MEDIMED MEDICAL SCHEME
Rules

Amendments with effect from

1 January 2023 **[Amended with effect from 2023/01/01]**

1. NAME

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

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, 7 Lutman Road, Richmond Hill, Port Elizabeth, 6001 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, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context—

(a) a word or expression in the masculine gender includes the feminine;
(b) a word in the singular number includes the plural, and *vice versa*; and
(c) the following expressions have the following meanings:

4.1 "Act",

the Medical Schemes Act (Act No 131 of 1998), and the regulations framed thereunder.

4.2 “Adult dependant”,

a dependant other than a child dependant.

4.3 "Approval",

prior written approval of the Board or its authorised representative.

4.4 "Auditor",

an auditor registered in terms of the Public Accountants' and Auditors' Act, 1991, (Act No. 80 of 1991).

4.5 "Beneficiary",’

a Member or a person admitted as a Dependant of a Member.

4.6 "Board",

the Board of Trustees constituted to manage the Scheme in terms of the Act and these Rules.

4.7 "Child",

a member’s natural child, or a stepchild or legally adopted child who or a child in the process of being legally adopted or a child who has been placed in the custody of the member or his/her spouse or partner and who is not a beneficiary of any other medical scheme.

4.8 “Child Dependant”,

in relation to a child, a child under the age of 21 who is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child over the age of 21 but under the age of 25 who is unmarried, not self supporting, is a full time student at an educational institution recognised by the Board and is accepted by the Board as a child dependant, or who, due to a mental or physical disability, is dependent upon the Member.

4.9 “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.

4.10 "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.

4.11 "Contracted fee",

the fee determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services.

4.12 "Contribution",

in relation to a Member, the amount, exclusive of interest, paid by or in respect of the Member and his/her registered Dependants if any, as membership fees and shall include contributions to personal medical savings accounts.

4.13 "Cost",

in relation to a benefit, the net amount payable in respect of a relevant health service.

4.14 "Council",

the council for Medical Schemes as contemplated in Act.

4.15 "Creditable coverage",

any period during which a late joiner was –

4.15.1 a member or a dependant of a medical scheme;

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

4.15.3 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

4.15.4 a member or dependant of the Permanent force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years.

4.16 "Dependant",

4.16.1 Member's spouse or partner who is not a member or a registered dependant of a member of a medical scheme;

4.16.2 a dependant child; .

4.16.3 the immediate family of a Member in respect of whom the Member is liable for family care and support;

4.16.4 any other person who is recognised by the Board as a dependant for purposes of these Rules.

4.16.5 To be eligible as a Dependant, other than as the Member's spouse or partner, a dependant must not be in receipt of a regular income in excess of the Social Pension.

4.17 "Designated Service Provider" (DSP),

a health care provider or group of providers selected by the Scheme as preferred provider/s to provide to the members, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.

4.18 "Domicilium citandi et executandi"

the member's chosen physical address at which notices in terms of rules 11 and 13 as well as legal process, or any action arising therefrom, may be validly delivered and served.

4.19 "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.

4.20 "Employee",

a person in the employment of an Employer.

4.21 "Eligible Employee",

an Employee of an Employer who is not a dependant of his spouse on another medical scheme.

4.22 "Employer",

a participating employer who has contracted with the Scheme for purposes of admission of all its Eligible Employees as Members of the Scheme

providing that an employer shall not have less than 20 Eligible employees.

4.23 "General Waiting Period",

a period in which a Beneficiary is not entitled to claim any benefits.

4.24 "Income",

for the purposes of calculating contributions in respect of —

4.24.1 a Member who is an Employee - gross monthly salary/ pensionable earnings and additional income received from other sources

4.24.2 a Member who registers a spouse or partner as a dependant — the higher of member or spouses or partner's salary or earnings;

4.24.3 a Continuation Member or other - total gross monthly earnings from all sources including employment and, in the absence of proof being provided in respect of 4.24.1 and 4.24.2, income will be deemed to be at the highest level.

4.25 "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 schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 consecutive months since 1 April 2001.

4.26 "Medical Savings Account" (MSA),

That portion of a member's contributions allocated to the members savings account which shall not exceed 25% of the total contribution.

Accumulated Savings is that portion of a member's MSA which is carried forward to the next calendar year and which bears interest at a rate to be determined by the Board from time to time.

4.27 "Medimed Scheme Tariff"

The tariff payable for health services as determined by the Board of Trustees.

4.28 "Member",

any person who is admitted as a Member of the Scheme in terms of these Rules.

4.29 "Member Family",

the Member and all the registered Dependants.

4.30 "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.

4.31 "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 cost 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.

4.32 "Prescribed minimum benefit condition",

a condition contemplated in the Diagnosis and Treatment Pairs in Annexure A of the Regulations of any emergency medical condition.

4.33 "Registrar",

the Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of section 18 of the Act.

4.34 "Social Pension",

the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (Act No. 59 of 1992*).*

4.35 "Spouse",

the person to whom the Member is married in terms of any law or custom.

5. OBJECTS

The objects of the Scheme are to undertake liability, in respect of its Members and their Dependants, in return for a contribution or premium —

(a) to make provision for the obtaining of any relevant health service;

(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/ or

(c) 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 rule 8, membership of the Scheme is available to Eligible Employees, or former employees of an Employer or his predecessor or successor in title as defined in these Rules and to any individual

6.2 Retirees

6.2.1 A Member shall retain his membership of the Scheme with his registered Dependants, if any, in the event of his retiring from the service of his Employer or his employment being terminated by his Employer on account of age, ill-health or other disability.

6.2.2 The Scheme shall inform the Member of his right to continue his membership and of the contribution payable from the date of retirement or termination of his employment. Unless such Member informs the Board in writing of his desire to terminate his membership, he shall continue to be a Member.

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 Board 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.

6.3.4 Where a Child Dependant/s has been orphaned, the eldest child may be deemed to be the Member, and any younger siblings, the Child Dependant/s

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of dependants

7.1.1 A Member may apply for the registration of his dependants at the time that he applies for membership in terms of Rule 8.

7.1.2 If a Member applies to register a new born or newly adopted child within 30 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 following the month of birth or adoption and 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 30 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 following the month of marriage and benefits will accrue as from the date of marriage. The Spouse shall not qualify for benefits until such time as the Member qualifies for benefits.

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.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 An orphaned minor may become a Member with the consent of his guardian.

8.2 No person may be a member of more than one medical scheme or a dependant:

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 respect of 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 an application for membership was made. The cost of any medical tests or examinations required to provide such medical report will be paid for by the Scheme. The Scheme may however designate a provider to conduct such tests or examinations.

8.4 Waiting periods

8.4.1 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-

8.4.1.1 a general waiting period of up to three months; and

8.4.1.2 a condition-specific waiting period of up to 12 months.

8.4.2 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-

8.4.2.1 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;

8.4.2.2 in respect of any person contemplated in this subrule, 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.

8.4.3 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.

8.5 No waiting periods may be imposed on:

8.5.1 a person in respect of whom 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-

8.5.1.1 change of employment; or

8.5.1.2 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 have been 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.

8.5.2 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;

8.5.3 a child dependant born during the period of membership;

8.6 The registered Dependants of a Member must participate in the same benefit option as the Member

8.7 Every Member will, on admission to membership, receive a detailed summary of these Rules that 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 is bound by these Rules as amended from time to time.

8.8 A Member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he may have against the Scheme. 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.

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, any member of such first-mentioned scheme who is a continuation member by virtue of his past employment by the particular employer and admit any person who has been a registered dependant of such member, as a dependant.

10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

10.1 Every Member shall be furnished with a membership card, containing such particulars as may be prescribed. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination 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 is construed as an abuse of the privileges of membership of the Scheme.

10.3 On termination of membership or on de-registration of a Dependant, the Scheme must, within 30 days of such termination, furnish such person with a certificate of membership and cover, containing such particulars as may be prescribed.

11. CHANGE OF ADDRESS OF MEMBER

A Member must notify the Scheme within 30 days of any change of address including his/her 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. TERMINATION OF MEMBERSHIP

12.1 Resignation

12.1.1 A Member, who, in terms of his conditions of employment is required to be Member of the Scheme, may not terminate his membership while he remains an Employee without the prior written consent of his Employer.

12.1.2 A member who resigns from the service of his/her Employer shall, subject to rule 12.6 on the date of such termination, be eligible to continue as an individual member without reapplying or the imposition of any new restrictions that did not exist at the time of his/her resignation.

12.2 Voluntary termination of membership

12.2.1 An individual member or *a* member, who is not required in terms of his conditions of employment to be a Member, may terminate his membership of the Scheme on giving 3 months written notice. All rights to benefits cease after the last day of membership.

12.2.2 Such notice period shall be waived in substantiated cases where membership of another medical scheme is compulsory as a result of a condition of employment.

12.2.3 A participating Employer may terminate his participation with the Scheme on giving 6 months written notice.

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 Member or Dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information. 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 total monthly Contributions payable to the Scheme by or in respect of a Member are as stipulated in Annexure A It shall be the responsibility of the Member to notify the Scheme of changes in Income that may necessitate a change in Contribution in terms of Annexure A.

13.2 Contributions from an Employer shall be due monthly in arrears and all other contributions shall be due monthly in advance - payable by not later than the 7th day of each month.Where Contributions or any other debt owing to the Scheme, have not been paid within thirty (30) days of the due date, the Scheme shall have the right -

13.2.1 to suspend all benefit payments in respect of claims which arose during the period of default;

13.2.2 to give the Member and/or Employer notice at his/her domicilium citandi et executandi that if Contributions or such other debts are not paid up to date within fourteen (14) days of such notice, membership may be cancelled.

13.3 In the event that payments are brought up to date, and provided membership has not been cancelled in terms of 13.2.2 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 on the arrear amount 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 and any such benefit paid may be recovered by the Scheme**.**

13.4 Unless specifically provided for in the rules in respect of Medical Savings Accounts, no refund of any assets of the Scheme or any portion of a Contribution shall be paid to any person where such Member's membership or cover in respect of any Dependant terminates during the course of a month.

13.5 The balance standing to the credit of a Member in terms of any option which provides for personal medical savings accounts shall, at all times remain the property of the Member.

