

**RULES OF MEDIPOS MEDICAL SCHEME
VALID FROM 1 JANUARY 2025
FOR THE YEAR 2025**

Table of Contents

1. Name	1
2. Legal Persona	1
3. Registered Office	1
4. Definitions	1
5. Objectives	11
6. Membership	11
7. Registration and de-registration of Dependant	12
8. Terms and Conditions Applicable to Membership	15
9. Transfer of Employer Groups from another Medical Scheme	19
10. Membership Cards and Certificate of Membership	19
11. Change of Address of Member	20
12. Cessation and Suspension of Membership	20
13. Contributions	21
14. liability of Employer and Member	23
15. Claims Procedure	24
16. Benefits Payable	27
17. Ex-Gratia Payments	28
18. Payment of Accounts	29
19. Governance	30
20. Duties of Board of Trustees	34
21. Powers of the Board	36
22. Duties of Principal Officer and Staff	38
23. Indemnification	40
24. Fidelity Guarantee	40
25. Banking Account	40
26. Auditor and Audit Committee	41
27. General Meetings	42
28. Voting at General Meetings	44
29. Settlement of Disputes and Complaints	45
30. Notice by Employer	46
31. Dissolution	47
32. Amalgamation and Transfer of Business	47
33. Perusal of Documents	48
34. Waiver of Time limits	48
35. Amendment of Rules	48

Annexures

A	Contributions
B1	Option A Benefits
B2	Option B Benefits
B3	Option C Benefits
C	Exclusions and Limitations
D	Dental Benefits Table
Appendix 1	Personal Medical Savings Accounts (PMSA)
Appendix 2	Prescribed Minimum Benefit's (PMB's)

MEDIPOS MEDICAL SCHEME

RULES

1. NAME

The name of the Scheme is MEDIPOS Medical Scheme, hereinafter referred to as the "Scheme". The abbreviated name is MEDIPOS.

2. LEGAL PERSONA

The Scheme, in its own name, is a body corporate, capable of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act and regulations and these rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 115 Paul Kruger Street, 2nd floor, Office No.224, Pretoria, 0002, but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

4. DEFINITIONS

In these Rules, words or expression defined in the Medical Schemes Act (Act 131 of 1998) and the regulations thereto, bear the meanings assigned to them in the Act and regulations and, unless inconsistent with the context

- (a) all words and expressions purporting the masculine gender shall include the feminine;
- (b) words signifying the singular number shall include the plural, and *vice versa*; and
- (c) the following expressions shall have the following meanings:
 - 4.1 "**Act**", the Medical Schemes Act (Act No 131 of 1998) and the regulations promulgated thereunder as amended from time to time.
 - 4.2 "**Acute Medicine**", shall mean medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of medicine treatment.
 - 4.3 "**Adult dependant**", shall mean a member's spouse or partner or a dependant who is 21 years or older, but excluding children who are students at a recognised tertiary institution are younger than 23 years, and dependent on the member.
 - 4.4 "**Algorithms**", shall mean the treatment guidelines developed by the Council for Medical Schemes for each PMB condition that specify which classes of drugs are appropriate for the treatment of the PMB conditions and the sequence in which the various classes of drugs should be used.
 - 4.5 "**Annual Limit**", the maximum amount to which benefits to a member and his registered dependants shall be paid by the Scheme in terms of these rules, which amount shall be calculated annually to coincide with the financial year of the Scheme.
 - 4.6 "**Approval**", prior written approval of the Board unless inconsistent with the context of the Rules.
 - 4.7 "**Auditor**", an auditor registered in terms of the Public Accountants' and Auditors' Act (Act No 80 of 1991).

- 4.8 **"Beneficiary"**, a member or person admitted as a dependant of a member.
- 4.9 **"BHF"**, the Board of Healthcare Funders of South Africa.
- 4.10 **"Board"**, shall mean the Board of Trustees constituted to manage the Scheme in terms of the Act and these rules.
- 4.11 **"Care plan"**, shall mean a list of consultations, investigations and other procedures that pertain to the care of a CDL condition (Chronic Disease List condition as per the Medical Schemes Act and its relevant regulations and amendments for Prescribed Minimum Benefits), over a period of time which may be adaptable to the patient's specific needs through a process of interaction and consultation with the Scheme's designated agent and/or medical advisors and which will be associated, where applicable, with the drugs as listed in the Council of Medical Schemes' Algorithms for the specific CDL conditions.
- 4.12 **"Certified"**, a process in which a relevant health service is screened by a case manager to ensure that it is medically necessary and that the service, the duration thereof, the cost thereof and the level of care is clinically appropriate.
- 4.13 **"Child dependant"**, a member's natural child or stepchild or legally adopted child or a grandchild financially dependent on the member/spouse/partner for family care and support or for whom a member/spouse/partner has a legal duty to support who is younger than 21; or a member's natural child or stepchild or legally adopted child a grandchild financially dependent on the member/spouse/partner for family care and support or for whom a member/spouse/partner has a legal duty to support who is younger than 23 years and a registered full-time student at a recognised tertiary institution; and who is not a beneficiary of any other medical scheme.
- 4.14 **"Chronic Medication"**, shall mean medicine prescribed by a person legally entitled to prescribe for an uninterrupted period of at least three (3)

months and which has been applied for in the manner, and at the frequency, prescribed by the Scheme from time to time, and which application has been accepted by the Scheme.

- 4.15 **"Clinically appropriate"**, the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.
- 4.16 **"Condition-specific waiting period"**, a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made.
- 4.17 **"Continuation member"**, a member who retains his membership of the Scheme in terms of rule 6.2 or a dependant who becomes a member of the Scheme in terms of rule 6.3.
- 4.18 **"Contribution"**, in relation to a member, the amount, exclusive of interest, paid by or in respect of the member and his registered dependants if any, as membership fees and shall include contributions to personal medical savings accounts.
- 4.19 **"Cost"**, in relation to a benefit, the nett amount payable in respect of a relevant health service.
- 4.20 **"Council "**, the Council for Medical Schemes as contemplated in the Act.
- 4.21 **"Creditable coverage"**, means any period in which a late joiner was-
- 4.21.1 a member or a dependant of a medical scheme;

4.21.2 a member or a dependant of an entity doing the business of a medical scheme which, at the time of his or her membership of such entity, was exempt from the provisions of the Act;

4.21.3 a uniformed employee of the South African National Defence Force; or a dependant of such employee, who received medical benefits from the South African National Defence force; or

4.21.4 a member or a dependant of the Permanent Force Continuation Fund; but

excluding any period of coverage as a dependant under the age of 21 years;

4.22 **"Date of Service",**

4.22.1 In the event of a consultation, visit or treatment, the date on which each consultation, visit or treatment took place, whether for the same illness or not;

4.22.2 In the event of an operation, procedure or confinement, the date on which such operation, procedure or confinement occurred;

4.22.3 In the event of hospitalisation, the date of each discharge from a hospital or nursing home, or date of cessation of membership, whichever occurs first;

4.22.4 In the event of any other service, the date on which such service was rendered or requirement obtained.

4.23 **"Dependant",**

4.23.1 the spouse of a member who is not a member or registered dependant of a member of a medical scheme;

- 4.23.2 the partner of a member who is not a member or a registered dependant of a member of a medical scheme. Provided that the member or partner of the member is not a party to a marriage or a party to any other marital relationship recognised by law.
- 4.23.3 the natural child, stepchild or legally adopted child or grandchild financially dependent on the member/spouse/partner for family care and support or for whom a member/spouse/partner has a legal duty to support of a member who is not a member or a registered dependant of a member of a medical scheme.
- 4.23.4 a member's parent (including an adoptive parent), brother and sister in respect of whom the member is liable for family care and support and who is not a member or a registered dependant of a member of a medical scheme.
- 4.23.5 any minor brother or sister of a child dependant, which child dependant has been orphaned and as a consequence thereof is registered as a member in terms of Rule 6.3 provided such minor brother or sister is registered as a dependant at the time the child dependant is registered as a member.
- 4.24 "**Designated agent**", a person who has contracted with the Scheme in terms of regulation 15A to provide a managed health care service.
- 4.25 "**Designated service provider**", a health care provider or group of providers selected by the Scheme as preferred provider/s to provide to the beneficiaries, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.
- 4.26 "**Domicilium citandi et executandi**", the member's chosen physical address at which notices as well as legal process, or any action arising therefrom, may be validly delivered and served.

- 4.27 **"Emergency medical condition"**, the sudden and, at the time, unexpected onset of a health condition 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 person's life in serious jeopardy.
- 4.28 **"Employee"**, a person in the employment of an employer.
- 4.29 **"Employer"**, South African Post Office Limited, Postbank, The Document Exchange (DOCEX), Post Office Retirement Fund and MEDiPOS Medical Scheme and any other associated or affiliated Company inclusive of MEDiPOS Medical Scheme as determined by the Board from time to time.
- 4.30 **"Financial year"**, shall mean a calendar year commencing on 1 January and ending 31 December.
- 4.31 **"Formulary"**, shall mean a list of preferred medicines considered by the Scheme to be those most useful in patient care, rated on the basis of clinical effectiveness, safety and cost.
- 4.32 **"General waiting period"**, a period during which a beneficiary is not entitled to claim any benefits.
- 4.33 **"Late joiner"**, an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical scheme as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.
- 4.34 **"Managed health care"**, clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management based programmes.

- 4.35 **"Medical Scheme Rate"**, shall mean
- 4.35.1 the National Health Reference Price List for Health Services in respect of relevant health services published by the Department of Health; or
 - 4.35.2 in the absence of the NHRPL being published by the Department of Health in a particular year a rate as determined by the Board of Trustees using the 2006 NHRPL Price List tariff structure and adjusted annually by inflationary increases; and
 - 4.35.3 in respect of specific disciplines, the tariff as negotiated by the Scheme with the respective providers.
- 4.36 **"Medically necessary"**, refers to relevant health services that meet all the following requirements:
- it is required to save life, sustain life or restore function of an affected limb, organ, or system;
 - no alternative exists that has a better outcome, is more cost- effective, and has a lower risk;
 - it is accepted by the relevant Service Provider-group as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;
 - it is not rendered for the convenience of the relevant Beneficiary or Service Provider;
 - for which outcome studies are available and acceptable to the Scheme as determined by the Clinical Committee established by the Board.
- 4.37 **"Medicine"**, shall mean a substance registered under the Medicines and Related Substances Act (Act No 101 of 1965) as amended or replaced from time to time.

- 4.38 **Medicine price**", shall mean the single exit price published in terms of the Medicines and Related Substances Act (Act No 101 of 1965) plus the dispensing fee authorised by the Board in respect of such medicine.
- 4.39 **"Member"**, shall mean any person who is admitted as a member of the Scheme in terms of these rules.
- 4.40 **"Member family"**, shall mean the member and all his registered dependants.
- 4.41 **"Partner"**, a person with whom the member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.
- 4.42 **"Pre-authorisation"**, shall mean the issuing of authorisation in advance to provider of healthcare services or a Beneficiary, in respect of relevant health services as defined in the Act once such has been certified and validated.
- 4.43 **"Pre-existing sickness condition"**, a sickness condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made;
- 4.44 **"Prescribed minimum benefits"**, the benefits contemplated in section 29(1) (o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of -
- (a) the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and
 - (b) any emergency medical condition.
- 4.45 **"Prescribed minimum benefit condition"**, a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

- 4.46 "**Prescription**", shall mean the medicine that a doctor or dentist or other person legally entitled to prescribe, prescribes at one time for one person for a condition under treatment.
- 4.47 "**Protocol**", a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways.
- 4.48 "**Registrar**", the Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of section 18 of the Act.
- 4.49 "**Rules**", shall mean the Rules of the Scheme including the annexures and any other provisions relating to the benefits granted or the contributions payable.
- 4.50 "**Rules-based and clinical management-based programmes**", a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy of, health care services, procedures or settings, on basis of which appropriate managed health care interventions are made.
- 4.51 "**Service**", shall mean any relevant health care service.
- 4.52 "**Spouse**", the spouse of a member to whom the member is married in terms of any law or custom.
- 4.53 "**Validated**", a process in which the validity of membership, availability of benefits and exclusions and/or limits applicable to relevant health services in respect of a Beneficiary is assessed and confirmed.

5. OBJECTIVES

The objectives of the Scheme are

- (a) to undertake liability, in respect of its members and their dependants, in return for a contribution;
- (b) to make provision for the obtaining of any relevant health service;
- (c) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/ or
- (d) to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with or in terms of an agreement with the Scheme.

6. MEMBERSHIP

6.1 Eligibility

Subject to the further provisions of these Rules, membership of the Scheme is restricted to:

6.1.1 Employees; and/or

6.1.2 Continuation members.

6.2 Continuation Members

6.2.1 A member shall retain his/her membership of the Scheme with his/her registered dependants, if any, as a Continuing Member in the event of:

6.2.1.1 such member retiring from the service of his/her employer; or

6.2.1.2 his/her employment being terminated by the employer on account of age, ill-health or other disability; or

6.2.1.3 such member being retrenched from his/her employment with the employer.

6.2.1.4 Such member having resigned from his/her employment with th employer, for whatever reason.

6.2.2 The Scheme shall inform the member of his/her right to continue his/her membership, and of the contribution payable from the date of retirement or retrenchment or termination of his/her employment. Unless such member informs the Scheme in writing of his/her desire to terminate his/her membership.

6.3 **Dependants of deceased members**

6.3.1 The dependants of a deceased member who are registered with the Scheme as his dependants at the time of such member's death, shall be entitled to membership of the Scheme without any new restrictions, limitations or waiting periods.

6.3.2 The Scheme shall inform the dependant of his right to membership and of the contributions payable in respect thereof. Unless such person informs the Scheme in writing of his intention not to become a member, he shall be admitted as a member of the Scheme.

6.3.3 Such a member's membership terminates if he becomes a member or a dependant of a member of another medical scheme.

7. **REGISTRATION AND DE-REGISTRATION OF DEPENDANTS**

7.1 **Registration of Dependants**

7.1.1 A prospective member may apply for the registration of his dependants at the time that he applies for membership in terms of

- 7.1.2 If a member applies to register a new born or newly adopted child within 60 days of the date of birth or adoption of the child, such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month of birth or adoption, except if the birth or adoption took place on the 15th or later of a month, in which case contributions shall be due from the first day of the following month. Benefits will accrue as from the date of birth or adoption.
- 7.1.3 If a member, who marries subsequent to joining the Scheme, applies within 60 days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month, except if the marriage took place on the 15th or later of a month, in which case contributions shall be due from the first day of the following month. Benefits will accrue as from the date of marriage.
- 7.1.4 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the member may apply to the Scheme for the registration of such person as a dependant, and such person shall thereupon registered by the Scheme as a dependant. Increased contributions shall be due as from the first day of the month in which such person qualified as a dependant, except if the person qualified as a dependant on the 15th or later of a month, in which case contributions shall be due from the first day of the following month. Benefits will accrue as from the date on which such person first became eligible for registration as a dependant.
- 7.1.5 On registration as dependant other than contemplated in rules 7.1.1 to 7.1.4, benefits in respect of such dependant shall be subject to the waiting periods as provided in terms of Rule 8.

7.2 De-registration of Dependants

- 7.2.1 A member shall inform the Scheme within 30 days of the occurrence of any event which results in any one of his dependants no longer satisfying the conditions in terms of which he may be a dependant.
- 7.2.2 When a dependant ceases to be eligible to be a dependant, he shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.
- 7.2.3 For the purposes of these rules a dependant shall be deemed to have ceased to be a dependant:

Where a child dependent reaches 21, dependency does not necessarily cease. Where such child does not study or there is no proof of further studies, he should be converted to adult status and contributions revised as such.

- 7.2.3.2 At the beginning of a financial year if a registered dependant qualified as a dependant in terms of rule 4.23. unless the member provides satisfactory evidence that the requirements to qualify as a dependant still apply. Such proof is to be provided before/by 31 March every year.
- 7.2.4 The cancellation of a dependant due to a change in marital status, where the Scheme receives notification outside the 30 day notice period, the benefits will be adjusted from the date of such change in status and the amendment in the rates applicable will take place at the beginning of the month following the Scheme receiving such notice.

7.2.5 When a dependant is deregistered as a result of death, OR OTHER involuntary circumstances, on the 15th or later of a month, contribution for the full month shall be paid. In cases where this involuntary deregistration or death takes place up to and including the 14th of the month, no contribution is payable for that month, provided that the member advises the Scheme of the date of such termination immediately it takes place. Benefits shall cease on that date.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

- 8.1 A minor may become a member with the consent of his parent or guardian.
- 8.2 No person may be a member or a dependant of a member of more than one medical scheme:
- 8.2.1 of more than one member of a particular medical scheme; or
 - 8.2.2 of members of different medical schemes; or
 - 8.2.3 claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member.
- 8.3 Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in respect of himself and his dependants, of age, income, state of health and of any prior membership or admission as dependant of any other medical scheme. The Scheme may require an applicant to provide the Scheme with a medical report in relation to any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which application for membership to the Scheme was made.

- 8.3.1 The Scheme shall pay to the applicant or relevant healthcare provider the costs of any medical tests or examinations required by the Scheme for the purposes of compilation of such report.
- 8.3.2 Proof of any prior membership of any other medical scheme must also be submitted.
- 8.3.3 The Scheme may however designate a provider to conduct such tests or examinations.
- 8.4 An employee joining the Scheme on commencement of employment shall be entitled to benefits as from the date on which employment commences.
- 8.5 If an employee elects not to join the Scheme when first becoming eligible or a member terminates his membership of the Scheme, he may apply to be admitted or re-admitted as a member of the Scheme. Such admission or re-admission to membership as a member of the Scheme shall be subject to the waiting periods as provided for in terms of these Rules.
- 8.6 **Waiting Periods**
- 8.6.1 The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application -
- 8.6.1.1 a general waiting period of up to three months; and
- 8.6.1.2 a condition-specific waiting of up to 12 months.
- These waiting periods shall also apply in respect of prescribed minimum benefits.
- 8.6.2 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant,

and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application-

8.6.2.1 a condition-specific waiting period of up to 12 months except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;

8.6.2.2 in respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

8.6.3 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a general waiting period of up to three months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

8.7 No waiting period may be imposed on:

8.7.1 a person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of-

8.7.1.1 change of employment; or

8.7.1.2 an employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must be furnished to the scheme to which an application is made for such transfer to occur at the beginning of the financial year.

Where the former medical scheme had imposed a general or condition specific waiting period in respect of persons referred to in this rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.

8.7.2 a beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;

8.7.3 a child dependant born during the period of membership.

8.8 The registered dependants of a member must participate in the same benefit option as the member.

8.9 Every member will, on admission to membership, receive a detailed summary of these rules, which shall include contributions, benefits, limitations, the member's rights and obligations. Members and their dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.

8.10 Payment of any contribution shall be deemed to constitute acknowledgement by the member that he shall, on behalf of himself and his dependants, be bound by these Rules and by any amendment thereto.

8.11 A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim which he has against the Scheme or any right to a benefit which he may have from the Scheme, as the case may be. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a member is entitled under these rules, or any right in respect of such benefit or payment of such benefit to such member, if a member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.

8.12 **Choice of options**

Each member shall indicate at the time that he joins the Scheme which of the benefit options he wishes to participate in.

8.13 **Transfer between options**

Changing between the options will only be allowed on 1 January of each year.

9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

If the members of a medical scheme who are members of that scheme by virtue of their employment by a particular employer, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Board will admit as a member, without a waiting period or the imposition of new restrictions on account of the state of his health or the health of any of his dependants, any member of such first-mentioned scheme including a continuation member by virtue of their past employment by the particular employer and register as a dependant, any person who has been a registered dependant of such member.

10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

10.1 Every member shall be issued with a membership card, containing such particulars as prescribed. This card must be exhibited to the supplier of a

service on request. It remains the property of the Scheme and shall be returned to the Scheme on cessation of membership.

