BP Medical Aid Society

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BP MEDICAL AID SOCIETY RULES
REGISTERED UNDER THE MEDICAL SCHEMES ACT 1998
(ACT NO 131 OF 1998)

1. NAME

The name of the Scheme is BP MEDICAL AID SOCIETY, hereinafter referred to as "the Scheme".

2. LEGAL PERSONA

The Scheme, in its own name is a body corporate, which shall be capable of suing and being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act and Regulations and these Rules and of acquiring, holding and alienating assets, movable and immovable.

3. REGISTERED OFFICE

The registered office of the Scheme shall be situated at BP Waterfront, Dock Road, Portswood Ridge, V&A Waterfront, CAPE TOWN, 8002 but the Board shall have the right to transfer such office to any other situation should circumstances so dictate.

4. DEFINITIONS

In these Rules words and expressions defined in the Medical Schemes Act 1998, bear the meanings thus assigned to them and, unless inconsistent with the context:

a. all words and expressions purporting the masculine gender shall include the feminine;

b. words signifying the singular number shall include the plural and vice versa; and

c. the following expressions shall have the following meanings:

4.1 **"Act",** the Medical Schemes Act, 1998 (Act No 131 of 1998), as amended, from time to time and the Regulations framed there under.

4.2 **"Admission Date",** the date on which a person may become a Member or a company or organisation may participate in the Scheme or becomes an Associate Employer, in terms of these Rules.

4.3 **"Annual Limit",** the maximum benefits to which a Member and his registered Dependants are entitled in terms of these Rules, and shall be calculated annually to coincide with the financial year of this Scheme being 31 December of each year.

4.4 **"Approval",** prior written approval of the Board or its authorized representative.

4.5 **"Associate Employer",** any associated or affiliated company or organisation, which has been admitted as an Employer in terms of these Rules.

4.6 **"Auditor",** an auditor registered under the Public Accountants' and Auditors' Act 1991 (Act No 80 of 1991).

4.7 **“Beneficiary”,** a Member or a person admitted as a Dependant of a Member.

4.8 **"Board",** the Board of Trustees constituted to administer the Scheme in terms of the Act and these Rules.

4.9 **“Certified”,** a process in which a relevant health service is screened by a case manager to ensure that it is medically necessary and that the service,

the duration thereof, the cost thereof and the level of care is clinically appropriate.

4.10 **“Child",** a Member's child, or a stepchild or legally adopted child, or a child in the process of being legally adopted, or a child who has been legally placed in the custody of a Member or his spouse or partner.

4.11 **“Clinically appropriate”,** the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.

4.12 **“Condition-specific waiting period”,** a period during which a Beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve month period ending on the date on which an application for admission as a Beneficiary was made.

4.13 **"Continuation Member",** a Member who retains his membership of the Scheme in terms of Rule 6.2, or a Dependant of a deceased Member who became a Member of the Scheme in terms of Rule 6.3.

4.14 **“Contracted fee”,** the fee determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services.

4.15 **“Contractor”,** any company, close corporation, partnership, organisation, association, firm, individual or any other person, body, enterprise or undertaking of whatsoever nature with whom the Scheme may conclude a medical care plan.

4.16 **"Contribution",** in relation to a Member, the amount, exclusive of interest, paid by or on behalf of the Member as membership fees.

4.17 **"Cost",** in relation to a benefit, the net or final amount payable in respect of a relevant health service.

4.18 **"Council",** the Council for Medical Schemes as contemplated in the Act.

4.19 **"Creditable coverage"** means any period in which a late joiner was -

4.19.1 A member or a dependant of a medical scheme;

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

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

4.19.4 A member or a dependant of the Permanent Force Continuation Fund; or

4.19.5 Covered under the Offshore Health Insurance Policy;

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

4.20 **"Date of Service",**

4.20.1 in the event of a consultation, visit or treatment by a medical practitioner, dentist, chiropractor, homeopath, naturopath, osteopath, herbalist, medical assistant or any other registered practitioner, the date on which each consultation, visit or treatment occurred, whether for the same illness or not.

4.20.2 in the event of an operation, procedure or confinement, the date on which each operation procedure or confinement occurred.

4.20.3 in the event of hospitalisation, the date of each discharge from a hospital or nursing home, or date of cessation of eligibility for benefit, whichever date occurs first.

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

4.21 **"Dependant",**

4.21.1 a Member's Spouse or Partner;

4.21.2 the parent, child, brother, sister or grandchild of the Member or the Member's spouse or partner, in respect of whom the Member is responsible for family care and support;

4.21.3 the immediate niece or nephew of the Member or the Member's spouse or partner, in respect of whom the Member is responsible for family care and support;

4.21.4 in exceptional circumstances (the details of which must be stated) any other dependant of a Member recognised as such by the Board;

Provided that such dependant is not a member or a registered dependant of a member of another medical scheme.

4.22 **"Designated service provider",** a health care provider or group of providers selected by the Scheme as the preferred provider or providers to provide to its Members, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.

4.23 **"Domicilium citandi et executandi",** the Member's chosen physical address at which notices in terms of Rules 11. and 13. as well as legal process, or any action arising therefrom, may be validly delivered and served.

4.24 **"Emergency medical condition",** the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

4.25 **"Employee",** a person in the employment of the Employer.

4.26 **"Employer",** BP SOUTHERN AFRICA (PROPRIETARY) LIMITED and any Associate Employer.

4.27 **"Evidence-based medicine"**, means the conscientious, explicit and judicious use of current best evidence-based medicine in making decisions about the care of Beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence-based medicine for systematic research.

4.28 **"General waiting period"**, a period in which a Beneficiary is not entitled to claim any benefits.

4.29 **"Income",** for the purposes of determining contributions in respect of: -

4.29.1 a Member who is an employee, his salary;

4.29.2 a Member who registers a Spouse or Partner as a Dependant, the higher of Member's or Spouse's or Partner's salary;

4.29.3 a Member who is a Continuation Member, the higher of 50% (fifty per centum) of his total monthly salary as at the date of retirement, or having left the employ of the Employer or on becoming entitled to a deferred pension, escalated from that date at the same rate as the annual increase in pensions of the BP Southern Africa Pension Fund, or the total monthly salary or pension of the Member's Spouse or Partner, if such person is registered with the Scheme and is either employed or retires after that date.

The Board shall have the right to call upon the Member to provide proof of the either the Member's or the Member's Spouse's or Partner's income to the Board's satisfaction. Where income cannot be determined, or the Member fails to provide the required proof within 14 (fourteen) days of receiving a written request to do so contributions shall be deemed to be based on the highest income band then used by the Scheme for such purposes, until proven otherwise.

4.30 "**Late joiner"**, means an applicant or the adult dependant of an applicant who, at the date of application for membership of admission as a Dependant, as the case may be, is 35 years of age or older, but excludes any Beneficiary who enjoyed creditable coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

4.31 **"Managed health care",** means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

4.32 **"Managed health care organisation",** means a person who has contracted with the Scheme in terms of regulation 15A to provide a managed health care service.

4.33 **"Medically necessary",** refers to relevant health services that meet all the following requirements:

- it is required to save life, sustain life or restore function of an affected limb, organ, or system;
- no alternative exists that has a better outcome, is more cost-effective, and has a lower risk;
- it is accepted by the relevant Service Provider-group as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;
- it is not rendered for the convenience of the relevant Beneficiary or Service Provider;

for which outcome studies are available and acceptable to the Scheme as determined by the Clinical Committee established by the Board.

4.34 **"Member",** a person who has been enrolled or admitted as and is still a Member of the Scheme, or who in terms of the Rules of the Scheme is a Member of the Scheme.

4.35 **"Member Family",** the Member and all his registered Dependants.

4.36 **"Mental or Physical Disability",** a mental or physical condition which, in the opinion of the Scheme's medical advisor, renders a Beneficiary unfit to obtain by virtue of a service, employment or a profession, the means, needed to enable him to be self-supporting.

4.37 **"Officer",** means any member of a Board of Trustees, any manager, principal officer, treasurer, clerk or other employee of the Medical Scheme, but does not include the auditor of the Scheme.

4.38 **"Offshore Health Insurance Policy",** the health insurance policy effected by the Employer to cover Employees and their Dependants for medical benefits while on assignment for the Employer outside South Africa.

4.39 **"Participating health care provider",** means a health care provider who, by means of a contract directly between the provider and the Scheme in terms of regulation 15A, or pursuant to an arrangement with a managed health care organization which has contracted with the Scheme in terms of regulation 15A, undertakes to provide a relevant health service to the Beneficiaries of the Scheme.