14 LIABILITIES OF EMPLOYER AND MEMBER

14.1 The liability of the Employer towards the Scheme is limited to any amounts payable in terms of any agreement between the Employer and the Scheme.

14.2 The liability of a Member to the Scheme is 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, which has not been repaid to the Scheme.

14.3 In the event of a Member ceasing to be a Member, any amount still owing by such Member is 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, must be accompanied by an account or statement as prescribed.

15.2 If an account, statement or claim is correct or where a correct account, statement or claim is received, as the case may be, the Scheme must, 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, any claim must, unless otherwise arranged, be signed and certified as correct and must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

15.4 Where a Member has paid an account, he shall, in support of his claim, submit a receipt.

15.5 Accounts for treatment of injuries or expenses recoverable from third parties, must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained.

15.6 If the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the Member and the relevant health care provider, within 30 days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and provider the opportunity to resubmit such corrected account or

statement to the Scheme within sixty days following the date from which it was returned for correction.

16. BENEFITS

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the Member to his registered Dependants. A Member must, on admission, elect to participate in any one of the available options, detailed in Annexure B.

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 provided that the member may change to another option in the case of midyear contribution increases or benefit changes.

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 within the period notified by the Scheme provided that the Member has had at least 30 days prior notification of any intended changes in benefits or contributions for the next year.

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 Annexure B covers the cost of service rendered in respect of the Prescribed Minimum Benefits.

16.5 No limitations or exclusions will be applied to the Prescribed Minimum Benefits.

16.6 The Scheme may exclude services from benefits as set out in Annexure C.

16.7 Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in the relevant benefit option chosen, 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.

16.8 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 repeat thereof.

17. PAYMENT OF ACCOUNTS

17.1 Payment of accounts or reimbursement of claims is restricted to the net amount payable in respect of such benefit and maximum amount of the benefit to which the member is entitlement in terms of the applicable benefit.

17.2 The Scheme may, whether by agreement or not with any supplier or group of suppliers of a service, pay the benefit to which the Member is entitled, directly to the supplier who rendered the service.

17.3 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.

17.4 Notwithstanding the provisions of this rule, the Scheme has the right to pay any benefit directly to the Member concerned.

18. GOVERNANCE

18.1 The affairs of the Scheme must be managed according to these Rules by a Board consisting of at least six ~~five~~ persons and not more than twelve persons who are fit and proper to be trustees.

18.2 At least half of such trustees must be elected by members from amongst members to serve terms of office of three years each.

18.3 The remaining trustees must be appointed by the participating employers also for a period of 3 years.

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

18.4.1 A person under the age of 21 years;

18.4.2 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;

18.4.3 a broker;

18.4.4 the auditor of the Scheme.

18.5 Retiring members of the Board are eligible for re-election provided no person shall serve more than 2 consecutive terms and no more than 3 terms all together.

18.6 The Board may fill by appointment, any vacancy arising during the term office of a member of the Board due to such member resigning in term of rule 18.13 or ceasing to hold office in terms of rule 18.14. A person so appointed must retire at the first ensuring annual general meeting and that meeting may fill the vacancy for the unexpired period of office of the vacating member of the Board.

18.7 Nominations to fill vacancies, signed by a proposer and seconder in good standing with the Scheme, must be signed by the candidate signifying his/her consent to stand for election and must be submitted to the Scheme together with a current curriculum vitae at least 10 days prior to the annual general meeting and the election must be carried out by the members present at the annual general meeting of the Scheme.

18.8 The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote

18.9 A quorum is constituted by a number of members of the Board physically presented at a meeting of that Board, or who attend via any virtual medium which number shall be not less than half of the members of the Board plus one. Members of the Board will, for the purposes of constituting a quorum, not include suspended Board members.

18.10 The Board must elect from its number a Chairperson and a Vice – Chairperson.

18.11 In the absence of the chairperson and vice-chairperson, the Board members present must elect one of their numbers to preside.

18.12 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson has a casting vote in addition to his deliberative vote.

18.13 A member of the Board may resign at any time by giving written notice to the Board.

18.14 A member of the Board ceases to hold office if —

18.14.1 he becomes mentally ill or incapable of managing his affairs;

18.14.2 he is declared insolvent or has surrendered his estate for the benefit of his creditors;

18.14.3 he is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;

18.14.4 he is removed by the court from any office of trust on account of misconduct;

18.14.5 he is disqualified under any law from carrying on his profession;

18.14.6 he ceases to be an appointee by a participating employer, or being a Board member elected by Members of the Scheme, he ceases to be a Member of the Scheme;

18.14.7 he absents himself from three consecutive meetings of the Board without the permission of the Chairperson; or

18.14.8 he is removed from office by the Council in terms of Section 46 of the Act.

18.14.9 he/she is removed from office in terms of rule 18.20.

18.15 The Board shall meet quarterly or at such intervals as it may deem necessary.

18.16 The chairperson may convene a special meeting should the necessity arise. Any two members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

18.17 The Board may, subject to participation by sufficient members to from a quorum, discuss and resolve matters by telephone or electronic conferencing means and may adopt resolutions on that basis.

18.18 Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as trustees.

18.19 Trustees of the Board and members of both the Audit and Risk Committee and the Investment Committee may receive remuneration which has been approved by the Board.

18.20 A member of the Board who acts in a manner which is seriously prejudical to the interests of beneficiaries of the medical scheme may be removed by the Board, provided that-

18.20.1 before a decision is taken to remove the member of the Board, the Board shall furnish that member with full details of the evidence which the Board has at its disposal regarding the conduct complained of, and allow such member a period of not less than 30 days in which to respond to the allegations;

18.20.2 the resolution to remove that member is taken by at least two thirds of the members of the Board;

18.20.3 the member shall have recourse to disputes procedures of the scheme or complaints and appeal procedures provided in the Act.

19. DUTIES OF BOARD OF TRUSTEES

19.1 The Board is responsible for the proper and sound management of the Scheme, in terms of these Rules.

19.2 The Board must act with due care, diligence, skill and in good faith.

19.3 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.

19.4 The Board must apply sound business principles and ensure the financial soundness of the Scheme.

19.5 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 of any person employed by the Scheme.

19.6 The chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

19.7 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.

19.8 The Board must ensure that proper control systems are employed by and on behalf of the Scheme.

19.9 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.

19.10 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.

19.11 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

19.12 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.

19.13 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.

19.14 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any Member or Dependant's state of health.

19.15 The Board must approve all disbursements.

19.16 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.

19.17 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.

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

20. POWERS OF BOARD

The Board has the power —

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

20.2 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;

20.3 to appoint a committee consisting of such Board members and other experts as it may deem appropriate.

20.4 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.

20.5 to appoint, compensate and contract with any accredited broker for the introduction or admission of a Member to the Scheme.

20.6 to contract with managed health care organisations subject to the provisions of the Act and its regulations;

20.7 to purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of ;

20.8 to let or hire movable or immovable property;

20.9 to sell movable and immovable property of the Scheme subject to sound business practice and fair value principles;

20.10 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;

20.11 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;

20.12 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 Members of the Scheme;

20.13 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;

20.14 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,

20.15 to contribute to any fund conducted for the benefit of employees of the Scheme;

20.16 to reinsure obligations in terms of the benefits provided for in these Rules.

20.17 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;

20.18 to contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes;

20.19 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.

21. DUTIES OF PRINCIPAL OFFICER AND STAFF

21.1 The staff of the Scheme must ensure the confidentiality of all information regarding its Members.

21.2 The principal officer is the executive officer of the Scheme and as such shall ensure that:

21.2.1 he acts in the best interests of the members of the Scheme at all times;

21.2.2 the decisions and instructions of the Board are executed without unnecessary delay;

21.2.3 where necessary, there is proper and appropriate communication between the Scheme and those parties, affected by the decisions and instructions of the Board;

21.2.4 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;

21.2.5 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;

21.2.6 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.

21.3 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 unless the Board appoints another person to handle this responsibility.

21.4 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 committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.

21.5 The principal officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

21.6 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 unless the Board appoints another person to handle this responsibility.

21.7 The principal officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto unless the Board appoints another person to handle this responsibility.

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

21.8.1 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.

21.8.2 A broker.

21.9 The provision of rules 18.14.1 – 18.14.5 apply mutatis mutandis to the principal officer.

22. INDEMNIFICATION & FIDELITY GUARANTEE

22.1 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.

22.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers (including members of the

Board) having the receipt or charge of moneys or securities belonging to the Scheme.

23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the first day of January to the 31st day of December of that year.

24. BANKING ACCOUNT

The Scheme must establish and maintain a banking account with a registered commercial bank. All moneys received must be deposited to the credit of such account and all payments must be made either by electronic transfer, tape exchange or by cheque under the joint signature of not less than two persons duly authorised by the Board.

25. AUDITOR & AUDIT COMMITTEE

25.1 An Auditor (who must be approved in terms of section 36 of the Act) must be appointed by resolution at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.

25.2 The following persons are not eligible to serve as Auditor of the Scheme -

25.2.1 a member of the Board;

25.2.2 an employee, officer or contractor of the Scheme;

25.2.3 an employee, director, officer or contractor of the Scheme's administrator, or of the holding company, subsidiary joint venture or associate of the administrator;

25.2.4 a person not engaged in public practice as an auditor;

25.2.5 a person who is disqualified from acting as an auditor in terms of the Companies Act, 1973.

25.3 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.

25.4 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.

25.5 The Auditor of the Scheme at all times has a right of access to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from the Board and the *other* officers of the Scheme such information and explanations as he deems necessary for the performance of his duties.

25.6 The Auditor must report to the Members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in general meeting.

25.7 The Board must appoint an audit committee in the prescribed manner.

26. GENERAL MEETINGS

26.1 Annual general meeting

26.1.1 The annual general meeting of Members must be held not later than 30th June of each year on a date which may be shown to permit reasonable attendance by members.

26.1.2 The notice convening the annual general meeting and agenda must be furnished to Members at least 21 days before the date of the meeting. Members will be furnished on request, copies of the annual financial statements, auditors report and annual report and these documents will be distributed at the annual general meeting. The non-receipt of such notice by a Member does not invalidate the

proceedings at such meeting provided that the notice procedure followed by the Board was reasonable.