10.2 The utilisation of a membership card by any person other than the member or his registered dependants, with the knowledge or consent of the member or his dependants, is not permitted and shall be construed as an abuse of the benefits of the Scheme.

10.3 A member may apply for replacement/additional membership cards at a cost to be determined by the Board from time to time.

10.4 On termination of membership or on de-registration of a dependant, the Scheme shall within 30 days of the termination of membership or at any time at the request of any former member or dependant, provide the member or dependant or medical scheme to which such member or dependant applies for membership, with a certificate stating the period of cover, type of cover and whether or not the person qualified for late joiner status.

11. CHANGE OF ADDRESS OF MEMBER

A member must notify the Scheme within 30 days of any change of address including his *domicilium citandi et executandi*. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member's neglecting to comply with the requirements of this rule.

12. CESSATION AND SUSPENSION OF MEMBERSHIP

12.1 Resignation

A member may terminate his membership of the Scheme by giving three (3) months written notice. Such member may subject to the provisions of Rule 8 be permitted to rejoin the Scheme at a later date.

12.2 Ceasing employment

Subject to any provision to the contrary contained in the Rules, a member who ceases to be an employee shall on the date of such termination, cease to be a member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto.

12.3 Death

Membership of a member terminates on his death.

12.4 Failure to pay amounts due to the Scheme

If a member fails to pay amounts due to the Scheme, his membership may be terminated as provided in these rules.

12.5 Abuse of privileges, False claims, Misrepresentation and Non-disclosure of Factual information

The Board may exclude from benefits or terminate the membership of a beneficiary whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or the non-disclosure of factual information required in terms of the Act. In such event he may be required by the Board to refund to the Scheme any sum which, but for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf.

13. CONTRIBUTIONS

13.1 The monthly contributions payable to the Scheme by and in respect of members (including continuation members) are as set out in Annexure A.

13.2 Contributions are calculated on the basis of one or more of the following elements:

13.2.1 The number of dependants of the member;

13.2.2 Whether or not a dependant is a child dependant;

13.2.3 The extent of the cover afforded to the member.

13.3 Contributions shall be paid monthly in arrears and shall be paid to the Scheme not later than the third business day of the month following the last business day of the month in which it became due.

Where contribution debt owing to the Scheme, have not been paid within thirty (30) days, and provided the member has been advised in writing, the Scheme shall have the right to suspend all further benefit payments in respect of the member, until such time as the debt has been paid. If such payment has not been repaid to the Scheme within a sixty (60) days period the Scheme shall have the right to cancel the member's membership of the Scheme. Such cancellation may only be proceeded with where the Scheme has given the member written notice of the Scheme's intention to terminate such membership in the event of non-payment by the end of such period.

A notice sent by prepaid registered post to the member at his *domicilium citandi et executandi* shall be deemed to have been received by the member on the 7th day after the date of posting. In the event that the member fails to nominate a *domicilium citandi et executandi*, the member's postal address or residential address on his application shall be deemed to be his *domicilium citandi et executandi*.

13.4 In the event that payments are brought up to date, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the member from the date of default.

13.5 On re-instatement of membership, the onus of proof of claims during the period of suspension of membership will remain with the member.

13.6 All contributions in respect of new members shall be payable from the first day of the month during which employment commences, except when the date on which employment commences is the 15th or later of a month, in

which case the contributions shall be payable from the first day of the month following. Benefits shall commence from the date on which employment commences.

- 13.7 When a member's employment terminates on the 15th or later of a month, contribution for the full month shall be paid. In cases where termination takes place up to and including the 14th of the month, no contribution is payable for that month, provided that the employer advises the Scheme of the date of such termination immediately it takes place. Benefits shall cease on the date of termination of employment.
- 13.8 Other than is provided for in these rules, no refund of any portion of a contribution shall be due to any member where such member's membership of that of any dependants has terminated.
- 13.9 Nothing in these Rules shall be construed as altering in any way the employer's right to terminate the service of an employee who is a member of the Scheme or to terminate or in any way vary the conditions of any agreement between the employer and the employee in regard to conditions of service.

14. LIABILITY OF EMPLOYER AND MEMBER

- 14.1 The liability of the employer shall be limited to the amount of his unpaid contributions or subsidies.
- 14.2 The liability of a member shall be limited to the amount of his unpaid contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants to which they were not entitled and which has not been repaid by him to the Scheme.
- 14.3 Any amount owing by a member to the Scheme in respect of himself or his dependants may be recovered by the Scheme. In the event of a member

ceasing to be a member, any amount still owing by such member shall a debt due to the Scheme and recoverable by it.

15. CLAIMS PROCEDURE

- 15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, shall be accompanied by an account or statement as prescribed.
- 15.2 If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme shall, in addition to the payment contemplated in Section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars -
- (a) the name and the membership number of the member;
 - (b) the name of the supplier of service;
 - (c) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment ;
 - (d) the total amount charged for the service concerned; and
 - (e) the amount of the benefit awarded for such service.
- 15.3 In order to qualify for benefits a claim shall be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered, unless in the opinion of the Board extenuating circumstances prevail.
- 15.4 Where an account has been paid by a member, he shall, in support of his claim, submit a receipt.
- 15.5 Accounts for treatment of injuries or expenses recoverable from third parties, shall be supported by a statement, setting out particulars of the circumstances in which the injury was sustained.

15.6 Where the Scheme is of the opinion that a claim is incorrect or unacceptable for payment, the Scheme shall notify the member and the provider of this fact within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is incorrect or unacceptable. The member and provider shall return a corrected claim within sixty days from which it was returned for correction.

15.7 Should the Scheme fail to notify the member and the provider or fail to provide an opportunity for correction and resubmission in terms of Rule 15.6, it shall, in the event of a dispute, be the Scheme's responsibility to demonstrate that such account, statement, or claim is erroneous or unacceptable for payment.

15.8 **Particulars to be contained in claims**

Every claim submitted by a member to the Scheme in respect of the rendering of any service or the supply of any medicine, requirement or accommodation in a hospital or nursing home, shall contain the following particulars:

15.8.1 the surname and initials of the member;

15.8.2 the surname, first name and other initials, if any, of the patient;

15.8.3 the name of the Scheme

15.8.4 the membership number of the member;

15.8.5 the name and practice code number, where applicable, of the supplier of the service;

15.8.6 the date on which each service was rendered;

15.8.7 the nature and the cost of each service;

15.8.8 the relevant diagnostic and other item code numbers that relate to the relevant health service;

15.8.9 where the account is a photocopy of the original, certification by supplier of the service by way of a rubber stamp or signature on such photocopy;

15.8.10 the name of the referring practitioner;

15.8.11 the name, quantity, dosage and the nett price payable by the member in respect of each supply of medicine, requirement or apparatus and in the case where a pharmacist has prescribed and supplied such medicine, the diagnosis of the condition for which such medicine was prescribed;

15.8.12 mention of, in the case where an account or statement refers to the use of an operating theatre where an operation was performed on a member or a dependant of that member -

15.8.12.1 the name and practice number of the practitioner who performed the operation concerned; and

15.8.12.2 the name or names of the practitioner or practitioners who assisted at such operation;

15.8.13 in the case where a pharmacist supplied medicine on the strength of a prescription to a member or a dependant of a member, as addendum to the account or statement, a photocopy of the original prescription, certified by the pharmacist connected with the pharmacy which supplied such medicine, as a true and exact copy or photocopy of such prescription.

15.9 Extension of time for submission of claims

It shall be the duty of a member to obtain accounts for all services rendered, from the supplier thereof. If, because of the extended nature of the

treatment or for any other reason whatsoever, a member is unable to obtain an account for services, or if he has in fact received an account but, because of special circumstances beyond his control, is unable to submit it within the period referred to in rule 15.3 and 15.6 above, the Board may, in its discretion, extend this period on condition that a written application for extension is received by the principal officer before the expiration of the said period.

15.10 Claims for services rendered outside the rand monetary area

Members submitting claims for services obtained outside the Rand monetary area must ensure that accounts are specified as detailed above, before submission to the Scheme. Such claims shall reflect the amount(s) in the equivalent South African currency and the rate of exchange used for conversion and shall bear a detailed description, in English, of each service rendered. Benefits on such claims shall be calculated as if the services had been rendered in the Republic of South Africa, and paid at the applicable rate of exchange ruling on the date the service was rendered against comparable tariff codes, as laid down by the NHRPL, failing which as determined by the medical advisor.

15.11 Claim statements

On finalisation of a claim the Scheme shall send to the member an advice regarding the benefit paid or the reason why a claim was rejected and if the full amount of any benefit is not paid out to the member, the reason therefor. This advice should be kept and used for income tax purposes.

16. BENEFITS PAYABLE

16.1 Subject to the limitations and exclusions imposed by Annexure C, members and their registered dependants shall be entitled to the benefits as set out in the Schedule of Benefits.

16.2 A member is entitled to change from one to another benefit option subject to the following conditions:

- 16.2.1 The change may be made only with effect from 1 January of any financial year. The Board may, in its absolute discretion, permit a member to change from one to another benefit option on any other date.
- 16.2.2 Application to change from one benefit option to another must be in writing and lodged with the Scheme within the period notified by the Scheme provided that the member may change to another option in the case of midyear contribution increases or benefit changes.
- 16.3 The Scheme shall, where an account has been rendered, pay any benefit due to a member, either to that member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.
- 16.4 Any benefit option offered in the Schedule of Benefits covers in full the cost of the Prescribed Minimum Benefits subject to Appendix 2.
- 16.5 The Scheme shall be entitled to withhold payment of any benefit to a member whose contributions or shortfalls are more than one month in arrears for any treatment during the period of arrears, and where accounts have been paid any such amounts may be recovered by the Scheme.

17. EX GRATIA PAYMENTS

The Board may, in its absolute discretion, authorise the making of ex-gratia payments, provided such payment is not contrary to the Objectives of the Scheme.

18. PAYMENT OF ACCOUNTS

- 18.1 Payment of accounts or reimbursement of claims is restricted to the nett amount payable in respect of such benefit and maximum amount of the benefit to which the member is entitled in terms of the applicable benefit and option elected.
- 18.2 The Scheme may, by mutual agreement with any supplier or group of suppliers of a service, pay the account or the benefit to which the member is entitled in respect of a service, direct to such supplier. The Scheme shall be entitled to determine, at its sole and absolute discretion, whether to enter into such Agreement.
- 18.3 Where the Scheme has paid an account or portion of an account or any benefit to which a member is not entitled, whether payment is made to the member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme.
- 18.4 Where such overpayment has not been paid within thirty (30) days of the date upon which it was corrected, and provided the member has been advised in writing, the Scheme shall have the right to suspend all further benefit payments in respect of the member, until such time as the debt has been paid. If such overpayment has not been repaid to the Scheme within a sixty (60) day period from the date it was corrected, the Scheme shall be entitled to cancel the defaulting member's membership of the Scheme. Such cancellation may only be proceeded with where the Scheme has given the member written notice of the Schemes intention to terminate such membership in the event of non-payment by the end of such period.
- 18.5 Notwithstanding the provisions of this rule, the Scheme has the right to pay any benefit directly to the member concerned.
- 18.6 Any benefit payment due to a member referred to in 15.10 shall be paid in rands into his bank account in the republic of South Africa.

19. GOVERNANCE

19.1 A Board consisting of ten (10) persons who are fit and proper to manage the business of the Scheme shall manage the affairs of the Scheme in accordance with these Rules and the provisions of the Act.

19.2 Five (5) members of the Board shall be elected by members from duly nominated members to hold office for a period of five (5) years. The remaining Trustees shall be appointed as follows:

19.2.1 Two (2) Trustees shall be appointed by the Board:

19.2.2 One (1) Trustees shall be appointed by South African Post Office Limited or any of its subsidiaries;

19.2.3 One (1) Trustees shall be appointed by the Postbank; and

19.2.4 One (1) Trustees shall be appointed by DOCEX,

Which Appointed Trustees shall also hold office for a period of five (5) years from the date of their respective appointments.

19.3 The following persons are not eligible to serve as members of the Board:

19.3.1 A person under the age of 21 years;

19.3.2 A person who is not a member of the Scheme;

19.3.3 An employee, director, officer, consultant or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;

19.3.4 A broker;

19.3.5 The principal officer of the Scheme; and

19.3.6 The auditor of the Scheme.

- 19.4 Retiring members of the Board are eligible for re-election and re-appointment provided no person shall serve more than a maximum of two consecutive terms.
- 19.5 In an election year names of candidates for election or re-election as Trustees, shall be submitted (signed by proposers and seconders in good standing with the Scheme and endorsed with the candidate's agreement to stand for election) together with an abridged curriculum vitae to the Principal Officer at least sixty (60) days before the Annual General Meeting of the Scheme.

The election of these candidates shall, if there be more than the required number of Trustees positions falling vacant be by majority vote of all the Members voting by ballot under arrangements made by the Board.

- 19.6 The names of candidates elected and/or appointed shall be announced at the Annual General Meeting.
- 19.7 At the sole discretion of the Board, the Board may appoint or request the Employer to appoint alternate Trustees to act during another Trustee's absence.
- 19.8 Any casual vacancy which may occur amongst the member elected Board members shall be filled by the remaining member elected board members from the eligible candidates at the last general election. A person so becoming a trustee shall hold office for the balance of the original term.

Should there be no eligible candidates available, the vacancy shall be filled by the remaining member elected Board members, from members. A person so appointed shall retire at the first ensuing Annual General Meeting and that meeting shall elect a Board member to hold office until the next general elections to be held by the Scheme.

Any vacancy which may occur amongst the SA Post Office Limited appointed Board members may be filled by the SA Post Office Limited and the person so appointed shall hold office for the remainder of the term of

office.

- 19.9 Half plus one members of the Board shall form a quorum.
- 19.10 Notwithstanding any vacancy on the Board, the remaining board members may act on its behalf; provided that if and so long as their number no longer meets the requirement fixed for a quorum, such Board members may act only for the purpose of increasing the number of board members to that number or for summoning a General Meeting of the Scheme, but for no other purpose.
- 19.11 The Board members may meet together for the dispatch of business, adjourn and otherwise regulate their meetings as they see fit.

Provided that a resolution in writing signed by all Board members who are then in the Republic of South Africa and forming a quorum in terms of rule 19.8 shall be effective for all purposes as if it had been passed at a meeting of the Board members duly convened, held and constituted. Any such resolution may consist of several copies of the resolution, each of which may be signed by one or more trustees (or their alternates, if applicable) and shall be deemed to have passed on the date on which it was signed by the last trustee who signed it unless a statement to the contrary is made in the resolution. Any resolution passed in terms of this rule shall be noted at the first meeting of the Board held after the passing of such resolution.

- 19.12 The Board may convene a special meeting should the necessity arise. Any three members of the Board may request the Chairman to convene a special meeting of the Board provided the matters to be discussed at the meeting are clearly stated in the request. Upon receipt of the request, the Chairman shall, within 7 days, convene a special meeting of the Board to deal with the matters stated therein.
- 19.13 The members of the Board shall be entitled to traveling and subsistence expenses properly and necessarily incurred by them in and about the business of the Scheme as determined by the Board from time to time.

- 19.14 Members of the Board may be paid a Honorarium as determined at the Annual General Meeting upon recommendation of the Board.
- 19.15 The Board may approve any other fee in respect of services, other than the duties as set out in Rule 20, rendered to the Scheme by members of the Board.
- 19.16 A member of the Board ceases to hold office:
- 19.16.1 If he should die; or
 - 19.16.2 If he is declared insane or is regarded incapable of managing his affairs; or
 - 19.16.3 If he is declared insolvent or has surrendered his estate for the benefit of his creditors; or
 - 19.16.4 If he is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or has committed perjury; or
 - 19.16.5 If he is removed by the court from any office of trust on account of misconduct; or
 - 19.16.6 If he resigns as a member of the Board; or
 - 19.16.7 If he is disqualified under any law from carrying on his profession; or
 - 19.16.8 In the case of a member representative if he ceases to be a member of the Scheme; or
 - 19.16.9 If he absents himself from three consecutive meetings of the Board without the consent of the chairman; or
 - 19.16.10 If he is removed from office by the Council in terms of Section 46 of the Act, or
 - 19.16.11 If his appointment as representative of the employer is withdrawn by the employer after an engagement with the Board, and provided that the employer can show that the conduct of the Trustee is seriously prejudicial to the interest of beneficiaries of the medical scheme;
 - 19.16.12 If he ceases to be a member of the Scheme.
- 19.17 Unless otherwise approved by the Board, one full week's notice of a Board

meeting, accompanied by an appropriate agenda, shall be given.

- 19.18 Matters before the Board shall be decided by a majority vote and in the event of an equality of votes the Chairman shall have a casting vote in addition to his deliberative vote.
- 19.19 The Board may delegate any of its powers to the Principal Officer or sub-committee; provided that the sub-committee so nominated shall in the exercising of its powers conform to any rules or instructions that may be imposed on or issued to it by the Board.
- 19.20 The Board shall cause the proceedings of all Board meetings to be properly minuted and the minutes of such meetings shall be laid before the first succeeding respective meeting. If the minutes of any such meetings are accepted and confirmed as correct, they shall be signed by the Chairman.
- 19.21 The Board shall appoint a Chairman and Vice-Chairman from amongst its members.
- 19.22 In the absence of the Chairman and Vice-Chairman, the Board members present shall elect one of their member to preside.

20. DUTIES OF BOARD OF TRUSTEES

- 20.1 The Board is responsible for the proper and sound management of the Scheme, in terms of these rules.
- 20.2 Board must act with due care, diligence, skill and in good faith.
- 20.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.
- 20.4 The Board must apply sound business "principles and ensure the financial soundness of the Scheme.

- 20.5 The Board shall appoint a principal officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the principal officer and any person employed by the Scheme.
- 20.6 The chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.
- 20.7 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.
- 20.8 The Board must ensure that proper control systems are employed by and on behalf of the Scheme.
- 20.9 The Board must ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the Rules.
- 20.10 The Board must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and the Rules.
- 20.11 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.
- 20.12 The Board must obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.
- 20.13 The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.
- 20.14 The Board must take all reasonable steps to protect the confidentiality of

medical records concerning any member or dependant's state of health.

20.15 Subject to rule 21.16 the Board must approve all disbursements.

20.16 The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme.

20.17 The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.

20.18 The Board shall disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme.

21. POWERS OF THE BOARD

The Board has the power -

21.1 to cause the termination of the services of any employee of the Scheme;

21.2 to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfillment of the Scheme's obligations under such appointments;

21.3 to appoint a sub-committee consisting of such Board members and other experts as it may deem appropriate;

21.4 to appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the

- regulations;
- 21.5 to appoint, compensate and determine the level of service of any accredited broker for the introduction or admission of a member to the Scheme;
- 21.6 to contract with managed health care organisations subject to the provisions of the Act and its regulations;
- 21.7 to purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it;
- 21.8 to let or hire movable or immovable property;
- 21.9 in respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such moneys upon security and to realise, re-invest or otherwise deal with such monies and investments;
- 21.10 with the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;
- 21.11 subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the beneficiaries of the Scheme;
- 21.12 to donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the beneficiaries;
- 21.13 to grant repayable loans to members or to make *ex gratia* payments on behalf of members in order to assist such members to meet commitments in regard to any matter specified in Rule 5;

- 21.14 to contribute to any fund conducted for the benefit of employees of the Scheme;
- 21.15 to reinsure obligations in terms of the benefits provided for in these rules in the prescribed manner;
- 21.16 to authorise the principal officer and/or such members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;
- 21.17 to contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes;
- 21.18 in general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these rules.

22. DUTIES OF PRINCIPAL OFFICER AND STAFF

- 22.1 The staff of the Scheme must ensure the confidentiality of all information regarding its members.
- 22.2 The principal officer is the executive officer of the Scheme and as such shall ensure that:
- 22.2.1 He acts in the best interests of the members of the scheme at all times;
- 22.2.2 the decisions and instructions of the Board are executed without unnecessary delay;

- 22.2.3 where necessary, there is proper and appropriate communication between the Scheme and those parties affected by the decisions and instructions of the Board;
- 22.2.4 he keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;
- 22.2.5 he keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of section 57(6) of the Act;
- 22.2.6 he does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.
- 22.3 The principal officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.
- 22.4 The principal officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Board, and any other duly appointed sub-committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.
- 22.5 The principal officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.
- 22.6 The principal officer shall keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.