4.40 **"Partner"** a person with whom the Member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

4.41 **"Pre-authorisation",** the issuing of authorisation to a provider of healthcare services or a Beneficiary, in respect of relevant health services as defined in the Act once such has been certified and validated.

4.42 **"Prescribed Minimum Benefits",** the benefits contemplated in section 29(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of –

4.43.1 the Diagnosis and Treatment Pairs listed in Annexure A of the Regulation, subject to any limitations specified in such Annexure A; and

4.43.2 any emergency medical condition.

4.43 **"Prescribed Minimum Benefit Condition",** a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulation or any emergency medical condition.

4.44 **"Protocol",** a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practise guidelines, standard treatment guidelines,

disease management guidelines, treatment algorithms and clinical pathways.

4.45 **"Registrar",** the Registrar or Deputy Registrar of Medical Schemes appointed under Section 18 of the Act.

4.46 **“Rules",** the Rules of the Scheme and shall include the Annexures and any other provisions relating to the benefits granted or the contributions payable.

4.47 **“Rules–based and clinical management-based programmes”,** a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy and efficiency of health care services, procedures or settings, on the basis of which appropriate managed health care interventions are made.

4.48 **"Salary",** the basic monthly salary, not including any special allowance during the temporary occupancy of an acting appointment, or any bonus, commission, over-time payment, travelling allowance, or cost of living allowance or any other emoluments of any kind whatsoever, or the pensionable portion, as advised by the employer to the Scheme, of the Member’s total cost to employer remuneration package.

4.49 **“Scheme Rate”,** the rate determined by the Board of Trustees at which claims are reimbursed. In respect of claims from Namibian Providers, the Scheme Rate will be the NAMAF tariff.

4.50 **"Spouse",** a person to whom the Member is married in terms of any law or custom.

4.51 **“Validated”,** a process in which the validity of membership, availability of benefits and exclusions and/or limits applicable to relevant health services in respect of a Beneficiary is assessed and confirmed.

5. OBJECTS

The objects of the Scheme are to:

5.1 establish and maintain a fund by contributions, including without limitation those by the Employer, donations or otherwise;

5.2 make provision for the obtaining by Members thereof and by Dependants of such Members, of any relevant health service;

5.3 make provision from such fund for the granting of assistance to Members in defraying expenditure incurred by them or their Dependants in connection with health care treatment as provided for and in accordance with the Rules of the Scheme; and/or

5.4 render a service, contemplated in these Rules, to Members and their Dependants, either by the Scheme itself or by any supplier, or group of suppliers of a service in association with or in terms of an agreement with the Scheme.

6. MEMBERSHIP/ELIGIBILITY

6.1 **Members / Former Members**

Employment or former employment of the Member by the Employer or his/her predecessor or successor in title as defined in these Rules, and is either voluntary or compulsory, depending on the Employee's conditions of employment.

6.2 **Retirees / Continuation Members**

6.2.1 A Member shall, retain his membership of the Scheme in the event of his:

6.2.1.1 service being terminated by the Employer on account of age, ill health or other disability; or

6.2.1.2 employment with the Employer being terminated through resignation, retirement or retrenchment on or after reaching fifty (50) years of age; or

6.2.1.3 his becoming entitled to a deferred pension from the BP Southern Africa Pension Fund; or

6.2.1.4 on reaching the age of fifty (50), after having not less than 10 years continuous service in the employ of the Employer and having resigned or been retrenched from such employment; or

6.2.1.5 on reaching the age of fifty (50) in respect of a Member in terms of Rule 6.4;

Provided that those persons qualifying for continuation membership in accordance with the provisions of 6.2.1.3 or 6.2.1.4 shall be entitled to continue as members upon application, if they leave the employ of the Employer through resignation or retrenchment within 12 months of their turning 50 (fifty) years of age.

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

6.3 **Dependants of Deceased Members**

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

6.3.2 The Scheme shall inform such Dependant of his right to membership and of the contributions payable in respect thereof. Unless such Member informs the Board in writing, of his desire to terminate his membership, he shall automatically continue as a Member.

6.3.3 His membership shall terminate if;

6.3.3.1 he becomes a member or is accepted as a dependant of a member of another registered medical scheme; or

6.3.3.2 he elects in writing not to become a Member.

6.4 **Retrenched Employees**

An Employee who is retrenched from the service of the Employer on or after attaining the age of (40) forty and has at least 5 years continuous service with the Employer at the date of retrenchment will be eligible to continue membership of the Scheme whilst remaining unemployed. On attainment of age (50) fifty, the Member will be entitled to become a Continuation Member in terms of Rule 6.2.1.5.

For the purpose of this Rule, a person will be unemployed if he/she is unable to generate the means needed to be self-supporting through formal employment or self-employment. An affidavit must be submitted on an annual basis as proof of continued unemployment.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of Dependants

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

7.1.1 Birth of infants

Members who elect to register a new-born or adopted child as a Dependant shall notify the Scheme within 30 days of the birth of an infant or adoption, in order to permit the infant's registration as a Dependant. Increased contributions in respect of children shall be due as from the first day of the month following birth or adoption. Benefits shall, nevertheless, accrue as from the date of birth or adoption.

7.1.2 Change in status

Members who after they have joined the Scheme, marry, remarry, are divorced or widowed or who enter into a relationship with a partner or terminate a relationship with such partner and who elect to register and/or withdraw Dependants are required to notify the Scheme within 30 days thereof, and to subscribe at the amended rates from the first day of the month following the change in their conjugal or similar status.

Benefits will, however, be adjusted from the date of such change in status.

Members who fail to take action under this Rule will render themselves liable to forfeiture of all benefits in respect of the changed status until they have given the required notification and paid the applicable contribution.

7.2 **De-registration of Dependants**

7.2.1 A Member shall inform the Scheme within 30 days of the occurrence of any event which results in any one of his Dependants no longer satisfying the conditions in terms of which he may be a Dependant.

7.2.2 When a Dependant ceases to be eligible to be a Dependant, he shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 A minor may become a Member in his own right with the consent of his parent or guardian.

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

8.2.1 of more than one Member of a particular medical Scheme; or

8.2.2 of members of different medical schemes or;

8.2.3 claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member or a dependant of a member.

8.3 Prospective Members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence of age, income, state of his health and the health of his Dependants. The Scheme may require of a applicant to provide it with a medical report in respect of any proposed Beneficiary relating to a condition for which medical advice, diagnosis, care or treatment was recommended or obtained within a period of 12 months immediately prior to the date on which application to the Scheme was made. The cost of any medical tests or examinations necessary to compile such report shall be borne by the Scheme. The Scheme may assign the performance of such tests and/or examinations to a preferred provider. Proof of any prior membership or cover of any other medical scheme must also be submitted.

8.4 On admission the Scheme may impose upon a person in respect of whom an application is made for membership or for registration as a Dependant-

8.4.1 a general waiting period of three months, during which period no insured benefits whatsoever shall accrue, but contributions shall be paid to the Scheme in full;

8.4.2 a condition-specific waiting period of up to 9 months on existing pregnancies in respect of all pregnancy, confinement and related services; and

8.4.3 a condition-specific waiting period of up to 12 months in respect of any condition contemplated in rule 8.3. If both a general waiting period and a condition-specific waiting period are imposed, they will run concurrently, but the provisions of the general waiting period shall predominate. No insured

benefits shall accrue for services in respect of a condition for which a waiting period has been imposed, but contributions shall be paid to the Scheme in full.

The above waiting periods shall not apply to an Employee of the Employer who served on assignment for the Employer outside South Africa and returns to employment with the Employer in South Africa and had continuous coverage with Offshore Health Insurance Policy for the duration of his assignment.

8.5 Subject to Rule 8.7, the general waiting period shall not apply-

8.5.1 to a person who has been a beneficiary of a medical scheme for a continuous period of more than twenty-four months immediately preceding his application and who applies within ninety days of ceasing to be such beneficiary;

8.5.2 to a child Dependant born during his parent's membership of the Scheme;

8.5.3 to a Beneficiary who changes from one benefit option to another;

8.5.4 to a person who was previously a beneficiary of a medical scheme and who applies within ninety days of ceasing to be such beneficiary, to become a Beneficiary of the Scheme because of a change of employment or of his Employer changing medical schemes or terminating its participation in the scheme concerned;

8.5.5 in respect of the prescribed minimum benefits, except where a person has not been a beneficiary of a medical scheme for at least ninety days immediately preceding his application; and

8.5.6 in respect of a Beneficiary who has registered as a participant on the HIV Programme referred to in rule 4.1 of Annexure B.