26.1.3 At least 10 Members of the Scheme present in person or who attend via any virtual medium constitute 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 must be postponed to a date determined by the Board, with notice of such postponed meeting being reissued in terms of rule 26.1.2 and Members then present constitute a quorum.

26.1.4 The financial statements and reports specified in rule 26.1.2 must be laid before the meeting.

26.1.5 Notices 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.

26.2 Special general meeting

26.2.1 The Board may call a special general meeting of Members if it is deemed necessary.

26.2.2 On the requisition of at least 15 Members of the Scheme, the Board must cause a special general meeting to be called within 30 days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitionists and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

26.2.3 The notice convening the special general meeting, containing the agenda, must be furnished to Members at least 14 days before the date of the meeting. The non-receipt of such notice by a Member does not invalidate the proceedings at such a meeting provided that the notice procedure followed by the Board was reasonable.

26.2.4 At least 30 Members present in person or who attend via any virtual medium constitute a quorum. If a quorum is not present at a special general meeting after the lapse of 30 minutes from the time fixed

for the commencement of the meeting, the meeting is regarded as cancelled.

27. VOTING AT MEETINGS

27.1 Every Member who is present at a general meeting of the Scheme has the right to vote, or may, subject to this rule, appoint another Member of the Scheme as proxy to attend, speak and vote in his stead.

27.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the Member and the person appointed as the proxy.

27.3 The chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson, if he is a Member, has a casting vote in addition to his deliberative vote.

28. COMPLAINTS AND DISPUTES

28.1 Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators shall also provide a dedicated toll free telephone number, which may be used, for dealing with telephonic complaints.

28.2 All complaints received in writing will be responded to by the Scheme in writing within 30 days of receipt thereof.

28.3 A disputes committee of three members, who may not be members of the Board, employees of the administrator of the Scheme or officers of the Scheme, must be appointed by the Board annually to serve a term of office of 3 years. At least one of such members shall be a person with legal expertise.

28.4 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, must be referred by the principal officer to the disputes committee for adjudication.

28.5 On receipt of a request in terms of this rule, the principal officer must convene a meeting of the disputes committee by giving not less than 21 days notice in writing to the complainant and all the members of the disputes committee, stating the date, time, and venue of the meeting and particulars of the dispute.

28.6 The disputes committee may determine the procedure to be followed.

28.7 The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.

28.8 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.

28.9 The operation of any decision which is the subject of an appeal under rule 28.8 shall be suspended pending the decision of the Council on such appeal.

29. TERMINATION OR DISSOLUTION

29.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution**.**

29.2 Members in general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for Members to decide by ballot whether the Scheme must be liquidated. Unless the majority of members decide that the Scheme must continue, the Scheme must be liquidated in terms of section 64 of the Act.

29.3 Pursuant to a decision by Members taken in terms of rule 29.2 the principal officer must, in consultation with the Registrar, furnished 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.

29.4 Every Member must be requested to return his 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, in consultation with the Registrar, a competent person as liquidator.

30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person. The Board must arrange for Members to be furnished with an exposition of the proposed transaction for consideration and to decide by ballot whether the proposed transaction should be proceeded with or not.

30.2 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.

30.3 The Registrar may, on good cause shown, ratify a lower percentage.

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any Beneficiary must on request and on payment of a fee of R20 per copy, be supplied by the Scheme with a copy of the following documents:

31.1.1 The Rules of the Scheme;

31.1.2 the latest audited annual financial statements, returns, Trustees reports and auditors report of the Scheme; and

31.1.3 the management accounts in respect of the Scheme and all of its benefit options.

31.2 A Beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in rule 31.1 and to make extracts therefrom.

31.3 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.

32. AMENDMENT OF RULES

32.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

32.2 No alteration, rescission or addition which affects the objects of the Scheme or which increases the rates of Contribution or decreases the extent of benefits of any particular benefit option of the Scheme by more than the National Treasury project of CPIX plus 3% during any financial year, is valid unless it has been approved by the Registrar after providing him with a detailed motivation for such an increase. Such motivation should include, for example, matters such as changes in demographics, benefit changes and the need to reach prescribed reserving levels.

32.3 Members must be furnished with a copy of such amendment within 14 days after registration thereof. Should a Member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.

32.4 Notwithstanding the provisions of rule 32.1 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.

32.5 No amendment, recession or addition of any rule shall be valid unless it has been approved and registered by the Registrar.

ANNEXURE A

1. Contributions are payable in *accordance with the scale of Contributions contained in the table below.*

2. *CONTRIBUTIONS PAYABLE*

The Contributions payable for each option shall be as follows and are stated in Rands:

2.1 ALPHA OPTION [Amended with effect from 1 January 2023]

Income Category		Adult	Child
ALL		R1,500	580

2.2 MEDISAVE STANDARD OPTION [Amended with effect from 1 January 2023]

Income Category		Adult	Child
<R10,000		R2,170	R490
R10,001 – R16,000		R2,270	R530
R16,001 – R22,000		R2,660	R580
R22,001 +		R2,900	R620

2.3 MEDISAVE MAX OPTION [Amended with effect from 1 January 2023]

Income Category		Adult	Child
<R10,000		R3,750	R680
R10,001 – R22,000		R4,050	R700
R22,001 +		R4,280	R760

2.4 MEDISAVE ESSENTIAL OPTION [Amended with effect from 1 January 2023]

Income Category		Adult	Child
<R10,000		R1,500	R480
R10,001 – R16,000		R1,800	R520
R16,001 – R22,000		R2,200	R570
R22,001 +		R2,600	R600

Included in the registered Contributions reflected in 2.2 and 2.3 above is an amount of 25% of the contributions which will be allocated to the MSA for each member.

Included in the registered Contributions reflected in 2.4 above is an amount of 10% of the contributions which will be allocated to the MSA for each member.

3. Premium penalties for persons joining late in life with effect from 1 April 2001.

Premium penalties will be applied to the late joiners ~

1 - 4 years	@	0.05	multiplied by the relevant contribution in 1 above
5 - 14 years	@	0.25	multiplied by the relevant contribution in 1 above
15 - 24 years	@	0.50	multiplied by the relevant contribution in 1 above
25+	@	0.75	multiplied by the relevant contribution in 1 above

Any years of creditable coverage which can be demonstrated by the applicant or his or her dependant shall be subtracted from his or her current age in determining the applicable penalty.

ALPHA OPTION **ANNEXURE B**

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100%	No limit	Services rendered by Public Hospitals and / or DSP
B.	PRIVATE & PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES and DAY CLINICS: 1. Accommodation in a general ward, high care ward and intensive care unit 2. Theatre fees 3. Medicines, materials and hospital equipment 4. Confinement and midwives 5. Psychiatric hospitalisation	1-4 100% Preferred provider 75% Non-preferred Provider 5. 100% up to R6 500 thereafter 75% up to R12 000 per member family (Includes hospital, psychiatrist and psychologist costs).	1-4 No limit	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R1000 per admission shall apply. In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the care or that the treatment could have been provided other than in hospital, then, notwithstanding the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. b) In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which co-payment shall apply. c) The price paid by the Scheme for medicines shall be subject to a medicine formulary and / or reference price list as defined by the Scheme's designated agent. d) A R500 admission fee is payable from the 3rd admission except in the case of an emergency

