ANNEXURE B.10
BEAT4

10.1 GENERAL CONDITIONS OF THE BENEFIT OPTION

(a) The Scheme's benefits on accounts properly lodged in terms of rule 15 shall be granted as shown in each paragraph hereunder, and the member shall be liable for the difference between the Scheme's benefits and the full amount of the account.

(b) No benefits shall be granted on accounts reaching the Scheme after the last day of the fourth month following the date on which the service was rendered.

(c) Where an account has been paid by the member in cash, such specified account plus proof of payment must be submitted to the Scheme before the last day of the fourth month following the date on which the service was rendered. The Scheme will then refund the member the applicable benefit amount.

(d) Direct payment will be made by the Scheme to a supplier of service who renders accounts in accordance with the Scheme tariff or contracted fee as agreed by the Scheme and the supplier.

(e) A member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.

(f) Benefits shall be based on the Scheme tariff or contracted fee as agreed by the Scheme and the supplier of service, whichever is applicable.

(g) The Scheme's financial year shall run from 1 January to 31 December.

(h) The benefits of the option shall be divided into four parts, namely:

- Scheme Benefits
- Individual Medical Savings Account (IMSA)
- Day-to-Day Benefits
- Vested Medical Savings Account

(i) A member shall qualify for the extent and level of minimum benefits provided for in regulation 8 in terms of the Medical Schemes Act (No. 131 of 1998) and Annexure D1 of these Rules, without deductibles or the use of co-payments.

(j) The Mediscor Reference Price (MRP) will be applied on al medicines where applicable.

10.2 CONDITIONS FOR SCHEME BENEFIT PAYMENT

(a) Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.

(b) Full cross subsidisation between members shall apply.

(c) Granting of benefits under the Scheme Benefits shall be subject to treatment protocols, preferred providers, designated service providers, network option services and/or medicine formularies accepted by the Scheme.

(d) No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained in advance or, in an emergency, on the first working day after admission to a hospital, by the Scheme or its proxy.

(e) No benefits in a private hospital or day clinic shall be granted if an authorisation number has not been obtained -in advance (in the case of planned major operations and dental procedures – preferably 14 days in advance) or, in an emergency, on the first working day after admission to a hospital, by the Scheme or its proxy.

(f) If a member or his dependants receive treatment in a private hospital or day clinic without an authorisation number having first been obtained (due to either prior application not made or because a prior application was refused), a **R500** surcharge per admission shall be imposed whenever an application is approved with retrospective effect.

(g) If an authorisation number has been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the member shall be liable for payment of the excess to the service provider.

10.2.1 Hospitals: contracted and non-contracted providers

Claims submitted by a contracted provider for accommodation in a general ward, intensive-care and high-care unit, theatre and material – 100% of the **contracted fee.** Claims submitted by non-contracted providers – 100% of the **Scheme tariff**.

10.2.2 Mental health clinics: contracted and non-contracted providers

Claims submitted by a contracted provider for accommodation and treatment of psychological and psychiatric conditions – 100% of the **contracted fee**. Claims submitted by non-contracted providers – 100% of the **Scheme tariff**. Benefits shall be subject to the following:

(i) The length of stay shall be limited to 21 days per beneficiary per financial year.

10.2.3 Registered institutions for the treatment of chemical and substance dependence/abuse

Accommodation and treatment for chemical and substance dependence/abuse – 100% of the Scheme tariff. Benefits shall be subject to the following:

(i) The length of stay shall be limited to 21 days per beneficiary per financial year; or

(ii) Benefits shall be limited to R18 600 per beneficiary per financial year.

10.2.4 Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation

Claims submitted by General Practitioners and Specialists for treatment during hospitalisation – 100% of the Scheme tariff or contracted fee.

10.2.5 Confinements

Benefits shall be paid as follows even if the baby dies before registration.

