions and indemnity in regard to third party claims

3.2.1 It is recorded that the relationship between the Scheme and its members shall at all times be deemed to be one of the utmost good faith.

The member therefore acknowledges and agrees that, notwithstanding anything to the contrary, or not specifically set out in the rules or Annexures of the Scheme, the member is under a duty of care to disclose all and any information or matters to the Scheme, which may in any manner impact upon or affect a decision or discretion which vests in the Scheme, concerning such member or his/her claim.

3.2.2 The Scheme shall effect payment, of any claims, for both Prescribed and non-Prescribed Minimum Benefit conditions, incurred by the member arising from the actions or omissions of any other third party and for such claim, the Scheme shall be entitled to request the member to complete an indemnity form, in order to be reimbursed the Scheme's portion of the claim from third parties concerned. In such an event the member shall:

3.2.2.1 be liable to repay to the Scheme all amounts in respect of medical costs paid by the Scheme and recovered by or on behalf of the member from the party responsible to compensate such member, free of any legal costs or deductions that may have been incurred in the recovery of such amount;

3.2.2.2 ensure that, prior to the settlement of any claim instituted against such other party, all the amounts set out above and paid by the Scheme, are included in such claim and form part of any settlement amount, whether globular or separately;

3.2.2.3 disclose to the Scheme, alternatively, instruct his/her legal representative to disclose to the Scheme, the full extent of any compensation awarded in respect of past and future medical expenses;

3.2.2.4 sign all documentation as may be required by the Scheme to obtain copies of all such information not in the Scheme's possession, relating to the member's medical accounts and records from the relevant practitioners and/or medical institutions;

3.2.2.5 sign all such documentation as may be required by the Scheme, to proceed with a claim in the member's name to recover any amounts expended by the Scheme, subject to the Scheme indemnifying the member against any costs which may arise as a result of the institution of such claim, if the Scheme is satisfied that a valid claim exists and the member elects not to proceed with it;

3.2.2.6 either personally or through his/her legal representative keep the Scheme informed, whether called upon by the Scheme to do so or not, as to the ongoing progress of his/her claim.

3.2.3 Should a member's claim referred to in paragraph 3.2.2 against the party liable for his/her injuries not be successful, alternatively, only be partially successful, then in such event the member shall be entitled to such benefits or portion of benefits in respect of which his/her claim has been unsuccessful as would have applied, should no claim have been possible *ab initio*, irrespective of the lapse of time.

3.3 Exclusions in regard to non-registered service providers

The Scheme shall not pay the costs for services rendered by:

3.3.1 persons not registered with a recognised professional body constituted in terms of an Act of Parliament;

3.3.2 any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law.

3.4 Specific exclusions

All costs for services rendered in respect of the following, unless specifically authorised by the Scheme:

NOTE: Exclusions marked with an asterisk (*) may be paid from the member's personal medical savings account if sufficient funds are available but such payments shall not accumulate to the safety net.

*3.4.1 Alternative Health Practitioners

All services not listed in paragraph D1 of Annexure B.

3.4.1.1 Acupuncture;
3.4.1.2 Aromatherapy;
3.4.1.3 Ayurvedics;
3.4.1.4 Herbalists;
3.4.1.5 Homeopathy;
3.4.1.6 Iridology;
3.4.1.7 Naturopathy;
3.4.1.8 Osteopathy;
3.4.1.9 Phytopathy;
3.4.1.10 Reflexology;
3.4.1.11 Therapeutic massage therapy (masseurs).

3.4.2 Ambulance services

Services not authorised or included in the preferred provider contract.

3.4.3 Appliances, external accessories and orthotics

3.4.3.1 appliances, devices and procedures not scientifically proven or appropriate;

3.4.3.2 back rests and chair seats;

3.4.3.3 bandages and dressings (except medicated dressings or bandages applied after a procedure), unless Prescribed Minimum Benefits;

3.4.3.4 beds, mattresses, pillows and overlays;

***3.4.3.5** blood pressure monitors;

3.4.3.6 long-term implantable ventricular assist devices and total artificial hearts – e.g. HeartWare and Berlin heart;

3.4.3.7 diagnostic kits, agents and appliances unless otherwise stated except for diabetic accessories;

3.4.3.8 electric tooth brushes;

3.4.3.9 humidifiers;

3.4.3.10 ionizers and air purifiers;

3.4.3.11 orthopaedic shoes, inserts' levelers and boots, unless explicitly stated in Annexure B and/or Prescribed Minimum Benefits;

3.4.3.12 pain relieving machines, e.g. TENS and APS;

3.4.3.13 stethoscopes;

3.4.3.14 oxygen hire or purchase, unless authorised and/or Prescribed Minimum Benefits;

3.4.3.15 CPAP machines, on Maxima Basis, Maxima Saver, Maxima Core, EntrySaver, EntryZone, Dynamic Saver, Dynamic Hospital Plan and Blue Door^{Plus} options, unless explicit benefit stated in annexure B.