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
C.	SURGICAL PROCEDURES INCLUDING MAXILLO FACIAL SURGERY	PMB 100% Non-PMB 75%	No limit	Osseo-integrated implants included in limit G.2.
D.	SPECIALIST SERVICES: 1. Consultations and visits – in hospital 2. Consultations and visits out of hospital 3. All other services unless stated otherwise in this annexure 4. Psychiatrist costs	1. PMB 100% Non-PMB 75% 2. 75%	1. No limit 2. R3 500PB Maximum R8 000PMF 3. No limit 4. In hospital - Included in B.5 Out of hospital - Included in D.2	To be recommended by a general practitioner with the exception of services by an ophthalmologist or gynecologist. All specialist services to be pre-authorised by the Scheme's designated agent failing which no benefit shall be paid.
E.	GENERAL PRACTITIONER SERVICES: 1. Consultations and visits – in hospital 2. Consultations and visits – out of hospital 3. All other services unless stated otherwise in this annexure	1. PMB 100% Non-PMB 75% 2. 75%	1. No limit 2. Included in D.2 3. No limit	
F.	CLINICAL TECHNOLOGISTS	75%	No limit	
G.	DENTAL SERVICES 1. Conservative and Specialised dentistry. Special dentistry (Including dentures) - Orthodontic - Root canal - Crowns - Bridges Osseo-integrated implants	1. 60%	1. R 5 000 PB R10 000 PMF	Dentures shall be limited to one set PB per two consecutive financial year period. All orthodontic services are subject to prior approval by the Scheme's designated agent. General anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of 12 years and impacted 3rd molars in which as an annual limit of R12 000 per member family including all hospital and doctor cost will apply.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
H.	PRESCRIBED MEDICINE AND INJECTION MATERIAL: 1. Acute sickness conditions 2. Pharmacy advised therapy (PAT) 3. Chronic sickness conditions 3.1 Chronic Disease List (CDL) included in PMB's 3.2 Non-CDL approved medication 4. Medicines given to a patient to take home (TTO). 5. Biologics	1. 60% 2. 60% 3.1 100% 3.2 75% 4. 100% 5. 75%	1. R3 200PB Maximum R6 000 PMF 2. R1 200 PMF R120 per prescription 3.1 Unlimited 3.2 R3 000 PB Maximum R6000 PMF 4. R300 per admission PB	a) Prescribed by a person legally entitled to prescribe. Includes medicines given to a patient to take home (TTO) in excess of 3 day's supply. b) Chronic medication subject to prior application and approval by the Scheme's designated agent. Only authorised medication for the treatment of approved chronic illness. c) Acute medicines refunded to provider at 60% of the scheme tariff . d) Chronic medicines paid to provider. e) Colostomy bags and diabetic test strips included in chronic medicines benefit. f) Biologics subject to prior application and approval by the Scheme's designated agent. The price paid by the Scheme shall be subject to a medicine formulary and/or reference price list as defined by the Scheme's designated agent.
I.	RADIOLOGY Including X-Rays, Diagnostic Scopes, MRI and CAT Scans, Ultra Sounds and Angiography 1. In-hospital 2. Out of hospital	1. PMB's 100% Non-PMB's 75% 2. 75%	No limit Maximum 2 scans per pregnancy	MRI and CAT Scans must be authorised by or on behalf of the Scheme except in emergencies failing which a co-payment of R800 per procedure shall apply. In the event of an emergency the Scheme shall be notified on the first working day following the procedure.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
J.	PATHOLOGY and MEDICAL TECHNOLOGY 1. In-hospital 2. Out of hospital	1. PMB's 100% Non-PMB's 75% 2. 75%	No limit	
K.	CHEMOTHERAPY, RADIOTHERAPY, ORGAN TRANSPLANTS and KIDNEY DIALYSIS	Preferred Provider 100% Non-Preferred Provider 75%	R200 000 PMF(Oncology) R100 000 PMF(Organ Transplant/Dialysis)	Subject to the approval of the Scheme's designated agent prior to the commencement of treatment or to the operation. Medication only provided by preferred provider. Hospital costs are paid at 100% per benefit B1.
L.	ORGAN TRANSPLANTS and KIDNEY DIALYSIS	Preferred Provider - 100%	Unlimited at the DSP as per Scheme protocols	Authorisation shall be obtained from the scheme (s) designated agent prior to the commencement of treatment failing which the scheme's liability will be limited to the cost of the service at DSP, unless PMB's apply.
M.	PSYCHOLOGY	60%	Inclusive in limit Q	Benefits for clinical – and counseling psychology.
N.	PHYSIOTHERAPY In and out of hospital	60%	Included in limit Q	In-hospital authorised by designated agent.
0.	BLOOD TRANSFUSIONS	100%	No limit.	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
P.	AMBULANCE SERVICES (Road and Air)	100%	Scheme's preferred provider No limit	Such transport is to be authorised by Scheme's preferred provided.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
R.	AUXILIARY SERVICES Includes all registered service providers not specifically referred in this annexure	60%	1. R2 500 PB and R 4 500 PMF In and out of hospital	To be recommended by a medical practitioner.
S.	PROSTHESIS 1. Internal 2. External	1. 100% 2. 100%	1. R 40 000 PMF Spinal Fusion R23 000 PMF; Intra Occular Lenses R2 500 PMF and Mesh R7 000 PMF 2. R 6 500 PMF	Authorisation shall be obtained from the Scheme's designated agent.
T.	MEDICAL and SURGICAL APPLIANCES: 1. Hearing Aids 2. Wheelchairs 3. Oxygen, cylinders 4. Nebulisers/ Glucometers	60%	R4 000 PMF Nebulisers and glucometers limited to R500 PMF - included in total limit for S Oxygen to be paid at 100% of Scheme tariff.	Subject to the approval from the Scheme's designated agent and supplied by preferred provider.
U.	OPTICS 1. Frames, Lenses, contact lenses and disposable contact lenses 2. Eye examinations 3. Refractive surgery	1. 0% 2. 100% 3. 100%	1. No benefit 2. One test per annum PB 3. R3000 PMF	Refractive surgery subject to approval from the Scheme's designated agent.
V.	ALTERNATIVES TO HOSPITALISATION: Including : Step-down Nursing Facilities, Private Nursing and Hospice	100 %	R15 000 PB	Subject to the approval from the Scheme's designated agent in lieu of hospitalisation.

	GENERAL	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
1.	ACQUIRED IMMUNE DEFICIENCY SYNDROME and RELATED ILLNESS	Benefits payable to preferred provider.	No Limit .	All services subject to PMB & approval by Scheme's designated agent and subject to formulary and protocols.
2.	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above.	R1000 per treatment and R2000 PMF, unless PMBs apply	All services included in limit subject to approval by Board.
3.	INFERTILITY	Benefits payable in terms of the relevant paragraphs above.	Only in respect of PMB, PMB rule will apply.	All services included in limit Benefit in respect of Investigation and Treatment only.
4.	BENEFITS REFUNDED TO MEMBER / PROVIDER IN PARAGRAPHS C,D,E,F,I,J,K & L			If claim is below R1, 000 the benefit shall be paid to the member. If claim exceeds a R1, 000 the benefit shall be paid to the provider. If the member submits the account and marks the claim as paid then the member will be refunderd
5.	COCHLEAR IMPLANTS	No benefit.		

6.	PREVENTATIVE CARE AND WELLNESS BENEFIT	100%	1. R1 500 PB 2. R3 000 PMF	Subject to pre-authorisation by the Scheme's designated agent the preventative care that will be covered includes: mammograms, PAP smears, prostate examinations, one flu vaccination, bone density scans, tonometry and one dental consultation. The cost of one Ante-Natal consultations is included in this benefit. The cost of services provided at the Scheme's facility are included in this benefit.
7.	MATERNITY BENEFIT	100%	1. 2 GP / Gynecology visits 2. 2 2D scans 3. 1 Pediatrician visit 4. Maternity bag	Subject to registration on the maternity programme. Gynaecologist confinement fee is limited to 200%. Home delivery is limited to R12 000 (only R1 200 will be paid should the home delivery end up being a hospital admission.) Antenatal vitamins are limited to R100 per month and is in the acute medication limit.
	CO – PAYMENTS (NON – PMB) 1. Conservative back and neck 2. Arthroscopy, FESS endometrial ablation, laparoscopy and hysterectomy 3. Nissan spinal surgery and joint replacements	100%	1. R3 000 2. R5 000 3. R10 00	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before a beneficiary is admitted to a hospital.

% Benefit	=	Medimed Scheme Tariff {whichever is the lesser}
PB	=	Per Beneficiary
PMF	=	Per Member Family

MEDICAL SAVINGS ACCOUNT (MSA) (Reg 10)

1. On admission to the Scheme, a MSA, held by the Scheme, shall be established in the name of the member concerned into which the contributions payable in respect of the MSA component shall be credited and benefits in respect thereof, shall be debited.

2. Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to utilise their MSA for all healthcare services indicated and any co-payments or shortfalls the member is responsible for.

3. Any balance in the MSA at the end of a financial year remains the property of the member and accumulates in his name**.**

4. 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.

5. On transfer to another option of the Scheme, which does not provide for such an account, any balance in the MSA will be refunded to the member, 5 months after such transfer and subject to applicable laws.

6. 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 which does not provide for a MSA, the balance due to the member must be refunded to the member 5 months after termination of membership, and subject to applicable laws.

7. Should a member 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 scheme within 5 months after termination of membership.

8. Whilst remaining a member;
The balance standing in credit of a member's Accumulated Savings Account may be used for the following purposes:

- to pay for elective benefits not covered by the MSA
- to pay for medical expenses for which the Scheme may not be liable
- to pay for the difference between the cost and the Medimed Scheme tariff in respect of medical services provided for in the rules.

Should the Scheme not be able to trace a Member three years after the Member has terminated his / her membership of the Scheme, the Member's accumulated savings plus interest will be transferred to the Scheme's reserves. Should the Member subsequently be traced, the accumulated savings plus interest will be refunded to the Member.

MEDISAVE STANDARD OPTION

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100%	No limit	Services rendered by Public Hospitals and / or DSP.
B.	PRIVATE & PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES and DAY CLINICS: 1. Accommodation in a general ward, high care ward and intensive care unit 2. Theatre fees 3. Medicines, materials and hospital equipment 4. Confinements and midwives – subject to registration on maternity program 5. In-hospital dental costs	100% Preferred provider 70% Non-preferred Provider	1-4 Unlimited 5. R12 000 PB (Includes hospital and all doctors' costs).	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R1000 per admission shall apply. In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the care or that the treatment could have been provided other than in hospital, then, not with- standing the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. b) In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. c) The benefit for psychiatric hospitalisation is limited to R6 000 PB including psychiatrist and psychologist costs. d) A R500 admission fee is payable from the 3rd admission except in the case of an emergency. e) The price paid by the Scheme for medicines shall be subject to a medicine formulary and/or reference price list as defined by the Scheme's designated agent.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
C.	SURGICAL PROCEDURES INCLUDING MAXILLO FACIAL SURGERY	100%	Included in D and E	Excludes Osseo-integrated implants (see General paragraph 5.). The procedures listed in Annexure C1 if performed out of hospital will be covered as if in hospital.
D.	SPECIALIST SERVICES: 1. Consultations and visits 1.1. Out of hospital 1.2. In-hospital 2. All other costs unless stated otherwise in this annexure 2.1. Out of hospital 2.2. In-hospital	Preferred provider 100% Non-preferred provider 70%	1.1 MSA 1.2 Included in D 2.2 2.1 MSA 2.2 Unlimited	To be recommended by a general practitioner with the exception of services by an ophthalmologist or gynecologist. All specialist services to be pre-authorised by the Scheme's designated agent failing which no benefit shall be paid, and certain out of hospital procedures can be authorized from benefit 2.2 depending on the nature and severity of the procedure.
E.	GENERAL PRACTITIONER SERVICES: 1. Consultations and visits 1.1. Out of hospital 1.2. In-hospital 2. All other costs unless stated otherwise in this annexure 2.1. Out of hospital 2.2. In-hospital	Preferred provider 100% Non-preferred provider 70%	1.1 MSA 1.2 Included in D 2.2 2.1 MSA 2.2 Included in D 2.2	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
F.	CLINICAL TECHNOLOGISTS All costs unless stated otherwise in this annexure. 1. Out of hospital 2. In-hospital	Preferred provider 100% Non-preferred provider 70%	1. MSA 2. Included in D 2.2	
G.	DENTAL SERVICES 1. Conservative and Restorative dentistry (includes plastic dentures) Special dentistry (Including metal base dentures)	1. 100% 100%	1. MSA MSA	All orthodontic services are subject to prior approval by the Scheme's designated agent.General anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of twelve years and impacted 3rd molars. Cost of dental services and anaesthetics for dental admissions included in B.5.
H.	PRESCRIBED MEDICINE AND INJECTION MATERIAL 1. Acute sickness conditions 2. Pharmacy advised therapy (PAT) 3. Chronic sickness conditions 3.1. Chronic Disease List (CDL) included in PMB's 3.2. Non-CDL approved chronic medication 4. Biologics 5. Acute Medication – Child Immunisation	1. 100% 2. 100% 3.1 100% 3.2 100% 4 75% 5 100%	1. MSA 2. MSA R160 per prescription to a maximum of R1 600PMF 3.1 Unlimited 3.2 R2 000 PB Maximum R4 000 PMF 5. 5. Subject to Acute Medication benefit	a) Prescribed by a person legally entitled to prescribe. Includes medicines given to a patient to take home (TTO) in excess of R300 per admission. b) Chronic benefit subject to prior application and approval from the Schemes designated agent. Only authorised medication for the treatment of approved chronic illness. c) A chronic disease condition is one that, due to its inherent pathological processes remains unresolved and invariably requires prolonged medication and/or other therapy to sustain life an optimal physical status through arresting or retarding and occasionally causing remission (temporary or permanent) of the disease. **d)** The price paid by the Scheme shall be subject to a medicine formulary and/or reference price list as defined by the Scheme's designated agent. e) Biologics subject to prior application and approval by the Scheme's designated agent.