(i) Medical practitioners – 100% of the Scheme tariff.
(ii) Nursing home and hospital fees in accordance with the provisions of paragraph 10.2.1.
(iii) Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife – 100% of the Scheme tariff Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding support shall be excluded from benefits.
(iv) . Midwife assisted births at a private midwife birth house – 100% of Scheme tariff. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits.

10.2.6 Surgical dentistry

Any surgical procedure that needs to be performed in a theatre, after pre-authorisation by the Scheme – 100% of the Scheme tariff, limited to R8 900 per family per financial year. Payment for Maxillofacial and oral surgery is strictly related to the following conditions:

(i) Severe trauma (soft tissue injuries, fractures of jaws and facial bones);
(ii) Cleft lip and palate;
(iii) Crouson's disease;
(iv) Malunited craniomaxillary disjunction;

(v) Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);
(vi) Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);
(vii) Salivary gland surgery (removal of gland or salivary stone);
(viii) Life threatening sepsis (Ludwig's angina);
(ix) Confirmed oral cancer.

10.2.7 Pathology and standard diagnostic imaging during hospitalisation

100% of the Scheme tariff.

10.2.8 Specialised diagnostic imaging during hospitalisation

MRI scans, CT scans, computer tomographic studies and isotope studies – 100% of Scheme tariff, subject to pre-authorisation.

10.2.9 Supplementary services during hospitalisation

Supplementary services includes services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, bio kinetics, private nursing and social workers – 100% of Scheme tariff on condition that the claim is related to the hospital admission of the patient.

10.2.10 Blood transfusions

Blood, operators' fees, transport charges and apparatus – 100% of the Scheme tariff.

10.2.11 Internal prosthesis surgically implanted during operations/ hospitalisation

Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of R63 500 per family per financial year.

Benefits will not be pro-rated but will be subject to the following conditions and maxima:

(i) Pre-authorisation by the Scheme.
(ii) Preferred providers may be appointed by the Scheme.
(iii) Co-payments may apply if preferred providers are not utilised.
(iii) Vascular prosthesis shall be limited to R20 900.
(iv) Endovascular prosthesis – no benefit
(v) Spinal prosthesis shall be limited to R20 900.
(vi) Artificial disk (single level based) – no benefit.
(vii) Drug eluting stent – no benefit.
(viii) Mesh shall be limited to R7 700.
(ix) Gynaecological/Urological prosthesis shall be limited to R5 700.
(x) Lens implant shall be limited to R4 400per lens.
(xi) Knee prosthesis shall be limited to R28 600.
(xii) Hip prosthesis and other major joints shall be limited to R21 500.
(xiii) Other Minor joints shall be limited to R8 800.

10.2.12 External prosthesis after operations

Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of R15 300 per family per financial year. Benefits shall be subject to the following:

(a) Pre-authorisation by the Scheme.
(b) Two quotations may be required.
(c) Preferred providers may be appointed by the Scheme.
(d) Artificial limbs are limited to one limb every 60 months.

10.2.13 Orthopaedic and medical appliances during hospitalisation

Back, leg, arm and neck supports, crutches, surgical foot wear and elastic stockings provided before discharge from hospital – 100% of the Scheme tariff.

10.2.14 Organ transplants

100% of the Scheme tariff subject to pre-authorisation and application of the Scheme protocols.

10.2.15 Peritoneal dialysis and haemodialysis

100% of the Scheme tariff subject to pre-authorisation and application of the Scheme protocols.

10.2.16 Ambulance and emergency evacuation services

100% of the cost of ambulance services on condition that the service has previously or, in an emergency, on the first working day after evacuation has been approved as clinically necessary by the preferred provider for ambulance services. No benefits shall be payable if the evacuation service was requested and delivered by a service provider other than the preferred provider.

10.2.17 Oncology

Radiation, chemotherapy, pathology, diagnostic imaging and consultations - 100% of the Scheme tariff or negotiated tariffs. Benefits shall be subject to the following:

(i) Pre-authorisation by the Scheme.
(ii) Preferred providers may be appointed.
(iii) Scheme protocol shall apply
(iv) Mediscor Reference Price (MRP) will be applied to medicine claims where applicable.