8.6 Subject to rule 8.7, a condition-specific waiting period shall not apply-

8.6.1 to a person who has been a beneficiary of a medical scheme for a continuous period of at least twenty-four months immediately preceding his application and who applies within ninety days of ceasing to be such beneficiary;

8.6.2 to a child Dependant born during his parent's membership of the Scheme;

8.6.3 to a Beneficiary who changes from one benefit option to another;

8.6.4 to a person who was previously a beneficiary of a medical scheme and who applies within ninety days of ceasing to be such beneficiary, to become a Beneficiary of the Scheme because of a change of employment or of his Employer changing medical schemes or terminating its participation in the scheme concerned;

8.6.5 in respect of the prescribed minimum benefits, except where a person has not been a beneficiary of a medical scheme for at least ninety days immediately preceding his application; and

8.6.6 in respect of a Beneficiary who has registered as a participant on the HIV Programme referred to in rule 4.1 of Annexure B.

8.7 The Scheme may apply the un-expired duration of a waiting period-

8.7.1 imposed on an applicant by a previous medical scheme if such waiting period had not expired at the time of termination from the previous medical scheme; and

8.7.2 where Beneficiaries change from one benefit option to another.

8.8 A Member, other than an Employee for whom it is a condition of employment to be a Member, shall be entitled to terminate membership of the Scheme by giving one month's written notice.

8.9 On re-admission to membership of the Scheme, such Member will be subject to the following waiting periods detailed in Rule 8.4, subject to Rules 8.5 and 8.6 during which no benefit shall accrue to such Member, but contributions shall be paid to the Scheme.

8.10 Should a Member elect not to register his eligible Dependants with the Scheme, such Dependants will, upon future application for registration, be subject to the waiting periods detailed in Rule 8.4, subject to Rules 8.5 and 8.6 during which no benefits will accrue to such Dependants but contributions shall be paid to the Scheme.

8.11 Nothing in these Rules shall be construed as altering in any way the Employer's right to either terminate the service of any Employee who is a Member of the Scheme or to terminate or amend any agreement between the Employer and the Employee in regard to conditions of service.

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

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

9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

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

9.2 An expatriate Employee, who was covered by the Offshore Health Insurance Policy for medical benefits during his term of expatriation and returns to South Africa, will be entitled to membership of the Scheme. Such Members and their Dependants will be readmitted to the Scheme without waiting periods or late joiner penalties. (This includes Dependants born outside of RSA).

10. MEMBERSHIP CARD

10.1 Every Member shall be given a membership card containing such particulars, as may be prescribed which he must exhibit to the supplier of

services when required to do so. This card remains the property of the Scheme and must be returned to the Scheme on cessation of membership.

10.2 The utilisation of a membership card by any person other than the Member or his registered Dependants, with the knowledge or consent of the Member

or his Dependants, is not permitted and shall be construed as an abuse of the benefits of the Scheme.

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

11. CHANGE OF ADDRESS OF MEMBERS

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

12. TERMINATION OF MEMBERSHIP

12.1 A Member for whom it is a condition of employment shall not be permitted to withdraw his membership. A Member for whom membership is voluntary may terminate membership on giving one month's written notice;

Provided that: -

a Member who is transferred to a company of the BP Group which is not an Associate Employer may cease to be a Member, without prejudice to his right to reinstatement on his return to the employ of an Associate Employer and also without prejudice to the continued entitlement to benefits of his Dependants who continue to reside in the area in which the Employer operates.

12.2 Except as otherwise herein provided, a Member who leaves the service of the Employer for any reason shall on the date of cessation of service, cease to be a Member, and all rights of participation in the benefits under

these Rules in respect of himself and his Dependants shall thereupon cease, except for claims in respect of services rendered prior to cessation of membership.

12.3 **Death**

Membership of a Member terminates at the end of the month of his death. With effect from the first day of the month next following the date of death, the Member's Spouse or Partner shall become the principal Member and if there is no Spouse, the eldest child shall become the principal Member. The effective date of the commencement of contributions in respect of the Dependants shall be the first day of the month next following the date of death of the Member.

12.4 **Failure to pay amounts due to the Scheme**

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

12.5 **Abuse of privileges, false claims, misrepresentation, and non-disclosure of factual information**

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

13. CONTRIBUTIONS

13.1 The total monthly contributions, payable to the Scheme by or in respect of a Member are as stipulated in Annexure A.

13.2 Contributions are calculated on the basis of the income of a Member or Spouse or Partner, whichever is the highest, and according to the number of Dependants as defined in these Rules.

13.3 Contributions shall be paid monthly in arrears and be payable by not later than the 3rd day of the following month. Where contributions or any other debt owing to the Scheme have not been paid within 30 days of the due date, the Scheme shall have the right:

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

13.3.2 to give the Member/Employer written notice at his domicilium citandi et executandi that if contributions or such other debts are not paid up to date within 10 days of posting of such notice membership may be cancelled. Such notice may be given by means of registered post.

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

13.4 In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with Rule 13.3.2, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses

associated with the default and to recover interest on the arrear amount at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the Member from the date of default and any such benefit paid will be recovered by the Scheme.

13.5 If an applicant is admitted as a beneficiary on or before the fifteenth day of the month, his/her first contribution shall be calculated as from the first day of the month in which he/she was admitted. If an applicant is admitted as a beneficiary after the fifteenth day of any month, his/her first contribution shall be payable from the first day of the month following his admission to the Scheme.

13.6 No refund or any portion of a contribution shall be due to any Member or other persons where such Member's membership or the registration of any of his Dependants terminates during the course of a month.

14. LIABILITY OF EMPLOYER AND MEMBERS

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

14.2 The liability of a Member shall be limited to the amount of his unpaid Contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his Dependants, which is liable to be repaid, and which has not been repaid by him to the Scheme.

14.3 In the event of any Member ceasing to be a Member, any amount owing by such former Member shall be a debt due to the Scheme and recoverable by it.

15. CLAIMS PROCEDURE

15.1 Every claim, submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, shall be accompanied by an account or statement, which shall comply with the provisions of the Act. Such a claim shall be accompanied by an account or statement setting out the following particulars:

a. the surname and initials of the Member;
b. the surname and first name and other initials (if any) of the patient;
c. the name of the Scheme
d. the membership number of the Member;
e. the practice code number, (if applicable) of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;
f. the date on which each service was rendered;
g. the nature and cost of each service rendered, including the item code number that relates to such service (if applicable), and where the supplier of service supplied medicine to the Member concerned or to a Dependant of that Member, the name, quantity, dosage and nett amount payable in respect of the medicine;
h. where a pharmacist supplies medicine according to a prescription to a Member or to a Dependant of a Member, a copy of the original prescription or a certified copy of such prescription ;
i. the name and practice code number of the referring medical practitioner or dentist;
j. where mention is made in such account or statement of the use of a theatre where an operation was performed on the Member or a Dependant of that Member: -
    (i) the name and practice code number of the medical practitioner or dentist who performed that operation;
    (ii) the name or names and the practice code number of every medical practitioner or dentist who assisted at that operation;
    (iii) all procedures carried out; and

(iv) the identity numbers of the Members and/or Dependants concerned.

k. where pre-authorisation has been obtained for the procedure or treatment, the pre-authorisation number issued by the Scheme's designated agent.

l. in the case of a first account or statement in respect of orthodontic treatment, a treatment plan indicating -

(i) the expected total amount the orthodontist will charge for the treatment;

(ii) the expected duration of the treatment;

(iii) the initial amount the Member has to pay; and

(iv) the monthly amount the Member has to pay.

15.2 If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme, shall in addition to the payment contemplated in Section 59(2) of the Act, dispatch to the Member a statement containing all the following particulars as prescribed: -

(a) the name and membership number of the Member;

(b) the name of the supplier of the service;

(c) the final date of service rendered by the supplier of the service on the account or statement which is covered by the payment;

(d) the total amount charged for the service concerned; and

(e) the amount of the benefit awarded for such service.

15.3 In order to qualify for benefits, any claim by a Member shall, unless otherwise arranged, be signed and certified as correct and shall be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

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

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

15.6 Notwithstanding the provisions of this Rule, where the Scheme is of the opinion that a claim is incorrect or unacceptable for payment, the Scheme shall notify the Member and the health care provider, where applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such a claim is incorrect or unacceptable. Such Member or provider must return such corrected claim within 60 days of the notice.

15.7 Claims for services rendered outside the Rand monetary area must be submitted as hereinbefore, together with receipted accounts. Such claims shall bear a detailed description, in English, of each service rendered. Benefits on such claims shall be calculated as if the services had been rendered in the Republic of South Africa at the Scheme rate.

16. BENEFITS PAYABLE

16.1 Subject to the limitations imposed by these Rules, Members shall be entitled to benefits as detailed in Annexure B and Appendix 1 hereto and such benefits shall extend through the Member to his Dependants;

PROVIDED THAT: -
such benefits shall only accrue from the date of admission;

AND PROVIDED FURTHER THAT: -
the benefit paid in terms of said Annexure B and Appendix 1 shall never exceed the amount actually charged for the service or supply in question.