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	RADIOLOGY All costs unless stated otherwise in this annexure. 1. Out of hospital 2. In-hospital 3. MRI, CT and Gallium scans	Preferred provider 100% Non-preferred provider 70%	1. MSA 2. Included in D 2.2 3. R15 000 per beneficiary 4. Annual limit R20 000 per family	MRI, CAT Scans and Gallium scans must be authorised by the Scheme's designated agent except in emergencies failing which a co payment of R800 per procedure shall apply. R800 Co-payment shall be deducted from savings. In the event of an emergency the Scheme shall be notified on the first working day following the procedure.
J.	PATHOLOGY and MEDICAL TECHNOLOGY All costs unless stated otherwise in this annexure. 1. Out of hospital 2. In-hospital	Preferred provider 100% Non-preferred provider 70%	1. MSA 2. Included in D2.2	
K.	CHEMOTHERAPY, RADIOTHERAPY,	100%	Annual Limit R250 000 PMF(Oncology) R100 000 PMF(Organ transplant /Dialysis) Subject to PMB	Subject to the approval of the Scheme's designated agent prior to the commencement of treatment or to the operation. Medication for chemotherapy to be supplied by the Scheme's agent. Consultations included in limit D1 or E1.
L.	ORGAN TRANSPLANTS and KIDNEY DIALYSIS	Preferred Provider - 100%	Unlimited at the DSP as per Scheme protocols	Authorisation shall be obtained from the Scheme(s) designated agent prior to commencement of treatment, failing which the Scheme's liability will be limited to the cost of the service at a DSP, unless PMB's apply

M.	PSYCHOLOGY	100%	MSA	In hospital psychology included in psychology hospital limit if authorised by Scheme's designated agent. Benefits for clinical – and counseling psychology.
N.	PHYSIOTHERAPY	100%	Included in limit Q	In-hospital authorised by designated agent.

		% BENEFITS	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
O.	BLOOD TRANSFUSIONS	100%	Included in limit B	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
P.	AMBULANCE SERVICES (Road and Air)	100%	Scheme's preferred provider – no limit.	Such transport is to be authorised by Scheme's preferred provider.
Q.	ALTERNATIVES TO HOSPITALISATION: Including : Step-down Nursing Facilities, Private Nursing and Hospice	100 %	R15 000 PB	Subject to the approval from the Scheme's designated agent in lieu of hospitalisation.

R.	AUXILIARY SERVICES Includes all registered providers not referred to in this annexure. 1. In-hospital 2. Out of hospital	100%	1. R3000 PMF 2. MSA	a) Pre-authorised by the Scheme's designated agent. b) To be recommended by a medical practitioner.
S.	PROSTHESIS 1. Internal 2. External	1. 100% 2. 100%	1. R35 000 PMF Spinal Fusion R22 000 PMF; Intra Occular Lenses R2 500 PMF and Mesh R5 000 PMF 2. R4 000 PMF	Authorisation shall be obtained from the Scheme's designated agent.
T.	MEDICAL and SURGICAL APPLIANCES: 1. Wheelchairs 2. Nebulisers/ Glucometers	100%	MSA	Maximum of R3 000 PB and R6 000 PMF for appliances to be paid from MSA and elective benefit per annum.
U.	OPTICAL SERVICES 1. Frames, lenses, contact lenses and disposable contact lenses 2. Eye examinations	1. 100% 2. 100%	1. MSA 2. MSA	Frames every 2 years.One eye test per annum PB. No benefit for refractive surgery. Maximum of R3 500PB and R7 000 PMF for optical services to be paid from MSA and elective benefit per annum.

	GENERAL	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
1.	ACQUIRED IMMUNE DEFICIENCY SYNDROME and RELATED ILLNESS	Benefits payable to preferred provider.	No Limit .	All services subject to approval by Scheme's designated agent and subject to formulary and protocols.
2.	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above.	R1000 per treatment and R2000 PMF, unless PMBs apply	All services included in limit subject to approval by Board.
3.	INFERTILITY	Benefits payable in terms of the relevant paragraphs above.	Only in respect of PMB, PMB rule will apply.	All services included in limit. Benefit in respect of Investigation and Treatment only, except for PMB's.
4.	COCHLEAR IMPLANTS –OSSEO-INTEGRATED IMPLANTS	No benefit.		
5.	OXYGEN, CYLINDERS	100%	R4000 PMF	
6.	ELECTIVE BENEFIT	100%	R6 000PB R12 000PMF	After members have utilised their MSA they have access to the Elective Benefit (EB).

	GENERAL	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
7.	PREVENTATIVE CARE AND WELLNESS BENEFIT	100%	1. R1 500PB 2. R3 000PMF	Subject to pre-authorisation by the Scheme's designated agent the preventative care that will be covered includes: mammograms, PAP smears, prostate examinations, conservative dentistry up to R400 per beneficiary including cost of consultation one flu vaccination, bone dentistry scans and tonometry. The cost of 4 Ante-Natal consultations is included in this benefit. The cost of services provided at the Scheme's facility are included in this benefit.
8.	MATERNITY BENEFIT	100%	1. 2 GP / Gynaecology visits 2. 2 2D scans 3. 1 Pediatrician visit 4. Maternity bag	Subject to registration on the maternity programme. Gynaecologist confinement fee is limited to 200%. Home delivery is limited to R12 000 (only R1 200 will be paid should the home delivery end up being a hospital admission) Antenatal vitamins are limited to R100 per month and is included in the acute medication limit.

Legend:

% Benefit	=	Medimed Scheme Tariff {whichever is applicable or the lesser}.
PB	=	Per Beneficiary
PMF	=	Per Member Family
MSA	=	Member Savings Account

MEDISAVE MAX OPTION

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100%	No limit	Services rendered by Public Hospitals and / or DSP.
B.	PRIVATE & PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES and DAY CLINICS: 1. Accommodation in a general ward, high care ward and intensive care unit 2. Theatre fees 3. Medicines, materials and hospital equipment 4. Confinement and midwives subject to registration on maternity program 5. In-hospital dental costs 6. Psychiatric hospitalisation	100% Preferred provider 70% Non-preferred Provider	1,2,3,4 Unlimited PB 5. R14 000 PB 6.The benefit for psychiatric hospitalisation is limited to R6000 PB thereafter 70% including psychiatrist and psychologist costs. Overall Maximum of R12 000 PMF subject to PMB.	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R1000 per admission shall apply. In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the care or that the treatment could have been provided other than in hospital, then, not with- standing the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. b) In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. c) A R500 admission fee is payable from the 3rd admission except in the case of an emergency. d) The price paid by the Scheme for medicines shall be subject to a medicine formulary and / or reference price list as defined by the Scheme's designated agent. e) The limit for in-hospital dental costs includes hospital and all doctors' costs.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
C.	SURGICAL PROCEDURES INCLUDING MAXILLO FACIAL SURGERY	100%	Included in D and E	Excludes Osseo-integrated implants. (see General paragraph 5). The procedures listed in Annexure C1 if performed out of hospital will be covered as if in hospital.
D.	SPECIALIST SERVICES: 1. Consultations and visits 1.1. Out of hospital 1.2. In-hospital 2. All other costs unless stated otherwise in this annexure 2.1. Out of hospital 2.2. In-hospital	Out of hospital Preferred provider 100% Non-preferred provider 70% In-hospital Preferred provider 150% Non-preferred provider 70%	 1.1 MSA 1.2 Included in D 2.2 2.1 MSA 2.2 Unlimited	To be recommended by a general practitioner with the exception of services by an ophthalmologist or gynecologist. All specialist services to be pre-authorised by the Scheme's designated agent failing which the co-payment will apply. .
E.	GENERAL PRACTITIONER SERVICES: 1. Consultations and visits 1.1. Out of hospital 1.2. In-hospital 2. All other costs unless stated otherwise in this annexure 2.1. Out of hospital 2.2. In-hospital	Out of hospital Preferred provider 100% Non-preferred provider 70% In-hospital Preferred provider 150% Non-preferred provider 70%	 1.1 MSA 1.2 Included in D 2.2 2.1 MSA 2.2 Included in D 2.2	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
F.	CLINICAL TECHNOLOGISTS All costs unless stated otherwise in this annexure 1. Out of hospital 2. In-hospital	Preferred provider 100% Non-preferred provider 70%	1. MSA 2. Included in D2.2	
G.	DENTAL SERVICES 1. Conservative and Restorative dentistry 2. Special dentistry (including dentures)	100%	1. MSA 2. MSA	a) All orthodontic services are subject to prior approval by the Scheme's designated agent b) General anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of twelve years and impacted 3rd molars. Cost of dental services and anaesthetics for dental admissions included in B.5

