ANNEXURE B.1
PACE1

1.1 GENERAL CONDITIONS OF THE BENEFIT OPTION

1.1.1 The Scheme's benefits on accounts properly lodged in terms of rule 15 of the registered Rules 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.

1.1.2 No benefits shall be granted on accounts reaching the Scheme after the last day of the 4th (fourth) month following the date on which the service was rendered.

1.1.3 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 4th (fourth) month following the date on which the service was rendered. The Scheme will then refund the Member the applicable benefit amount.

1.1.4 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.

1.1.5 A Member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.

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

1.1.7 The Scheme's financial year shall run from 1 January to 31 December.

1.1.8 The benefits of the option shall be divided into the following:

1.1.8.1 Scheme Benefits;

1.1.8.2 Personal Medical Savings Account (PMSA);

1.1.8.3 Day-to-Day Benefits; and

1.1.8.4 Bonus Account (Vested Medical Savings).

1.1.9 A Member shall qualify for the extent and level of prescribed 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.

1.1.10 The Mediscor Reference Price (MRP) will be applied on all medicines where applicable.

1.2 CONDITIONS FOR SCHEME BENEFIT PAYMENT

1.2.1 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.

1.2.2 Full cross subsidisation between Members shall apply.

1.2.3 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.

1.2.4 No benefits in a private hospital or day clinic shall be granted by the Scheme or its proxy if Pre-Authorisation and an authorisation number has not been obtained in advance;

1.2.4.1 In the event of planned major operations and dental procedures at least 14 (fourteen) days before the event; or

1.2.4.2 In an emergency, on the 1st (first) working day after admission.

1.2.5 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 1st (first) working day after admission to a hospital, by the Scheme or its proxy.

1.2.6 If a Member or his Dependant(s) receive treatment in a private hospital or day clinic without first obtaining Pre-Authorisation and an authorisation number, 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.

1.2.7 If Pre-Authorisation and an authorisation number have 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.

1.2.8 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 **Scheme tariff** where services are authorised or approved by the Scheme, in its sole discretion.

1.2.9 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 **Scheme tariff** where services are authorised or approved by the Scheme, in its sole discretion. Benefits shall be subject to the following:

1.2.9.1 The length of stay shall be limited to 21 (twenty-one) days per beneficiary per financial year.

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

Accommodation and treatment for chemical and substance dependence/ abuse – 100% of Scheme tariff. Notwithstanding the maximum/s quantified, prescribed

minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits shall be subject to the following:

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

1.2.10.2 Benefits shall be limited to R20 100 per beneficiary per financial year.

1.2.11 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 Scheme tariff alternatively the contracted fee, as the case may be.

1.2.12 Confinements

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

1.2.12.1 Medical practitioners – 100% of Scheme tariff;

1.2.12.2 Nursing home and hospital fees in accordance with the provisions of rule 1.2.8 of this Annexure;

1.2.12.3 Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife – 100% of 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; and

1.2.12.4 Midwife assisted births at a private midwife birth house – 100% of the Scheme tariff. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits.

1.2.13 Surgical dentistry

Any surgical procedure that needs to be performed in a theatre after Pre-Authorisation by the Scheme – 100% of Scheme tariff, limited to R9 700 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum

benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Payment for Maxillofacial and oral surgery is strictly related to the following conditions:

1.2.13.1 Severe trauma (soft tissue injuries, fractures of jaws and facial bones);
1.2.13.2 Cleft lip and palate;
1.2.13.3 Crouson's disease;
1.2.13.4 Malunited craniomaxillary disjunction;
1.2.13.5 Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);
1.2.13.6 Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);
1.2.13.7 Salivary gland surgery (removal of gland or salivary stone);
1.2.13.8 Life threatening sepsis (Ludwig's angina); and
1.2.13.9 Confirmed oral cancer.

1.2.14 Pathology and standard diagnostic imaging during hospitalisation

Benefits at 100% of Scheme tariff.

