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 Vested Medical Savings Account.

1.1.9 A Member shall qualify for the extent and level of Prescribed Minimum Benefits (PMB) 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, and such benefits are payable at cost.

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, funding guidelines, preferred providers, designated service providers (DSPs), 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, unless the excess costs were as a direct result of treatment received and necessary for the beneficiary and authorisation could not be obtained in time.

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, services in respect of PMB conditions are paid in full if rendered by a 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 R25 200 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 Dental / Oral / Jaw surgery
Pre-Authorisation must be obtained for any surgical procedure that needs to be performed in a theatre. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a DSP, as stipulated in the Medical Schemes Act.

1.2.13.1 Dental and Oral surgery (in or out of hospital)

100% of Scheme tariff, limited to R6 300 per family per financial year for the following procedures performed either in or out of hospital:

- **1.2.13.1.1** Surgical extractions of teeth / roots / impactions / failed implants;
- **1.2.13.1.2** Surgical drainage of dental abscess;
- **1.2.13.1.3** Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis);
- **1.2.13.1.4** Root canal related surgery;
- **1.2.13.1.5** Dental implant related surgery;
- **1.2.13.1.6** Pre-prosthetic (preparatory to dental prosthetics) surgery;
- **1.2.13.1.7** Orthodontic related / orthognathic surgery.

1.2.13.2 Major Medical Maxillofacial surgery

100% of Scheme tariff limited to R10 200 per family per financial year, strictly related to the following conditions:

- **1.2.13.2.1** Severe trauma (soft tissue injuries, fractures of jaws and facial bones);
- **1.2.13.2.2** Cleft lip and palate;
- **1.2.13.2.3** Crouson’s disease;
- **1.2.13.2.4** Malunited craniomaxillary disjunction;
- **1.2.13.2.5** Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);
- **1.2.13.2.6** Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);
- **1.2.13.2.7** Salivary gland surgery (removal of gland or salivary stone);
- **1.2.13.2.8** Life threatening sepsis (Ludwig’s angina); and
- **1.2.13.2.9** 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, biokinetics, 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 limited to R70 650 per family per financial year. Notwithstanding the maximum/quantified, services in respect of PMB conditions are paid in full if rendered by a 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 or DSPs may be appointed by the Scheme;
1.2.18.3 Co-payments may apply if preferred providers or DSPs are not utilised;
1.2.18.4 Vascular prosthesis shall be limited to R25 650;
1.2.18.5 Pacemaker dual chamber limited to R43 850;
1.2.18.6 Endovascular and catheter based procedures and delivery mechanisms – no benefit;
1.2.18.7 Spinal prosthesis shall be limited to R25 650;
1.2.18.8 Artificial disks, spacers and similar devices – no benefit;
1.2.18.9 Drug eluting stent – no benefit apart from PMB conditions and DSPs apply;
1.2.18.10 Mesh shall be limited to R9 650;
1.2.18.11 Gynaecological/Urological prosthesis shall be limited to R6 950;
1.2.18.12 Lens implant shall be limited to R5 350 per lens;
1.2.18.13 Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R12 650.
1.2.18.14 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 R26 200;
   1.2.18.13.2 Knee prostheses shall be limited to R34 750; and
   1.2.18.13.3 Other minor joints shall be limited to R10 800.

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 limited to R17 950 per family per financial year. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a 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 or DSPs 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 Refractive eye surgery
100% of Scheme tariff limited to R7 000 per eye, subject to Pre-Authorisation, application of Scheme protocols and preferred providers or DSPs. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a DSP, as stipulated in the Medical Schemes Act.

1.2.21 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.

1.2.22 Organ transplants

Benefits 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.

1.2.23 Peritoneal dialysis and haemodialysis

Benefits for PMB conditions only, 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.

1.2.24 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.

1.2.25 Oncology

Benefits for PMB conditions only and shall be subject to the following:
1.2.25.1 Pre-Authorisation by the Scheme;
1.2.25.2 Preferred providers or DSPs appointed by the Scheme, i.e. State facilities, where contracts are available, are the Scheme’s first choice;
1.2.25.3 Scheme protocols shall apply; and
1.2.25.4 Mediscor Reference Price (MRP) will be applied to medicine claims where available.