16.2 The Board shall have the right, notwithstanding the provisions of Rules 12.4 and 13.3, to withdraw or refuse payment of benefits to Members whose contributions are more than one month in arrear, and where accounts have been paid in accordance with Rule 17. such a Member shall be held liable for the full amount.

16.3 The Scheme shall pay any benefit due to a Member within 30 days of receipt of the claim pertaining to such benefit. As set out in Rule 15.7, resigned members residing outside the Rand monetary area will forfeit credit amounts less that R350.

16.4 The Scheme covers in full the services rendered in respect of the prescribed minimum benefits in accordance with Appendix 1.

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

16.6 Benefits are not transferable from one financial year to another or from one category to another.

17. PAYMENT OF ACCOUNTS

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

17.2 Any discount whether on an individual basis or bulk discount received in respect of a relevant health service shall be for the benefit of the Member in determining the net amount payable for the service and appropriate deduction from the applicable benefit limit.

17.3 The Scheme may, by mutual agreement with any supplier or group of suppliers of a service, pay the account or the benefit to which the Member is entitled in respect of a service rendered, direct to such supplier.

17.4 Where the Scheme has paid an account or portion of an account, or any benefit to which a Member is not entitled, whether payment is made to the Member or to the supplier of a service, the amount of any such overpayment shall be recoverable by the Scheme.

17.5 The Scheme shall have the right, notwithstanding the provisions of Rule 17.3 or Rule 17.4 above to pay the benefit direct to the Member.

18. GOVERNANCE

18.1 The affairs of the Scheme shall be managed according to the Rules by a Board consisting of seven (7) persons who are fit and proper to be Trustees, of whom:

18.1.1 three (3) persons shall be appointed by the Employer, for the period running from the close of one Annual General Meeting to the close of the next succeeding Annual General Meeting, as provided in 18.2;

18.1.2 three (3) persons must be elected by Members from amongst Members, as contemplated in 18.6;

18.1.3 one (1) who must be a Member of the Scheme, shall be elected for a term of 3 (three) years, running from the close of one Annual General Meeting to the close of the third Annual General Meeting thereafter, by the Trade Union(s) represented in the National Bargaining Forum or its equivalent, which is recognized by the Employer, as representing those of its Employees who are trade union members. Such person's name shall be advised by the Trade Union(s) concerned in the manner contemplated in 18.2.

18.2 The names of the Employer-appointed Trustees shall be advised by the Employer to the Principal Officer in writing not later than 30 days prior to the Annual General Meeting of each year. The name of the Trade Union-appointed Trustee shall be advised to the Principal Officer in writing not later than 30 days prior to the relevant Annual General Meeting.

18.3 Member-elected Trustees shall hold office for a period of three years, except for one Trustee, determined by agreement between them and failing such agreement by lot, who will not retire at the 2005 Annual General Meeting, but who will serve for a period of 4 years to the close of the Annual General Meeting in 2006. Provided that elections for the vacant position(s) of Trustees shall be held in each year thereafter on the basis that the Trustee who has been, or Trustees who have been, in office for three years shall retire.

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

18.4.1 a person under the age of 21 years;

18.4.2 a director, employee, partner, officer, consultant, contractor, representative or agent of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;

18.4.3 a broker;

18.4.4 the Principal Officer of the Scheme; and

18.4.5 the auditor of the Scheme;

18.5 Retiring Members of the Board are eligible for re-election.

18.6 In an election year names of candidates for election or re-election as Trustees, shall be submitted (signed by proposers and seconders and endorsed with the candidate's agreement to stand for election) to reach the Principal Officer at least 60 (sixty) days before the Annual General Meeting of the Scheme. The election of these candidates shall, if there be more than the required number of Trustee positions falling vacant be by majority vote of all the Members voting by ballot under arrangements made by the Board.

18.7 The names of candidates elected and/or appointed shall be announced at the Annual General Meeting.

18.8 Any casual vacancy that occurs during any term of office of the Board shall be filled for the remainder of that term as follows –

18.8.1 by the Employer, in the case of an Employer-appointed Trustee;

18.8.2 by the Trade Union(s), in the case of the Trade Union-appointed Trustee elected by that forum; and

18.8.3 by the Board, in the case of Member-elected Trustees from the list of previous candidates who are willing to serve as Trustees, failing which, by way of special election following the procedure laid down in rule 18.6, provided that where such a vacancy occurs within three months of the end of term of office for any such Trustee(s) leaving such vacancy the Board shall not be obliged to fill such vacancy.

18.9 The Board may co-opt such knowledgeable persons for such purposes and periods as it thinks fit to assist it in its deliberations provided that such persons shall not have a vote.

18.10 The quorum for Board Meetings shall be 4 members of the Board. In exceptional circumstances, relating to the Society's compliance with statutory obligations, or as determined by the Board, and provided that a meeting has been duly convened, and that it is likely that a quorum may not be present, the Chairman, acting on the recommendation of the Principal Officer, may arrange a video link for such person/s who cannot be present in order to establish a quorum for that purpose.

18.11 The Board shall at the first meeting after the Annual General Meeting elect from its number the Chairman and Vice-Chairman of the Scheme. The persons so elected shall hold office for one year to coincide with the next Annual General Meeting and shall be eligible for re-election during their period of office as Trustees.

18.12 The Chairman shall preside at all meetings of the Board. In the absence of the Chairman and Vice-Chairman from any meeting, the other members of the Board shall elect one of their number to act in his stead for that meeting.

18.13 Except as otherwise provided herein, matters coming before the Board shall be decided by a majority vote.

18.14 A member of the Board may at any time tender his written resignation from office to the Board.

18.15 A member of the Board shall cease to hold office if:

18.15.1 he is declared insane or incapable of managing his affairs;

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

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

18.15.4 he is removed by the Court from any office of trust on account of misconduct;

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

18.15.6 he ceases to be an appointee by the Employer or the Trade Union(s), whichever is applicable, or being a Member-elected Trustee, he ceases to be a Member of the Scheme;

18.15 .7 he absents himself from two consecutive meetings of the Board without the prior written permission of the Chairman; or

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

18.15.9 the provisions of Rules 18.15.1 to 18.15.5 apply *mutatis mutandis* to the Principal Officer.

18.16 The Board shall meet at least once a quarter, or at such intervals as it may deem necessary; each meeting being convened by the Principal Officer.

18.17 The Chairman may, however, convene a special meeting should the necessity arise. Any two members of the Board may request the Chairman to convene a special meeting of the Board to discuss matters stated in the request and the Chairman shall, within the next seven days, convene the requested special meeting.

18.18 Notwithstanding any vacancy on the Board, the continuing members thereof may act on its behalf PROVIDED HOWEVER that if and so long as their number is reduced below three the continuing members may act for the purpose of restoring the number of Member-elected Trustees of the Board

to three or for summoning a general meeting of the Scheme and for requesting action in terms of Rule 18.8 but for no other purpose.

18.19 Members of the Board and officers of the Scheme shall not be entitled to any remuneration, honorarium or any other fee in respect of services rendered in their capacity as members of the Board or officers, save as decided/agreed by the Board of Trustees from time to time. Any remuneration paid to members of the Board shall be disclosed to Members at the next Annual General Meeting.

18.20. A resolution of the Board set forth in writing and signed as approved by a quorum of the members of the Board shall be as valid as if it had been passed at a meeting of the Board. Such a resolution, whether the resolution be passed or not:

18.20.1 shall be noted at the next meeting of the Board;

18.20.2 shall be preserved among the minutes of the meetings of the Board; and

18.20.3 shall include a resolution approved by means of electronic mail, provided that the Trustee approving the resolution is clearly identified.

18.21 A member of the Board who acts in a manner which is seriously prejudicial to the interest of Beneficiaries of the Scheme may be removed by the Board, provided that:

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

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

18.21.3 the member shall have recourse to the disputes procedures of the Scheme or complaints and appeal procedures provided for in the Act.

19. DUTIES OF THE BOARD OF TRUSTEES

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

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

19.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.

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

19.5 The Board shall appoint a Principal Officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the Principal Officer and of any person employed by the Scheme. The following persons are not eligible to be the Principal Officer:

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

19.5.2 a broker.

19.6 The Chairman shall preside over and ensure the due and proper conduct of, meetings, and to see that the Rules are properly applied.

19.7 The Board shall cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper working of the Scheme. The books of account shall be made up at the end of each financial year and shall be audited by the auditor of the Scheme.