22.7 The principal officer shall ensure preparation of the annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

22.8 The following persons are not eligible to be a principal officer:

22.8.1 an employee, director, officer, consultant or contractor of the administrator of the Scheme, or of the holding company, subsidiary, joint venture or associate of that administrator.

22.8.2 a broker

22.9 The provisions of rules 19.15.1 - 19.15.10 apply mutatis mutandis to the principal officer.

23. INDEMNIFICATION

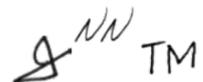
The Board and any officer of the Scheme is indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim in connection with the Scheme, not arising from their negligence, dishonesty or fraud.

24. FIDELITY GUARANTEE

The Board shall ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers.

25. BANKING ACCOUNT

The Scheme shall maintain a banking account in the name of the Scheme with a registered commercial bank. All moneys received shall be deposited to the credit of such account and all payments shall be made either by cheque under the joint signature of not less than two persons nominated by the Board or by electronic transfer.



26. AUDITOR & AUDIT COMMITTEE

- 26.1 An auditor (who must be approved by the Registrar in terms of section 36 of the Act) must be appointed at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.
- 26.2 The Board may at any time terminate the services of an Auditor so appointed and appoint another Auditor in his place, provided such termination is not contrary to the provisions of the Public Accountants and Act, 1991 (Act No 80 of 1991).
- 26.3 The following persons are not eligible to serve as auditor of the Scheme-
- 26.3.1 a member of the Board;
 - 26.3.2 an employee, officer or contractor of the Scheme;
 - 26.3.3 an employee, director, officer or contractor of the Scheme's administrator, or of the holding company, subsidiary, joint venture or associate of the administrator;
 - 26.3.4 a person not engaged in public practice as an auditor; and
 - 26.3.5 a person who is disqualified from acting as an auditor in terms of the Companies Act, 1973.
- 26.4 Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board must within 30 days appoint another auditor to fill the vacancy for the unexpired period.
- 26.5 If the members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this rule, the Board must within 30 days make such appointment, and if it fails to do so, the Registrar may at any time do so.
- 26.6 The auditor of the Scheme shall have the right of access at all times to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from Officers of the Scheme and the

Administrator, such information and explanations as he thinks necessary for the performance of his duties.

26.7 The auditor shall make a report to the members of the Scheme on the financial statement examined by him and laid before them in General Meetings. A copy of such report shall be sent to the employer who will keep it for the information of employees and a copy shall be available for inspection by members at the Offices of the Scheme.

26.8 The Board shall appoint an audit committee of five members of whom two shall be members of the Board.

27. GENERAL MEETINGS

27.1 Annual general meeting

27.1.1 The annual general meeting of members must be held not later than 31 July of each year.

27.1.2 Members and continuation members shall be furnished with a notice convening the annual general meeting, containing the agenda, the Board Report and a summary of the financial statements and other documents provided for in section 37 of the Act at least 21 days before the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such a meeting.

27.1.3 Thirty (30) members of the Scheme present or virtually in person shall form a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed until the same day and time of the next week and the members then present shall form a quorum.

Provided that if the same day of the next week is a public holiday, the meeting will be postponed till the first working day following the public holiday.

27.1.4 The financial statements and other documents provided for in section 37 of the Act shall be laid before the meeting.

27.1.5 Notice of motions to be placed before the annual general meeting must reach the principal officer not later than seven days prior to the date of the meeting.

27.1.6 In order to enable members resident in different parts of South Africa to attend and participate in the Annual General Meeting, the Board may direct that the Annual General Meeting take place in any appropriate form or fashion including virtual meeting. Provided that no such arrangements shall be prejudicial to the rights of members. For the sake of clarity it is recorded that such arrangements may take the form of a series of Regional meetings at which the quorum shall be no less than thirty (30) members.

27.2 Special general meeting

27.2.1 A special general meeting of members may be called by the Board, if it is deemed necessary.

27.2.2 At the request of at least 12 members of the Scheme, the Board shall cause a special general meeting to be called within 21 days. The request shall state the objects of the meeting and shall be signed by all the members and delivered to the Principal Officer at the registered office of the Scheme.

27.2.3 The notice convening the special general meeting, containing the agenda, shall be displayed prominently at the employer's places of business and dispatched to continuation members at least 14 days before the date of

the meeting. The non-receipt of such notice by any member does not invalidate the proceedings at such a meeting.

27.2.4 Fifty (50) members present in person or virtually shall form a quorum. If a quorum is not present at a special general meeting called by the Board after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed till the same day and time of the next week and the members then present shall form a quorum: Provided that if the same day of the next week is a public holiday, the meeting will be postponed till the first working day following the public holiday:

Provided further that if a quorum is not present at a special general meeting convened at the request of members after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.

28. VOTING AT GENERAL MEETINGS

28.1 Every member who is present at a general meeting of the Scheme and whose contributions are not in arrear, shall have the right to vote at the meeting or, subject to the provisions of Rule 27.2, appoint another person who is a member of the Scheme as a proxy to attend, speak and vote in his stead.

28.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and shall be signed by the member and the other person appointed as the proxy; provided that the signature of any serving trustee nominated as proxy will not be required. The proxy form shall be deposited not later than 7 days before the time for holding the meeting at the registered office of the Scheme or at such other place or places as the Board shall decide and of which notice has been given in the notice of the meeting.

- 28.3 Failure to comply with the provisions of Rule 28.2 shall be render any proxy invalid.
- 28.4 The Chairman-s decision as to whether or not any proxy is valid shall be final and binding.
- 28.5 The chairperson shall determine whether voting shall be by ballot or by a show of hands. In the event of the votes being equal, the Chairman has a casting vote in addition to his deliberative vote.

29. SETTLEMENT OF DISPUTES AND COMPLAINTS

- 29.1 Members may lodge complaints, in writing, to the Scheme. The Scheme shall also provide a dedicated telephone number which may be used for dealing with telephonic complaints.
- 29.2 All written complaints will be responded to in writing within 30 days of receipt thereof.
- 29.3 The Board will appoint a Disputes Committee comprising of six (6) suitable and qualified persons, who shall not be members of the Board, employees or officers of the Scheme or the administrator.
- 29.4 Three (3) persons from rule 29.3 above, one of which shall be a person with legal expertise, shall always be available to adjudicate over any dispute that may arise in terms of rule 29.5.
- 29.5 Any dispute, which may arise between a member, prospective member, former member or a person claiming by virtue of such member and the Scheme or an officer of the Scheme, shall be referred by the Principal Officer to the disputes committee for adjudication.
- 29.6 On receipt of a request in terms of this Rule, the Principal Officer shall convene a meeting of the disputes committee by giving not less than 21

days notice in writing to the complainant, members of the Committee and all members of the disputes committee, stating the date, place and hour of the meeting and particulars of the dispute.

- 29.7 The disputes committee shall determine the procedure to be followed.
- 29.8 The parties to any dispute have the right to be heard before such committee either in person or through a representative.
- 29.9 An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than three months after the date on which the decision concerned was made or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.
- 29.10 The operation of any decision which is the subject of any appeal under rule 29.9 shall be suspended pending the decision of the Council on such appeal.

30. DISSOLUTION

- 30.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution.
- 30.2 Members in a general meeting may propose that the Scheme should be dissolved, in which event the Board must arrange for members to decide by ballot whether the Scheme must be liquidated.
- 30.3 Pursuant to a decision by members taken in terms of rule 30.2 the principal officer must, in consultation with the Registrar, furnish to every member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

30.4 Every member must be requested to return his/her ballot paper duly completed before a set date. If at least 50 per cent of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, subject to the approval of the Registrar, a competent person as liquidator.

31. AMALGAMATION AND TRANSFER OF BUSINESS

31.1 The Scheme may, subject to the provisions of section 63 of the Act, amalgamate with or transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme. Before such event the Board must arrange for members to decide by ballot whether the proposed amalgamation or transfer should be proceeded with or not.

31.2 If at least 50 per cent of the members return their ballot papers duly completed and if the majority thereof is in favour of the amalgamation or transfer then, subject to section 63 of the Act, the amalgamation or transfer may be concluded.

32. PERUSAL OF DOCUMENTS

32.1 Any beneficiary shall on request and on payment of a fee of R 50.00 per copy, be supplied by the Scheme with a copy of the following documents:

32.1.1 The rules of the Scheme;

32.1.2 the latest audited annual financial statements, returns, Trustee reports and auditor's report of the Scheme and accompanying management accounts in respect of its benefit options.

32.2 A beneficiary shall be entitled to inspect free of charge at the registered office of the Scheme any of the document referred to in rule 33.1 and to make extracts therefrom.

32.3 This rule shall not be construed to restrict a person's rights in terms of the Promotion of Access to Information Act, Act no 2 of 2000.

33. WAIVER OF TIME LIMITS

With the exception of circumstances in which such determination might be inequitable or inconsistent with these Rules or the Objectives of the Scheme, the Board shall have the right to waive or relax or condone the non-compliance with any time period provided for in these Rules

34. AMENDMENT OF RULES

34.1 The Board shall be entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

34.2 No alteration, rescission or addition shall be valid unless it has been approved and registered by the Registrar in terms of the Act.

34.3 Members shall be furnished with a copy of each amendment within 21 days after registration thereof. Should a member's rights, obligations, contributions or benefits be amended, he shall be given 30 days advance notice of such change.

34.4 Notwithstanding the provisions of rule 35.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.

34.5 No alteration, rescission or addition which affects the objectives of the Scheme shall be valid unless it has been approved by a majority of members present in a general meeting or by ballot.



ANNEXURE A

CONTRIBUTIONS

1. CONTRIBUTIONS

Contributions in respect of members shall be as calculated in terms of the Schedule set out hereunder.

2. SCHEDULE OF CONTRIBUTIONS

The contribution tables which follows shall form the basis for contributions with effect from 1 January 2025 to 31 December 2025. Contributions shall be payable monthly in arrears. No contribution is made toward a Personal Medical Savings Account in respect of Options A and C.

Contributions from 1 January 2025 to 31 December 2025

Option A	Member	Adult Dependant	Child Dependant
	8 787	8 430	2 052

Option B	Dependant type	Total Contribution	Savings contribution (included in total contribution)
R0 – R8 8185	Member	3 363	151
	Adult Dependant	3 159	142
	Child Dependant	996	45
R8 186 - R11 140	Member	3 510	158
	Adult Dependant	3 312	149
	Child Dependant	1 044	47
R11 141 - R14 985	Member	3 675	165

Option B	Dependant type	Total Contribution	Savings contribution (included in total contribution)
	Adult Dependant	3 486	157
	Child Dependant	1 104	50
R14 986+	Member	3 768	170
	Adult Dependant	3 579	161
	Child Dependant	1 131	51

Option C	R0 – R8 185	R8 186 – R11 140	R11 141 – R14 985	R14 986+
Member	1 707	1 878	2 055	2 121
Adult Dependant	1 470	1 653	1 812	1 854
Child Dependant	453	561	615	630

3. PREMIUM PENALTIES FOR PERSONS JOINING LATE IN LIFE

3.1 Premium penalties may be applied to a late joiner. Such penalties shall be applied only to that portion of the contribution relative to the late joiner and shall not exceed the following bands:

Penalty Bands	Maximum Penalty
1 –4 years	0.05 x contribution
5 –14 years	0.25 x contribution
15 – 24 years	0.5 x contribution
25 + years	0.75 x contribution



The following formula shall be applied to determine the applicable penalty

STM
NN



band:

A = B minus (35 + C) where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of application

C = number of years of creditable coverage which can be demonstrated.

3.2 Should a late joiner penalty already have been imposed and evidence of creditable coverage is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the time that such evidence was provided.

3.3 If an applicant is unable to obtain documentary proof to substantiate periods of creditable coverage, he shall be entitled to produce a sworn affidavit declaring such detailed information and that reasonable efforts to obtain documentary evidence of such periods of creditable coverage were unsuccessful.

ANNEXURE B1

REGISTERED BY ME ON

Milana Masewanganyi
 2025/01/13
 Signed by Milana Masewanganyi
 m.masewanganyi@medicalschemes.co.za
 1460102025 16:15:27(UTC+02:00)
 REGISTRAR OF MEDICAL SCHEMES

2025 SCHEDULE OF BENEFITS: OPTION A

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular Appendix 2 concerning the provision of the statutory Prescribed Minimum Benefits, "PMB's")

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	
A. MAJOR MEDICAL EXPENSES (MME)		Subject to the Overall Annual Limit	1. Sub-limits as defined in this Annexure may be pro-rated, i.e. calculate from the date of admission to membership to the end of the financial year. 2. Once the sub-limits are reached, only the diagnosis, treatment and care costs of the prescribed minimum benefit conditions will be paid in full.
1. HOSPITALISATION (includes ward fees, theatre fees, recovery rooms, confinements, specialized intensive care, high care and materials used in hospital)	Benefits for PMBs and non-PMBs: 100% of cost at negotiated rate in hospital	Subject to the Overall Annual Limit	1. Subject to pre-authorisation and approval by the Scheme. 2. All non-emergency admissions are subject to pre-authorisation 3 working days prior to the admission date. 3. A co-payment of R2 640 for failing to pre-authorise prior to Admission will apply. 4. Emergencies must be pre-authorised within 24 hours of admission or first working day after such emergency treatment or admission. 5. Private ward accommodation will be at general ward rate subject to certification by the attending practitioner as essential for the recovery of the patient and approved by the Scheme. 6. Confinements are subject to a maximum of three (3) days for normal deliveries and four (4) days for caesarian sections. A further stay may be authorised at the discretion of the case manager.
a) Medicines used in hospital	100% of medicine price	Subject to the Overall Annual Limit	1. Pre-authorisation of admission required. 2. Medicines will be subject to medicine reference pricing.
b) Medicines dispensed from discharge from hospital [to take out medicine (TTO)]	100% of medicine price	Subject to the Overall Annual Limit	1. Pre-authorisation of admission required. 2. Medicines will be subject to medicine reference pricing. 3. TTO's limited to maximum of 7 day's supply of medicines.

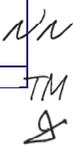
NA
 TM
 S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
c) Psychiatric institutions	100% of cost	Subject to a limit of R47 410 per family per annum for all related costs Continued benefits for PMBs subject to pre-authorisation and PMB regulations	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Includes treatment on a day patient basis, in lieu of hospitalisation, subject to pre-authorisation. 3. If a patient is admitted to a hospital, other than a psychiatric institution, all related accounts will be paid at cost subject to the limit and PMBs. 4. Benefit is pro-rated if member joins during benefit year.
d) Substance and Alcohol abuse	100% of cost	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. If a patient is admitted to a hospital, all related accounts will be paid at cost subject to the limit and PMBs.
e) Rehabilitation Centres	100% of cost	Subject to the Overall Annual Limit and in lieu of hospitalisation for all related costs	<ol style="list-style-type: none"> 1. Subject to Pre-authorisation and approval by the Scheme. 2. The benefit covers beneficiaries who had become temporarily disabled as a result of acute injuries caused by trauma, infection, spinal cord injury, brain injury or bleeding or infarction resulting in stroke. Available only immediately following such an event. Progressive conditions such as Multiple Sclerosis and Parkinson's disease is not included. 3. The Scheme's designated agent will liaise with the case manager of the Hospital/facility and the treating doctor to assess appropriateness of care.
f) Care in lieu of hospitalisation	100% of cost or Medical Scheme Rate (MSR), whichever is the lesser	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Subject to pre-authorisation at accredited facilities only and by registered nurses. 2. This benefit covers the phase after or instead of hospitalisation. 3. Excludes frail care. 4. The Scheme's designated agent will liaise with the case manager of the Hospital and the treating doctor to assess appropriateness of step-down transfer. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge at an accredited provider and/facility, in accordance with the beneficiary's clinical motivation from doctors and case managers. 5. Benefit is pro-rated if member joins during benefit year.
2. Medical Specialists and General Practitioners		Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
2.1 General Practitioners Surgery and in-hospital procedures and visits	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
2.2 Specialists			1. Subject to pre-authorisation and approval by the Scheme.



NA
TM
S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
Surgery and in-hospital procedures and visits a) Non-preferred specialist Network b) Preferred Specialist Network	100% of cost or MSR, whichever is the lesser 100% of cost or 110% of MSR, whichever is the lesser	Subject to the Overall Annual Limit	2. Referral can be provided from a network or non-network General Practitioner. <div style="border: 1px solid red; padding: 5px; text-align: center;"> REGISTERED BY ME ON Mina Maswanganj  2025/01/13 Signed by Mina Maswanganj, m.maswanganj@medicalschemes.co.za 14010525 16:15:47(JT0-02:00) REGISTRAR OF MEDICAL SCHEMES </div>
2.3) Anaesthetics	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
2.4) Perfusionist	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
2.5) Clinical Technology	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
2.6) Procedures (normally performed in hospital) performed in the doctor's rooms	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to Scheme's Major Medical Procedures List and pre-authorisation.
2.7) Circumcision (out-of-hospital)	100% of cost or MSR, whichever is the lesser	Subject to limit of R2 080 per beneficiary per annum	
3. Radiology and Pathology		Subject to the Overall Annual Limit	In respect of PMB conditions, Radiology and Pathology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost.
a) Radiology and Pathology while hospitalised (excluding MRI, CAT, Radio-isotope and Ultrasound scans)	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
b) Advanced Radiology MRI, CAT, Radio-isotope scans and Ultra sound scans (in and out of hospital)	100% of cost or MSR, whichever is the lesser	Subject to a limit of R38 520 per family per annum	1. Subject to pre-authorisation and approval by the Scheme.



SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
4. Maternity		Subject to the Overall Annual Limit	Beneficiary enrollment on the Maternity Management Programme is encouraged.
a) Antenatal Classes	100% of cost or MSR, whichever is the lesser	Limited to 5 antenatal classes per pregnancy	
b) Antenatal Consultations	100% of cost or MSR, whichever is the lesser	Limited to 9 antenatal consultations per pregnancy	
c) Ultrasound Scans for Pregnancy	100% of cost or MSR, whichever is the lesser	Limited to 2 scans (2D) per pregnancy	
d) Confinement in a registered birthing unit and confinement out of hospital	100% of cost or MSR, whichever is the lesser	Limited to and included in the Maternity Benefits	Subject to pre-authorization and approval by the Scheme.
e) Additional Maternity Benefits 1. Blood grouping test 2. Flu vaccination 3. Haemoglobin measurement test 4. Hearing screening for new-born 5. Mental health visit with psychologist 6. Nutritional assessment with dietician 7. Postnatal mid-wife Visits 8. VDRL test 9. Breastfeeding visit with nurse or specialist 10. Congenital hypothyroidism screening 11. Full blood count 12. Urine analysis test 13. Vitamins	100% of cost or MSR, whichever is the lesser	1. Limited to 1 test per pregnancy 2. Limited to 1 per pregnancy 3. Limited to 2 test per pregnancy 4. Limited to 1 test per newborn 5. Limited to 2 per pregnancy 6. Limited to 1 test per pregnancy 7. Limited to 6 per pregnancy 8. Limited to 1 test per pregnancy 9. Limited to 1 per pregnancy 10. Limited to 1 test per pregnancy 11. Limited to 1 test per pregnancy 12. Limited to 12 tests per pregnancy 13. Limited to R1 30 per pregnancy	1. Subject to pre-authorization and approval by the Scheme. 2. Once the additional maternity limits have been reached, tests will be paid from the applicable benefit limit.
5. Oncology (Cancer)	100% of cost at DSP or 75% of cost or MSR, whichever is the lesser, at a non-DSP	Limited to R499 500 per beneficiary per annum, for PMBs and non-PMBs - thereafter unlimited for PMBs	1. Patients are encouraged to enroll on the Oncology Benefit Management Programme. 2. Non-Prescribed Minimum Benefits and Prescribed Minimum Benefits formularies apply as per the Designated Service Provider's (DSPs) treatment protocols. 3. Benefit is subject to submission of a 12-month treatment plan by the treating Oncologist and the approval thereof prior to the commencement of treatment. 4. Benefits in respect of cancer related medicines, radiotherapy, chemotherapy, oncologist, pathology, X-ray, mammograms, MRI

MM
TM
S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS																																																						
			<p>scans, CT scans and radio-isotope scans will be paid from the Oncology benefit.</p> <p>5. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.</p>																																																						
<p>6. MEDICAL APPLIANCES</p> <p>a) Internal Prosthesis/Devices</p> <div data-bbox="89 829 358 995" style="border: 1px solid red; padding: 5px; margin: 10px 0;"> <p style="text-align: center; color: red; font-weight: bold;">REGISTERED BY ME ON</p> <p style="font-size: 8px;">Mina Maswanganyi</p> <p style="font-size: 24px; font-weight: bold; margin: 0;">MPH</p> <p style="font-size: 12px;">2025/01/13</p> <p style="font-size: 8px;">Signed by: Mina Maswanganyi m.maswanganyi@medicallaw.co.za 14/01/2025 16:14:47(UTC+02:00)</p> <p style="text-align: right; font-size: 10px;"> e-signature</p> <p style="text-align: center; color: red; font-weight: bold; border-top: 1px dashed red; border-bottom: 1px dashed red;">REGISTRAR OF MEDICAL SCHEMES</p> </div>	<p>100% of cost or MSR, whichever is the lesser</p>	<p>Limited to R88 620 per family per annum and subject to the following sub-limits per beneficiary per annum:</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr><td>Cardiac Stents (each) max 3 stents</td><td style="text-align: right;">R30 410</td></tr> <tr><td>• Drug eluting Stents (each)</td><td style="text-align: right;">R22 550</td></tr> <tr><td>• Bare Metal</td><td style="text-align: right;">R12 720</td></tr> <tr><td>Aorta Stent graft</td><td style="text-align: right;">R65 790</td></tr> <tr><td>Peripheral Arterial Stent Graft</td><td style="text-align: right;">R50 090</td></tr> <tr><td>Cardiac pacemakers</td><td style="text-align: right;">R88 610</td></tr> <tr><td>Cardiac valves (each) max 2 valves</td><td style="text-align: right;">R46 250</td></tr> <tr><td>Total Hip Replacement</td><td style="text-align: right;">R73 920</td></tr> <tr><td>Total Knee Replacement</td><td style="text-align: right;">R67 800</td></tr> <tr><td>Total Shoulder Replacement</td><td style="text-align: right;">R63 510</td></tr> <tr><td>Elbow Replacement</td><td style="text-align: right;">R63 510</td></tr> <tr><td>Temperomandibular (TM) Joint Replacement</td><td style="text-align: right;">R63 510</td></tr> <tr><td>Ankle Replacement</td><td style="text-align: right;">R63 510</td></tr> <tr><td>Finger Replacement</td><td style="text-align: right;">R41 810</td></tr> <tr><td>Toe (Total or Partial) Replacement</td><td style="text-align: right;">R41 810</td></tr> <tr><td>Bryan's and other intervertebral disc prosthesis</td><td style="text-align: right;">R51 520</td></tr> <tr><td>Mesh grafts</td><td style="text-align: right;">R36 970</td></tr> <tr><td>Intra-stromal corneal ring segments</td><td style="text-align: right;">R35 400</td></tr> <tr><td>Spinal Instrumentation</td><td style="text-align: right;">R61 250</td></tr> <tr><td>Other approved spinal implantable devices and intervertebral discs</td><td style="text-align: right;">R60 650</td></tr> <tr><td>Bone lengthening devices</td><td style="text-align: right;">R54 510</td></tr> <tr><td>Neuro-stimulation (ablation devices for Parkinson's)</td><td style="text-align: right;">R58 660</td></tr> <tr><td>Vagal stimulator for intractable Epilepsy</td><td style="text-align: right;">R46 660</td></tr> <tr><td>Detachable platinum coils</td><td style="text-align: right;">R60 650</td></tr> <tr><td>Embolic protection devices</td><td style="text-align: right;">R60 500</td></tr> <tr><td>Intraocular lens (per lens)</td><td style="text-align: right;">R5 560</td></tr> <tr><td>Carotid Stent</td><td style="text-align: right;">R24 400</td></tr> </table>	Cardiac Stents (each) max 3 stents	R30 410	• Drug eluting Stents (each)	R22 550	• Bare Metal	R12 720	Aorta Stent graft	R65 790	Peripheral Arterial Stent Graft	R50 090	Cardiac pacemakers	R88 610	Cardiac valves (each) max 2 valves	R46 250	Total Hip Replacement	R73 920	Total Knee Replacement	R67 800	Total Shoulder Replacement	R63 510	Elbow Replacement	R63 510	Temperomandibular (TM) Joint Replacement	R63 510	Ankle Replacement	R63 510	Finger Replacement	R41 810	Toe (Total or Partial) Replacement	R41 810	Bryan's and other intervertebral disc prosthesis	R51 520	Mesh grafts	R36 970	Intra-stromal corneal ring segments	R35 400	Spinal Instrumentation	R61 250	Other approved spinal implantable devices and intervertebral discs	R60 650	Bone lengthening devices	R54 510	Neuro-stimulation (ablation devices for Parkinson's)	R58 660	Vagal stimulator for intractable Epilepsy	R46 660	Detachable platinum coils	R60 650	Embolic protection devices	R60 500	Intraocular lens (per lens)	R5 560	Carotid Stent	R24 400	<p>1. Subject to pre-authorisation and approval (including all accompanying temporary or permanent devices).</p> <p>2. Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.</p> <p>3. Benefit is pro-rated if member joins during benefit year.</p>
Cardiac Stents (each) max 3 stents	R30 410																																																								
• Drug eluting Stents (each)	R22 550																																																								
• Bare Metal	R12 720																																																								
Aorta Stent graft	R65 790																																																								
Peripheral Arterial Stent Graft	R50 090																																																								
Cardiac pacemakers	R88 610																																																								
Cardiac valves (each) max 2 valves	R46 250																																																								
Total Hip Replacement	R73 920																																																								
Total Knee Replacement	R67 800																																																								
Total Shoulder Replacement	R63 510																																																								
Elbow Replacement	R63 510																																																								
Temperomandibular (TM) Joint Replacement	R63 510																																																								
Ankle Replacement	R63 510																																																								
Finger Replacement	R41 810																																																								
Toe (Total or Partial) Replacement	R41 810																																																								
Bryan's and other intervertebral disc prosthesis	R51 520																																																								
Mesh grafts	R36 970																																																								
Intra-stromal corneal ring segments	R35 400																																																								
Spinal Instrumentation	R61 250																																																								
Other approved spinal implantable devices and intervertebral discs	R60 650																																																								
Bone lengthening devices	R54 510																																																								
Neuro-stimulation (ablation devices for Parkinson's)	R58 660																																																								
Vagal stimulator for intractable Epilepsy	R46 660																																																								
Detachable platinum coils	R60 650																																																								
Embolic protection devices	R60 500																																																								
Intraocular lens (per lens)	R5 560																																																								
Carotid Stent	R24 400																																																								

NA

TM

S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
		Any other internal prosthesis R63 930	
b) General Prosthesis/Devices Benefit 	100% of cost or MSR, whichever is the lesser	Limited to Internal Prosthesis/Devices Benefit and a sub-limit of R24 100 per beneficiary per annum subject to the following sub-limits: Middle ear bone implants R24 100 Vocal cord prosthesis R24 100 Macroplasty injection – urethra R24 100 Penile prosthesis R24 100 Vascular/arterial grafts and patches R24 100 Atrium- and Ventricular Septum Patches R24 100 Mammary/breast implants R9 140 TVT Sling device R4 430 Proctor livingstone and Celestine Tubes R8 990 Renal artery stent R16 120 Oesophagus Stent R16 120 Ureter Stent R16 120 Urethra Stent R16 120 Ductus choledochus Stent R16 120 Other blood vessels stents R16 120 Permanent supra-public catheters R6 440 Testis prosthesis R16 120 Gold weight implants upper eyelid R16 120 Anal and other sphincter stimulating device R16 120	<ol style="list-style-type: none"> Subject to pre-authorisation and approval (including all accompanying temporary or permanent devices). Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. Benefit is pro-rated if member joins during benefit year.

NN
TM
g

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
c) External Medical Appliances, Aids and Supporting Devices 	100% of cost or MSR, whichever is the lesser	Limited to R10 280 per family per annum and includes the following sub-limit: Orthotic shoe/inner sole: Limited to R2 560 per family per annum and limited to PMBs only	<ol style="list-style-type: none"> Subject to application and approval by the Scheme. Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit for continuous Glucose monitoring devices and Insulin Pumps subject to pre-authorisation and the criteria as set out in Scheme policies. Provided that no benefit shall be available for Action Potential Simulation (APS) machines unless approved by the Scheme. Benefit is pro-rated if member joins during the benefit year.
d) Home Oxygen, cylinders, concentrators and ventilation expenses	100% of cost or MSR, whichever is the lesser	Limited to R19 540 per beneficiary per annum	1. Subject to pre-authorisation and approval by the Scheme.
e) Hyperbaric Oxygen	100% of cost or MSR, whichever is the lesser	Limited R60 080 per beneficiary per annum	1. Subject to pre-authorisation and approval by the Scheme.
f) Artificial Limbs and Artificial Eyes	100% of cost or MSR, whichever is the lesser	Limited to R81 630 per family per annum and subject to the following sub-limits: <ul style="list-style-type: none"> R81 630 per artificial leg or arm per family per annum R27 110 per artificial eye per family per annum 	<ol style="list-style-type: none"> Subject to pre-authorisation and approval by the Scheme. Benefit is pro-rated if member joins during benefit year.
g) Hearing Aids	100% of cost or MSR, whichever is the lesser	Limited to R24 370 per beneficiary per cycle	<ol style="list-style-type: none"> Subject to pre-authorisation and approval by the Scheme. Benefit is pro-rated if member joins during benefit year. Excludes repairs and batteries. "Cycle" shall mean a 2 year cycle.
7. Kidney Dialysis Medicines	100% of cost or MSR, whichever is the lesser 100% of medicine price	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Subject to pre-authorisation and approval by the Scheme. This includes the cost of all related approved medication, provided authorisation has been obtained via the Medicine Risk Management Programme. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
8. Chronic medication			1. Benefits are subject to prior application and approval via the

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
Specified Non-PMB and PMB Conditions	100% of medicine price	Limited to R13 550 per family per annum for PMB and specified non-PMB chronic conditions	Medicine Risk Management Programme. 2. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service. 3. Members are encouraged to make use of the Pharmacy Network to minimize possible co-payments. 4. Benefit is pro-rated if member joins during benefit year.
PMB Chronic Conditions	100% of medicine price	Unlimited benefit once Chronic Medicine limit above is exhausted	
9. Organ Transplants Hospital accommodation, surgical related services and procedures Anti-rejection drugs and Immunosuppressant drugs	100% of cost or MSR, whichever is the lesser 100% of medicine price	Subject to the Overall Annual Limit Limited to R454 500 per family per annum	1. Subject to pre-authorisation and approval by the Scheme. 2. Services rendered to the donor, where the recipient is a beneficiary of the Scheme, and the transportation of organ is included in this benefit. 3. This includes the cost of all related approved anti-rejection medication, provided authorisation has been obtained via the Medicine Risk Management Programme. 4. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
10. Hospice Nursing, Private Nursing, and Healthcare Institute 	100% of cost or MSR, whichever is the lesser	Limited to R40 250 per family per annum	1. Subject to pre-authorisation at accredited facilities only and by registered nurses. 2. This benefit covers the acute phase after or instead of hospitalisation. 3. Not for long-term or chronic care. 4. Excludes frail care. 5. The Scheme's designated agent will liaise with the case manager of the Hospital and the treating doctor to assess appropriateness of step-down transfer. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge at an accredited provider and/facility, in accordance with the beneficiary's clinical motivation from doctors and case managers. 6. Benefit is pro-rated if member joins during benefit year.
11. Other Services			
a) Blood Transfusions	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	1. Includes the cost of blood, blood equivalents, blood products and the transport of blood. 2. Subject to pre-authorisation and approval by the Scheme.
b) Ambulance Services	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	1. Subject to benefit validation and claims adjudication.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
c) Radial Keratotomy/Eximer Laser (including Holmium procedures, LASIK, Phakic lenses and intrastromal rings)	100% of cost or MSR, whichever is the lesser	Limited to R12 550 per family per annum	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
d) Medical Auxiliaries – In hospital Psychology, Orthotic Consultations, Occupational Therapy, Dietician, Physiotherapy, Social worker and speech therapy	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. This benefit covers any of these services rendered in-hospital by an approved and registered paramedical and auxiliary service provider. 2. Treatment in respect of a CDL-related PMB condition is subject to The Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full.
e) Cochlear Implants	100% of cost or MSR, whichever is the lesser	Limited to R320 200 per family per annum with the following applicable sub-limits: <ul style="list-style-type: none"> i) Pre-op evaluation & associated costs: <ul style="list-style-type: none"> • R15 980 ii) Intra-operative audiology testing: <ul style="list-style-type: none"> • R970 iii) Post-op rehabilitation: <ul style="list-style-type: none"> • R35 400 iv) Upgrade of sound processor: (80% of cost): <ul style="list-style-type: none"> • R72 500 v) Repairs outside warranty: <ul style="list-style-type: none"> • Subject to Cochlear Implant benefit vi) Batteries and spares: <ul style="list-style-type: none"> • Subject to External Medical Appliances benefit 	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
f) Maxillo-facial and Oral Surgery	100% of cost or MSR, whichever is the lesser	Limited to R19 120 per family per annum	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
g) HIV/AIDS Benefit	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Medicine and hospital pre-authorisation is required. 2. Enrollment on the HIV/AIDS Management Programme is encouraged. 3. This benefit includes medication, doctors' consultations and Blood Tests required for the treatment of the condition, as well as the cost of prophylaxis for preventative treatment. HIV resistance test is subject to pre-authorisation and approval. 4. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
Medicines	100% of medicine price		



UN
TM
g

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
h) Prescribed Minimum Benefits	100% of cost	Subject to the Overall Annual Limit	Any service falling within the Prescribed Minimum Benefits which is rendered by the Scheme's Designated Service Provider (DSP) to beneficiaries subject to Appendix 2.
B. PREVENTATIVE CARE BENEFITS 	100% of cost or MSR, whichever is the lesser	Payable from major medical expense benefit subject to the following limitations: Oral Contraceptives – Monthly limit of R170 Vitamins – limited to R340 per beneficiary per annum 1 test per adult beneficiary per annum: <ul style="list-style-type: none"> • Blood Glucose Screening • Blood Pressure • Cholesterol Screening • Body Mass Index Flu Vaccine – 1 per beneficiary per annum Prostate testing – over the age of 45 Mammograms – over the age of 40 Bone density screening – over the age of 65 Additional tests and procedures: Stool tests for cancer screening – 1 every 2 years for ages between 45 and 75 HPV vaccination – 1 course for ages between 9 and 25 Vasectomy – 1 per a life	<ol style="list-style-type: none"> 1. Members are encouraged to make use of the Pharmacy Network where applicable to minimise possible co-payments. 2. Once the preventative limits have been reached, tests will be paid from the applicable benefit limit.
C. DAY-TO-DAY (DTD) BENEFIT		Maximum Annual Limits: R9 500 per member R9 500 per adult dependant R1 830 per child dependant	<ol style="list-style-type: none"> 1. Benefits for services rendered to a patient prior to being admitted to hospital, but which may have a direct bearing on the admission are regarded as Day-to-Day benefits. 2. Benefits for follow-up services after the patient has been discharged from hospital are regarded as Day-to-Day benefits. 3. The Day-to-Day benefit depends on the family size. The sum of the sub-limit for each registered beneficiary will be the family limit.
1. General Practitioners Visits, consultations and out-patient visits (a) Network General Practitioner	100% of agreed tariff	Subject to the Overall Day-to-Day Limit	<ol style="list-style-type: none"> 1. Members are encouraged to make use of the GP Network to minimize possible co-payments.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
(b) Non-Network General Practitioner (non-DSP)	80% of cost or MSR, whichever is the lesser		
2. Specialists a) Non-preferred specialist Network Visits, consultations and out-patient visits b) Preferred Specialist Network Visits, consultations and out-patient visits	100% of cost or MSR, whichever is the lesser 100% of cost or 110% MSR, whichever is the lesser	Subject to the Overall Day-to-Day Limit 	1. Benefits are only covered if: <ul style="list-style-type: none"> A member was referred by a general practitioner; AND Pre-authorisation was obtained from the Scheme for the first consultation at a given specialist.
3. Acute Medicine (a) Prescribed (acute) medicines (b) Pharmacist advised Therapy (PAT)	100% of medicine price 100% of medicine price	Subject to Overall Day-to-Day Limit and Annual Sub-Limits of: R4 750 per member R4 750 per adult dependant R 920 per child dependant Limited to R1 920 per family per annum and further subject to Overall Day-to-Day Limit	1. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service. 2. The prescribed (acute) medicines benefit depends on the family size. The sum of the sub-limit for each registered beneficiary will be the family limit. 3. Pharmacist advised therapy (PAT) medicines applies to medicines classified as schedules 0, 1, and 2, which can be purchased without a doctor's prescription. 4. Members are encouraged to make use of the Pharmacy Network to minimize possible co-payments. 5. Benefit is pro-rated if member joins during benefit year.
4. Auxiliary Services Occupational Therapy, Speech Therapy, Physiotherapy, Psychology, Social Worker, Audiometry, Chiropractors, Dietician No benefit for Biokinetics, Chiropody, Orthoptist, Orthotic Consultation, Remedial Therapy, Reflexology, Homeopaths, Naturopaths, ART Therapy, Acupuncturists and Osteopaths	100% of cost or MSR, whichever is the lesser	Limited to R3 140 per family per annum and further subject to Overall Day-to-Day Limit	1. This benefit covers any of these services rendered out-of-hospital by an approved and registered paramedical and auxiliary service provider. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full. 4. Benefit is pro-rated if member joins during benefit year.
5. Palliative Care Programme	100% of cost or MSR, whichever is the lesser	Payable from major medical expense benefit subject to the Overall Annual Limit	Subject to Pre-authorisation and approval by the Scheme

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
D. PRIMARY CARE BENEFIT (PCB)			
1. Radiology (Out-of-hospital)	100% of cost or MSR, whichever is the lesser	Limit of R2 270 per family per annum subject to the Major Medical Expense benefit	1. Benefit is pro-rated if member joins during benefit year.
2. Pathology (Out-of-hospital)	100% of cost or MSR, whichever is the lesser	Subject to the Overall Day-to-Day Limit	1. This benefit covers any pathology services rendered out-of-hospital. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full.
E. OPTICAL			
Frames and prescription lenses/add-ons, Clear single Vision, Clear Aquity, Flat-top Bifocal, Clear Aquity Multifocal, Contact lenses and Eye tests	100% of cost or MSR, whichever is the lesser	Subject to R5 070 per beneficiary every two (2) years which includes a frame sub-limit of R1 600	1. Optical benefit is not subject to Overall Day-to-Day Limit. 2. Benefit is pro-rated if member joins during benefit year.
F. DENTISTRY			
Basic Dentistry Includes routine prophylaxis scaling and polishing (cleaning), fluoride application, fillings, non-surgical tooth extraction and root canal treatment	100% of cost or MSR, whichever is the lesser	Subject to a maximum limit of R10 930 per family per annum	1. Subject to the Scheme's Managed Care protocols and benefits. 2. All specialized/advanced procedures including orthodontic services are subject to prior approval. 3. In-hospital dentistry is subject to prior approval and pre-authorisation. 4. Benefit is pro-rated if member joins during the benefit year. 5. Refer to Annexure D for details of dental benefits and exclusions applicable.
Advanced Dentistry and Dental Implants Includes dentures, inlays/onlays, surgical periodontal management, crowns and bridges as well as orthodontic treatment and dental implants	100% of cost or MSR, whichever is the lesser	Subject to a maximum of R20 370 per family per annum	6. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
G. PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)	Not applicable		No allocation to Personal Medical Savings Account (PMSA)



MM
TM
S

ANNEXURE B2

REGISTERED BY ME ON

Milana Maswanganji

 2025/01/13

Signed by Milana Maswanganji
m.maswanganji@medicalschemes.co.za
148912025 16:13:30(UTC+02:00)

 **REGISTRAR OF MEDICAL SCHEMES**

2025 SCHEDULE OF BENEFITS: OPTION B

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular Appendix 2 concerning the provision of the statutory Prescribed Minimum Benefits, "PMB's")

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	
A. MAJOR MEDICAL EXPENSES (MME)		Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Sub-limits as defined in this Annexure may be pro-rated, i.e. calculated from the date of admission to membership to the end of the financial year. Once the sub-limits are reached, only the diagnosis, treatment and care costs of the prescribed minimum benefit conditions will be paid in full.
1. HOSPITALISATION (includes ward fees, theatre fees, recovery rooms, confinements, specialised intensive care, high care and materials used in hospital)	Benefits for PMBs and non-PMBs: 100% of cost at negotiated rate in hospital	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Subject to pre-authorisation and approval by the Scheme. All non-emergency admissions are subject to pre-authorisation 3 working days prior to the admission date. A co-payment of R2 640 for failing to pre-authorise prior to Admission will apply. Emergencies must be pre-authorised within 24 hours of admission or first working day after such emergency treatment or admission. Private ward accommodation will be at general ward rate subject to certification by the attending practitioner as essential for the recovery of the patient and approved by the Scheme. Confinements are subject to a maximum of three (3) days for normal deliveries and four (4) days for caesarian sections. A further stay may be authorised at the discretion of the case manager.