1.2.15 Specialised diagnostic imaging during hospitalisation

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

1.2.16 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 and is in line with the Scheme funding guidelines and protocols.

1.2.17 Blood transfusions

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

1.2.18 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 Scheme tariff after discount with a maximum of R68 600 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits will not be pro-rated but will be subject to the following conditions and maxima:

1.2.18.1 Pre-Authorisation by the Scheme;
1.2.18.2 Preferred providers may be appointed by the Scheme;
1.2.18.3 Co-payments may apply if preferred providers are not utilised;
1.2.18.4 Vascular prosthesis shall be limited to R22 600;
1.2.18.5 Pacemaker dual chamber R 38 700*;
1.2.18.6 Endovascular prosthesis and delivery mechanisms– no benefit;
1.2.18.7 Spinal prosthesis shall be limited to R22 600;
1.2.18.8 Artificial disks, spacers and similar devices – no benefit;
1.2.18.9 Drug eluting stent – no benefit;
1.2.18.10 Mesh shall be limited to R8 500;
1.2.18.11 Gynaecological/Urological prosthesis shall be limited to R6 100;
1.2.18.12 Lens implant shall be limited to R4 700 per lens; and
1.2.18.13 Joint replacement surgery (A joint connects two bones in the body and includes skull joints, throat joints, thorax joints, spine and pelvis joints, both upper limbs and both lower limbs) will be excluded from benefits except for PMB conditions. The following maxima will apply to the prosthesis if pre-authorised by the Scheme or its proxy:
1.2.18.13.1 Hip prosthesis and other major joints shall be limited to R23 100;
1.2.18.13.2 Knee prostheses shall be limited to R30 700; and
1.2.18.13.3 Other minor joints shall be limited to R9 500.

*Subject to clinical motivation, treatment protocols, DSP and Scheme approval.

1.2.19 External prosthesis after operations

Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons – 100% of Scheme tariff after discount with a maximum of R16 600 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits shall be subject to the following:

1.2.19.1 Pre-Authorisation by the Scheme;
1.2.19.2 2 (two) quotations may be required;
1.2.19.3 Preferred providers may be appointed by the Scheme; and
1.2.19.4 Artificial limbs are limited to 1 (one) limb every 60 (sixty) months.

1.2.20 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 Scheme tariff.

1.2.21 Organ transplants

Beneftis for PMB conditions only. 100% of Scheme tariff subject to Pre-Authorisation, application of Scheme protocols and designated service providers (DSPs) appointed by the Scheme to provide diagnosis, treatment and care in respect of the aforesaid medical condition/s.

1.2.22 Peritoneal dialysis and haemodialysis

100% of Scheme tariff subject to Pre-Authorisation, application of Scheme protocols and designated service providers (DSPs) appointed by the Scheme to provide diagnosis, treatment and care in respect of the aforesaid medical condition/s.

1.2.23 Ambulance and emergency evacuation services

Benefits shall be subject to Pre-Authorisation/approval by the Scheme's Preferred Provider for Ambulance services, ER24.

100% of Scheme tariff for ambulance services on condition that the service has previously or, in an emergency, on the 1st (first) working day after evacuation had 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.

1.2.24 Oncology

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

1.2.24.1 Pre-Authorisation by the Scheme;
1.2.24.2 Preferred providers may be appointed;
1.2.24.3 Scheme protocols shall apply; and
1.2.24.4 Mediscor Reference Price (MRP) will be applied to medicine claims where available.