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

19.9 The Board must ensure that adequate and appropriate information is communicated to the Members regarding their rights, benefits, contributions and duties in terms of the Rules.

19.10 The Board must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and the Rules.

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

19.12 The Board must obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.

19.13 The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.

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

19.15 The Board must approve all disbursements.

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

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

19.18 The Board shall cause the proceedings of all meetings to be properly minuted, which minutes shall be laid before the next meeting and, when accepted as correct, shall be confirmed by the Chairman.

19.19 The Board shall, at least once in every six months, render to the Employer a report on the financial position of the Scheme.

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

20. POWERS OF THE BOARD

The Board shall have the power:

20.1 to appoint and cause the termination of the services of any employee of the Scheme.

20.2 to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations.

20.3 to appoint committees consisting of such of its members and other experts as it may appoint and to delegate any of its powers to such committees.

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

20.5 to appoint consultants to the Scheme at fees to be determined by the Board;

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

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

20.8 to let or hire movable or immovable property;

20.9 to grant loans secured by first mortgage bonds over immovable property, by way of investment of its funds, PROVIDED HOWEVER, that the loan secured by any such mortgage bond shall in no case exceed 75% of the sworn appraised value of such immovable property;

20.10 in respect of any monies not immediately required to meet current charges upon the Scheme, to lend, invest, put out on interest, place on deposit, make advances or otherwise deal with such monies upon such securities and in such manner as the Board may from time to time determine and realise, vary, reinvest or otherwise deal with such securities as it may from time to time determine;

20.11 with the prior approval of the Council, to borrow money on current account from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

20.12 subject to the provisions of the law, to cause the Scheme, whether on its own or in association with any person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the Members of the Scheme;

20.13 to donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the Members;

20.14 to grant loans (which shall not exceed such maximum amount as may be determined by the Board in its discretion from time to time in respect of any one Member and his registered Dependants at any one time except to the extent that such limitation is inconsistent with the Scheme's obligations under the Act or to the extent that the Board may permit) in respect of the difference between the accounts of a supplier and the benefit due in respect of that account. Every such loan shall bear such interest (if any) as the Board may determine from time to time and shall be repayable in such manner, as the Board shall direct. Loans so granted shall be advanced by the Scheme paying the concerned creditors in full;

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

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

20.17 to authorise the Principal Officer, and/or such members of the Board, from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;

20.18 from time to time, subject to such Rules or instructions as it may determine to entrust to or confer upon the Principal Officer such of the powers and authorities vested in it as it may think fit, and may from time to time revoke or vary all or any of such powers and authorities;

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

20.20 to in its absolute discretion, make 'ex gratia' payments to providers of a service or an "ex gratia" award to the Member provided it is satisfied that undue hardship would otherwise be imposed upon a Member, but shall not authorise payment for services other than those provided for in these Rules;

20.21 in general to do anything which it deems necessary or expedient to perform its functions on any matters not specifically covered by these Rules at the Board’s discretion, PROVIDED THAT any such action or decision of the Board shall not be inconsistent with the objects of the Scheme and in accordance with the provisions of the Act.

21. DUTIES OF SCHEME'S OFFICERS

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

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

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

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

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

21.2.4 he keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;

21.2.5 he keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of section 57(6) of the Act;

21.2.6 he does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.

21.3 The Principal Officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.

21.4 The Principal Officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall

attend all meetings of the Board, and any other duly appointed committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.

21.5 The Principal Officer shall be responsible for the supervision of the employees employed by the Scheme unless the Board decides otherwise.

21.6 The Principal Officer shall keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.

21.7 The Principal Officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

22. INDEMNIFICATION AND FIDELITY GUARANTEE

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

22.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud on the part of any members of the Board, the Principal Officer or clerical staff engaged on the business of the Scheme.

23. FINANCIAL YEAR OF THE SCHEME

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

24. BANKING ACCOUNT

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

25. AUDITOR AND AUDIT COMMITTEE

25.1 Subject to section 36 of the Act, an auditor who is in public practice shall be appointed at each annual general meeting to hold office from the conclusion of that meeting until the conclusion of the next annual general meeting.

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

25.2.1 a member of the Board;

25.2.2 an employee, officer or contractor of the Scheme;

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

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

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

25.3 Where the post of auditor becomes vacant during the year the Board shall, within 30 days, appoint another auditor to fill the vacancy for the unexpired period.

25.4 Where at an annual general meeting no auditor is appointed or re-appointed, the Board shall, within 30 days as from the date of the meeting, appoint an auditor to fill the vacancy, and if it fails to do so, the Registrar may at any time do so.

25.5 The auditor of the Scheme shall have a right of access at all times to the books and accounts and vouchers of the Scheme, and shall be entitled to require from the officers of the Scheme such information and explanations as he thinks necessary for the performance of his duties.

25.6 The auditor shall make a report to the Members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme at the annual general meeting.

25.7 The Board must appoint an audit committee of at least 5 members of whom at least 2 must be members of the Board. The majority of the members of such committee, including the chairperson, shall be persons who are not

officers of the Scheme or the administrator of the Scheme, the controlling company of the administrator or any subsidiary of it's controlling company.

26. GENERAL MEETINGS (only Members of the Scheme may constitute a quorum and vote at such meetings)

26.1 Annual General Meeting

26.1.1 The annual general meeting of Members shall be held in JOHANNESBURG or at such other venue as determined by the Board not later than the 30th of June of each year for the transaction of ordinary business and any special business of which due notice has been received by the Principal Officer at least 7 days prior to the annual general meeting.

26.1.2 The notice convening the annual general meeting containing the agenda and accompanied by the Board's report and the audited financial statements shall be despatched to all Members at least 21 days before the date of the meeting. The non-receipt of such notice by a Member shall not, however, invalidate the proceedings at such a meeting.

26.1.3 Fifteen Members of the Scheme, physically present shall form a quorum. If a quorum is not present after the lapse of half an hour from the time fixed for the commencement of the meeting, the meeting shall be postponed by one hour and the Members then present shall form a quorum.

26.1.4 Annual audited financial statements together with a copy of the Board's report shall be laid before the meeting.

26.2 **Special General Meeting**

26.2.1 Special General Meeting – Board's Requisition

A special general meeting of Members may be called at any time by the Board giving at least 14 days notice to all Members. The provisions of Rule 26.1.3 shall apply to the quorum at such a meeting.

26.2.2 Special General Meeting - Members' Requisition

On receipt by the Principal Officer of a requisition signed by not less than twenty four Members calling upon the Board to convene a special general meeting and noting the objects for which it is required, the Board shall convene such a meeting by giving not less than 21 days notice in writing to all Members of the Scheme, the meeting to be held within 30 (thirty) days of receipt of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitioners and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

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

26.2.4 In the event of the Board having failed to convene a special general meeting within the specified time, the requisitioners may themselves convene such a meeting by giving similar written notice to all Members of the Scheme. Any resolution

carried at a meeting convened under this Rule shall be put to ballot under Rule 27.5.

26.2.5 Twenty-four Members of the Scheme physically present shall form a quorum. If a quorum is not present after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.

27. VOTING AT GENERAL MEETINGS

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

27.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the Member and the person appointed as the proxy and delivered to the Principal Officer not later than 24 hours before the scheduled start of the meeting, in original form or by fax.

27.3 The Chairman shall determine whether voting shall be by ballot or by a show of hands, PROVIDED HOWEVER that where the Members are called upon to vote on any matter which affects the rate of contribution, or the nature or extent of benefit, the voting shall be by ballot. In the event of the votes at such a meeting being equal, the Chairman shall if he is a Member of the Scheme have a casting, in addition to a deliberative, vote. Subject to Rule 26.2.3 a resolution so adopted shall be binding on all the Members.

27.4 Minutes

The Board shall cause the proceedings of all general meetings to be properly minuted. The minutes of an annual general meeting shall be laid

before the next annual general meeting and those of a special general meeting shall be laid before the next annual general meeting or, as the Board may decide, before any other special general meeting held before that annual general meeting. All minutes, when accepted as correct, shall be confirmed by the Chairman.

27.5 Ballots

27.5.1 A general ballot shall be taken in the circumstances and the manner set out in these Rules and at such other times as the Board thinks fit.

27.5.2 Blank ballot papers will be issued to all Members by the Principal Officer to whom they must be returned completed within one month of date of issue. If half or more of the duly completed papers register votes against the proposal put to ballot that proposal shall be rejected.