TM
S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
a) Medicines used in hospital	100% of medicine price	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Pre-authorisation of admission required. 2. Medicines will be subject to medicine reference pricing.
b) Materials used in hospital	100% of cost	Subject to the Overall Annual Limit	Pre-authorisation of admission required.
c) Medicines dispensed from discharge from hospital [to take out medicine (TTO)]	100% of medicine price	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Pre-authorisation of admission required. 2. Medicines will be subject to medicine reference pricing. 3. TTO's limited to maximum of 7 day's supply of medicines.
d) Psychiatric institutions	100% of cost	<p>Subject to a limit of R21 780 per family per annum for all related costs</p> <p>Continued benefits for PMBs subject to pre-authorisation and PMB regulations</p>	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Includes treatment on a day patient basis, in lieu of hospitalisation, subject to pre-authorisation. 3. If a patient is admitted to a hospital, other than a psychiatric institution, all related accounts will be paid at cost subject to the limit and PMBs. 4. Benefit is pro-rated if member joins during benefit year.
e) Substance and Alcohol abuse	100% of cost	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. If a patient is admitted to a hospital, all related accounts will be paid at cost subject to the limit and PMBs.
f) Rehabilitation Centres	100% of cost	Subject to the Overall Annual Limit and in lieu of hospitalisation for all related costs	<ol style="list-style-type: none"> 1. Subject to Pre-authorisation and approval by the Scheme. 2. The benefit covers beneficiaries who had become temporarily disabled as a result of acute injuries caused by trauma, infection, spinal cord injury, brain injury or bleeding or infarction resulting in stroke. Available only immediately following such an event. Progressive conditions such as Multiple Sclerosis and Parkinson's disease are not included. 3. The Scheme's designated agent will liaise with the case manager of the Hospital/facility and the treating doctor to assess appropriateness of care.



SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
g) Care in lieu of hospitalisation	100% of cost or Medical Scheme Rate (MSR), whichever is the lesser	Subject to the Overall Annual Limit 	<ol style="list-style-type: none"> 1. Subject to pre-authorisation at accredited facilities only and by registered nurses. 2. This benefit covers the phase after or instead of hospitalisation. 3. Excludes frail care. 4. The Scheme's designated agent will liaise with the case manager of the Hospital and the treating doctor to assess appropriateness of step-down transfer. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge at an accredited provider and/facility, in accordance with the beneficiary's clinical motivation from doctors and case managers. 5. Benefit is pro-rated if member joins during benefit year.
2. Medical Specialists and General Practitioners		Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
2.1 General Practitioners Surgery and in-hospital procedures and visits	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
2.2 Specialists Surgery and in-hospital procedures and visits	100% of cost or MSR, whichever is the lesser		<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme, 2. Referral can be provided from a network or non-network General Practitioner
a) Non-preferred specialist Network	100% of cost or MSR, whichever is the lesser		
b) Preferred Specialist Network	100% of cost or 110% of MSR, whichever is the lesser		
2.3) Anaesthetics	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
2.4) Perfusionist	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
2.5) Clinical Technology	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
2.6) Procedures (normally performed in hospital) performed in the doctor's rooms	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to Scheme's Major Medical Procedures List and pre-authorisation.
2.7) Circumcision (out-of-hospital)	100% of cost or MSR, whichever is the lesser	Subject to a limit of R2 080 per beneficiary per annum	
3. Radiology and Pathology		Subject to the Overall Annual Limit	In respect of PMB conditions, Radiology and Pathology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost.
a) Radiology and Pathology while hospitalised (excluding MRI, CAT, Radio isotope and Ultrasound scans)	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
b) Advanced Radiology MRI, CAT, Radio-isotope scans and Ultra Sound scans (in and out of hospital)	100% of cost or MSR, whichever is the lesser	Limited to a limit of R27 110 per family per annum	1. Subject to pre-authorisation and approval by the Scheme.
4. Maternity		Subject to the Overall Annual Limit	Beneficiary enrollment on the Maternity Management Programme is encouraged.
a) Antenatal Classes	100% of cost or MSR, whichever is the lesser	Limited to 5 antenatal classes per pregnancy	
b) Antenatal Consultations	100% of cost or MSR, whichever is the lesser	Limited to 9 antenatal consultations per pregnancy	
c) Ultrasound Scans for Pregnancy	100% of cost or MSR, whichever is the lesser	Limited to 2 scans (2D) per pregnancy	
d) Confinement in a registered birthing unit and confinement out of hospital		Limited to and included in the Maternity Benefits	Subject to pre-authorisation and approval by the Scheme.

TM
S
NN

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
	100% of cost or MSR, whichever is the lesser		
e) Additional Maternity Benefits <ol style="list-style-type: none"> 1. Blood grouping test 2. Flu vaccination 3. Haemoglobin measurement test 4. Hearing screening for new-born 5. Mental health visit with psychologist 6. Nutritional assessment with dietician 7. Postnatal mid-wife Visits 8. VDRL test 9. Breastfeeding visit with nurse or specialist 10. Congenital hypothyroidism screening 11. Full blood count 12. Urine analysis test 13. Vitamins 	100% of cost or MSR, whichever is the lesser	<ol style="list-style-type: none"> 1. Limited to 1 test per pregnancy 2. Limited to 1 test per pregnancy 3. Limited to 2 tests per pregnancy 4. Limited to 1 test per newborn 5. Limited to 2 per pregnancy 6. Limited to 1 test per pregnancy 7. Limited to 6 per pregnancy 8. Limited to 1 test per pregnancy 9. Limited to 1 per pregnancy 10. Limited to 1 test per pregnancy 11. Limited to 1 test per pregnancy 12. Limited to 12 tests per pregnancy 13. Limited to R130 per pregnancy 	<p>Once the additional maternity limits have been reached, tests will be paid from the applicable benefit limit.</p> 
5. Oncology (Cancer)	100% of cost at DSP or 75% of cost or MSR, whichever is the lesser, at a non-DSP	Limited to R299 700 per beneficiary per annum, for PMBs and non-PMBs - thereafter unlimited for PMBs	<ol style="list-style-type: none"> 1. Patients` are encouraged to enroll on the Oncology Benefit Management Programme. 2. Non-Prescribed Minimum Benefits and Prescribed Minimum Benefits formularies apply as per the Designated Service Provider`s (DSPs) treatment protocols. 3. Benefit is subject to submission of a 12-month treatment plan by the treating Oncologist and the approval thereof prior to the commencement of treatment. 4. Benefits in respect of cancer related medicines, radiotherapy, chemotherapy, oncologist, pathology, X-ray, mammograms, MRI scans, CT scans and radio-isotope scans will be paid from the Oncology benefit. 5. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme`s formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
6. MEDICAL APPLIANCES a) Internal Prosthesis/Devices 	100% of cost or MSR, whichever is the lesser	Limited to R75 510 per family per annum and subject to the following sub-limits per beneficiary per annum: Cardiac Stents (each) max 3 stents R28 980 • Drug eluting Stents (each) R17 710 • Bare Metal R9 560 Aorta Stent R55 800 Peripheral Arterial Stent Graft R42 970 Cardiac pacemakers R72 500 Cardiac valves (each) max 2 valves R41 080 Total Hip Replacement R54 240 Total Knee Replacement R54 650 Total Shoulder Replacement R52 360 Elbow Replacement R44 960 Temporomandibular (TM) Joint Replacement R44 960 Ankle Replacement R44 960 Finger Replacement R28 820 Toe (Total or Partial) Replacement R28 820 Bryan's and other intervertebral disc prosthesis R35 400 Mesh grafts R6 440 Intra-stromal corneal ring segments R24 100 Spinal Instrumentation R34 530 Other approved spinal implantable devices and intervebral discs R51 520 Bone lengthening devices R46 370 Neuro-stimulation (ablation devices For Parkinson's) R49 800 Vagal stimulator for intractable epilepsy R39 680 Detachable platinum coils R51 660 Embolic protection devices R51 520 Intraocular lens (per lens) R4 430 Carotid Stent R20 700 Any other internal prosthesis R57 080	<ol style="list-style-type: none"> Subject to pre-authorisation and approval (including all accompanying temporary or permanent devices). Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. Benefit is pro-rated if member joins during benefit year.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS																																						
 <p>b) General Prosthesis/Devices Benefit</p>	100% of cost or MSR, whichever is the lesser	<p>Limited to Internal Prosthesis/Devices Benefit and a sub-limit of R12 720 per beneficiary per annum subject to the following sub-limits:</p> <table border="0"> <tr><td>Middle ear bone implants</td><td>R12 720</td></tr> <tr><td>Vocal cord prosthesis</td><td>R12 720</td></tr> <tr><td>Macroplasty injection – urethra</td><td>R12 720</td></tr> <tr><td>Penile prosthesis</td><td>R12 720</td></tr> <tr><td>Vascular/arterial grafts and patches</td><td>R12 720</td></tr> <tr><td>Atrium- and Ventricular Septum patches</td><td>R12 720</td></tr> <tr><td>Mammary/breast implants</td><td>R4 570</td></tr> <tr><td>TVT Sling device</td><td>R2 140</td></tr> <tr><td>Proctor livingstone and Celestine tubes</td><td>R4 710</td></tr> <tr><td>Renal artery stent</td><td>R6 440</td></tr> <tr><td>Oesophagus Stent</td><td>R8 000</td></tr> <tr><td>Ureter Stent</td><td>R8 000</td></tr> <tr><td>Urethra Stent</td><td>R8000</td></tr> <tr><td>Ductus choledochus Stent</td><td>R8 000</td></tr> <tr><td>Other blood vessels stents</td><td>R8 000</td></tr> <tr><td>Permanent supra-public catheters</td><td>R3 060</td></tr> <tr><td>Testis prosthesis</td><td>R8 000</td></tr> <tr><td>Gold weight implants upper eyelid</td><td>R9 560</td></tr> <tr><td>Anal and other sphincter stimulating device</td><td>R8 000</td></tr> </table>	Middle ear bone implants	R12 720	Vocal cord prosthesis	R12 720	Macroplasty injection – urethra	R12 720	Penile prosthesis	R12 720	Vascular/arterial grafts and patches	R12 720	Atrium- and Ventricular Septum patches	R12 720	Mammary/breast implants	R4 570	TVT Sling device	R2 140	Proctor livingstone and Celestine tubes	R4 710	Renal artery stent	R6 440	Oesophagus Stent	R8 000	Ureter Stent	R8 000	Urethra Stent	R8000	Ductus choledochus Stent	R8 000	Other blood vessels stents	R8 000	Permanent supra-public catheters	R3 060	Testis prosthesis	R8 000	Gold weight implants upper eyelid	R9 560	Anal and other sphincter stimulating device	R8 000	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval (including all accompanying temporary or permanent devices). 2. Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 3. Benefit is pro-rated if member joins during benefit year.
Middle ear bone implants	R12 720																																								
Vocal cord prosthesis	R12 720																																								
Macroplasty injection – urethra	R12 720																																								
Penile prosthesis	R12 720																																								
Vascular/arterial grafts and patches	R12 720																																								
Atrium- and Ventricular Septum patches	R12 720																																								
Mammary/breast implants	R4 570																																								
TVT Sling device	R2 140																																								
Proctor livingstone and Celestine tubes	R4 710																																								
Renal artery stent	R6 440																																								
Oesophagus Stent	R8 000																																								
Ureter Stent	R8 000																																								
Urethra Stent	R8000																																								
Ductus choledochus Stent	R8 000																																								
Other blood vessels stents	R8 000																																								
Permanent supra-public catheters	R3 060																																								
Testis prosthesis	R8 000																																								
Gold weight implants upper eyelid	R9 560																																								
Anal and other sphincter stimulating device	R8 000																																								
c) External Medical Appliances, Aids and Supporting Devices	100% of cost or MSR, whichever is the lesser	<p>Limited to R8 430 per family per annum and includes the following sub-limit:</p> <p>Orthotic shoe/inner sole: Limited to R2 560 per family per annum and limited to PMBs only</p>	<ol style="list-style-type: none"> 1. Subject to application and approval by the Scheme. 2. Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit for continuous Glucose monitoring devices and Insulin Pumps subject to pre-authorisation and the criteria as set out in the Scheme policies. 3. Provided that no benefit shall be available for Action Potential Simulation (APS) machines unless approved by the Scheme. 4. Benefit is pro-rated if a member joins during the benefit year. 																																						
d) Home Oxygen, cylinders, concentrators and ventilation expenses	100% of cost or MSR, whichever is the lesser	Limited to R17 980 per beneficiary per annum	1. Subject to pre-authorisation and approval by the Scheme.																																						
e) Hyperbaric Oxygen	100% of cost or MSR, whichever is the lesser	Limited to R60 080 per beneficiary per annum	1. Subject to pre-authorisation and approval by the Scheme.																																						

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
f) Artificial Limbs and Artificial Eyes	100% of cost or MSR, whichever is the lesser	Limited to R63 500 per family per annum and subject to the following sub-limits: <ul style="list-style-type: none"> R63 500 per artificial leg or arm per family per annum R27 110 per artificial eye per family per annum 	<ol style="list-style-type: none"> 1. Subject to pre-authorization and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
g) Hearing Aids	100% of cost or MSR, whichever is the lesser	Limited to R20 410 per beneficiary per cycle	<ol style="list-style-type: none"> 1. Subject to pre-authorization and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year. 3. Excludes repairs and batteries. 4. "Cycle" shall mean a 2 year cycle.
7. Kidney Dialysis Medicines	100% of cost or MSR, whichever is the lesser 100% of medicine price	Subject to the Overall Annual Limit 	<ol style="list-style-type: none"> 1. Subject to pre-authorization and approval by the Scheme. 2. This includes the cost of all related approved medication, provided authorisation has been obtained via the Medicine Risk Management Programme. 3. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
8. Chronic medication Specified Non-PMB and PMB Chronic Conditions PMB Chronic Conditions	100% of medicine price 100% of medicine price	Limited to R9 140 per family per annum for PMB and specified non-PMB chronic conditions Unlimited benefit once Chronic Medicine limit above is exhausted	<ol style="list-style-type: none"> 1. Benefits are subject to prior application and approval via the Medicine Risk Management Programme. 2. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service. 3. Members are encouraged to make use of the Pharmacy Network to minimize possible co-payments. 4. Benefit is pro-rated if member joins during benefit year.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
9. Organ Transplants Hospital accommodation, surgical related services and procedures Anti-rejection drugs and immunosuppressant drugs	100% of cost or MSR, whichever is the lesser 100% of medicine price	Subject to the Overall Annual Limit Limited to R381 900 per family per annum	<ol style="list-style-type: none"> Subject to pre-authorisation and approval by the Scheme. Services rendered to the donor, where the recipient is a beneficiary of the Scheme, and the transportation of organ is included in this benefit. This includes the cost of all related approved anti-rejection medication, provided authorisation has been obtained via the Medicine Risk Management Programme. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
10. Hospice Nursing, Private Nursing, and Healthcare Institute 	100% of cost or MSR, whichever is the lesser	Limited to R28 120 per family per annum	<ol style="list-style-type: none"> Subject to pre-authorisation at accredited facilities only and by registered nurses. This benefit covers the acute phase after or instead of hospitalisation. Not for long-term or chronic care. Excludes frail care. The Scheme's designated agent will liaise with the case manager of the Hospital and the treating doctor to assess appropriateness of step down transfer. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge at an accredited provider and/facility, in accordance with the beneficiary's clinical motivation from doctors and case managers. Benefit is pro-rated if member joins during benefit year.
11. Other Services			
a) Blood Transfusions	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Includes the cost of blood, blood equivalents, blood products and the transport of blood. Subject to pre-authorisation and approval by the Scheme.
b) Ambulance Services	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to benefit validation and claims adjudication.
c) Radial Keratotomy/Eximer Laser (including Holmium procedures, LASIK, Phakic lenses and intrastromal rings)	100% of cost or MSR, whichever is the lesser	Limited to R7 720 per family per annum	<ol style="list-style-type: none"> Subject to pre-authorisation and approval by the Scheme. Benefit is pro-rated if member joins during benefit year.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
d) Medical Auxiliaries – In hospital Psychology, Orthotic Consultations, Occupational Therapy, Dietician, Physiotherapy, Social worker and Speech therapy	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. This benefit covers any of these services rendered in-hospital by an approved and registered paramedical and auxiliary service provider. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full.
e) Cochlear Implants 	100% of cost or MSR, whichever is the lesser	Limited to R256 100 per family per annum with the following applicable sub-limits: <ol style="list-style-type: none"> i) Pre-op evaluation & associated costs: <ul style="list-style-type: none"> • R15 970 ii) Intra-operative audiology testing: <ul style="list-style-type: none"> • R970 iii) Post-op rehabilitation: <ul style="list-style-type: none"> • R35 400 iv) Upgrade of sound processor: (80% of cost): <ul style="list-style-type: none"> • R72 500 v) Repairs outside warranty: <ul style="list-style-type: none"> • Subject to Cochlear Implant benefit vi) Batteries and spares: <ul style="list-style-type: none"> • Subject to External Medical Appliances benefit 	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
f) Maxillo-facial and Oral Surgery	100% of cost or MSR, whichever is the lesser	Limited to R19 120 per family per annum	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
g) HIV/AIDS Benefit Medicines	100% of cost or MSR, whichever is the lesser 100% of medicine price	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Medicine and hospital pre-authorisation is required. 2. Enrollment on the HIV/AIDS Management Programme is encouraged. 3. This benefit includes medication, doctors' consultations and blood tests required for the treatment of the condition, as well as the cost of prophylaxis for preventative treatment. HIV resistance test is subject to pre-authorisation and approval. 4. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
h) Prescribed Minimum Benefits	100% of cost	Subject to the Overall Annual Limit	Any service falling within the Prescribed Minimum Benefits which is rendered by the Scheme's Designated Service Provider (DSP) to beneficiaries subject to Appendix 2.
B. PREVENTATIVE CARE BENEFITS 	100% of cost or MSR, whichever is the lesser	Payable from major medical expense benefit subject to the following limitations: Oral Contraceptives – Monthly limit of R170 1 test per adult beneficiary per annum: <ul style="list-style-type: none"> • Blood Glucose Screening • Blood Pressure • Cholesterol Screening • Body Mass Index Flu Vaccine - 1 per beneficiary per annum Prostate testing – over the age of 45 Mammograms – over the age of 40 Bone density screening – over the age of 65 Vitamins – limited to R340 per beneficiary per annum Additional tests and procedures: Stool tests for cancer screening – 1 every 2 years for ages between 45 and 75 HPV vaccination – 1 course for ages between 9 and 25 Vasectomy – 1 per a life	<ol style="list-style-type: none"> 1. Members are encouraged to make use of the Pharmacy Network where applicable to minimise possible co-payments. 2. Once the preventative limits have been reached, tests will be paid from the applicable benefit limit.
C. DAY-TO-DAY (DTD) BENEFIT		Maximum Annual Limits: R5 580 per member R5 580 per adult dependant R1 080 per child dependant	<ol style="list-style-type: none"> 1. Benefits for services rendered to a patient prior to being admitted to hospital, but which may have a direct bearing on the admission are regarded as Day-to-Day benefits. 2. Benefits for follow-up services after the patient has been discharged from hospital are regarded as Day-to-Day benefits. 3. The Day-to-Day benefit depends on the family size. The sum of the sub-limit for each registered beneficiary will be the family limit.
1. General Practitioners Visits, consultations and out-patient visits (a) Network General Practitioner		Subject to the Overall Day-to-Day Limit	<ol style="list-style-type: none"> 1. Members are encouraged to make use of the GP Network to minimise possible co-payments.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
(b) Non-Network General Practitioner (non-DSP)	100% of agreed tariff 80% of cost or MSR, whichever is the lesser		
2. Specialists a) Non-preferred specialist Network Visits, consultations and out-patient visits b) Preferred Specialist Network Visits, consultations and out-patient visits	100% of cost or MSR, whichever is the lesser 100% of cost or 110% MSR, whichever is the lesser	Subject to the Overall Day-to-Day Limit 	1. Benefits are only covered if: <ul style="list-style-type: none"> • A member was referred by a general practitioner; AND • Pre-authorisation was obtained from the Scheme for the first consultation at a given specialist.
3. Acute Medicine (a) Prescribed (acute) medicines (b) Pharmacist advised Therapy (PAT)	100% of medicine price 100% of medicine price	Subject to Overall Day-to-Day Limit and Annual Sub-Limits of: R2 800 per member R2 800 per adult dependant R550 per child dependant Limited to R1 280 per family per annum and further subject to Overall Day-to-Day Limit	1. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service. 2. The prescribed (acute) medicines benefit depends on the family size. The sum of the sub-limit for each registered beneficiary will be the family limit. 3. Pharmacist advised therapy (PAT) medicines applies to medicines classified as schedules 0, 1, and 2, which can be purchased without a doctor's prescription. 4. Members are encouraged to make use of the Pharmacy Network to minimize possible co-payments. 5. Benefit is pro-rated if member joins during benefit year.
4. Auxiliary Services Occupational Therapy, Speech Therapy, Physiotherapy, Psychology, Social Worker, Audiometry, Chiropractors, Dietician No benefit for Biokineticists, Chiropody, Orthoptist, Orthotic Consultation, Remedial Therapy, Reflexology, Homeopaths, Naturopaths, ART Therapy, Acupuncturists and Osteopaths	100% of cost or MSR, whichever is the lesser	Limited to R1 850 per family per annum and further subject to Overall Day-to-Day Limit	1. This benefit covers any of these services rendered out-of-hospital by an approved and registered paramedical and auxiliary service provider. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full. 4. Benefit is pro-rated if member joins during benefit year.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
5. Palliative Care Programme	100% of cost or MSR, whichever is the lesser	Payable from major medical expense benefit subject to the Overall Annual Limit	Subject to Pre-authorisation and approval by the Scheme