1.2.25 Benefits for medicine

1.2.25.1 All medicines payable from the Scheme Benefit shall be subject to the following:

1.2.25.1.1 Pre-Authorisation: A Member must apply on the Scheme's prescribed application form to qualify for chronic medicine benefits and shall qualify for benefits from the date on which the application was received by the Scheme or its proxy;
1.2.25.1.2 The Scheme treatment protocols and clinical funding guidelines;
1.2.25.1.3 The Scheme's formulary (medicine list);
1.2.25.1.4 Where medicines have generic alternatives registered with the Medicines Control Council (MCC) of South Africa, the Scheme will reimburse those medicines up to the Mediscor Reference Price (MRP) for that active ingredient;
1.2.25.1.5 Benefit amount of medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as determined by the Scheme, plus VAT, where applicable;
1.2.25.1.6 Approved PMB, CDL and non-CDL chronic medicine costs will be paid from the non-CDL limit first. Thereafter, only

approved PMB and CDL chronic medicine costs will continue being paid by the Scheme;

1.2.25.1.7 Mediscor Reference Price (MRP) is applied throughout; and

1.2.25.1.8 Designated service providers (DSP) may apply.

1.2.25.2 Medicine for non-CDL chronic conditions

Medicines on the formulary will be reimbursed at 85% of 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 65% of Scheme tariff and the Member will have a 35% co-payment.

The following maxima per financial year will apply:

M	M1+
R6 300	R12 700

1.2.25.2.1 Specified chronic conditions

Acne	Endometriosis
Attention Deficit Disorder (ADD) / Attention Deficit Hyperactive Disorder (ADHD)	Gout Prophylaxis
Chronic allergic rhinitis	Major Depression
Chronic anaemia	Migraine prophylaxis
Eczema	Polycystic Ovarian Disease

1.2.25.3 Medicine for Chronic Disease List (CDL) conditions:

CDL chronic medicines prescribed by a medical practitioner on the formulary will be reimbursed at 100% of Scheme tariff without a co-payment. If a Member, however, opts to use a non-formulary medicine, the Scheme will reimburse that product at 65% and the Member will have a 35% co-payment.

1.2.25.4 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 7 (seven) days.

1.2.26 Prescribed Minimum Benefits (PMB)

Medicine for a limited set of conditions as specified in Annexure A of the Regulations in terms of the Medical Schemes Act (no 131 of 1998), Annexure D1 of these Rules – 100% of the cost.

Benefits shall be subject to the following:

1.2.26.1 Pre-Authorisation;

1.2.26.2 The Scheme treatment protocols and clinical funding guidelines;

1.2.26.3 Designated service providers (DSP);

1.2.26.4 Formularies; and

1.2.26.5 Mediscor Reference Price (MRP).

1.2.27 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.

1.2.28 Specialised Diagnostic Imaging out of hospital

MRI scans, CT scans, computer tomographic studies and isotope studies - 100% of Scheme tariff, limited to R10 600 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

1.2.29 Maternity benefit

1.2.29.1 Antenatal consultations – 100% of Scheme tariff with a maximum of up to 12 (twelve) antenatal consultations per beneficiary per financial year; and

1.2.29.2 Ultrasound sonar – 100% of Scheme tariff for 2 (two) ultrasound sonar per beneficiary per financial year.

1.2.30 International emergency medical cover

Over and above the provisions for foreign claims, referred to in Rule 16.12 of the registered Rules, Members and their Dependant(s) qualify for the following additional benefit:

100% of Scheme tariff for the cost of services for worldwide international emergency medical cover Pre-Authorised/approved by the Scheme's Preferred Provider, ER24. Benefits shall be subject to the following:

1.2.30.1 The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs.

1.2.30.2 Beneficiaries have access to 90 (ninety) days cover per trip.

1.2.30.3 A Member has to notify the preferred provider at least 48 (forty-eight) hours in advance when he and or his Dependant(s) are travelling overseas. Failure to notify the preferred provider will result in claims not entertained.

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

1.2.31 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, limited to R2 600 per family per financial year.

1.2.32 Preventative care

1.2.32.1 Benefit at 100% of Scheme tariff for:

Preventative Care Benefit	Gender and Age Group	Quantity and Frequency	Benefit Criteria
Influenza vaccine	All ages	1 (one) per beneficiary per financial	Applicable to all active Members and beneficiaries

		year	
Pneumonia Programme	Children < 2 (two)years High risk adult group	Once in 60 (sixty) months	Funding for children < 2 (two) years: Parents to contact the Scheme 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 (sixty) months	Limited to R1 500 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 (six) 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 (six) weeks.