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
H.	PRESCRIBED MEDICINE AND INJECTION MATERIAL		1. MSA	a) Prescribed by a person legally entitled to prescribe. Includes medicines given to a patient to take home (TTO) in excess of R300 per admission.
	1. Acute sickness conditions	1. 100%	2. MSA R160 per prescription to a maximum of R1600 PMF 3.1 Unlimited 3.2 R3 500 PB	b) Chronic benefit subject to prior application and approval from the Scheme's designated agent. Only authorised medication for the treatment of approved chronic illness.
	2. Pharmacy advised therapy (PAT)	2. 100%		c) A chronic disease condition is one that, due to its inherent pathological processes remains unresolved and invariably requires prolonged medication and/or other therapy to sustain life an optimal physical status through arresting or retarding and occasionally causing remission (temporary or permanent) of the disease.
	3. Chronic sickness conditions		Maximum R7 000 PMF	d) The price paid by the Scheme shall be subject to a medicine formulary and/or reference price list as defined by the Scheme's designated agent.
	3.1. Chronic Disease List (CDL) included in PMB's	3.1 100%		
	3.2. Non-CDL approved chronic medication	3.2 100%	5. Subject to Acute Medication benefit	e) Biologics subject to prior application and approval by the Scheme's designated agent.
	4. Biologics	4. 75%		
	5. Acute Medication – Child Immunisation	5. 100%		

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	RADIOLOGY All costs unless stated otherwise in this annexure. 1. Out of hospital 2. In-hospital 3. MRI, CT and Gallium scans	Preferred provider 100% Non-preferred provider 70%	1. MSA 2. Included in D2.2 3. R20 000 per beneficiary 4. Annual limit R30 000 per family Maximum 2 scans per pregnancy	MRI, CAT Scans and Gallium scans must be authorised by or on behalf of the Scheme except in emergencies failing which a co-payment of R1,000 per procedure shall apply. R1,000 Co-payment shall be deducted from savings. In the event of an emergency the Scheme shall be notified on the first working day following the procedure.
J.	PATHOLOGY and MEDICAL TECHNOLOGY All costs unless stated otherwise in this annexure. 1. Out of hospital 2. In-hospital	Preferred provider 100% Non-preferred provider 70%	1. MSA 2. Included in D2.2	
K.	CHEMOTHERAPY, RADIOTHERAPY,	100%	Annual Limit R400 000 PMF(Oncology) R200 000 PMF(Organ transplant/Dialysis)	Subject to the approval of the Board prior to the commencement of treatment or to the operation. Medication for chemotherapy to be supplied by the Scheme's agent. Consultations included in limit D1 or E1.
L.	ORGAN TRANSPLANTS and KIDNEY DIALYSIS	Preferred Provider - 100%	Unlimited at the DSP as per Scheme protocols	Authorisation shall be obtained from the Scheme(s) designated agent prior to commencement of treatment, failing which the Scheme's liability will be limited to the cost of the service at a DSP, unless PMB's apply

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
M.	PSYCHOLOGY	100%	MSA	In hospital psychology included in psychology hospital limit if authorised by Scheme's designated agent. Benefits for clinical – and counseling psychology.
N.	PHYSIOTHERAPY	100%	Included in limit Q	In-hospital authorised by designated agent.
O.	BLOOD TRANSFUSIONS	100%	Included in limit B	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
P.	AMBULANCE SERVICES (Road and Air)	100%	Scheme's preferred provider – no limit Other providers no benefit	Such transport is to be authorised by Scheme's preferred provider.
Q.	ALTERNATIVES TO HOSPITALISATION: Including : Step-down Nursing Facilities, Private Nursing and Hospice	100 %	R20 000 PB	Subject to the approval from the Scheme's designated agent in lieu of hospitalisation.
R.	AUXILIARY SERVICES Includes all registered providers not referred to in this annexure. 1. In-hospital 2. Out of hospital	100%	1. R4000 PMF 2. MSA	a) Pre-authorised by the Scheme's designated agent b) To be recommended by a medical practitioner.

64	**SERVICE**	**% BENEFIT**	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
S.	PROSTHESIS 1. Internal 2. External	100%	1. R40 000 PMF Spinal Fusion R25 000 PMF Intra Occular Lenses R2 500 PMF and Mesh R7 000 PMF 2. R6 000 PMF	Authorisation shall be obtained from the Scheme's designated agent.
T.	MEDICAL and SURGICAL APPLIANCES: 1. Wheelchairs 2. Nebulisers/ Glucometers	100%	MSA	Subject to the approval from the Scheme's designated agent and supplied by preferred provider. Maximum of R4000 PB and R8000 PMF for appliances to be paid from MSA and elective benefit per annum.
U.	OPTICAL SERVICES 1. Frames, Lenses, contact lenses and disposable contact lenses 2. Eye examinations	1. 100% 2. 100%	1. MSA 2. MSA	Frames every 2 years. One eye test per annum PB. No benefit for refractive surgery. Maximum of R4 000PB and R8 000 PMF for optical services to be paid from MSA and elective benefit per annum.

	GENERAL	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
1.	ACQUIRED IMMUNE DEFICIENCY SYNDROME and RELATED ILLNESS	Benefits payable to preferred provider.	No Limit .	All services approved by Scheme's designated agent and subject to formulary and protocols.
2.	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above.	R1000 per treatment and R2000 PMF, unless PMBs apply.	All services included in limit subject to PMB and approval by Scheme's designated agent.
3.	INFERTILITY	Benefits payable in terms of the relevant paragraphs above.	Only in respect of PMB, PMB rule will apply.	All services included in limit. Benefit in respect of Investigation and Treatment only.
4.	COCHLEAR IMPLANTS and OSSEO-INTEGRATED IMPLANTS	No benefit.		
5.	OXYGEN, CYLINDERS	100%	R6000 PMF	
6.	ELECTIVE BENEFIT	100%	R7 500 PB R15 000 PMF	After members have utilised their MSA (medical savings account) they have access to the Elective Benefit (EB).

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
7.	PREVENTATIVE CARE AND WELLNESS BENEFIT	100%	1 R1 600PB 2.R3 200PMF Medimed Scheme Tariff	Subject to pre-authorisation by the Scheme's designated agent the preventative care that will be covered includes: mammograms, PAP smears, prostate examinations, conservative dentistry up to R500 per beneficiary including cost of consultation, one flu vaccination, bone density scans and tonometry. The cost of 6 Ante-Natal consultations is included in this benefit. The cost of services provided at the Scheme's facility is included in this benefit.
8.	MATERNITY BENEFIT	100%	1. 2 GP / Gynaecology visits 2. 2 2D scans 3. 1 Pediatrician visit 4. Maternity bag	Subject to registration on the maternity programme. Gynaecologist confinement fee is limited to 200%. Home delivery is limited to R12 000 (only R1 200 will be paid should the home delivery end up being a hospital admission) Antenatal vitamins are limited to R100 per month and is included in the acute medication limit.

Legend:

% Benefit	=	Medimed Scheme Tariff {whichever is applicable or the lesser}.
PB	=	Per Beneficiary
PMF	=	Per Member Family
MSA	=	Member Savings Account

MEDISAVE ESSENTIAL OPTION

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100%	No limit	Services rendered by Public Hospitals and / or DSP
B.	PRIVATE & PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES and DAY CLINICS: 1. Accommodation in a general ward, high care war and intensive care unit 2. Theatre fees 3. Medicines, materials and hospital equipment 4. Visits by medical practitioners 5. Confinement and midwives 6. In-hospital dental costs	Preferred provider 100% Non-preferred provider 80%	1,2,3,4,5 Unlimited at Preferred Provider 7. R10 000PMF	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R1000 per admission shall apply. In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the care or that the treatment could have been provided other than in hospital, then, notwithstanding the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. b) In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. c) The benefit for psychiatric treatment is limited to R4000 PB regardless of the type of hospital or institution including psychiatrist and psychologist. d) The price paid by the Scheme for medicines shall be subject to a medicine formulary and / or reference price list as defined by the Scheme's designated agent. e) A R500 admission fee is payable from the 3rd admission except in the case of an emergency

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
C.	SURGICAL PROCEDURES INCLUDING MAXILLO FACIAL SURGERY	100%	No limit	If referred by preferred provider and/or pre-authorised by the Scheme's Designated Agent 100%, else 0%.
D.	SPECIALIST SERVICES: 1. Consultations and visits (out of hospital) 2. All other services unless stated otherwise in this annexure.	100%	R3000 PB R6000 PMF	If referred by a preferred provider and/or pre-authorised by the Scheme's Designated Agent 100% else 0%
E.	GENERAL PRACTITIONER SERVICES: 1. Consultations and visits (out of hospital) 2. Out of town visits 3. Second opinion benefit visits	Preferred provider 100% Non- preferred provider 0%	1. No limit – 2. MSA 3. 2 Consultations PMF plus acute medication up to a maximum of R500 PMF.	a) The preferred provider may charge an afterhours consultation levy of R50. b) Consultations and acute medication at any provider within the same provider network.
F.	CLINICAL TECHNOLOGISTS	Preferred provider 100% Non- preferred provider 0%	Included in limit B	Through preferred provider.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
G.	DENTAL SERVICES 1. Conservative and Restorative dentistry (includes plastic dentures) 2. Special dentistry (including metal base dentures)	Preferred provider 100% Non-referred provider 0%	1. Included in specialized dentistry limit 2. R3200 PB R5500 PMF	a) Dentures shall be limited to one set PB per two consecutive financial year period. All orthodontic services are subject to prior approval by the Board. b) General anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of 12 years and impacted 3rd molars.
H.	PRESCRIBED MEDICINE AND INJECTION MATERIAL: 1. Acute sickness conditions 2. Pharmacy advised therapy.(PAT) 3. Chronic sickness conditions 4. Company prescriptions	Preferred provider 100% Non- preferred provider 0%	1. No Limit 2. MSA R120 per prescription R450 PMF 3. PMB's only 4. MSA	Subject to prescription by preferred provider or on referral by preferred provider. Medication prescribed according to a formulary a) Prescribed by a person legally entitled to prescribe. Includes medicines given to a patient to take home (TTO). b) Chronic medication subject to prior application and approval by the Scheme's designated agent. Only authorised medication for the treatment of approved chronic illness. c) Chronic medication Includes colostomy kits and diabetic test strips. d) Prescriptions by the company employed doctor will be paid to a maximum of R300 PMF.