3.4.4 Blood, blood equivalents and blood products

3.4.4.1 Erythropoietin, unless approved by the relevant managed healthcare programme and/or Prescribed Minimum Benefits;

3.4.4.2 Hemopure (bovine blood).

3.4.5 Dentistry

3.4.5.1 orthodontic treatment over the age of 21 years;

3.4.5.2 periodontal plastic procedures for cosmetic reasons;

3.4.5.3 dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable;

3.4.5.4 general anaesthetics, conscious analgo sedation and hospitalisation for dental work, except in the case of patients under the age of 8 years or bony impaction of the third molars;

3.4.5.5 all general anaesthetics and conscious analgo sedation in the practitioner's rooms, unless pre-authorised.

3.4.6 Hospitalisation

3.4.6.1 If application for a pre-authorisation reference number (PAR) for a clinical procedure, treatment or specialised radiology is not made, a late PAR penalty of R1000 may be imposed at the discretion of the Scheme;

3.4.6.2 accommodation and services provided in a geriatric hospital, old age home, frail care facility or similar institution, unless Prescribed Minimum Benefits.

3.4.7 Infertility

***3.4.7.1** Medical and surgical treatment, which is not included in the Prescribed Minimum Benefits in the Regulations to the Medical Schemes Act 131 of 1998, Annexure A, Paragraph 9, Code 902M, including:

- Assisted Reproductive Technology (ART);
- In-vitro fertilization (IVF);
- Gamete Intrafallopian tube transfer (GIFT);
- Zygote Intrafallopian tube transfer (ZIFT);
- Intracytoplasmic sperm injection (ICSI);

***3.4.7.2** vasovasostomy (reversal of vasectomy);

***3.4.7.3** salpingostomy for reversal of tubal ligation.

3.4.8 Maternity

3.4.8.1 3D and 4D scans;

3.4.8.2 2D scans in excess of 2, unless motivated for an appropriate medical condition;

3.4.9 Medicine and injection material

3.4.9.1 Anabolic steroids and immunostimulants, unless Prescribed Minimum Benefits;

3.4.9.2 IUD's and other contraceptives, unless specified in Annexure B or the acute formulary on the Dynamic Saver, Dynamic Hospital Plan and Blue Door^{Plus} options;

3.4.9.2 Oral contraception for skin conditions, parenteral, foams;

3.4.9.3 cosmetic preparations, emollients, moisturizers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and suntanning preparations, medicated shampoos and conditioners, except for the treatment of lice, scabies and other microbial infections and coal tar products for the treatment of psoriasis;

3.4.9.4 erectile dysfunction and loss of libido medical treatment;

3.4.9.5 food and nutritional supplements including baby food and special milk preparations unless prescribed for malabsorptive disorders and if registered on the relevant managed healthcare programme or for mother to child transmission (MTCT) prophylaxis and if registered on the relevant managed healthcare programme or when used during an authorized hospital admission, subject to the relevant managed healthcare programme;

3.4.9.6 injection and infusion material, except for out-patient parenteral treatment (OPAT) and diabetes;

3.4.9.7 the following medicines, unless they form part of the public sector protocols (which is not funded via a sponsorship or grant) and are authorised by the relevant managed healthcare programme:

3.4.9.7.1 maintenance Rituximab or other monoclonal antibodies in the first-line setting for haematological malignancies;

3.4.9.7.2 liposomal ampthotericin B for fungal infections;

3.4.9.7.3 protein C inhibitors such as Xigris, for septic shock and septicaemia;

3.4.9.7.4 trastuzumab for the treatment of HER2-positive early breast cancer and metastatic breast cancer on the options that do not offer Specialised Drug benefits, namely, the Maxima Basis, Maxima Standard, Maxima Standard^{Elect}, Maxima Saver, Maxima Core, Maxima EntrySaver, Maxima EntryZone, Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus}options;

3.4.9.7.5 any specialised drugs as defined by the managed care company (e.g. biological, tyrosine kinase inhibitors) that have not convincingly demonstrated a median overall survival advantage of more than 3 (three) months in locally advanced or metastatic malignancies, unless deemed cost-effective for the specific setting, compared to standard therapy (excluding specialized drugs) as defined in established and generally accepted treatment protocols, for example sorafenib for hepatocellular carcinoma, bevacizumab for colorectal and metastatic breast cancer.