NN
TM
S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
D. PRIMARY CARE BENEFIT (PCB)			
1. Radiology (Out-of-hospital)	100% of cost or MSR, whichever is the lesser	Limited to R1 800 per family per annum subject to the Major Medical Expenses limit	1. Benefit is pro-rated if member joins during benefit year.
2. Pathology (Out-of-hospital)	100% of cost or MSR, whichever is the lesser	Subject to the Overall Day-to-Day Limit 	1. This benefit covers any pathology services rendered out-of-hospital. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full or claims can be paid from available savings.
E. OPTICAL Frames and prescription lenses/add-ons, Clear single Vision, Clear Aquity, Flat-top Bifocal, Clear Aquity Multifocal, Contact lenses and Eye tests	100% of cost or MSR, whichever is the lesser	Subject to R3 760 per beneficiary every two (2) years including a frame sub-limit of R1 200	1. Optical benefit is not subject to Overall Day-to-Day Limit. 2. Benefit is pro-rated if member joins during benefit year.
F. DENTISTRY Basic Dentistry Includes routine prophylaxis scaling and polishing (cleaning), fluoride application, fillings, non-surgical tooth extraction and root canal treatment Advanced dentistry and Dental Implants Includes metal based dentures, inlays/onlays, surgical periodontal management, crowns and bridges as well as orthodontic treatment and dental implants	100% of cost or MSR, whichever is the lesser 100% of cost or MSR, whichever is the lesser	Subject to a maximum limit of R8 990 per family per annum Subject to a maximum limit of R13 490 per family per annum	1. Subject to the Scheme's Managed Care protocols and benefits. 2. All specialized/advanced procedures including orthodontic services are subject to prior approval. 3. In-hospital dentistry is subject to prior approval and pre-authorisation. 4. Benefit is pro-rated if member joins during the benefit year. 5. Refer to Annexure D for details of dental benefits and exclusions applicable. 6. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.

TM NN

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
G. PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA) 	100% of cost	<p>Income band R0 – R8,185: Principal member – R1,812 Adult dependant – R1,704 Child dependant – R540</p> <p>Income band R8,186 – R11,140: Principal member – R1,896 Adult dependant – R1,788 Child dependant – R564</p> <p>Income band R11,141 – R14,985: Principal member – R1,980 Adult dependant – R1,884 Child dependant – R600</p> <p>Income band R14,986+: Principal member – R2,040 Adult dependant – R1,932 Child dependant – R612</p>	<p>A monthly allocation of 4.5% of the total monthly contribution will apply to the Personal Medical Savings Account (PMSA) as follows:</p> <p>This savings allocation amount is included in the total monthly contribution payable by the member</p> <p>The following benefits are payable from savings where applicable:</p> <ul style="list-style-type: none"> • Co-payments for the use of a non-network GP, non-DSP hospital and late authorisations. • Benefit limits that have been exceeded. • Shortfalls due to charges billed above the Scheme rate and medicine reference pricing to the use of non-formulary drugs. • Specialist claims where a member failed to obtain a GP referral. • Benefit authorisations that have been declined. • Non-oral contraceptives (patches, injectables and devices). <p>The following benefits are payable from positive savings where applicable:</p> <ul style="list-style-type: none"> • Optical (tinting and hardening). • Non-PMB claims received during a waiting period and for certain exclusions.

ANNEXURE B3

REGISTERED BY ME ON

Mina Maswanganyi
2025/01/13
Signed by Mina Maswanganyi
m.maswanganyi@medicalschemes.co.za
14012025 16:10:06(UTC+02:00)

REGISTRAR OF MEDICAL SCHEMES

2025 SCHEDULE OF BENEFITS: OPTION C

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular Appendix 2 concerning the provision of the statutory Prescribed Minimum Benefits, "PMB's")

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	
A. MAJOR MEDICAL EXPENSES (MME)		Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Sub-limits as defined in this Annexure may be prorated, i.e. calculated from the date of admission to membership to the end of the financial year. Once the sub-limits are reached, only the diagnosis, treatment and care costs of the prescribed minimum benefit conditions will be paid in full.
1. HOSPITALISATION (includes ward fees, theatre fees, recovery rooms, confinements, specialized intensive care, high care and materials used in hospital)	Benefits for PMBs and non-PMBs: 100% of cost at negotiated rate in hospital	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Subject to pre-authorization and approval by the Scheme. All non-emergency admissions are subject to pre-authorization 3 working days prior to the admission date. A co-payment of R2 640 for failing to pre-authorise prior to Admission will apply. Emergencies must be pre-authorized within 24 hours of admission or first working day after such emergency treatment or admission. Private ward accommodation will be at general ward rate subject to certification by the attending practitioner as essential for the recovery of the patient and approved by the Scheme. Confinements are subject to a maximum of three (3) days for normal deliveries and four (4) days for caesarian sections. A further stay may be authorised at the discretion of the case manager.
a) Medicines used in hospital	100% of medicine price	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> Pre-authorization of admission required. Medicines will be subject to medicine reference pricing.
b) Materials used in hospital	100% of cost	Subject to the Overall Annual Limit	Pre-authorization of admission required.

TM & VN

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
c) Medicines dispensed from discharge from hospital [to take out medicine (TTO)]	100% of medicine price	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Pre-authorisation of admission required. 2. Medicines will be subject to medicine reference pricing. 3. TTO's limited to maximum of 7 day's supply of medicines.
d) Psychiatric institutions	100% of cost	Limited to PMBs only	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Includes treatment on a day patient basis, in lieu of hospitalisation, subject to pre-authorisation. 3. If a patient is admitted to a hospital, other than a psychiatric institution, all related accounts will be paid at cost subject to PMBs.
e) Substance and Alcohol abuse	100% of cost	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. If a patient is admitted to a hospital, all related accounts will be paid at cost subject to the limit PMBs.
f) Rehabilitation Centres	100% of cost	Subject to the Overall Annual Limit and in lieu of hospitalisation for all related costs	<ol style="list-style-type: none"> 1. Subject to Pre-authorisation and approval by the Scheme. 2. The benefit covers beneficiaries who had become temporarily disabled as a result of acute injuries caused by trauma, infection, spinal cord injury, brain injury or bleeding or infarction resulting in stroke. Available only immediately following such an event. Progressive conditions such as Multiple Sclerosis and Parkinson's disease are not included. 3. The Scheme's designated agent will liaise with the case manager of the Hospital/facility and the treating doctor to assess appropriateness of care.
g) Care in lieu of hospitalisation	100% of cost or Medical Scheme Rate (MSR), whichever is the lesser	Subject to the Overall Annual Limit	<ol style="list-style-type: none"> 1. Subject to pre-authorisation at accredited facilities only and by registered nurses. 2. This benefit covers the phase after or instead of hospitalisation. 3. Excludes frail care. 4. The Scheme's designated agent will liaise with the case manager of the Hospital and the treating doctor to assess appropriateness of step-down transfer. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge at an accredited provider and/facility, in accordance with the beneficiary's clinical motivation from doctors and case managers. 5. Benefit is pro-rated if member joins during benefit year.
2. Medical Specialists and General Practitioners		Subject to the Overall Annual Limit	Subject to Pre-authorisation and approval by the Scheme.



SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
2.1 General Practitioners Surgery and in-hospital procedures and visits	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
2.2 Specialists Surgery and in-hospital procedures and visits	100% of cost or MSR, whichever is the lesser		1. Subject to pre-authorisation and approval by the Scheme, 2. Referral can be provided from a network or non-network General Practitioner
a) Non-preferred specialist Network	100% of cost or MSR, whichever is the lesser		
b) Preferred Specialist Network	100% of cost or 110% of MSR, whichever is the lesser		
c) Anaesthetics	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
d) Perfusionist	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	
e) Procedures (normally performed in hospital) performed in the doctor's rooms	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to Scheme's Major Medical Procedures List and pre-authorisation.
f) Circumcision (out-of-hospital)	100% of cost or MSR, whichever is the lesser	Subject to a limit of R2 080 per beneficiary per annum	
3. Radiology and Pathology		Subject to the Overall Annual Limit	In respect of PMB conditions, Radiology and Pathology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost.

Handwritten initials and signature

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
a) Radiology and Pathology while hospitalised (excluding MRI, CAT, Radio isotope and Ultra sound scans)	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	Subject to pre-authorisation and approval by the Scheme.
b) Advanced Radiology MRI, CAT, Radio-isotope scans and Ultrasound scans (in and out of hospital)		Limited to R13 550 per family per annum	1. Subject to pre-authorisation and approval by the Scheme.
4. Maternity		Subject to the Overall Annual Limit and Maternity Care Plan	1. Subject to pre-authorisation and approval by the Scheme. 2. Beneficiary enrollment on the Maternity Management Programme is encouraged.
a) Antenatal Classes	100% of cost or MSR, whichever is the lesser	Limited to 5 antenatal classes per pregnancy	
b) Antenatal Consultations	100% of cost or MSR, whichever is the lesser	Limited to 8 antenatal consultations per pregnancy	
c) Ultrasound Scans for Pregnancy	100% of cost or MSR, whichever is the lesser	Limited to 2 scans (2D) per pregnancy	
d) Confinement in a registered birthing unit and confinement out of hospital	100% of cost or MSR, whichever is the lesser	Limited to and included in the Maternity Benefits	Subject to pre-authorisation and approval by the Scheme.

MM
TM
S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
e) Additional Maternity Benefits 1. Blood grouping test 2. Flu vaccination 3. Haemoglobin measurement test 4. Hearing screening for new-born 5. Mental health visit with psychologist 6. Nutritional assessment with dietician 7. Postnatal mid-wife Visits 8. VDRL test 9. Breastfeeding visit with nurse or specialist 10. Congenital hypothyroidism screening 11. Full blood count 12. Vitamins	100% of cost or MSR, whichever is the lesser	1. Limited to 1 test per pregnancy 2. Limited to 1 per pregnancy 3. Limited to 2 tests per pregnancy 4. Limited to 1 test per newborn 5. Limited to 2 per pregnancy 6. Limited to 1 test per pregnancy 7. Limited to 6 per pregnancy 8. Limited to 1 test per pregnancy 9. Limited to 1 per pregnancy 10. Limited to 1 test per pregnancy 11. Limited to 1 test per pregnancy 12. Limited R130 per pregnancy	1. Subject to pre-authorisation and approval by the Scheme. 2. Once the additional maternity limits have been reached, tests will be paid from the applicable benefit limit. 
5. Oncology (Cancer)	100% of cost at DSP or 75% of cost or MSR, whichever is the lesser, at a non-DSP	Limited to PMBs only	1. Patient `s are encouraged to enroll on the Oncology Benefit Management Programme. 2. Non-Prescribed Minimum Benefits and Prescribed Minimum Benefits formularies apply as per the Designated Service Provider`s (DSPs) treatment protocols. 3. Benefit is subject to submission of a 12-month treatment plan by the treating Oncologist and the approval thereof prior to the commencement of treatment. 4. Benefits in respect of cancer related medicines, radiotherapy, chemotherapy, oncologist, pathology, X-ray, mammograms, MRI scans, CT scans and radio-isotope scans will be paid from the Oncology benefit. 5. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme`s formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
6. Dental Implants (including surgeon`s fees)	Not applicable	No benefit	

TM *[Signature]*

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
7. Medical Appliances			
a) Internal Prosthesis/Devices	100% of cost or MSR, whichever is the lesser	Limited to R30 410 per member family per annum 	<ol style="list-style-type: none"> Subject to pre-authorisation and approval (including all accompanying temporary or permanent devices). Where the treatment is deemed to be clinically appropriate and Medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. Benefit is pro-rated if member joins during benefit year.
b) External Medical Appliances, Aids and Supporting Devices	100% of cost or MSR, whichever is the lesser	Limited to R8 000 per family per annum and includes the following sub-limit: Orthotic shoe/inner sole: Limited to R2 560 per family per annum and limited to PMBs only	<ol style="list-style-type: none"> Subject to application and approval by the Scheme. Where the treatment is deemed to be clinically appropriate and medically necessary, an additional benefit may be granted by the Scheme's medical advisor in excess of the limit for continuous Glucose monitoring devices and Insulin Pumps subject pre-authorisation and the criteria as set out in the Scheme policies. Provided that no benefit shall be available for Action Potential Simulation (APS) machines unless approved by the Scheme. Benefit is pro-rated if a member joins during the benefit year.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
c) Home Oxygen, cylinders, concentrators and ventilation expenses	100% of cost or MSR, whichever is the lesser	Limited to R17 980 per beneficiary per annum	1. Subject to pre-authorisation and approval by the Scheme.
d) Hyperbaric Oxygen	100% of cost or MSR, whichever is the lesser	Limited to R60 080 per beneficiary per annum	1. Subject to pre-authorisation and approval by the Scheme.
e) Artificial Limbs and Artificial Eyes	100% of cost or MSR, whichever is the lesser	Limited to R32 820 per family per annum and subject to the following sub-limits: <ul style="list-style-type: none"> R32 820 per artificial leg or arm per family per annum R22 700 per artificial eye per family per annum 	1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
f) Hearing Aids	100% of cost or MSR, whichever is the lesser	Limited to R15 110 per beneficiary per cycle	1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year. 3. Excludes repairs and batteries. 4. "Cycle" shall mean a 2 year cycle.

REGISTERED BY ME ON

Mina Maswanganyi

2025/01/13
Signed by Mina Maswanganyi
m.maswanganyi@medicalschemes.co.za
14/01/2025 16:07:53 (UTC+02:00)

REGISTRAR OF MEDICAL SCHEMES

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
8. Kidney Dialysis Medicines	100% of cost or MSR, whichever is the lesser 100% of medicine price	Limited to PMBs only Limited to the above	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. This includes the cost of all related approved medication, provided authorisation has been obtained via the Medicine Risk Management Programme. 3. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
9. Chronic medication Limited to PMB Chronic Conditions	100% of medicine price	Limited to PMBs only 	<ol style="list-style-type: none"> 1. Benefits are subject to prior application and approval via the Medicine Risk Management Programme. 2. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not on the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service. 3. Members are encouraged to make use of the Pharmacy Network to minimise possible co-payments.
10. Organ Transplants Hospital accommodation, surgical related services and procedures Anti-rejection drugs and immunosuppressant drugs	100% of cost or MSR, whichever is the lesser 100% of medicine price	Subject to the Overall Annual Limit and limited to PMBs only Limited to the above	<ol style="list-style-type: none"> 1. Subject to pre-authorisation and approval by the Scheme. 2. Services rendered to the donor, where the recipient is a beneficiary of the Scheme, and the transportation of organ is included in this benefit. 3. This includes the cost of all related approved anti-rejection medication, provided authorisation has been obtained via the Medicine Risk Management Programme. 4. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
11. Hospice Nursing, Private Nursing, and Healthcare Institute	100% of cost or MSR, whichever is the lesser	Limited to R10 270 per family per annum	<ol style="list-style-type: none"> 1. Subject to pre-authorisation at accredited facilities only and by registered nurses. 2. This benefit covers the acute phase after or instead of hospitalisation. 3. Not for long-term or chronic care. 4. Excludes frail care. 5. The Scheme's designated agent will liaise with the case manager of the Hospital and the treating doctor to assess appropriateness of step-down transfer. The Scheme's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge at an accredited provider and/facility, in accordance with the beneficiary's clinical motivation from doctors and case managers. 6. Benefit is pro-rated if member joins during benefit year

TM
S

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
12. Other Services		Subject to the Overall Annual Limit	
a) Blood Transfusions	100% of cost or MSR, whichever is the lesser		1. Includes the cost of blood, blood equivalents, blood products and the transport of blood. 2. Subject to pre-authorisation and approval by the Scheme.
b) Ambulance Services	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	1. Subject to benefit validation and claims adjudication.
c) Radial Keratotomy/Eximer Laser (including Holmium procedures, LASIK, Phakic lenses and intrastromal rings)	Not applicable	No benefit	
d) Medical Auxiliaries – In hospital Psychology, Orthotic Consultations, Occupational Therapy, Dietician, Physiotherapy, Social worker and speech therapy	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	1. This benefit covers any of these services rendered in-hospital by an approved and registered paramedical and auxiliary service provider. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full.
e) Cochlear Implants	100% of cost or MSR, whichever is the lesser	Limited to PMBs only	1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
f) Maxillo-facial and Oral Surgery	100% of cost or MSR, whichever is the lesser	Limited to R19 120 per family per annum	1. Subject to pre-authorisation and approval by the Scheme. 2. Benefit is pro-rated if member joins during benefit year.
g) HIV/AIDS Benefit	100% of cost or MSR, whichever is the lesser	Subject to the Overall Annual Limit	1. Medicine and hospital pre-authorisation is required. 2. Beneficiary enrollment on the HIV/AIDS Management Programme is encouraged. 3. This benefit includes medication, doctors' consultations and blood tests required for the treatment of the condition, as well as the cost of prophylaxis for preventative treatment. HIV resistance test is subject to pre-authorisation and approval.
Medicines	100% of medicine price		



SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
			4. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
h) Prescribed Minimum Benefits	100% of cost	Subject to the Overall Annual Limit	Any service falling within the Prescribed Minimum Benefits which is rendered by the Scheme's Designated Service Provider (DSP) to beneficiaries subject to Appendix 2.
B. PREVENTATIVE CARE BENEFITS 	100% of cost or MSR, whichever is the lesser	Payable from major medical expense benefit subject to the following limitations: Oral Contraceptives – Monthly limit of R170 1 test per adult beneficiary per annum: <ul style="list-style-type: none"> • Blood Glucose Screening • Blood Pressure • Cholesterol Screening • Body Mass Index Flu Vaccine - 1 per beneficiary per annum Prostate testing – over the age of 45 Mammograms – over the age of 40 Bone density screening – over the age of 65 Vitamins – limited to R340 per beneficiary per annum Additional tests and Procedures: Stool tests for cancer screening – 1 every 2 years for ages between 45 and 75 HPV vaccination – 1 course for ages between 9 and 25 Vasectomy – 1 per a life	1. Members are encouraged to make use of the Pharmacy Network where applicable to minimise possible co-payments. 2. Once the preventative limits have been reached, tests will be paid from the applicable benefit limit.
C. DAY-TO-DAY (DTD) BENEFIT		Maximum Annual Limits: R3 240 per member R3 240 per adult dependant R840 per child dependant	1. Benefits for services rendered to a patient prior to being admitted to hospital, but which may have a direct bearing on the admission are regarded as Day-to-Day benefits. 2. Benefits for follow-up services after the patient has been discharged from hospital are regarded as Day-to-Day benefits. 3. The Day-to-Day benefit depends on the family size. The sum of the sub-limit for each registered beneficiary will be the family limit.