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	RADIOLOGY 1. X-Rays 2. Scopes – Diagnostic 3. Scans - MRI and CAT 4. Scans - Ultra Sound 5. Angiography	Preferred provider 100% Non- preferred provider 0%	Basic radiology - No limit. Specialised radiology limited to a maximum – R10 000 PB R15 000 PMF Maximum 2 scans per pregnancy	MRI and CAT Scans must be authorised by or on behalf of the Scheme except in emergencies failing which a co payment of R500 per procedure shall apply. In the event of an emergency the Scheme shall be notified on the first working day following the procedure. Mammograms to be paid at 100% of Scheme tariff – no referral required.
J.	PATHOLOGY and MEDICAL TECHNOLOGY	Preferred provider 100% Non- preferred provider 0%	No limit	
K.	CHEMOTHERAPY, RADIOTHERAPY, ORGAN TRANSPLANTS and KIDNEY DIALYSIS	100%	R50000 PMF	Subject to the approval of the preferred provider prior to the commencement of treatment or to the operation. Limited to PMB conditions
L.	PSYCHOLOGY	100%	Included in limit Q	If referred by preferred provider. Benefits for clinical – and counseling psychology.
M.	PHYSIOTHERAPY	100%	Included in limit in Q	In-hospital authorised by designated agent.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
N.	BLOOD TRANSFUSIONS	100%	Included in limit B	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
O.	AMBULANCE SERVICES (Road and Air)	Preferred provider 100% Non- preferred provider 0%	No limit	Such transport is to be authorised by Scheme's preferred provider.
P.	ALTERNATIVES TO HOSPITALISATION: 1. Step-down Nursing Facilities 2. Private Nursing 3. Hospice	100 %	R6 000 PB	Subject to the approval of the preferred provider.
Q.	AUXILIARY SERVICES Includes all registered providers not referred to in this annexure. 1. In-hospital 2. Out of hospital	100%	1. R2000 PB 2. MSA	a) Pre-authorised by the Scheme's Designated Agent. b) To be referred by preferred provider.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
R.	PROSTHESES 1. Internal 2. External	 1. 100% 2. 100%	 1. R20000 PMF 2. R3 000 PMF	Subject to approval by Scheme's designated agent. Limited to PMB conditions . Limit will apply where the service is voluntarily obtained from a Non-DSP.
S.	MEDICAL and SURGICAL APPLIANCES: 1. Hearing Aids 2. Wheelchairs 3. Oxygen, cylinders 4. Nebulisers/ Glucometers	100%	MSA	Subject to the approval of the preferred provider.
T.	OPTICAL SERVICES 1. Frames, Lenses and contact lenses 2. Eye examinations	 1. 100% 2. 100%	Preferred Provider Network (PPN) Limit on lenses. Frames from specified range. Non preferred provider limited to: Eye test R325 Single vision:R185/lens Bi- or multifocal: R420/lens Frames : R300. Contact lenses : R785 Preferred provider no limit. Non PPN provider limit R540	a) No benefit for tinting and hardening. b) Benefit every 2 years PB. c) Benefit for single vision or bi-focal or multi-focal or contact lenses. d) No benefit for refractive surgery. e) Beneficiaries may use the frame allowance of R300 towards cost of alternative frame (not in specified range) or towards lens enhancements if no frame required. f) An eye examination includes tonometry, glaucoma screening and visual field screening.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
1.	ACQUIRED IMMUNE DEFICIENCY SYNDROME and RELATED ILLNESS	Benefits payable to preferred provider.	No Limit.	All services subject to approval by Schemes designated agent and subject to formulary PMB's and protocols.
2.	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above.	R1000 per treatment and R2000 PMF, unless PMBs apply.	Treatment through preferred provider.
3.	INFERTILITY	Benefits payable in terms of the relevant paragraphs above.	Only in respect of PMB, PMB rule will apply.	All services included in limit. Benefit in respect of Investigation and Treatment only, except for PMB's.
4.	COCHLEAR IMPLANTS	No benefit.		
5.	OSSEO-INTEGRATED IMPLANTS	No benefit.		
6.	NON PREFERRED PROVIDER BENEFIT For out of hospital GP costs and acute medication.	100%	Limited to R2 500PB and R5 000PMF.	Only for members who do not have access to the preferred provider for the year. For these members the non-preferred provider benefit for I and J will be 100% subject to limit D.
7.	CASUALITY BENEFIT For casuality GP costs.	100%	R5 00PMF.	Only for members who do not have access to the nominated GP at the time of casualty consultation.

8.	MATERNITY BENEFIT	100%	2 GP / Gynaecology visits 2 2D scans 1 Pediatrician visit Maternity bag	Subject to registration on the maternity programme. Gynaecologist confinement fee is limited to 200%. Home delivery is limited to R12 000 (only R1 200 will be paid should the home delivery end up being a hospital admission) Antenatal vitamins are limited to R100 per month and is included in the acute medication limit.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS

Legend:

% Benefit	=	Medimed Scheme Tariff {whichever is applicable or the lesser}.
PB	=	Per Beneficiary
PMF	=	Per Member Family
M	=	Single Member
M+	=	Member with dependants
PP	=	Preferred Provider
NPPB	=	Non preferred provider benefit

ANNEXURE C
EXCLUSIONS AND LIMITATIONS
(Benefits available under the Prescribed Minimum Benefits are payable without limitation where services are rendered by public hospitals)

EXCLUSIONS

1. Unless otherwise provided for in the Act or its regulations (including Prescribed Minimum Benefits) or decided by the Board and not inconsistent with the Medical Scheme's Act, expenses incurred in connection with any of the following will not be paid by the Scheme:

1.1 All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a Member or a Dependant and for which any other party is liable, where appropriate, to action the recovery. The Member is however entitled to such benefits as would have been allowed in terms of the rules provided that the member will agree to sign a third party claim where applicable and to reimburse the Scheme upon receipt of payment of any money paid out in respect of benefits paid by the Scheme in respect of medical expenses.

1.2 All costs of whatsoever nature incurred for treatment of self-inflicted sickness conditions or injuries or the excessive use of intoxicating substance or drug or material violation of the law, unless in accordance with the Prescribed Minimum Benefits.

1.3 All costs in respect of injuries arising from professional sport, speed contests and speed trials, unless in accordance with the Prescribed Minimum Benefits.

1.4 All costs for operations, medicines, treatment and procedures for cosmetic purposes and the treatment of obesity and its direct implications (includes sclerotherapy except in the case of haemorrhoids), unless in accordance with the Prescribed Minimum Benefits.

1.5 Holidays for recuperative purposes. Accommodation and/or treatment in headache and stress-relief clinics, spas and resorts for health, slimming, recuperative or other similar purposes.

1.7 All costs that are more than the annual maximum benefit to which a Member is entitled in terms of the Rules.

1.8 Charges for appointments which a Member or Dependant fails to keep.

1.9 Costs for services rendered by —

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

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

1.10 Travelling expenses incurred by practitioners.

1.10.1 Any benefits that are not available under the Prescribed Minimum Benefits and not included in Annexure B hereof.

1.10.2 Treatment of sexually transmitted diseases, unless in accordance with the Prescribed Minimum Benefits.

1.13 Treatment of alcoholism and drug addiction, unless in accordance with the Prescribed Minimum Benefits.

1.14 Accommodation in convalescent or old age homes or similar institutions catering for the aged.

1.15 Infertility tests and treatments unless in accordance with the Prescribed Minimum Benefits. Such treatments include histero-salpyngograms, hormone tests, laparoscopies, histeroscopes, surgery (uterus and tubal), manipulation of ovulation, semen analysis, basic counseling and advice on sexual behavior, temperature charts and the treatment of local infections.

1.16 Medical treatment necessitated as a result of non-compliance with prescribed therapy.

1.17 Medical examinations or evaluations for employers or employment and/or insurance, and/or school readiness tests, and/or for legal purposes.

1.18 Hire of medical, surgical and other appliances, except if authorised by the Scheme's designated agent or, unless in accordance with the Prescribed Minimum Benefits.

1.19 Medicines not on the formulary if a formulary is applicable.

1.20 Immunosuppressants unless post organ transplant.

1.21 Immunization unless authorised by the Board.

1.22 The treatment of Tuberculosis except surgical treatment in hospital as per the Prescribed Minimum Benefits unless services provided through the Scheme's Wellness Programme.

1.23 Chemotherapy, Radiotherapy and Dialysis where the beneficiary is immunocompromised will only be funded according to documented criteria if the beneficiary is enrolled on the Scheme's Wellness Programme , unless in accordance with the Prescribed Minimum Benefits.

1.24 Services in respect of which claims are received more than 4 months after the date of service.

1.25 Medication provided in terms of the Auxiliary Services benefit except where:

- the medication is supplied to treat a condition diagnosed by a medical doctor, and
- the medication is authorised by the Scheme's designated agent.

1.31 Any expenses in respect of sickness conditions that were subject to waiting periods when the Member joined the Scheme.

1.32 Costs associated with vocational guidance, marriage guidance, school therapy or attendance at remedial educational schools or clinics.

1.33 Costs associated with active participation in wars, riots or civil disobedience, unless in accordance with the Prescribed Minimum Benefits.

1.34 Expenses arising from experimental, unproven or unregistered treatment practices.

1.35 Compensation for pain and suffering, loss of income, funeral expenses or any other claim for damages.

1.36 Medicines, material and procedures appearing on the Scheme's exclusion list, Subject to the Prescribed Minimum Benefits.

1.37 All cost in respect of medicine not approved by the Medicine Control Council.

1.38 All cost in respect of the use of medication for indications not registered by the Medicine Control Council (i.e. Off-label indication).

1.39 Organ and tissue donations to any person other than to a member or dependant of a member.

1.40 Payment of claims for additional and/or alternative procedures performed which are not in accordance with the original authorization and for which a motivation confirming the medical appropriateness of said procedure(s) was not received.

1.41 All costs in respect of an authorized procedure which is not completed due to a decision by the member or the member's family. All costs already incurred prior to this decision being taken will be for the member's own account.