28. SETTLEMENT OF COMPLAINTS AND DISPUTES

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

28.2 All complaints received in writing will be responded to by the Scheme in writing within 30 (thirty) days of receipt thereof. In the event of such response not having led to the resolution of a complaint, the Member shall have the right to request that the complaint either be referred to the Board, or the disputes committee for a decision. If the decision of the Board does not lead to the resolution of the complaint the Member may then elect to refer the matter to the disputes committee. Any referral of the complaint to either the Board, or the disputes committee, shall be made within 30 (thirty)

days of the date of the written response by the Scheme, notifying the Member of the outcome of the Scheme's decision, whether such decision was made by the Principal Officer, or the Administrator or the Board.

28.3 A disputes committee consisting of three members, who may not be members of the Board as defined in the Rules, or the Principal Officer or any other officer of the Scheme as defined in the Act, or of the administrator, shall be appointed annually by the Board.

28.4 The appointment of the disputes committee shall be announced at the annual general meeting.

28.5 Any dispute, which may arise between a Member, prospective Member or a person claiming by virtue of such Member, and the Scheme or an officer of the Scheme shall be referred in writing to the Principal Officer for submission to the disputes committee for review.

28.6 On receipt of a dispute in terms of this rule, the Principal Officer shall convene a meeting of the disputes committee as soon as is reasonably possible after having received the written complaint. A quorum for any meeting of the disputes committee shall consist of three members.

28.7 The meeting shall be convened by giving not less than 21 (twenty one) days written notice to the complainant and all the members of the disputes committee, stating the particulars of the dispute; as well as the date and time of the meeting.

28.8 The venue for the meeting shall be the registered address of the Scheme, or any other venue deemed agreed to be more appropriate by all the members of the disputes committee.

28.9 Should the complainant elect to be represented by a representative, the complainant is required to inform the Principal Officer of his/her

representative's qualifications at least 5 (five) working days prior to the meeting.

28.10 The disputes committee shall determine if the parties to the dispute will meet in person or if the parties can be linked via teleconference and/or video conference.

28.11 Should all parties be required to meet in person, the Scheme will pay travel costs to the value of R2 500.00 for both the complainant and his/her representative as well as one night's reasonable accommodation costs for the complainant and his/her representative. The accommodation costs will be paid at the lesser of rates quoted by the Scheme's travel agents and the claim for costs.

28.12 The disputes committee may determine the procedure to be followed, which, without limiting the generality hereof, shall allow for the following:

28.12.1 the disputes committee to appoint its own Chairperson to preside at the hearing of any dispute;

28.12.2 the parties to the dispute have the right to be heard before the disputes committee either in person or through a representative. Only one person (either the complainant or the representative) is permitted to present evidence. The complainant is permitted to confer with his/her representative;

28.12.3 the parties to the dispute may seek legal advice at their own cost;

28.12.4 all proceedings will be conducted in English. Where the complainant's chosen language is not English, the Scheme may pay for the cost of a translation service;

28.12.5 the limitation of the evidence placed before such disputes committee to that which was placed in writing before the Principal Officer by the parties to the dispute, either at the time that the dispute was referred to the Principal Officer, or not later than 5 (five) working days before the time set for the hearing of the dispute;

28.12.6 the parties to the dispute then being entitled to receive copies of any evidence which they may not have received relating to the facts of the dispute not later than 3 (three) working days before the time set for the hearing of the dispute;

28.12.7 where a recording of any proceedings has given rise to a factual dispute, a party shall be entitled to receive a certified copy of the transcript detailing the relevant part of that recorded proceeding, provided that this shall be at the written request of such party who shall be required to pay for the estimated cost of providing such transcript at the time that the request is made;

28.12.8 the decision of the disputes committee being made as expeditiously as possible after the conclusion of the hearing of the dispute, provided that if there are any delays in such decision being made the parties to the dispute shall be kept informed of progress and the reasons for any possible delay(s);

28.12.9 the parties to the dispute to receive written notification of the decision of the disputes committee containing the reasons for such decision within 10 (ten) working days of it having been made.

28.13 The decision of the disputes committee shall be binding on the parties concerned; PROVIDED however that it may be made the subject of an

appeal to the Council for Medical Schemes against the decision of the disputes committee, in terms of chapter 5 of the Regulations to the Act.

28.14 Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than 3 (three) months after the date on which the decision concerned was made. or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.

28.15 The operation of any decision which is the subject of any appeal under rule 28 shall be suspended pending the decision of the Council on such appeal.

29. TERMINATION OR DISSOLUTION

29.1 The Scheme shall be dissolved only by order of a competent court or by a decision of Members as provided for in 29.3.

29.2 In the event of the dissolution of the Scheme in pursuance of an order of Court, the winding up of the Scheme shall be effected in accordance with the conditions contained in the order and as provided in the Act.

29.3 If the Members present at a general meeting are of the opinion that the Scheme should be dissolved, the Principal Officer shall upon direction by the Board despatch to every Member by registered post a memorandum containing the reasons for such a step, together with a ballot paper, PROVIDED THAT the memorandum and ballot paper shall before despatch be forwarded to the Registrar for comment. Every Member shall be requested to return his ballot paper duly completed before a fixed date. If at least 50 % (fifty per cent) of the Members return their ballot papers duly completed and if the majority thereof are in favour of the dissolution of the Scheme the Board shall take a formal decision that the Scheme shall be dissolved with effect from a fixed date from which date no further contributions shall be payable to the Scheme. If two successive attempts to

obtain a return of at least fifty per cent of the ballot papers fail, the Board shall refer the matter to the Registrar who may prescribe a lower percentage.

29.4 If a decision to dissolve the Scheme has been taken in terms of Rule 29.3 the dissolution shall be effected in accordance with the memorandum and as provided for in the Act. For this purpose the Board shall appoint, in consultation with the Registrar, a competent person as liquidator.

30. AMALGAMATIONS / TRANSFERS

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

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

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

31. PERUSAL OF DOCUMENTS

31.1 Any Beneficiary shall on request be supplied by the Scheme free of charge with a copy of the Rules, latest audited financial statements, returns, Board report, auditors report, management accounts, together with the agenda for the annual general meeting or, any other such information as may be prescribed by law.

31.2 Additional copies of the documents mentioned in Rule 31.1 shall be supplied by the Scheme on application and payment of a charge of R5.00 per copy.

31.3 A Beneficiary shall be entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 31.1 and to make extracts there from.

31.4 Any person who is entitled to access to information shall apply to the Scheme and may obtain such information in compliance with the Promotion of Access to Information Act.

32. AMENDMENT OF RULES

32.1 Unless otherwise provided for in the Rules, the Board shall be entitled to alter or rescind any Rule or Annexure or to make any addition to the Rules or Annexure.

PROVIDED THAT: -

32.1.1 No alteration, rescission or addition which;

32.1.1.1 affects the objects of the Scheme or decreases the extent of any benefit by more than 15% during any financial year; and

32.1.1.2 is not one made mandatory by any legislative act or directive issued by the Registrar or other authority competent in that behalf shall be valid unless it has been approved by a majority of Members present in person or by proxy at a general meeting or by ballot arranged in the manner prescribed by Rule 27.5.

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

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

32.3 Notwithstanding the provisions of Rule 32.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any Rule that is inconsistent with the provisions of the Act.

32.4 Any amendment to the Rules relating to benefits shall operate in respect of expenses incurred after the coming into effect of the amendment. Benefits on other expenses shall be paid according to the Rules as they stood at the date of service.

Appendix 1

PRESCRIBED MINIMUM BENEFITS (PMB'S).

1. DEFINITIONS

"Prescribed minimum benefits", the benefits contemplated in section 29(1)(o) of the Act and consist of the provision of the diagnosis, treatment and care costs of —

(a) the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and

(b) any emergency medical condition. (Regulation 7).

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

2. DESIGNATION OF SERVICE PROVIDERS

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

2.1 Clicks and Dis-Chem (for the provision of medication)

2.2 Mediclinic and Life Healthcare hospitals (for hospitalisation)

2.3 State/Public Hospital Facilities

2.4 BPMAS GP Network

2.5 Netcare 911 (for emergency transportation services)

2.6 Independent Clinical Oncology Network (ICON) (for oncology treatment)

2.7 BPMAS Specialist Network

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

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

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

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

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

4.1 In respect of private hospital accommodation, 10% of the actual cost incurred.

4.2 In respect of General Practitioner Consultations and Services, the difference between the actual cost incurred and 80% of the Scheme Rate for these services.

4.3 In respect of all other services, the difference between the actual cost incurred and the benefit payable in terms of the Scheme rules.

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

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

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

5.2.1 the service was not available from the designated service provider or could not be provided without unreasonable delay;

5.2.2 immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a designated service provider; or

5.2.3 in respect of hospital accommodation, there was no designated service provider within 25 kilometers of the Beneficiary's ordinary place of personal residence; or

5.2.4 in respect of other services, there was no designated service provider within a reasonable distance from the Beneficiary's ordinary place of personal residence.