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
1. General Practitioners Visits, consultations and out-patient visits (a) Network General Practitioner (b) Non-Network General Practitioner (non-DSP)	100% of agreed tariff 80% of cost or MSR, whichever is the lesser	Subject to the Overall Day-to-Day Limit 	Members are encouraged to make use of the GP Network to minimise possible co-payments.
2. Specialists a) Non-preferred specialist Network Visits, consultations and out-patient visits b) Preferred Specialist Network Visits, consultations and out-patient visits	100% of cost or MSR, whichever is the lesser 100% of cost or 110% MSR, whichever is the lesser	Subject to the Overall Day-to-Day Limit	1. Benefits are only covered if <ul style="list-style-type: none"> • A member was referred by a general practitioner; AND • Pre-authorisation was obtained from the Scheme for the first consultation at a given specialist.
3. Acute Medicine (a) Prescribed (acute) medicines (b) Pharmacist advised Therapy (PAT)	100% of medicine price 100% of medicine price	Subject to Overall Day-to-Day Limit and Annual Sub-Limits of: R1 940 per member R1 940 per adult dependant R520 per child dependant Limited to R990 per family per annum and further subject to Overall Day-to-Day Limit	1. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase medicine not in the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service. 2. The prescribed (acute) medicines benefit depends on the family size. The sum of the sub-limit for each registered beneficiary will be the family limit. 3. Pharmacist advised therapy (PAT) medicines applies to medicines classified as schedules 0, 1, and 2, which can be purchased without a doctor's prescription. 4. Members are encouraged to make use of the Pharmacy Network to minimise possible co-payments. 5. Benefit is pro-rated if member joins during benefit year.

NN
TM
g

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
<p>4. Auxiliary Services Occupational Therapy, Speech Therapy, Physiotherapy, Psychology, Social Worker, Audiometry, Chiropractors, Dietician</p> <p>No benefit for: Biokineticists, Chiropody, Orthoptist, Orthotic Consultation, Remedial Therapy, Reflexology, Homeopaths, Naturopaths, ART Therapy, Acupuncturists and Osteopaths</p>	100% of cost or MSR, whichever is the lesser	Limited to R1 090 per family per annum and further subject to Overall Day-to-Day Limit	<ol style="list-style-type: none"> 1. This benefit covers any of these services rendered out-of-hospital by an approved and registered paramedical and auxiliary service provider. 2. Treatment in respect of a CDL-related PMB condition is subject to the Care Plan and Appendix 2. 3. Once the limit is reached, only the cost in respect of the diagnosis, treatment and care costs of a PMB condition will be paid in full. 4. Benefit is pro-rated if member joins during benefit year.
			
5. Advanced Dentistry	100% of cost or MSR, whichever is the lesser	Subject to Overall Day-to-Day Limit	<ol style="list-style-type: none"> 1. Subject to the Scheme's Managed Care protocols and benefits. 2. All specialised/advanced procedures including orthodontic services are subject to prior approval. 3. In-hospital dentistry is subject to prior approval and pre-authorisation. 4. Benefit is pro-rated if member joins during the benefit year. 5. Refer to Annexure D for details of dental benefits and exclusions applicable. 6. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not on the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
D. PRIMARY CARE BENEFIT (PCB)			
1. Radiology (Out-of-hospital)	100% of cost or MSR, whichever is the lesser	Limited to R1 070 per family per annum subject to the Major Medical Expenses limit	1. Benefit is pro-rated if member joins during benefit year.
2. Pathology (Out-of-hospital)	100% of cost or MSR, whichever is the lesser	Limited to R980 per beneficiary per annum subject to the Major Medical Expenses benefit.	1. Benefit is pro-rated if member joins during benefit year.

MW
TM
g

SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
E. Optical Frames and prescription lenses/add-ons, Clear single Vision, Clear Aquity, Flat-top Bifocal, Clear Aquity Multifocal, Contact lenses and Eye tests	100% of cost or MSR, whichever is the lesser	Subject to R1 480 per beneficiary every two (2) years, which includes a frame sub-limit of R500	1. The Optical benefit is not subject to the Overall Day-to-Day Limit. 2. Benefit is pro-rated if member joins during benefit year.
F. Basic Dentistry Includes routine prophylaxis scaling and polishing (cleaning), fluoride application, fillings, non-surgical tooth extraction and root canal treatment	100% of cost or MSR, whichever is the lesser	Subject to a maximum limit of R3 800 per family per annum 	1. Subject to the Scheme's Managed Care protocols and benefits. 2. In-hospital dentistry is subject to prior approval and pre-authorisation. 3. Refer to Annexure D for details of dental benefits and exclusions applicable. 4. Benefit is pro-rated if member joins during the benefit year. 5. Medicines will be subject to generic and/or formulary reference pricing. If a member chooses to purchase a medicine not on the Scheme's formulary, the member will be required to pay the difference between the costs of these medicines as a co-payment at point of service.
G. PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)	Not applicable		No allocation to Personal Medical Savings Account (PMSA)

 TM S
 NN

ANNEXURE C

EXCLUSIONS AND LIMITATIONS

PRESCRIBED MINIMUM BENEFITS (PMBs)

The Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits (PMB) as per regulation 8 of the Act. Furthermore, where a managed health care 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

1. EXCLUSIONS

Subject to the above clause, expenses incurred in connection with any of the following will not be paid by the Scheme unless otherwise authorised by the Board:

- 1.1 Costs of whatsoever nature incurred for treatment arising out of an injury sustained by a member or a dependant and for which any other party is liable. The member is entitled to such benefits as would have applied in normal conditions irrespective of the lapse of time: Provided that the member informs the Scheme of the potential claim against the other party and of the relevant health care expenses incurred in the manner and within the time period applicable to normal claims for benefits under the Scheme : Provided further that a claim in respect of the said expenses is lodged by the member or dependant against the other party concerned and pursued with due diligence, with the Scheme being kept fully informed. Should the member or dependant not pursue the claim against such other party to the satisfaction of the Board, it may require the member to cede or procure the cession of such claim to the Scheme, in which event the member or dependant shall provide the Scheme with all such assistance and co-operation as it may reasonably require in pursuing such claim. Provided

that on receipt of payment from any third party in respect of medical expenses the member shall be obliged to pay to the Scheme any monies paid out by the Scheme in respect of this benefit.

1.2 Costs arising directly or indirectly from intentional, self-inflicted injury even if the member or dependant was psychologically unstable at the time, except for PMBs.

1.3 All costs in respect of injuries arising from speed contests, speed trials and professional sports or any other recreational, or dangerous activity, unless the injury, activity or treatment required is a Prescribed Minimum Benefit:

1.4 Investigations, operations or treatments for cosmetic purposes, obesity, infertility, artificial insemination, impotence and erectile dysfunction or treatment of an experimental nature, except for PMBs.

A medical or surgical procedure, treatment, cause of treatment, equipment, drug or medicine will be regarded as experimental:

1.4.1 if it is under study, investigation, in a test period or part of or in a clinical research state.

1.5 Holidays for recuperative purposes.

1.6 Except for PMBs the purchase of:

- patent medicine and proprietary preparations;
- applicators, toiletries and beauty preparations;
- bandages, cotton wool and similar aids, unless payable from positive savings where applicable;
- patented foods, including baby foods;
- non-oral contraceptives, apparatus to prevent pregnancy and emergency contraceptives, unless payable from positive savings where applicable;

- tonics, nutritional supplements, unless payable from positive savings where applicable;
 - slimming preparations and drugs as advertised to the public;
 - household and biochemical remedies;
 - sunglasses;
 - exercise equipment;
 - any drug or medicine not registered by the Medicines Control Council or similar authority or medicines not registered for that specific condition.
- 1.7 All costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules of the Scheme, unless payable from savings where applicable.
- 1.8 Examinations for insurance, employment, visas, pilot and driving licenses or examinations for enrolment to University and College.
- 1.9 Except if covered under Rule P of the NHRPL guide (travelling expenses), any travelling or conveyance by whomsoever and of whatsoever nature except as by Ambulance or Ambulance Aircraft within the Republic of South Africa and Namibia.
- 1.10 The purchase of medicines prescribed by a person not legally entitled thereto.
- 1.11 Costs of appointments cancelled or not kept by members.
- 1.12 Costs for services rendered by:
- 1.12.1 Persons not registered with a recognised professional body constituted in terms of an Act of Parliament;
- 1.12.2 Any institution, except a state or provincial hospital, not registered in terms of any law.

2. LIMITATION OF BENEFITS

Provided that no limitations shall apply in respect of any service falling within the prescribed minimum benefits, the following limitations shall apply:

- 2.1 The maximum benefits to which a member and his dependants shall be entitled in any financial year shall be limited as set out in Annexure "B".
- 2.2 Members admitted during the course of a financial year shall be entitled to the benefits set out in Annexure B with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.
- 2.3 In cases where a specialist, except an eye specialist or gynaecologist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, in the discretion of the Board, be limited to the amount that would have been paid to a general practitioner for the same service. In cases where a specialist is part of the Preferred Provider Network, the reimbursement rate allowed by the Scheme will be in accordance with the negotiated rate.
- 2.4 Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or to the nearest unbroken pack for every such prescription or repeat thereof.
- 2.5 In the case of illness of a protracted nature, , the Board will have the right to insist on the member or dependant obtaining a secondary medical opinion which will be funded by the Scheme. The Board may nominate the specialist in consultation with the attending practitioner.

Annexure D - MEDiPOS Dental Benefit Table

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular Appendix 2 concerning the provision of the statutory Prescribed Minimum Benefits, "PMB's")

Dental benefits are paid at the MEDiPOS Dental Tariff (MDT). Hospitalisation and all specialised dentistry procedures must be pre-authorized. Dental benefits are subject to clinical protocols and managed care interventions which may require treatment plans and/or radiographs prior to benefit application. Scheme exclusions apply to dental benefits. In terms of the funding of dental benefits, these will be covered at the MEDiPOS dental tariff which is equal to the medical scheme rate (MSR) as defined in terms of the Scheme Rules.

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
BASIC DENTISTRY			
Consultations	Two annual consultations per beneficiary. Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry.	Two annual consultations per beneficiary. Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry.	Two annual consultations per beneficiary. Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry.
X-rays: <i>Intra-oral</i>	Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry.	Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry.	Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry.
X-rays: <i>Extra-oral</i>	One per beneficiary in a two-year period. Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry. Additional benefit may be granted where specialised dental treatment planning/follow up is required.	One per beneficiary in a two-year period. Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry. Additional benefit may be granted where specialised dental treatment planning/follow up is required.	One per beneficiary in a two-year period. Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry. Additional benefit may be granted where specialised dental treatment planning/follow up is required.

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
BASIC DENTISTRY (continued)			
Oral hygiene	<p>Two annual scale and polish treatments per beneficiary. Benefit is subject to clinical protocols.</p> <p>Benefit for fissure sealants is limited to individuals younger than 16 years of age.</p> <p>Oral hygiene instruction will be covered once annually per beneficiary</p> <p>Professionally applied fluoride will be covered for a maximum of two per annum</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Oral hygiene evaluation • Dental bleaching <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry</p>	<p>Two annual scale and polish treatments per beneficiary. Benefit is subject to clinical protocols.</p> <p>Benefit for fissure sealants is limited to individuals younger than 16 years of age.</p> <p>Oral hygiene instruction will be covered once annually per beneficiary</p> <p>Professionally applied fluoride will be covered for a maximum of two per annum</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Oral hygiene evaluation • Dental bleaching <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry</p>	<p>Two annual scale and polish treatments per beneficiary. Benefit is subject to clinical protocols.</p> <p>Benefit for fissure sealants is limited to individuals younger than 16 years of age.</p> <p>Oral hygiene instruction will be covered once annually per beneficiary</p> <p>Professionally applied fluoride will be covered for a maximum of two per annum</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Oral hygiene evaluation • Dental bleaching <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry</p>
Fillings	<p>Once per tooth within 12 months. Benefit for re-treatment of a tooth is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Resin bonding for restorations that are charged as a separate procedure to the restoration • The polishing of restorations • Gold foil restorations, not applicable from positive savings. • Ozone therapy, not applicable from positive savings. 	<p>Once per tooth within 12 months. Benefit for re-treatment of a tooth is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Resin bonding for restorations that are charged as a separate procedure to the restoration • The polishing of restorations • Gold foil restorations, not applicable from positive savings. • Ozone therapy, not applicable from positive savings. 	<p>Once per tooth within 12 months. Benefit for re-treatment of a tooth is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Resin bonding for restorations that are charged as a separate procedure to the restoration • The polishing of restorations • Gold foil restorations, not applicable from positive savings. • Ozone therapy, not applicable from positive savings.

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
BASIC DENTISTRY (continued)			
Root canal therapy and extractions	Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry Scheme exclusions: <ul style="list-style-type: none"> • Direct pulp capping procedures 	Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry Scheme exclusions: <ul style="list-style-type: none"> • Direct pulp capping procedures 	Benefit is subject to clinical protocols. Covered at the MEDiPOS Dental Tariff Rates and paid from Basic dentistry. Scheme exclusions: <ul style="list-style-type: none"> • Direct pulp capping procedures
SPECIALISED/ADVANCED DENTISTRY			
Plastic dentures and associated laboratory costs	Benefit limited to once per beneficiary per jaw (frame) every 24 months. Benefit is subject to clinical protocols. Benefit is available for the denture repairs, denture tooth replacements. Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dentistry Scheme exclusions: <ul style="list-style-type: none"> • Diagnostic dentures and associated laboratory costs • Snoring appliances and associated laboratory costs, not applicable from positive savings. • The cost of gold, precious metal, semi-precious metal and platinum foil, not applicable from positive savings. • Provisional dentures and associated laboratory costs • Mouthguards • Metal inlays in artificial teeth or attached to metal dentures frames and plates 	Benefit limited to once per beneficiary per jaw (frame) every 24 months. Benefit is subject to clinical protocols. Benefit is available for the denture repairs, denture tooth replacements. Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dentistry Scheme exclusions: <ul style="list-style-type: none"> • Diagnostic dentures and associated laboratory costs • Snoring appliances and associated laboratory costs, not applicable from positive savings. • The cost of gold, precious metal, semi-precious metal and platinum foil, not applicable from positive savings. • Provisional dentures and associated laboratory costs • Mouthguards • Metal inlays in artificial teeth or attached to metal dentures frames and plates 	Benefit limited to once per beneficiary per jaw (frame) every 24 months. Benefit is subject to clinical protocols. Benefit is available for the denture repairs, denture tooth replacements. Covered at the MEDiPOS Dental Tariff Rates and paid from day to day benefit. Scheme exclusions: <ul style="list-style-type: none"> • Diagnostic dentures and associated laboratory costs • Snoring appliances and associated laboratory costs, not applicable from positive savings. • The cost of gold, precious metal, semi-precious metal and platinum foil, not applicable from positive savings. • Provisional dentures and associated laboratory costs • Mouthguards • Metal inlays in artificial teeth or attached to metal dentures frames and plates

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
SPECIALISED/ADVANCED DENTISTRY (continued)			
Partial metal frame dentures and associated laboratory costs	<p>Benefit limited to once per beneficiary per jaw (frame) every 24 months. Benefit is subject to clinical protocols.</p> <p>Pre-authorisation required</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • The metal base to full dentures and associated laboratory costs • High impact acrylic • The cost of gold, precious metal, semi-precious metal and platinum foil, not applicable from positive savings. • Gold plating of metal denture plates and frames, not applicable from positive savings. • Metal inlays in artificial teeth or attached to metal dentures frames and plates 	<p>Benefit limited to once per beneficiary per jaw (frame) every 24 months. Benefit is subject to clinical protocols.</p> <p>Pre-authorisation required</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • The metal base to full dentures and associated laboratory costs • High impact acrylic • The cost of gold, precious metal, semi-precious metal and platinum foil, not applicable from positive savings. • Gold plating of metal denture plates and frames, not applicable from positive savings. • Metal inlays in artificial teeth or attached to metal dentures frames and plates 	<p>Benefit limited to once per beneficiary per jaw (frame) every 24 months. Benefit is subject to clinical protocols.</p> <p>Pre-authorisation required</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from day-to-day benefit.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • The metal base to full dentures and associated laboratory costs • High impact acrylic • The cost of gold, precious metal, semi-precious metal and platinum foil, not applicable from positive savings. • Gold plating of metal denture plates and frames, not applicable from positive savings. • Metal inlays in artificial teeth or attached to metal dentures frames and plates
Crown and bridge and associated laboratory costs, including porcelain/ceramic inlays/onlays	<p>Pre-authorisation is required. Limited to once per tooth every 36 months.</p> <p>Benefit is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Scheme exclusions:</p> <p>Provisional crowns and associated laboratory costs as per guidelines</p> <ul style="list-style-type: none"> • Emergency crowns that are not placed as temporary crowns during crown preparation and associated laboratory costs. 	<p>Pre-authorisation is required. Limited to once per tooth every 36 months.</p> <p>Benefit is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Provisional crowns and associated laboratory costs as per guidelines • Emergency crowns that are not placed as temporary crowns during crown preparation and associated laboratory costs. 	<p>Pre-authorisation is required. Limited to once per tooth every 36 months.</p> <p>Benefit is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from day to day benefit.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Provisional crowns and associated laboratory costs as per guidelines • Emergency crowns that are not placed as temporary crowns during crown preparation and associated laboratory costs.