3.4.9.7.6 Carmustine wafers for the treatment of malignant gliomas.

3.4.9.7.7 Any new chemotherapeutic drug that has not convincingly demonstrated a survival advantage of more than 3 months in advanced or metastatic malignancies, unless pre-authorised by the managed care organisation as a cost-effective alternative to standard chemotherapy.

3.4.9.8 medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines (except for schedule 0, 1 and 2 medicines supplied by a registered pharmacist);

3.4.9.9 medicines for intestinal flora;

3.4.9.10 medicines defined as exclusions by the relevant managed healthcare programme;

3.4.9.11 medicines or chemotherapeutic agents not approved by the Medicine Control Council unless Section 21 approval is obtained and pre-authorised by the relevant managed healthcare programme;

3.4.9.12 medicines not authorised by the relevant managed healthcare programme;

3.4.9.13 new medicines that have not been reviewed by the relevant managed healthcare programme;

3.4.9.14 patent medicines, household remedies and proprietary preparations and preparations not otherwise classified;

3.4.9.15 slimming preparations for obesity;

3.4.9.16 smoking cessation and anti-smoking preparations;

3.4.9.17 tonics, evening primrose oil, fish liver oils, multi-vitamin preparations and/or trace elements, and/or mineral combinations except for registered products that include haemotinics and products for use, unless Prescribed Minimum Benefits and for:

- infants and pregnant mothers;
- malabsorption disorders;
- HIV positive patients;

3.4.9.18 new indications for existing medicines that have not been reviewed by the relevant managed healthcare programme, unless standard of care in public sector and Prescribed Minimum Benefits;

3.4.9.19 biological drugs (except for Beta Interferon for the treatment of Multiple Sclerosis as per the Prescribed Minimum Benefits algorithm) on Maxima Standard, Maxima Standard^{Elect}, Maxima Basis, Maxima Saver, Maxima Core, Maxima EntrySaver, Maxima Entry Zone, Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus} options;

3.4.9.20 all benefits for clinical trials unless pre-authorised by the relevant managed healthcare programme;

3.4.9.21 diagnostic agents, unless authorised and/or Prescribed Minimum Benefits;

3.4.9.22 growth hormones, unless pre-authorised;

3.4.9.23 immunoglobulins and immune~~,~~ stimulants oral and parenteral, unless pre-authorised;

3.4.9.24 Erythropoietin, unless Prescribed Minimum Benefit;

3.4.9.25 medicines used specifically to treat alcohol and drug addiction, unless Prescribed Minimum Benefits, or specifically provided for in Annexure B.

3.4.10 Mental health

3.4.10.1 Sleep therapy;

3.4.10.2 Adult ADHD.

3.4.11 Non-surgical procedures and tests

3.4.11.1 Epilation – excluding opthalmology;

3.4.11.2 hyperbaric oxygen therapy except for specific conditions pre-authorised by the relevant managed healthcare programme.

3.4.12 Optometry

3.4.12.1 Tinted or coloured plano lenses and other cosmetic effect contact lenses, (other than prosthetic lenses) and contact lens accessories and solutions;

3.4.12.2 Optical devices which are not regarded by the relevant managed healthcare progamme as clinically essential or clinically desirable;

3.4.12.3 Readers by registered pharmacies;

3.4.12.4 Sun glasses.

3.4.13 Organs and Haemopoietic stem cell (bone marrow) Transplantation and Immunosuppressive Medication

3.4.13.1 Organs and haemopoietic stem cell (bone marrow) donations to any person other than to a member or dependant of a member on this Scheme;

3.4.14 Additional Medical Services

3.4.14.1 Art therapy;

3.4.14.2 Additional Medical Services for Blue Door^{Plus}.

3.4.15 Physical Therapy (Physiotherapists, Biokinetics and Chiropractics), unless Prescribed Minimum Benefits

3.4.15.1 Chiropractor benefits in hospital;

3.4.15.2 Chiropractic x-rays;

3.4.15.3 Physical therapy for Maxima Core, Dynamic Hospital Plan, Maxima EntryZone and Blue Door^{Plus} out of hospital.

3.4.16 Prostheses internal and external – unless PMB's

3.4.16.1 Cochlear implants;

3.4.16.2 Custom-made hip arthroplasty for inflammatory and degenerative joint disease;

3.4.16.3 Transcatheter Aortic Valve Implantation (TAVI), including percutaneous valve replacements and repairs excluded on Maxima Saver, Maxima Core, Maxima Basis, Maxima EntrySaver, EntryZone, Dynamic Saver, Dynmic Hospital Planand Blue Door^{Plus} options;

3.4.16.4 Total ankle replacement- excluded unless there is a specified benefit in annexure B;

3.4.16.5 Implantable defibrillators in the setting of primary prevention on Maxima Saver, Maxima Core, Maxima Basis, Maxima EntrySaver, Maxima EntryZone, Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus} options;

3.4.16.6 Bi-ventricular pacemakers excluded on Maxima Saver, Maxima Core, Maxima Basis, Maxima EntrySaver, EntryZone, Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus}options;

***3.4.16.7** Osseo-integrated implants for dental purposes to replace missing teeth, unless specifically provided for in Annexure B.