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

6. MEDICATION

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

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

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

6.2 Where a prescribed minimum benefit includes medication, and the formulary includes medication that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a Beneficiary, and that Beneficiary knowingly declines the formulary medicine and opts to use another medicine instead, the member will be liable for 25% of the cost.

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

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

8. DIAGNOSTIC TESTS FOR AN UNCONFIRMED PMB DIAGNOSIS

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

9. CHRONIC CONDITIONS

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

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

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy disease
7. Chronic renal disease
8. Coronary artery disease
9. Chronic obstructive pulmonary disorder
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus type 1&2
13. Dysrhythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. Hyperlipidaemia
18. Hypertension
19. Hypothyroidism
20. Multiple sclerosis
21. Parkinson's disease
22. Rheumatoid arthritis
23. Schizophrenia
24. Systemic lupus erythematosus
25. Ulcerative colitis

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

BP MEDICAL AID SOCIETY
CONTRIBUTIONS AND LATE JOINER PENALTIES

1. PREAMBLE

The Society provides cover to the Employees and retirees of the Employer, and to their registered Dependants. The total monthly contributions payable by or in respect of a Member in accordance with the provisions of Rule 13. shall be as indicated in this Annexure identified as Annexure A.

2. CONTRIBUTIONS FOR THE PERIOD 1 APRIL 2015 TO 31 MARCH 2016

INCOME BANDS	MEMBER RATE	ADULT RATE	CHILD RATE
0 – 1 070	339	240	81
1 071 – 2 630	1 043	737	270
2 631 – 2 810	1 448	1 035	371
2 811 – 3 530	1 654	1 170	422
3 531 – 4 370	1 928	1 337	477
4 371 – 6 580	2 055	1 404	502
6 581 – 8 590	2 209	1 519	548
8 591 – 10 810	2 381	1 666	586
10 811 – 13 100	2 527	1 778	629
13 101 – 17 320	2 686	1 911	653
17 321 – 26 140	2 808	1 988	697
26 141 – 37 070	2 912	2 055	724
37 071 – 45 590	3 014	2 126	753
45 591 – 54 410	3 114	2 190	784
54 411	3 220	2 264	815

3. CONTRIBUTIONS FOR THE PERIOD 1 APRIL 2016 TO 31 MARCH 2017

INCOME BANDS	MEMBER RATE	ADULT RATE	CHILD RATE
0 – 1 130	368	261	88
1 131 – 2 780	1 132	800	293
2 781 – 2 970	1 572	1 123	403
R2 971 - R3 740	1 795	1 270	458
R3 741 - R4 630	2 092	1 451	518
R4 631 - R6 970	2 230	1 524	545
R6 971 - R9 100	2 397	1 649	595
R9 101 - R11 450	2 584	1 808	636
R11 451 - R13 880	2 742	1 930	683
R13 881 - R18 360	2 915	2 074	709
R18 361 - R27 700	3 047	2 157	757
R27 701 - R39 290	3 160	2 230	786
R39 291 - R48 320	3 271	2 307	818
R48 321 - R57 670	3 379	2 377	851
R57 671 +	3 494	2 457	885

3.1 The adult rate applies to the Spouse(s) and Partner(s) of a Member; and any other Dependant(s) of the Member aged 27 years and older other than a Dependant suffering from a mental or physical disability.

3.2 The child rate applies to a brother(s) or sister(s) of the Member; grandchildren of the Member and any other Dependant(s) of the Member under age 27 years; including a Dependant suffering from a permanent mental or physical disability.

3.3 Contribution rates for child dependants are only levied on the first three children.

3.4 The above contribution table reflects the total contributions payable to the Scheme by and/or in respect of Members.

LATE JOINER PENALTIES (Contribution penalties for persons joining late in life)

4.1 A late joiner is a new Member or a Dependant who is 35 years of age or older when he/she joins the Scheme and who has not enjoyed creditable coverage after the age of 35 years as provided for in Rule 4.19. However, the following people will not be regarded as late joiners:

4.1.1 if a person enjoyed coverage with one or more medical schemes before 1 April 2001 without a break in cover of more than three consecutive months since 1 April 2001, or

4.1.2 if the effective date of commencement of an Employee's membership of the Scheme coincides with the date of commencement of employment with the Employer. This exemption will also apply to the Spouse, Partner and/or Child of the Member, provided that the effective date of the commencement of the Dependant's membership of the Scheme coincides with the date of the Member's commencement of employment or the date on which the Dependant first becomes eligible to join the Scheme, whichever is the later date.

4.2 Premium penalties in addition to the contributions detailed in this Annexure A may be applied in respect of late joiners as determined by the Board. Such penalties shall be applied only to that portion of the contribution relative to the late joiner and shall not exceed the following bands:

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

The following formula shall be applied to determine the applicable penalty band:

A = B minus (35 plus C)

Where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of application

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

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

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

BP MEDICAL AID SOCIETY

ANNEXURE B

CONDITIONS RELATING TO GRANTING AND PAYMENT OF BENEFITS

EXPLANATORY NOTE

1. Members and their registered dependants, whose contributions have been paid and are not subject to any suspension of benefits in terms of the Rules, shall be entitled to the benefits for health services provided to them as set out in the following schedule Annexure B1, subject to the exclusions listed under Annexure C.

2. In the event of Members requiring non-emergency hospitalisation and surgical procedures, especially those of an elective nature, as well as the provision of those other health care services specified in Annexure B1, Members shall be required to obtain pre-authorisation from the Society's appointed managed care provider before -

   2.1 admission to any hospital, which includes day hospitals;
   2.2 any such surgical procedures, especially elective procedures carried out on them,
   2.3 such other health services are provided to them,

   in order to qualify for benefits for any of these.

3. In the event of hospitalisation in the case of an emergency the Society must be notified thereof within 24 hours or on the first working day after such an emergency admission or treatment having been initiated, failing which the co-payment referred to in paragraph 4.7.1 shall be applied. Notwithstanding anything to the contrary contained in the Rules the Society shall not refuse such authorisation or pre-authorisation for a prescribed minimum benefit in a public hospital.

4. The following principles and conditions will apply in all cases where pre-authorisation is required -

4.1 The Society's appointed managed health care provider, in conjunction with the Society's appointed medical adviser as may be required by the Society in accordance with specific authority delegated to him/her, shall use best practice and cost effective guidelines in order to assess whether to grant such request for pre-authorisation or not.

4.2 In assessing and making its decision such managed health care provider shall be required to determine the appropriate facility – including step-down, sub-acute and hospice facilities; scope of treatment – including medical management and medication: level of care – including rehabilitation and maintenance; length of stay and overall cost, in accordance with clinical protocols which it may have developed and/or applies, in accordance with the principles of evidence-based medicine, taking into account considerations of cost effectiveness and affordability.

4.3 If pre-authorisation is obtained and the treatment does not exceed the authorisation, the treatment will qualify for the benefits as stated;

4.4 If pre-authorisation is obtained and the authorisation is exceeded, benefits will only accrue for the costs relating to the authorised treatment.

4.5 All decisions relating to a Member's, or provider's request on behalf of a Member, for pre-authorisation including any other approval relating thereto, as well as any other benefit for which approval is required under the benefit schedule - Annexure B1 – which are required to be made by the Society's managed health care provider and/or the medical adviser appointed by the Society, as the case may be, shall be recorded and conveyed to the Member, and such provider concerned, in writing,

If the event of any such request being declined such written notification shall include the reasons for this,

4.6 The costs for treatment in excess of that pre-authorised shall be payable by the member. In exceptional cases the Board may agree to a retrospective authorisation for treatment and thus benefits for those costs exceeding those authorised, upon such terms and conditions as the Board may determine, provided a Member or the provider of such services asks for this in writing and such request is justified by way a written clinical motivation.;

4 7 If treatment is undergone without pre-authorisation having been obtained a Member may make a retrospective application for an authorisation.

4.7.1 In the event of such authorisation being granted the benefit may (except in cases of emergency) be subject to a co-payment of 20% of the cost of the hospital account subject to a maximum of R1000 (one thousand rands) per case.

4.7.2 If authorisation is declined no benefits will accrue to the Member;

4.7.3 Authorisation for and benefits relating to the costs incurred by a Member for the provision of any health care services covered under the Prescribed Minimum Benefits ("PMBs") Diagnosis and Treatment Pairs ("DTPs") and/or Chronic Disease List of conditions, " (CDLs") may not be refused, but shall be covered in full, in accordance rule 16.4 read with Appendix 1.