10.2.18 Benefits for medicine

The following principles apply for the reimbursement of medicine:

(a) Where medicines have generic alternatives registered with the Medicines Control Council (MCC) of South Africa, the Scheme will

reimburse those medicines up to the generic reference price (MRP) for that active ingredient.

(b) Benefit amount of medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as determined by the Scheme, plus VAT.

(c) A member must apply on the Scheme's prescribed application form to qualify for chronic medicine benefits. A member shall qualify for benefits from the date on which the application was received by the Scheme or its proxy.

(d) Approved PMB, CDL and non-CDL chronic mediation costs will be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medication costs continue being paid by the Scheme.

(e) Designated service providers (DSP) may apply.

(i) Medicine for non-CDL chronic conditions

The Scheme's benefit for medicine for non-CDL chronic conditions is subject to the use of a formulary (medicine list). Medicines on the formulary will be reimbursed at 85% of the Scheme tariff with a 15% co-payment. If a member, however, opts to use a non-formulary medicine, the Scheme will reimburse that product at 70% of the Scheme tariff and the member will have a 30% co-payment.

The following maxima per financial year will apply:

M	**M1+**
R6 500	R12 900

(ii) Specified chronic conditions

Acne	Grave's disease
Attention Deficit Disorder (ADD) / Attention Deficit Hyperactive Disorder (ADHD)	Major Depression
Chronic allergic rhinitis	Migraine prophylaxis
Chronic anaemia	Obsessive Compulsive Disorder

Eczema	Paraplegia/Quadriplegia
Endometriosis	Polycystic Ovarian Disease
Female Menopause	Pulmonary embolism
Gout Prophylaxis	Stroke

(iii) Medicine for Chronic Disease List (CDL) conditions:

The Scheme's medicine benefits for CDL medicines, prescribed by a medical practitioner are subjected to a formulary (medicine list). Medicines on the formulary will be reimbursed at 100% of the Scheme tariff without a co-payment. If a member, however, opts to use a non-formulary medicine, the Scheme will reimburse that product at 70% and the member will have a 30% co-payment.

(iv) Take home medicine after discharge from hospital

Medicine prescribed by the treating doctor upon discharge from hospital (and relating to the admission), to take home, will be paid at 100% of Scheme tariff, subject to MRP and a maximum supply of seven days.

10.2.19 Prescribed Minimum Benefits (PMB)

Medicine for a limited set of 270 conditions as specified in Annexure A of the Regulations in terms of the Medical Schemes Act (no 131 of 1998) and Annexure D1 of these Rules – 100% of the cost. Benefits shall be subject to the following:

(i) Pre-authorisation
(ii) The Scheme treatment protocols and clinical funding guidelines
(iii) Designated service providers (DSP)
(iv) Formularies
(v) Mediscor Reference Price (MRP)

10.2.20 Alternatives to hospitalisation

Services rendered by step-down facilities approved by the Scheme, registered private nurses and hospices – 100% of the fees approved by the Scheme. Pre-authorisation shall apply.

10.2.21 Preventative care

(i) 100% of the Scheme tariff for:

Preventative Care Benefit	Gender and Age Group	Quantity and Frequency	Benefit Criteria
Influenza vaccine	All ages	One per beneficiary per financial year	Applicable to all active members and beneficiaries
Pneumonia Programme	Children < 2yrs High risk adult	Once in 60 months	Funding for children < 2yrs: The Scheme in advance to pre-arrange funding prior to obtaining the vaccine Funding for adults: The Scheme will identify certain high risk individuals who will be advised to be immunised
Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children		
Female contraceptives	All females of child bearing age	Quantity and frequency depending on product up to the maximum allowed amount, Mirena device – one device in 60 months	Limited to R1 400 per family per financial year. Includes all items classified in category of female contraceptives
Document Based Care (DBC) Back rehabilitation programme	All ages	Up to 6 weeks treatment plan as per approval	Applicable to beneficiaries who have serious spinal or back problems and may require surgery. The Scheme identifies