1.2.26 Benefits for medicine

1.2.26.1 All medicines payable from the Scheme Benefit shall be subject to the following:
   1.2.26.1.1 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;
   1.2.26.1.2 The Scheme treatment protocols and clinical funding guidelines;
   1.2.26.1.3 The Scheme’s formulary (medicine list);
   1.2.26.1.4 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;
   1.2.26.1.5 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;
   1.2.26.1.6 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;
   1.2.26.1.7 Mediscor Reference Price (MRP) is applied throughout; and
   1.2.26.1.8 Designated service providers (DSP) may apply.

1.2.26.2 Medicine for non-CDL chronic conditions

Medicine for non-CDL chronic conditions, as listed on the formulary, will be reimbursed at 85% of Scheme tariff and a co-payment of 15% will apply. If a Member, however,
opts to use medicine not listed on the formulary, the Scheme will reimburse that product at 65% of Scheme tariff and a co-payment of 35% will apply.

The following maxima per financial year will apply:

<table>
<thead>
<tr>
<th>M</th>
<th>M+</th>
</tr>
</thead>
<tbody>
<tr>
<td>R5 200</td>
<td>R10 450</td>
</tr>
</tbody>
</table>

1.26.26.1 Specified chronic conditions

<table>
<thead>
<tr>
<th>Acne - severe</th>
<th>Gout Prophylaxis*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic rhinitis</td>
<td>Major Depression*</td>
</tr>
<tr>
<td>Attention Deficit Disorder (ADD)</td>
<td>Attention Deficit Hyperactive Disorder (ADHD)</td>
</tr>
<tr>
<td>Migraine prophylaxis</td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
</tr>
</tbody>
</table>

* Non-CDL medicine benefits for these conditions will apply where provision is not made in the Diagnosis and Treatment Pairs constituting the Prescribed Minimum Benefits package as listed in the Medical Schemes Act.

1.26.26.3 Medicine for Chronic Disease List (CDL) and prescribed minimum benefit (PMB) conditions:

PMB and 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.

1.26.27 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.
1.2.28 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:

1.2.28.1 Pre-Authorisation;
1.2.28.2 The Scheme treatment protocols and clinical funding guidelines;
1.2.28.3 Designated service providers (DSP);
1.2.28.4 Formularies; and
1.2.28.5 Mediscor Reference Price (MRP).

1.2.29 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.

1.2.30 Specialised Diagnostic Imaging out of hospital

MRI scans, CT scans, computer tomographic studies and isotope studies - 100% of Scheme tariff, limited to R11 450 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.

1.2.31 Maternity benefit

1.2.31.1 Antenatal consultations – 100% of Scheme tariff with a maximum of up to 12 (twelve) antenatal consultations per beneficiary per financial year; and
1.2.31.2 Ultrasound sonar – 100% of Scheme tariff for 2 (two) ultrasound sonar per beneficiary per financial year.

1.2.32 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:

1.2.32.1 The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs.
1.2.32.2 Beneficiaries have access to 90 (ninety) days cover per trip.
1.2.32.3 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.
1.2.32.4 General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.