1.42 All costs in respect of an authorized procedure which is not completed due to a hospital limitation, for example, faulty equipment or lack of prescribed medication. Any costs already incurred in preparation for this procedure will be for the hospital's own account.

1.43 Telephonic consultations, writing of prescriptions or motivational letters and costs for confirming medical aid benefits.

1.44 Accommodation in a private room of a hospital, unless clinically indicated and prescribed by a medical practitioner and authorized by the Scheme

1.45 Any costs associated with search and rescue.

1.46 Interest charged on overdue accounts or legal fees incurred as a result of delayed or non-payment of accounts due to it being the member's fault

1.47 Services provided outside of a practitioners registered scope of practice..

1.48 Chiropractic services in hospital.

1.49 X-Rays by chiropractors.

1.50 Costs for investigations done in hospital that could be done on an outpatient basis, unless pre-authorised by the Scheme's designated agent.

1.51 All costs for healthcare services which are not appropriate and necessary for the diagnosis or treatment of a health condition.

2. LIMITATION OF BENEFITS

2.1 The maximum benefits to which a Member and his Dependants are entitled in any financial year are limited as set out in Annexure B.

2.2 Members admitted during the course of a financial year are 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 of illness of a protracted nature, the Board shall have the right to insist upon a Member or Dependant consulting any particular specialist the Board may nominate in consultation with the attending practitioner. In such cases, if such specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

2.4 Medical costs incurred while traveling outside South Africa will be covered in Rands subject to the Medimed Scheme tariff and the Schemes specified limits. The submitted accounts should be in a readable format and will be processed at the Scheme's discretion.

2.5 Costs in respect of organ and tissue donations for Scheme members will be funded to the maximum of the cost of South African donors.

2.6 Any authorised rehabilitation will only be considered, subject to the benefit limit, to the point where the beneficiary no longer shows clinical improvement.

2.7 For routine or scheduled elective surgery, a second opinion may be required, failing which the Scheme, in the discretion of the Board, may impose a percentage co-payment to the member. The Scheme will bear the consultation costs for such second opinion.

2.8 If the Scheme or its managed health care organization has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of clinical guidelines.

2.9 If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to those conditions as the Scheme or its managed healthcare organisation may impose. "Medically necessary" refers to services or supplies that meet all the following requirements:

(a) They should restore normal function of an affected limb, organ or system;

(b) No alternative exists that has a better outcome, is more cost-effective, or has a lower risk;

(c) They are accepted by the relevant service provider as optimal necessary for the specific condition and at an appropriate level to render safe and adequate care;

(d) They are not rendered or provided for the convenience of the relevant beneficiary or service provider and

(e) Outcome studies are available and acceptable to the Scheme in respect of such services or supplies.

2.10 The Scheme reserves the right not to pay for any new technology, investigational procedures/interventions or new drugs/medication as applied in

clinical medicine unless motivation by means of clinical data has been presented to and accepted by the clinical committee in regard to the following aspects of such technology, procedures or drugs:

(a) Their therapeutic role in clinical medicine;

(b) Their cost-efficiency or affordability;

(c) Their value relative to existing services or supplies;

(d) Their local indications, application and outcome studies and

(e) Their role in drug therapy as established by the Scheme's managed healthcare organisation.

2.11 An exclusion period of one or more years may be imposed by the Scheme to assess the local indications, application and outcome figures on all new medicines/technology/procedures or any instance where evidence is lacking or still under review before it can be considered for inclusion in relation to benefits paid.

ANNEXURE C1

OUT OF HOSPITAL PROCEDURES PAID FROM SCHEME RISK

The following procedures will be paid from the in-hospital benefit if done in a day clinic, day ward, the out-patient section of a hospital or a suitably equipped procedure room. Overnight admissions will not be covered (unless there are complications). Pre-authorisation required. The procedures include, but are not limited to:

ENT	Nasal polypectomy, Antrostomy, Nasal cautery, Deep proof puncture, Ethmoidectomy, Nasal and sinus endoscopy, Drainage of sinuses, Turbinectomy, Tonsillectomy with adenoidectomy younger than 12 years of age, Myringotomy and grommets
Gynaecological	Dilation and cutterage (D&C) and diagnostic D&C, D&C polypectomy, Hysteroscopy, Diagnostic laparoscopy, Laparoscopic sterilization, Cone biopsy, Cauterisation of cervix
Orthopaedic	Arthoscopy diagnostic with menisectomt, with debridement, carpal tunnel release, Ganglion excision, Removal of small hardware (plates, k-wires, screws), Bunionectomy (unilateral), Epidural block, Intra-atricular hydrocortisone injection, Tennis elbow release
Ophthalmic	Cataract extraction, Meibomian cyst excision, Pterygium exision, Keratectomy, Dachrocystorhinostomy
Urological	Circumcision, Vasectomy, Cystoscopy diagnostic or with urethral dilation, Orchidopexy
Other	Exision of superficial benign tumours, Gastroscopy, Colonoscopy, Fibreoptic sigmoidoscopy, Paediatric rigid sigmoidoscopy, Breast biopsy, Endoscopic retrograde cholangiopancreatography (ERCP), Bronchoscopy, Hernia repair (unilateral inguinal and femoral), Drainage of superficial abscesses, Extraction of impacted wisdom teeth, Apicectomy, Superficial wound debridement, Minor perianal surgery, Hickman line insertion or a-port line insertion, Superficial foreign body removal, Exision of ingrown toe-nail

The following procedures will be paid from the procedures-in-rooms benefit if performed in a doctor's room or suitably equipped procedure room up to 100% of the Medimed Scheme Tariff. Pre-authorisation required. The procedures include, but are not limited to:

ENT	Drainage of ear abscess, Removal of foreign bodies, Nasal plugging for epistaxis
Gynaecological	Cauterisation of warts, Colposcopy
Other	Gastroscopy, Colonoscopy, Sigmoidoscopy, Indirect laryngoscopy, removal of impacted wisdom teeth

APPENDIX 2
PRESCRIBED MINIMUM BENEFITS (PMB's)

1. APPOINTMENT OF DESIGNATED SERVICE PROVIDERS

The public service is the Designated Service Provider for all options for the delivery of Prescribed Minimum Benefits. The scheme has agreements with private providers and where public services are not accessible and there is no reasonable access to a contracted private provider, the scheme will make arrangements with private providers who will be deemed designated service providers in such instances. A comprehensive list of the contracted private providers is available on request and is regularly updated.

2. PRESCRIBED MINIMUM BENEFITS OBTAINED FROM DESIGNATED SERVICE PROVIDERS

100% of the cost in respect of diagnosis, treatment and care costs of PMB Conditions if those services are obtained from a DSP, subject to the Scheme's Managed Care Protocols. Where no formal arrangement with a DSP exists for PMB conditions, members have freedom of choice of provider. The onus shall be on the Scheme to ensure that the services are available and have the patient admitted to the DSP.

3. PRESCRIBED MINIMUM BENEFITS VOLUNTARY OBTAINED FROM OTHER PROVIDERS

If a Beneficiary voluntarily obtains diagnosis, treatment and care 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 such benefit limitations and scheme approved tariff as are normally applicable in terms of the relevant option chosen by the Member.

4. PRESCRIBED MINIMUM BENEFITS INVOLUNTARY OBTAINED FROM OTHER PROVIDERS

4.1. If a Beneficiary involuntary obtains diagnosis, treatment and care 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 that Prescribed Minimum Condition.

4.2. For the purposes of paragraph 4.1, a Beneficiary will be deemed to have involuntary obtained a service from a provider other than a Designated Service Provider, if:

4.2.1. The service was not available from the Designated Service Provider or would not be provided with unreasonable delay;

4.2.2. Immediate medical or surgical treatment for a Prescribed Minimum benefit Condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a Designated Service Provider; or

4.2.3. There was no Designated Service Provider within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

4.3. Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a Member prior to involuntary obtaining a service from a provider other than a Designated Service Provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 4.2 are applicable.

5. MEDICATION

5.1. Where a Prescribed Minimum Benefit includes medication, the Scheme will pay 100% of the cost of the medication of that medication is obtained from a Designated Service Provider or is involuntary obtained from a provider other than a Designated Service Provider, and

5.1.1. The medication is included on the applicable formulary in use by the Scheme; or

5.1.2. The formulary does not include medication which is clinically appropriate and effective for the treatment of the Prescribed Minimum Benefit Condition.

5.2. Where a Prescribed Minimum Benefit includes medication and:

5.2.1. That medication is voluntary obtained from a provider other than a Designated Service Provider; or

5.2.2. The formulary indicates a medication which is clinically appropriate and effective for the treatment of a Prescribed Minimum Benefit Condition suffered by a Beneficiary, and that Beneficiary knowingly declines the medication on the formulary and opts to use another medication instead,

then a co-payment equal to the difference between the cost of the medication so obtained and the reference price of the formulary medication will apply.

6. PRESCRIBED MINIMUM BENEFITS OBTAINED FROM A 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 public hospital, without limitation.

7. DIAGNOSTIC TEST FOR AN UNCONFIRMED PRESCRIBED MINIMUM BENEFIT DIAGNOSIS

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

8. CO-PAYMENTS

Co-payments in respect of the costs for Prescribed Minimum Benefits may not be paid out of the Medical Savings Accounts.

9. CHRONIC CONDITIONS

Any benefit option covers the full cost was services rendered in respect of the Prescribed Minimum Benefits 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.

PRESCRIBED MINIMUM BENEFIT CONDITIONS

Addison's disease	**Asthma**
Bipolar mood disorder	**Bronchiectasis**
Cardiac failure	**Cardiomyopathy disease**
Chronic renal disease	**Coronary artery disease**
Chronic obstructive pulmonary disorder	**Chrohn's disease**
Diabetes insipidus	**Diabetes mellitus type 1 and 2**
Dysrhythmias	**Epilepsy**
Glaucoma	**Haemophilia**
Hyperlipidaemia	**Hypertension**
Hypothyroidism	**Multiple sclerosis**
Parkinson's disease	**Rheumatoid arthritis**
Schizophrenia	**Systemic lupus erythematosus**
Ulcerative colitis	