3.4.17 Radiology and radiography

3.4.17.1 MRI scans ordered by a general practitioner unless there is no reasonable access to a specialist;

3.4.17.2 Positron Emission Tomography for screening (other than Oncology), unless Prescribed Minimum Benefits and where this is standard in the public sector or unless specifically provided for in Annexure B;

3.4.17.3 Bone densitometry performed by a general practitioner or specialist not included in the Scheme credentialed list;

3.4.17.4 CT colonography (virtual colonoscopy) for Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus}, unless Prescribed Minimum Benefits;

3.4.17.5 MDCT Coronary Angiography for screening, unless Prescribed Minimum Benefits;

3.4.17.6 MDCT Coronary Angiography for Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus}, unless Prescribed Minimum Benefits;

3.4.17.7

If application for a pre-authorisation reference number (PAR) for specialised radiology procedures is not made, a late PAR penalty of R1000 may be imposed at the discretion of the Scheme;

3.4.17.8 All screening that has not been pre-authorised or is not in accordance with the Scheme's policies and protocols and Prescribed Minimum Benefits regulations;

3.4.17.9 Electrophysiological/ neuro-muscular tests, unless specifically pre-authorised.

3.4.18 Surgical procedures

***3.4.18.1** Abdominoplasties and the repair of divarication of the abdominal muscles;

3.4.18.2 Blepharoplasties, unless causing demonstrated functional visual impairment and pre-authorised;

3.4.18.3 Breast augmentation;

3.4.18.4 Breast reconstruction – unless mastectomy following cancer and pre-authorised;

3.4.18.5 Breast reductions;

3.4.18.6 Erectile dysfunction surgical procedures;

3.4.18.7 Gender reassignment medical or surgical treatment;

***3.4.18.8** Genioplasties as an isolated procedure;

***3.4.18.9** Keloid surgery, except for functional impairment;

***3.4.18.10** Obesity - surgical treatment, including Bariatric surgery;

***3.4.18.11** Otoplasties;

***3.4.18.12** Pectus excavatum / carinatum;

3.4.18.13 Refractive surgery, unless specifically provided for in Annexure B;

***3.4.18.14** Revision of scars except for functional impairment;

3.4.18.15 Rhinoplasties for cosmetic purposes;

3.4.18.16 All costs for cosmetic surgery performed over and above the codes authorised for admission;

3.4.18.17 Rhizotomies and facet pain blocks excluded on Maxima Basis, Maxima Saver, Maxima Core, Maxima EntrySaver, Maxima EntryZone, Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus} options;

3.4.18.18 Robotic assisted surgery, other than for radical prostatectomy where authorized by the managed healthcare organization; additional costs relating to use of the robot during such pre-authorised surgery, and including additional fees pertaining to theatre time, disposables, and equipment fees remain excluded;

3.4.18.19 Deep brain stimulation excluded on Maxima Basis, Maxima Saver, Maxima Core, Maxima EntrySaver, Maxima EntryZone, Dynamic Saver, Dynmic Hospital Plan and Blue Door^{Plus} options;

3.4.18.20 Balloon Sinuplasty excluded on Maxima Basis, Maxima Saver, Maxima Core, Maxima EntrySaver, Maxima EntryZone, Dynamic Saver, Dynmic Hospital Plan and Blue Door[Plus] options;

3.4.18.21 Laparoscopic and Arthroscopic in the setting of gonarthrosis and osteo-arthritis procedures, unless specifically provided for in Annexure B for a particular option, or authorised by the managed health care organisation in accordance with managed care protocols.

3.5 Items not mentioned in Annexure B

3.5.1 Appointments which a beneficiary fails to keep;

3.5.2 Autopsies;

3.5.3 Cryo-storage of foetal stem cells and sperm;

3.5.4 Holidays for recuperative purposes;

3.5.5 Nuclear or radio-active material or waste: all costs for medical treatment as a result of exposure;

3.5.6 Telephone consultations;

3.5.7 Travelling expenses;

3.5.8 Veterinary products.