1.2.33 Preventative Care

1.2.33.1 Preventative Care Benefits at 100% of Scheme tariff for:

<table>
<thead>
<tr>
<th>Preventative Care Benefit</th>
<th>Gender and Age Group</th>
<th>Quantity and Frequency</th>
<th>Benefit Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza vaccine</td>
<td>All ages</td>
<td>1 (one) per beneficiary per financial year</td>
<td>Applicable to all active Members and beneficiaries</td>
</tr>
<tr>
<td>Pneumonia Programme</td>
<td>Children &lt; 2 (two) years High risk adult group</td>
<td>Once in 60 (sixty) months</td>
<td>Funding for children &lt; 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</td>
</tr>
<tr>
<td>Paediatric immunisations</td>
<td>Paediatric vaccines according to the State recommended programme for babies and children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female contraceptives</td>
<td>All females of child bearing age</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quantity and frequency depending on product up to the maximum allowed amount, Mirena device – one device in 60 (sixty) months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited to R1 800 per family per financial year. Includes all items classified in category of female contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Based Care (DBC) back and neck rehabilitation programme</td>
<td>All ages</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 (six) weeks treatment plan as per Scheme approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Applicable to beneficiaries with serious back or neck problems that 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 of 12 (twelve) sessions is drawn up and initiated over a period of 6 (six) weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIB titre immunisation</td>
<td>Children 5 (five) years and younger</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One vaccine at 6 (six), 10 (ten) and 14 (fourteen) weeks after birth. 1 (one) booster vaccine between 15-18 (fifteen and eighteen) months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the booster vaccine was not administered timeously, the maximum age to which it will be allowed is 5 (five) years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td>Females 40 (forty) years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Once every 24 (twenty-four)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scheme tariff shall apply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PAP smear
- Females 18 (eighteen) years and older
- Once every 24 (twenty-four) months per beneficiary
- 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).

| 1.2.33.2 Preventative dentistry | 100% of Scheme tariff per beneficiary for: |

<table>
<thead>
<tr>
<th>DESCRIPTION OF SERVICE</th>
<th>AGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit)</td>
<td>Above 12 (twelve) years Under 12 (twelve) years</td>
<td>Once per financial year Twice per financial year</td>
</tr>
<tr>
<td>Full mouth intra-oral radiographs</td>
<td>All ages</td>
<td>Once every 36 (thirty-six) months</td>
</tr>
<tr>
<td>Intra-oral radiograph</td>
<td>All ages</td>
<td>2 (two) x photos per year</td>
</tr>
<tr>
<td>Scaling and/or polishing</td>
<td>All ages</td>
<td>Twice per financial year</td>
</tr>
<tr>
<td>Fluoride treatment</td>
<td>All ages</td>
<td>Twice per financial year</td>
</tr>
<tr>
<td>Fissure sealing</td>
<td>Up to and including 21 (twenty-one) years</td>
<td>In accordance with accepted protocol</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>During primary and mixed denture stages</td>
<td>Once per space</td>
</tr>
</tbody>
</table>
1.2.34 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 from the date of service. For services rendered at a non-network provider the following maxima per beneficiary shall apply every 24 (twenty-four) months from the date of service. 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 from the date of service, irrespective if the beneficiary utilised the services of PPN or a non-network provider:

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>MAXIMUM BENEFIT PER BENEFICIARY PER 24 (TWENTY-FOUR) MONTHS FROM THE DATE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations</td>
<td>R350</td>
</tr>
<tr>
<td>Single-vision lenses OR</td>
<td>R165</td>
</tr>
<tr>
<td>Bifocal lenses OR</td>
<td>R360</td>
</tr>
<tr>
<td>Multifocal OR</td>
<td>R660</td>
</tr>
<tr>
<td>Contact lenses</td>
<td>A maximum amount of R1 000 towards the cost for contact lenses per beneficiary every 24 (twenty-four) months from the date of service, irrespective if the beneficiary utilised the services of PPN or a non-network provider.</td>
</tr>
<tr>
<td>Spectacle frames</td>
<td>R550</td>
</tr>
</tbody>
</table>

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 pertaining to day-to-day benefits referred to in rules 1.3.12 and 1.4 of this Annexure, subject to the exclusions referred to in Annexure C of the registered Rules. The funds in the Member’s PMSA shall not be used to pay the cost pertaining to PMB services or to offset contributions.

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 20% of gross annual contributions.

1.3.4 The Member is responsible for managing the PMSA. 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 B1 at 100% of the Scheme tariff.

1.3.5 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.

1.3.6 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).

1.3.7 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.

1.3.8 Should a Member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme 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.

1.3.9 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.
1.3.10 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.

1.3.11 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. On termination of membership, funds in the Member’s PMSA may be used to offset any debt owed by the member including outstanding contributions.

1.3.12 **Over-the counter medicine**

100% of the Scheme tariff up to the limit of R525 per family, subject only to funds being available in the PMSA. The Mediscor Reference Price (MRP) will be applied on all medicines where applicable.