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
SPECIALISED/ADVANCED DENTISTRY (continued)			
Implants and associated laboratory costs	<p>Pre-authorisation is required. Limited to one implant per tooth site for lifetime. Benefit is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dentistry and Implant dental benefit</p> <p>Cost of implant components is limited to R3 500 per implant per five-year period per implant site, inclusive of all components related to the implant and superstructure.</p>	<p>Pre-authorisation is required. Limited to one implant per tooth site for lifetime. Benefit is subject to clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dentistry and Implant dental benefit</p> <p>Cost of implant components is limited to R3 500 per implant per five-year period per implant site, inclusive of all components related to the implant and superstructure.</p>	<p>No benefit</p>
Orthodontics and associated laboratory costs	<p>Pre-authorisation is required for removable appliance therapy, functional appliance therapy, partial fixed appliance therapy (preliminary treatment) and comprehensive fixed appliance therapy.</p> <p>Benefit is subject to Clinical protocols.</p> <p>Authorised benefits are payable from a specialised dental benefit.</p> <p>Pre-authorisation cases will be clinically assessed using orthodontic indices.</p> <p>Previous orthodontic treatment phases carried out by the same provider to be deducted from the currently intended phase (excluding the preceding space maintainers or subsequent retention phase), except where the case involves a cleft palate history.</p>	<p>Pre-authorisation is required for removable appliance therapy, functional appliance therapy, partial fixed appliance therapy (preliminary treatment) and comprehensive fixed appliance therapy.</p> <p>Benefit is subject to Clinical protocols.</p> <p>Authorised benefits are payable from a specialised dental benefit.</p> <p>Pre-authorisation cases will be clinically assessed using orthodontic indices.</p> <p>Previous orthodontic treatment phases carried out by the same provider to be deducted from the currently intended phase (excluding the preceding space maintainers or subsequent retention phase), except where the case involves a cleft palate history.</p>	<p>Pre-authorisation is required for removable appliance therapy, functional appliance therapy, partial fixed appliance therapy (preliminary treatment) and comprehensive fixed appliance therapy.</p> <p>Benefit is subject to Clinical protocols.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from day to day benefit.</p> <p>Pre-authorisation cases will be clinically assessed using orthodontic indices.</p> <p>Previous orthodontic treatment phases carried out by the same provider to be deducted from the currently intended phase (excluding the preceding space maintainers or subsequent retention phase), except where the case involves a cleft palate history.</p>

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
SPECIALISED/ADVANCED DENTISTRY (continued)			
<p>Orthodontics and associated laboratory costs ...continued</p>	<p>Initial fee of active fixed or partially fixed orthodontics limited for funding to approximately 20% of the total cost (excluding the diagnostic and retainer procedures).</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Benefit is limited to individuals younger than 21 years of age.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Orthodontic re-treatment and any related laboratory costs • Orthognathic (jaw correction) surgery and any related hospital and laboratory costs except where related to PMB scenarios • Invisible retainer material • Lingual orthodontics 	<p>Initial fee of active fixed or partially fixed orthodontics limited for funding to approximately 20% of the total cost (excluding the diagnostic and retainer procedures).</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Benefit is limited to individuals younger than 21 years of age.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Orthodontic re-treatment and any related laboratory costs • Orthognathic (jaw correction) surgery and any related hospital and laboratory costs except where related to PMB scenarios • Invisible retainer material • Lingual orthodontics 	<p>Initial fee of active fixed or partially fixed orthodontics limited for funding to approximately 20% of the total cost (excluding the diagnostic and retainer procedures).</p> <p>Benefit is limited to individuals younger than 21 years of age.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Orthodontic re-treatment and any related laboratory costs • Orthognathic (jaw correction) surgery and any related hospital and laboratory costs except where related to PMB scenarios • Invisible retainer material • Lingual orthodontics.
<p>Periodontics</p>	<p>Pre-authorisation is required. Benefit is subject to clinical protocols.</p> <p>Benefit is limited to conservative, non-surgical therapy only (<i>root planning</i>) limited to once per site per two year period</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Surgical periodontics which includes periodontal flap surgery, tissue grafting and the hemisection of a tooth • Perio chip placement 	<p>Pre-authorisation is required. Benefit is subject to clinical protocols.</p> <p>Benefit is limited to conservative, non-surgical therapy only (<i>root planning</i>) limited to once per site per two year period</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Advanced dental benefit</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Surgical periodontics which includes periodontal flap surgery, tissue grafting and the hemisection of a tooth • Perio chip placement 	<p>Pre-authorisation is required. Benefit is subject to clinical protocols.</p> <p>Benefit is limited to conservative, non-surgical therapy only (<i>root planning</i>) limited to once per site per two year period</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from day to day benefit.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Surgical periodontics which includes periodontal flap surgery, tissue grafting and the hemisection of a tooth • Perio chip placement

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
SPECIALISED/ADVANCED DENTISTRY (continued)			
<p>Maxillo-Facial Surgery and Oral Pathology <i>including Wisdom Teeth removal.</i></p>	<p>Benefit is subject to clinical protocols.</p> <p>Subject to clinical protocols:</p> <p>The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Maxillofacial and Oral Surgery benefit.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Orthognathic (jaw correction) surgery • The closure of an oral-antral opening (currently code 8909) when claimed during the same visit with impacted teeth (currently codes 8941, 8943 and 8945) is a scheme exclusion. • The auto-implantation of teeth 	<p>Benefit is subject to clinical protocols.</p> <p>Subject to clinical protocols:</p> <p>The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Maxillofacial and Oral Surgery benefit.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Orthognathic (jaw correction) surgery • The closure of an oral-antral opening (currently code 8909) when claimed during the same visit with impacted teeth (currently codes 8941, 8943 and 8945) is a scheme exclusion. • The auto-implantation of teeth 	<p>Benefit is subject to clinical protocols.</p> <p>Subject to clinical protocols:</p> <p>The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis.</p> <p>Covered at the MEDiPOS Dental Tariff Rates and paid from Maxillofacial and Oral Surgery benefit.</p> <p>Scheme exclusions:</p> <ul style="list-style-type: none"> • Orthognathic (jaw correction) surgery • The closure of an oral-antral opening (currently code 8909) when claimed during the same visit with impacted teeth (currently codes 8941, 8943 and 8945) is a scheme exclusion. • The auto-implantation of teeth
HOSPITALISATION AND ANAESTHETICS			
<p>Hospitalisation (general anaesthetic)</p>	<p>Pre-authorisation is required. Admission protocols apply.</p> <p>In hospital dental admissions will only be considered for the following procedures:</p> <ul style="list-style-type: none"> • Dependants under the age of 8 years for multiple procedures 	<p>Pre-authorisation is required. Admission protocols apply.</p> <p>In hospital dental admissions will only be considered for the following procedures:</p> <ul style="list-style-type: none"> • Dependants under the age of eight years for multiple procedures 	<p>Pre-authorisation is required. Admission protocols apply.</p> <p>In hospital dental admissions will only be considered for the following procedures:</p> <ul style="list-style-type: none"> • Dependants under the age of eight years for multiple procedures

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
	<ul style="list-style-type: none"> • Excision of lesions greater than 1.25cm in size • Patients with either physical, mental or medically compromising conditions which inhibit dental treatment under local anaesthesia • Mentally retarded patients or physically impaired patients • Patients with oro-facial or dental trauma including fractures • Management of acute infection • Patients who have proven allergy to local anaesthetic • Removal or extraction of two or more impacted teeth • Surgical extraction of teeth in more than one quadrant • Full dental clearance/extractions in both jaws • More than one quadrant of periodontal surgery on the same day • Root removal in the maxillary antrum • Surgical exposures of unerupted canines • Stomatoplasty or vestibuloplasty • Removal of exostosis • Placement of more than one endosteal implants • Posterior apicectomies. 	<ul style="list-style-type: none"> • Excision of lesions greater than 1.25cm in size • Patients with either physical, mental or medically compromising conditions which inhibit dental treatment under local anaesthesia • Mentally retarded patients or physically impaired patients • Patients with oro-facial or dental trauma including fractures • Management of acute infection • Patients who have proven allergy to local anaesthetic • Removal or extraction of two or more impacted teeth • Surgical extraction of teeth in more than one quadrant • Full dental clearance/extractions in both jaws • More than one quadrant of periodontal surgery on the same day • Root removal in the maxillary antrum • Surgical exposures of unerupted canines • Stomatoplasty or vestibuloplasty • Removal of exostosis • Placement of more than one endosteal implants • Posterior apicectomies. 	<ul style="list-style-type: none"> • Excision of lesions greater than 1.25cm in size • Patients with either physical, mental or medically compromising conditions which inhibit dental treatment under local anaesthesia • Mentally retarded patients or physically impaired patients • Patients with oro-facial or dental trauma including fractures • Management of acute infection • Patients who have proven allergy to local anaesthetic • Removal or extraction of two or more impacted teeth • Surgical extraction of teeth in more than one quadrant • Full dental clearance/extractions in both jaws • More than one quadrant of periodontal surgery on the same day • Root removal in the maxillary antrum • Surgical exposures of unerupted canines • Stomatoplasty or vestibuloplasty • Removal of exostosis • Placement of more than one endosteal implants • Posterior apicectomies.
HOSPITALISATION AND ANAESTHETICS (continued)			
Hospitalisation (general anaesthetic) ...continued	Scheme exclusions: <ul style="list-style-type: none"> • Where the only reason for admission to hospital is dental fear and anxiety • Where the only reason for the admission request is for a sterile facility The cost of dental materials for procedures performed under general anaesthesia	Scheme exclusions: <ul style="list-style-type: none"> • Where the only reason for admission to hospital is dental fear and anxiety • Where the only reason for the admission request is for a sterile facility The cost of dental materials for procedures performed under general anaesthesia	Scheme exclusions: <ul style="list-style-type: none"> • Where the only reason for admission to hospital is dental fear and anxiety • Where the only reason for the admission request is for a sterile facility The cost of dental materials for procedures performed under general anaesthesia

DENTAL BENEFIT	OPTION A	OPTION B	OPTION C
Laughing gas in dental rooms	Pre-authorisation required, subject to clinical protocols	Pre-authorisation required, subject to clinical protocols	Pre-authorisation required, subject to clinical protocols
IV conscious sedation in rooms	<p>Pre-authorisation required, subject to clinical protocols</p> <p>All anaesthetics costs will be paid from day-to-day benefit for dental procedures performed under conscious sedation</p>	<p>Pre-authorisation required, subject to clinical protocols</p> <p>All anaesthetics costs will be paid from day-to-day benefit for dental procedures performed under conscious sedation</p>	<p>Pre-authorisation required, subject to clinical protocols</p> <p>All anaesthetics costs will be paid from day-to-day benefit for dental procedures performed under conscious sedation</p>

Dentistry exclusions, not payable from positive savings

Basic Dentistry

Filling

- Gold foil restorations
- Ozone therapy

Specialised/Advance Dentistry

Plastic dentures and associated laboratory costs

- Snoring appliances and associated laboratory costs
- The cost of gold, precious metal, semi-precious metal and platinum foil

Partial metal frame dentures and associated laboratory costs

- The cost of gold, precious metal, semi-precious metal and platinum foil
- Gold plating of metal denture plates and frames

Additional Scheme exclusions:

- Any dental procedure deemed to be cosmetic
- Electrognathographic recordings, pantographic recordings and other such electronic analyses, unless payable from positive savings where applicable.
- Nutritional and tobacco counselling
- Caries susceptibility and microbiological tests, unless payable from positive savings where applicable.
- Fissure sealants on patients 16 years and older, unless payable from positive savings where applicable.
- Pulp tests, unless payable from positive savings where applicable.
- Cost of Mineral Trioxide, unless payable from positive savings where applicable.
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments, unless payable from positive savings where applicable.
- Appointment not kept
- Special report, unless payable from positive savings where applicable.
- Dental testimony including Dento-legal fees
- Treatment plan completed (currently code 8120), unless payable from positive savings where applicable.
- Enamel microabrasion, unless payable from positive savings where applicable.
- Behaviour management
- Intramuscular or subcutaneous injection, unless payable from positive savings where applicable.
- Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures
- Metal or gold restorations on anterior teeth
- Orthodontic treatment for beneficiaries above the age of 21 years, unless payable from positive savings where applicable.

APPENDIX 1

PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)

- 1 On admission to the Scheme, should a member select to join an option with a savings portion, a PMSA, held by the Scheme, shall be established in the name of the member concerned into which the contributions received and allocated by the Scheme in respect of the PMSA shall be credited and benefits in respect thereof, shall be debited.
- 2 The amount allocated to the PMSA by the Scheme for the benefit of the member may not exceed 25% of the total gross contributions in respect of the member during the financial year concerned.
- 3 A member shall have access to the equivalent of his full annual PMSA contribution on 1 January each year. Members joining during the year shall, on joining, have access to the equivalent of a pro-rated portion of the total annual PMSA. Changes to contribution levels i.e. changes in number of dependants shall likewise result in benefits that are subject to the PMSA being appropriately pro-rated. Pro-rating shall be based on full months available until the end of the financial year of joining or exiting in which the change of number of dependants occurred. Any such advance contemplated in this rule shall be available to a member, interest free.
- 4 Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to claim for all health care services, indicated under PMSA in the Benefit Schedules at 100% of the cost. Members may use their positive savings balances to fund non-PMB claims for waiting periods and certain exclusion.
- 5 Funds allocated to the member's PMSA shall be available for the exclusive benefit of the member and his dependants. Any credit balance in the PMSA at the end of a financial year accumulates for the benefit of the member and is carried forward to the new benefit year.

- 6 Upon the death of the member, the balance due to the member will be transferred to his dependants who continue membership of the Scheme or paid into his estate in the absence of such dependants.
- 7 On transfer to another benefit option of the Scheme, which does not provide for a savings account, any balance standing to the credit of the member in the PMSA will be refunded to the member, not later than 5 months after such transfer and subject to applicable taxation laws.
- 8 Should a member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme or option which does not provide for a PMSA, the balance due to the member must be refunded to the member not later than 5 months after termination of membership, and subject to applicable tax laws.
- 9 Should a member transfer to another benefit option or be admitted to membership of another medical scheme, which provides for a similar account, the balance due to the member must be transferred to such benefit option or scheme not later than 5 months after transfer to benefit option or termination of membership, as the case may be, provided on condition the ex-member advises the Scheme of details of the other Scheme joining.
- 10 The funds in the member's medical savings account may not be used to pay for the costs of a prescribed minimum benefit or to offset contributions.
- 11 On termination of membership, funds in the member's PMSA may be used to offset any debt owed by the member including outstanding contributions.
- 12 The money available in the member's PMSA may also be used to reimburse such member for costs incurred by him in respect of hospitalisation and related benefits where pre-authorisation has been declined, but members nonetheless wish to receive the relevant health service. In which case reimbursement to the member will be on the basis of the submission of receipted accounts.

- 13 For all benefits that are funded out of a member's PMSA, such member and his dependants may use any provider of their choice.
- 14 All disbursements from a PMSA shall be limited to the amount available in the account and shall be made only on the submission of the relevant claims in terms of these rules.
- 15 Any negative balance in a member's PMSA shall be recoverable from him by the Scheme upon his termination of membership, or in the event of his death, from his estate.
- 16 Positive balances will be maintained in the Scheme's investment account. The proportionate interest and other income, net of fees, earned in this portfolio will accrue to the members' positive savings account balances, monthly after month end, less any advance portions.

APPENDIX 2

PRESCRIBED MINIMUM BENEFITS (PMB'S)

1. DEFINITIONS

“**Prescribed minimum benefits**”, the benefits contemplated in section 29(1) (o) of the Act and consist of the provision of the diagnosis, treatment and care costs of –

- (a) the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and
- (b) any emergency medical condition (Regulation 7).

“**Prescribed minimum benefit condition**”, a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

2. DESIGNATION OF SERVICE PROVIDERS

The Scheme designates the following service provider(s) for the delivery of prescribed minimum benefits to its beneficiaries:

- 2.1 Independent Clinical Oncology Network (ICON) (for oncology treatment)
- 2.2 Pharmacy Network
- 2.3 GP Network
- 2.4 Life Healthcare, Mediclinic, National Hospital Network (NHN) and Clinix Health Group hospitals (for hospitalisation)

The above service provider(s) shall for the purposes of this Appendix be referred to as “designated service providers”.

3. PRESCRIBED MINIMUM BENEFITS (OTHER THAN MEDICATION) OBTAINED FROM DESIGNATED SERVICE PROVIDERS

100% of the cost in respect of diagnosis, treatment and care costs, other than medication, of prescribed minimum benefits conditions if those services are obtained from a designated service provider.

4. PRESCRIBED MINIMUM BENEFITS (OTHER THAN MEDICATION) VOLUNTARITLY OBTAINED FROM OTHER PROVIDERS

If a Beneficiary voluntarily obtains, treatment and care, other than medication, in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to a co-payment equal to:

- 4.1 In respect of oncology treatment, 25% of the actual cost incurred.
- 4.2 In respect of hospitalization, a R7 270 co-payment.
- 4.3 In respect of general practitioner (GPs), a co-payment equal to 20% of cost or 20% of MSR, whichever co-payment is the higher.
- 4.4 In respect of all other services, the difference between the actual cost incurred and the benefit payable in terms of the scheme rules.

5. PRESCRIBED MINIMUM BENEFITS (OTHER THAN MEDICATION) INVOLUNTARILY OBTAINED FROM OTHER PROVIDERS

5.1 If a Beneficiary involuntarily obtains diagnosis, treatment and care, other than medication, in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the Scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions, subject to PMB regulations.

5.2 For the purposes of Rule 5.1 of the Appendix, a Beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

- 5.2.1 the service was not available from the designated service provider or could not be provided without unreasonable delay;
- 5.2.2 immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonable precluded the Beneficiary from obtaining such treatment from a designated service provider; or
- 5.2.3 there was no designated service provider within a reasonable distance from the Beneficiary's ordinary place of personal residence.

5.3 Except in the case of a medical emergency, pre-authorisation shall be obtained by a Member prior to obtaining a service from a non-DSP provider in terms of this Rule, to enable the Scheme to confirm the circumstances contemplated above are applicable.

6. MEDICATION

6.1 Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of the medication, subject to generic and/or therapeutic reference pricing, if that medication is obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider, *and*

6.1.1 the medication is included on the applicable formulary in use by the Scheme; or

6.1.2 the formulary does not include a medicine that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

6.2 Where a prescribed minimum benefit includes medication, and the formulary includes medication that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a Beneficiary, and that Beneficiary knowingly declines the formulary medicine and opts to use another medicine instead, the member will be liable for the difference between the actual costs incurred and the benefit payable in terms of the Scheme Rules.

7. PRESCRIBED MINIMUM BENEFITS OBTAINED FROM A STATE/PUBLIC HOSPITAL

Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the costs of prescribed minimum benefits obtained in a State/Public Hospital, without limitation.

8. DIAGNOSTIC TESTS FOR AN UNCONFIRMED PMB DIAGNOSIS

Where diagnostic tests and examinations are performed but do not result in confirmation of a prescribed minimum benefit condition diagnosis, except for an emergency medical condition, such diagnostic tests or examinations are not considered to be a prescribed minimum benefit.

9. CO-PAYMENTS

Co-payments in respect of the costs for PMB's may not be paid out of PMSAs.

10. CHRONIC CONDITIONS

Any benefit option covers the full cost for services rendered in respect of the prescribed minimum benefits for the chronic disease list, which includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions.

11. DIAGNOSIS (CHRONIC DISEASE LIST – PRESCRIBED MINIMUM BENEFITS)

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy disease
7. Chronic renal disease
8. Coronary artery disease
9. Chronic obstructive pulmonary disorder
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus type 1 & 2
13. Dysrhythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. Hyperlipidaemia

18. Hypertension
19. Hypothyroidism
20. Multiple sclerosis
21. Parkinson's disease
22. Rheumatoid arthritis
23. Schizophrenia
24. Systemic lupus erythematosus
25. Ulcerative colitis

The HIV/AIDS benefit provided will be in accordance with the National Antiretroviral Treatment Guidelines and the algorithms specified within the prescribed minimum benefits for the treatment and management of HIV/AIDS.