HIB titre immunisation	Children 5 (five) years and younger	One vaccine at 6 (six), 10 (ten) and 14 (fourteen) weeks after birth. 1 (one) booster vaccine between 15-18 (fifteen and eighteen) months	If the booster vaccine was not administered timeously, the maximum age to which it will be allowed is 5 (five) years.
Mammogram	Females 40 (forty) years and older	Once every 24 (twenty-four) months	Scheme tariff shall apply
PAP smear	Females 40 (forty)years 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 (ten) years and older	1 (one) per beneficiary per financial year	A screening benefit package at selected Preferred Providers.
Human Papilloma Virus (HPV) vaccinations	Girls 9 (nine) – 26 (twenty-six) years old.	3 (three) vaccinations per beneficiary	GSK's Cervarix vaccinations shall be funded at Mediscor Reference Price (MRP).

1.2.32.2 100% of Scheme tariff for preventative dentistry:

DESCRIPTION OF SERVICE	AGE	FREQUENCY
General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit)	Above 12 (twelve) years Under 12 (twelve) years	Once per financial year Twice per financial year

Full mouth intra-oral radiographs	All ages	Once every 36 (thirty-six) months
Intra-oral radiograph	All ages	2 (two) 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 (twenty-one) years	In accordance with accepted protocol
Space maintainers	During primary and mixed denture stages	Once per space

1.2.33 Optical benefits

Optometry services shall be obtained and paid by Preferred Provider Network (PPN) at 100% of contracted fee per beneficiary every 24 (twenty-four) months. For services rendered at a non-network provider the following maxima per beneficiary shall apply every 24 (twenty-four) 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 R1 000 towards the cost for contact lenses per beneficiary every 24 (twenty-four) months, irrespective if the beneficiary utilised the services of PPN or a non-network provider:

DESCRIPTION	**MAXIMUM BENEFIT PER BENEFICIARY PER 24 (TWENTY-FOUR) MONTHS**
Consultations	R290
Single-vision lenses OR	R150
Bifocal lenses OR	R325
Multifocal OR	R600
Contact lenses	A maximum amount of R1 000 towards the cost for contact lenses per beneficiary every 24 (twenty-four) months, irrespective if the beneficiary utilised the services of PPN or a non-network provider.
Spectacle frames	R500

1.3 CONDITIONS FOR PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA) PAYMENT

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

1.3.2 The PMSA shall be used solely for medical expenses relating to day-to-day benefits referred to in rule 1.4 of this Annexure, subject to the exclusions referred to in Annexure C of these Rules.

1.3.3 The full annual amount that is paid into the PMSA at the beginning of the financial 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 PMSA. The PMSA benefit is limited to 21% of gross annual contributions.

1.3.4 Subject to sufficient funds being available at the date on which a claim is processed, Members shall be entitled to claim for all health care services provided for under rule 1.4 of this Annexure at 100% of the cost. Any balance in the PMSA 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.

1.3.5 Upon the death of the Member, the balance due to the Member will in the 5th (fifth) month thereafter be transferred to his Dependant(s) who continue membership of the Scheme, or paid into his estate in the absence of such Dependant(s).

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

1.3.7 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 PMSA, the balance due to the

Member must be refunded to the Member 5 (five) months after termination of membership, and subject to applicable laws.

1.3.8 Should a Member be admitted to membership of another medical Scheme, which provides for a similar account, the balance due to the Member will be transferred to such Scheme within 5 (five) months after termination of membership.

1.3.9 The decision to grant the funds in the PMSA 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.

1.3.10 Any debit balance in the PMSA 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.

1.4 CONDITIONS FOR DAY-TO-DAY BENEFITS PAYMENT

1.4.1 Payment of day-to-day benefits may be subject to payment from the PMSA first and shall be indicated as such in this section 1.4 of these Rules.