### 1.4 CONDITIONS FOR DAY-TO-DAY BENEFITS PAYMENT

1.4.1 Benefits may be subject to payment from the PMSA first and shall be indicated as such in this rule 1.4 of this Annexure B1 of the registered Rules.

1.4.2 Full cross subsidisation between Members shall apply.

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

1.4.4 All benefits mentioned in rule 1.4 in this Annexure B1 are subject to the annual maxima for the Member with this Dependant(s) and/or 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:
1.4.5 Acute medicine

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

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 Scheme tariff.

1.4.5.2 Homeopathic remedies, injections and herbal remedies – 100% of the Scheme tariff provided that a nappi code is provided. If a nappi code is not provided, benefits shall be paid from the Vested Medical Savings Account.

Once the funds in the PMSA have been depleted, benefits shall be paid at 100% of the Scheme tariff, subject to the overall day-to-day limit and the following maxima per financial year.

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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.

Once the funds in the PMSA have depleted, benefits shall be paid at 100% of the Scheme tariff, subject to the overall day-to-day limit and the following maxima per financial year. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a DSP, as stipulated in the Medical Schemes Act.
1.4.7 **Oral and dental benefits**

This benefit further covers for all basic and specialised dentistry not defined under Preventative dentistry benefits or Dental / Oral / Jaw surgical benefits indicated in this Annexure B10.

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) - Pre-Authorisation shall be required for orthodontic treatment; and
1.4.7.4 Dental implants, implant costs and all laboratory costs related to the aforementioned services.

Once the funds in the PMSA have been depleted, benefits shall be paid at 100% of the Scheme tariff, subject to the overall day-to-day limit and the following maxima per financial year. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a DSP, as stipulated in the Medical Schemes Act.

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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.

Once the funds in the PMSA have depleted, benefits shall be paid at 100% of the Scheme tariff, subject to the overall day-to-day limit and the combined maximum of
R9 000 per family per financial year. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a 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, biokinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV’s), psychiatric treatment, psychologists and social workers.

Once the PMSA is depleted, benefits shall be paid at 100% of Scheme tariff, subject to the overall day-to-day limit and the following maxima per financial year. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a DSP, as stipulated in the Medical Schemes Act.

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1.4.10 Wound care and related private nursing services

Wound care including dressings and Negative Pressure Wound Therapy (NPWT) treatment and related private nursing services out of hospital – once the funds in the PMSA have been depleted, benefits shall subject to 100% of Scheme tariff and be limited to the overall day-to-day limit and R2 850 per family per financial year.

1.4.11 Standard diagnostic imaging and pathology out of hospital

Once the PMSA is depleted, benefits shall be paid at 100% of Scheme tariff, subject to the overall day-to-day limit and the following maxima per financial year. Notwithstanding the maximum/s quantified, services in respect of PMB conditions are paid in full if rendered by a DSP, as stipulated in the Medical Schemes Act.
1.5 CONDITIONS FOR VESTED MEDICAL SAVINGS ACCOUNT PAYMENTS

1.5.1 The funds in the Vested Medical Savings Account shall be used solely for medical expenses referred to in rules 1.3.12, 1.5.10 and those relating day-to-day benefits, except for PMB services, and may be subject to the exclusions referred to in Annexure C of these Rules. These funds may further only be used once all funds in the PMSA and day-to-day overall limits have been depleted.

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

1.5.3 A Member may claim, upon his request, for any co-payments or shortfalls, for which he is liable, except for PMB services and shall be entitled to claim for all health care services as provided for under this rule 1.5 at Scheme tariff, subject to the availability of sufficient funds at the date when 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, within 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).

1.5.6 On transfer to another option of the Scheme, which does not provide for a PMSA account, any balance in the Vested Medical Savings Account will be refunded to the Member, within 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 or Vested Medical Savings
Account, the balance due to the Member must be refunded to the Member within 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 PMSA or 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 Any debit balance in the Vested Medical Savings Account 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. On termination of membership, funds in the Member’s Vested Medical Savings Account may be used to offset any debt owed by the member including outstanding contributions.

1.5.10 Rehabilitation after trauma

Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma - 100% of the Scheme tariff, subject only to funds being available in the Vested Medical Savings Account.

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.