			appropriate participants for evaluation at the DBC Centre. Based on the outcomes of the evaluation, a rehabilitation treatment plan is drawn up and initiated which lasts approximately 6 weeks.
HIB titre immunisations	Children 5years and younger	One vaccine at 6, 10 and 14 weeks after birth. 1 booster vaccine between 15-18 months	If the booster vaccine was not administered timeously, the maximum age to which it will be allowed is 5 years
Mammogram	Females 40 years and older	Once every 24 months	Scheme tariff shall apply
PAP smear	Females 40years and older	Once per financial year	To be done at a gynaecologist or general practitioner. Consultation fees paid from the consultation benefit
Biometric screening: - Glucose test (finger prick test) - Cholesterol test (finger prick test) - Blood Pressure - Body Mass Index (BMI)	All beneficiaries 10 years and Older	One per beneficiary per financial year	A screening benefit package at selected Preferred Provider Pharmacies.
Human Papilloma Virus (HPV) vaccinations	Girls 9 – 13 years old	Three vaccinations per beneficiary	GSK's Cervarix vaccinations shall be funded at Mediscor Reference Price (MRP).

(i) 100% of the Scheme tariff for preventative dentistry:

DESCRIPTION OF SERVICE	**AGE**	**FREQUENCY**
General full mouth examination by a general dentist (incl. gloves and use of	Above 12 years Under 12 years	Once per financial year

DESCRIPTION OF SERVICE	AGE	FREQUENCY
sterile equipment for this visit)		Twice per financial year
Full mouth intra-oral radiographs	All ages	Once every 36 months
Intra-oral radiograph	All ages	2 x photos per year
Scaling and/or polishing	All ages	Twice per financial year
Fluoride treatment	All ages	Twice per financial year
Fissure sealing	Up to and including 21 years	In accordance with accepted protocol
Space maintainers	During primary and mixed denture stage	Once per space

10.2.22 Specialised Diagnostic Imaging out of hospital

MRI scans, CT scans, computer tomographic studies and isotope studies - 100% of the Scheme tariff, limited to R11 000 per family per financial year.

10.2.23 International emergency medical cover

Over and above the provisions for foreign claims, referred to in Rule 16.12, members and their dependents qualify for the following additional benefit:

100% for the cost of services for worldwide international emergency medical cover: Provided that benefits are subject to the following:

(i) The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs.
(ii) Beneficiaries have access to 90 days cover per trip.
(iii) A member has to notify the preferred provider at least 48 hours in advance when he and or his dependents are travelling overseas. Failure to notify the preferred provider will result in claims not entertained.

(iv) General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.

10.2.24 Optical benefits

Optometry services shall be obtained and paid by Preferred Provider Network (PPN) at 100% of cost per beneficiary every 24 months. For services rendered at a non-network provider the following maxima per beneficiary shall apply every 24 months. Notwithstanding the aforesaid, Optometry services relating specifically to contact lenses shall be dealt with as follows: Preferred Provider Network (PPN) shall pay a maximum amount of R1210-00 towards the cost for contact lenses per beneficiary every 24 months, irrespective if the beneficiary utilised the services of PPN or a non-network provider:

DESCRIPTION	MAXIMUM BENEFIT PER BENEFICIARY PER 24 MONTHS
Consultations	R290-00
Single-vision lenses OR	R150-00
Bifocal lenses OR	R325-00
Multifocal lenses OR	R600-00
Contact lenses	A maximum amount of R1210-00 towards the cost for contact lenses per beneficiary every 24 months, irrespective if the beneficiary utilised the services of PPN or a non-network provider.
Spectacle frames	R500-00

10.2.25 Maternity benefit

(a) Antenatal consultations – 100% of Scheme tariff with a maximum of up to 12 antenatal consultations per beneficiary per financial year
(b) Ultrasound sonar – 100% of Scheme tariff for two ultrasound sonar per beneficiary per financial year.