1.4.2 Full cross subsidisation between Members shall apply.

1.4.3 Granting of benefits may be subject to treatment protocols, preferred providers, designated service providers (DSPs) and/or medicine formularies accepted by the Scheme.

1.4.4 All benefits mentioned in rule 1.4 of this Annexure are subject to the annual maxima for the Member with this Dependant(s) as provided for in the relevant subparagraphs and the exclusions referred to in Annexure C of the registered Rules. The following combined overall limit for day-to-day benefits shall apply per financial year:

M	M+
R8 200	R16 300

1.4.5 Acute and over the counter medicine

1.4.5.1 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.

1.4.5.2 Medicine over the counter – 100% of the cost, subject only to the day-to-day acute limit of R590 per family per financial year and funds being available in the Bonus Account (Vested Medical Savings).

1.4.5.3 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 PMSA or Bonus Account (Vested Medical Savings)

Benefits, with the exception of medicine over the counter, shall be subject to the overall day-to-day limit and the following maxima per financial year once the PMSA is depleted:

M	M+
R1 800	R3 700

1.4.6 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 Scheme tariff or contracted fee. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

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

M	**M+**
R1 600	R3 300

1.4.7 Oral and dental benefits

This benefit further covers for all basic and specialised dentistry not defined under preventative dentistry or surgical dentistry indicated in this annexure - 100% of Scheme tariff. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

Specialised dentistry includes:

1.4.7.1 Prosthodontics services (crowns, bridges, inlays, veneers and dentures);

1.4.7.2 Periodontics services (gum diseases);

1.4.7.3 Orthodontic services (correction of irregular teeth by means of braces, retainers or similar);

1.4.7.4 Dental implants, implant costs and all laboratory costs related to the aforementioned services; and

1.4.7.5 Pre-Authorisation for orthodontic treatment shall be required.

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

M	**M+**
R2 900	R5 900

1.4.8 Orthopaedic and medical appliances out of hospital

Back, leg, arm and neck supports, crutches, surgical foot wear, elastic stockings, stoma products, oxygen and diabetic supplies for non-PMB conditions, wheel chairs and hearing aids. 100% of Scheme tariff with a combined maximum of R8 300 per family per financial year. Notwithstanding the maximum/s quantified, prescribed

minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

1.4.9 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. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

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

M	**M+**
R3 200	R6 600

1.4.10 Standard diagnostic imaging and pathology out of hospital

100% of Scheme tariff. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act.

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

M	**M+**
R2 400	R4 700

1.5 CONDITIONS FOR BONUS ACCOUNT (VESTED MEDICAL SAVINGS) PAYMENTS

1.5.1 The Bonus Account (Vested Medical Savings) funds shall be used solely for medical expenses relating 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 PMSA and day-to-day overall limits are depleted.

1.5.2 No cross subsidisation between Members will apply in respect of the Bonus Account (Vested Medical Savings).

1.5.3 A Member may claim, upon request, for any co-payments or shortfalls that the Member is responsible for and shall be entitled to claim for all health care services provided for under this rule 1.5, subject to sufficient funds being available at the date on which a claim is processed.

1.5.4 Any balance plus interest at the end of a financial year remains the property of the Member and accumulates to his credit.

1.5.5 Upon the death of the Member, the balance due to the Member will in the fifth month thereafter be transferred to his Dependant(s) who continue membership of the Scheme, or paid into his estate in the absence of such Dependant(s).

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

1.5.7 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 PMSA, the balance due to the Member must be refunded to the Member 5 (five) months after termination of membership, and subject to applicable laws.

1.5.8 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.

1.5.9 Rehabilitation after trauma

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

1.6 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 Dependant(s) 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 rule 1.1.5 of this Annexure B1 of the registered Rules.