10.3 CONDITIONS FOR INDIVIDUAL MEDICAL SAVINGS ACCOUNT (IMSA) PAYMENTS

(a) The IMSA shall be used solely for medical expenses relating to day-to-day benefits referred to in paragraph 10.3, subject to the exclusions referred to in Annexure C of these Rules.

(b) On admission to the Scheme, an IMSA, held by the Scheme is established in the name of the member concerned into which the contributions payable in respect of the IMSA component shall be credited and benefits in respect thereof, shall be debited.

(c) The full annual amount that is paid into the IMSA at the beginning of the year has to be reached/used by the member before the day-to-day benefits provided for by the Scheme comes into effect. No cross subsidisation between members will apply in respect of the IMSA. The IMSA benefit is limited to 20% of gross annual contributions.

(d) Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to claim for all health care services provided for under paragraph 10.3 at 100% of the cost. Any balance in the IMSA at the end of a financial year remains the property of the member and accumulates to his credit. Interest income shall be allocated on a pro-rata basis at month-end and shall accrue to this balance.

(e) Upon the death of the member, the balance due to the member will be transferred to his registered dependents that continue membership of the Scheme or paid into his estate in the absence of such dependents.

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

(g) 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 an IMSA, the balance due to the member must be refunded to the member 5 (five) months after termination of membership, and subject to applicable laws.

(h) 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 (five) months after termination of membership.

(i) The decision to grant the funds in the IMSA annually to the member as an interest free loan in advance up to the end of the financial year, shall vest in the discretion of the Scheme.

(j) Any debit balance in the IMSA arising during or at the end of the financial year remains the member's liability and is repayable to the Scheme upon membership termination. A debit balance arises when the monetary savings amount used exceeds the total monetary amount refunded by the member to the Scheme on a monthly basis.

10.3.1 Medicine – acute and over the counter

Acute medicines prescribed by a medical practitioner or dentist or person legally authorised thereto by law and over the counter medicine – 100% of cost.

The day to day benefit and overall limit shall apply for acute medicine only, after the available balance of the IMSA is depleted.

10.3.2 Oral and dental benefits

Specialised dentistry includes prosthodontics (crowns, bridges, inlays, veneers and dentures), periodontics (gum disease) and orthodontic (correction of irregular teeth by means of braces, retainers or similar) services, dental implants, implant costs and all laboratory costs related to the services mentioned. This benefit further covers for all basic and specialised dentistry not defined under preventative dentistry or surgical dentistry indicated in this annexure - 100% of cost.

The day to day benefit and overall limit shall apply after the available balance of the IMSA is depleted.

10.3.3 Supplementary benefits out of hospital

Supplementary benefits includes services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, bio kinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's),, psychiatric treatment, psychologists and social workers – 100% of cost.

The day to day benefit and overall limit shall apply after the available balance of the IMSA is depleted.

10.3.4 Pathology and standard diagnostic imaging out of hospital

100% of cost.

The day to day benefit and overall limit shall apply after the available balance of the IMSA is depleted.

10.3.5 Consultations, visits, injections and treatments out of hospital

Consultations, visits, diagnostic examinations, injections, emergency unit visits (where a procedure room was used) and treatments by general practitioners, medical specialists and homeopaths and herbalists – 100% of cost.

The day to day benefit and overall limit shall apply after the available balance of the IMSA is depleted.

10.3.6 Rehabilitation after trauma

Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma - 100% of cost.

10.4 DAY-TO-DAY BENEFITS

(a) All benefits mentioned in section 10.4 below are subject to the annual maxima for the member with his dependents as provided for in the relevant subparagraphs and the exclusions referred to in Annexure C. The following combined overall limit for day to day benefits shall apply per financial year:

M	M+
R8 800	R17 500

(b) Cross subsidisation between members shall apply.

10.4.1 Consultations, visits, injections and treatments

Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners and Specialists, Homeopaths and Herbalists – 100% of the Scheme tariff or contracted fee. Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

M	M+
R2 200	R3 800

10.4.2 Acute medicine

(i) Medicine other than that referred to as chronic medicine and excluding medicine referred to in Annexure C2, prescribed out of a hospital by a medical practitioner or dentist or a person authorised thereto by law – 100% of the cost.

(ii) Homeopathic remedies, injections and herbal remedies – 100% of the cost provided that a nappi code is provided. If a nappi code is not provided benefits shall be paid from the IMSA.

Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

M	M+
R2 000	R4 000

10.4.3 Oral and dental benefits

Specialised dentistry includes prosthodontics (crowns, bridges, inlays, veneers and dentures) periodontics (gum diseases) and orthodontic (correction of irregular teeth by means of braces, retainers or similar) services, dental implants, implant costs and all laboratory costs related to the services mentioned. Pre-authorisation for orthodontic treatment shall be required.

This benefit further covers for all basic and specialised dentistry not defined under preventative dentistry or surgical dentistry indicated in this annexure - 100% of the Scheme tariff, limited to the overall day-to-day limit and the following maxima per financial year:

M	M+
R3 300	R6 600

10.4.4 Standard diagnostic imaging and pathology out of hospital

100% of the Scheme tariff. Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

M	M+
R2 200	R4 400

10.4.5 Supplementary benefits out of hospital

Supplementary benefits includes services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists,

bio kinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), , psychiatric treatment, psychologists and social workers – 100% of Scheme tariff. Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

M	M+
R3 300	R6 600

10.4.6 Wound care and related private nursing services

Wound care including dressings and Negative Pressure Wound Therapy (NPWT) treatment and related private nursing services – 100% of Scheme tariff. Benefits shall be subject to the overall day-to-day limit and a maximum of R3 300 per family per financial year.

10.4.7 Orthopaedic, surgical and medical appliances out of hospital

Appliances shall include any of the items listed below - 100% of Scheme tariff. Benefits shall be subject to the overall day-to-day limit and a maximum of R7 700 per family per financial year:

(i) Hearing aid.
(ii) Back, leg, arm and neck supports.
(iii) Wheel chairs.
(iv) Surgical footwear.
(v) Crutches.
(vi) Speech appliances.
(vii) Elastic stockings
(viii) Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.

10.5 CONDITIONS FOR VESTED SAVINGS ACCOUNT PAYMENTS

(a) The Vested Savings Account funds shall be used solely for medical expenses relating to day-to-day benefits and may be subject to the exclusions referred to in Annexure C of these Rules. These funds shall further only be used once all funds in the IMSA and day to day overall limits are depleted.

(b) No cross subsidisation between members will apply in respect of the Vested Savings Account.

(c) Members may claim, upon request, for any co-payments or shortfalls that the member is responsible for.

(d) Any balance plus interest at the end of a financial year remains the property of the member and accumulates to his credit.

(e) Upon the death of the member, the balance due to the member will be transferred to his registered dependents that continue membership of the Scheme or paid into his estate in the absence of such dependents.

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

(g) 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 an IMSA, the balance due to the member must be refunded to the member 5 (five) months after termination of membership, and subject to applicable laws.

(h) 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 (five) months after termination of membership.

10.6 MAXIMUM BENEFITS

Where a maximum amount of benefits has been imposed per financial year, the benefits shall be calculated at the maximum for the financial year in which the service was rendered. Where maximum benefits apply to a financial year, the maximum benefits for which a member and his dependants qualify shall be determined in accordance with the actual membership status at the date on which the service is rendered.

Benefit maxima for members shall be calculated pro-rata for the financial year in which they join the Scheme as referred to in paragraph 10.1 (e)