5. Any other authorisation and/or approval required under the benefits schedule, Annexure B1, relating to the provision of relevant health services concerning hospitalisation, medical management, treatment or care costs – including without limitation - the diagnosis of any medical condition, the provision of medicines, prosthesis and surgical appliances shall be determined according to the clinical protocols, guidelines, formularies, care plans, established or followed by the managed health care provider appointed by the Society, according to evidence based medicine, taking into account considerations of cost effectiveness and affordability .

6. A Member shall have the right to appeal any decision made by the Society's managed health care provider provided that the following three stage internal appeals process is strictly followed, namely -

6.1 Notice of any such appeal, which shall include any relevant clinical motivation(s), as well as supporting documents and diagnostic test results , is addressed in writing to the fund manager of the Society appointed by the administrators of the Society;

6.2 Such first stage appeal is initially conducted through the managed health care provider's internal appeal committee / body appointed to deal with such matters;

6.3 The decision of such committee / body and reasons shall be conveyed to the Member in writing.

6.4 A Member shall be entitled to appeal against any such committee/body decision further through the office of the Principal Officer of the Society, provided that

6.4.1 notice of any such second appeal, which shall include any previous and further relevant clinical motivation(s), as well as supporting documents and diagnostic test results, is addressed in writing to the Principal Officer of the Society;

6.4.2 the decision relating to any such appeal shall be taken either by the

6.4.2.1 the Principal Officer, acting under the delegated authority of the Board of Trustees, subject to referral of any issues relating to clinical matters to the Society's appointed Medical Adviser for advice; or

6.4.2.2 the Medical Adviser, acting under the delegated authority of the Board of Trustees; or

6.4.2.3 the Clinical Sub-Committee of the Society, acting in terms of the mandate / terms of reference granted by the Board of Trustees.

6.4.3 the decision of either the Principal Officer, the Medical Adviser or Clinical Sub-Committee, as well as reasons in the event of the appeal being refused, will be conveyed to the Member in writing.

6.5 A Member shall have the right of appeal against any decision taken by either the Principal Officer, Medical Adviser or Clinical Sub-Committee to the Board of Trustees, through the office of the Principal Officer, provided that

6.5.1 notice of any such third stage appeal, which shall include any previous and further relevant clinical motivation(s), as well as supporting documents and diagnostic test results is addressed to the Board of Trustees in writing;

6.5.2 the decision of the Board of Trustees, as well as reasons in the event of the appeal being refused, will be conveyed to the Member in writing.

6.6 A Member shall have right to have the three stage appeals process shortened in order to appeal directly to the Principal Officer, Medical Adviser, Clinical Sub-Committee or the Board of Trustees. This shall only be permitted in emergency medical condition circumstances, as defined under the Act and such other emergency circumstances which the Principal Officer, as advised by the Medical Adviser permits

6.7 A member shall only be entitled to pursue the settlement of complaints and disputes procedures, covered by rule 28 of the Society's Rules, regarding any decision taken by the Society's managed health care provider which the Member has appealed against under this clause 5, once such Member has

fully exhausted the Member's remedies under the three stage internal appeals process outlined above.

7. Claims must be submitted in accordance with the claims procedure set out in Rule 15.

8. Benefits shall be calculated from 1 January to 31 December of each year, based on the services rendered during that year. These shall be pro-rated if a Member and/or dependant joins the Society during the year.

9. Unexpended benefits cannot be accumulated and are not transferable from one financial year to another or from one category to another.

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10. The Society has and shall continue to select and contract with Designated Service Providers ("DSPs") and preferred providers of health care services to Members. It has also contracted with its Managed Health Care provider for the provision of managed health care related programmes.

10.1 The DSPs and managed health care programmes ensure the appropriate and cost effective diagnosis, treatment and care for Members for all the Prescribed Minimum Benefit conditions, whether these are the PMB DTPs and CDL's.

10.2 In so doing the Society has established and shall cause to be established DSP networks, such as the DSP hospital networks, DSP pharmacy networks as well as those relating to designated general practitioner networks (GP Networks).

10.3. It may be necessary over time to give further consideration to the establishing of other networks, such as those for specialists and the treatment of mental health, drug and alcohol dependency, as well as hospice care.

10.4 The managed care programmes which the Society has contracted for relate to

10.4. hospital risk,

10.4.2 chronic medicine

10.4.3 HIV & AIDS

10.4.4 disease risk

10.4.5 oncology

10.4.5 elder care

10.4.6 maternity

10.4.7 prescribed minimum benefits

10.5 In addition to the establishment of and contracting with DSP and preferred provider networks and the provision of the managed health care programmes the Society seeks to manage its exposure to the vagaries of health risk through the establishment of treatment protocols, the use of formularies, capitation agreements and limitations on disease coverage which the Board may find appropriate for the management of the benefits detailed in these rules.

Schedule of benefits 2017

SUBJECT TO THE PROVISIONS OF THESE RULES, READ IN CONJUNCTION WITH ANNEXURE B, MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS:

(UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
	STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER APPENDIX 1	100% of cost	No limit, subject to use of relevant DSPs	1. Services to be rendered by Designated Service Providers (DSP). For purposes of prescribed minimum benefits, designated service providers are Mediclinic, Life Healthcare and/or State / Public Hospitals, Independent Clinical Oncology Network (ICON), the BPMAS GP Network, Netcare 911Clicks and Dis-Chem
	ALL MEDICAL BENEFITS		Overall annual limit: R2 000 000 pfpa	1. The overall annual limit is not pro -rated where the date of admission to membership occurs during the financial year. 2. Sub-limits as defined in this Annexure may be pro-rated, i.e. calculated from the date of admission to membership to the end of the financial year. 3. Once the overall annual limit and/or sub-limits are reached, only the diagnosis, treatment and care costs of the prescribed minimum benefit conditions will be paid in full.
1. HOSPITALISATION AND RELATED BENEFITS				

All hospitalisation requires pre-authorisation from the Society's designated agent or hospital DSP.

1. Authorisation shall be obtained from the Society's designated agent or hospital DSP before a Beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which the Member will be liable for a co-payment of 20% of the cost of the hospital account, up to maximum of R1 000, except for Prescribed Minimum Benefits. This is in addition to any co-payment in terms of note 4 below.
2. In the event of an emergency, the Society shall be notified of such emergency within one working day after admission.
3. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient.
4. **Unless the Beneficiary is deemed to have involuntarily obtained a service from a provider other than a DSP, a Member will be liable for a co-payment of 10% of the cost of the non-DSP hospital account, up to a maximum of R10 000, if a non-DSP provider is used. A Beneficiary will be deemed to have involuntarily obtained a service from a non-DSP provider, –**
   - 4.1 if the service was not available from the DSP or could not be provided without unreasonable delay;
   - 4.2 if there was no DSP within 25 kilometers of the Beneficiary's ordinary place of residence; or
   - 4.3 in the case of an emergency as defined in the Medical Schemes Act.

   Except in the case of note 4.3, pre-authorisation shall be obtained by a Member prior to obtaining a service from a non-DSP provider in terms of this Rule, to enable the Society to confirm that the circumstances contemplated above are applicable. Where a beneficiary has been admitted to hospital due to an emergency and where there is a DSP within 25 kilometers of their residence, the patient must be transferred to a DSP hospital, provided the DSP has the appropriate facilities, as soon as stabilised. Should this transfer not take place, a co-payment as contemplated in 4 above will be applied.
5. If the choice of a provider or a change of provider would result in a reduction of the quality of care or an overall increase in the cost of care, special authorisation may be sought at the time of pre-authorisation for treatment at a non-DSP, without a co-payment.

	SERVICE	**BENEFIT (Subject to Annual Limits)**	**ANNUAL LIMITS**	**CONDITIONS/REMARKS**
1.1	PRIVATE & STATE/PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES & DAY CLINICS		Subject to the Overall Annual Limit	1. Subject to pre-authorisation by the Society's designated agent or hospital DSP. 2. Benefit is not pro-rated if member joins during benefit year.
	I. Accommodation in a general ward, high care ward and intensive care unit.	100% of Agreed Tariff at DSP or 90% of Agreed Tariff at other providers		
	2. Theatre fees.	100% of Agreed Tariff at DSP or 90% of Agreed Tariff at other providers		
	3. Medicines, materials and hospital equipment.	100% of cost (TTO limited to 7 days) at DSP or 90% of Agreed Tariff at other providers		
	4. Visits by medical practitioners.	100% of cost up to a maximum of 100% of the Society Rate If network provider is used, 150% of Society rate		3. In-hospital consultations are subject to the overall annual limit.

	5. Nursing services and all other non-psychiatric in-hospital services. 6. Confinement and midwives.	100% of Agreed Tariff at DSP or 90% of Agreed Tariff at other providers 100% of Agreed Tariff at DSP or 90% of Agreed Tariff at other providers		
1.2	SURGICAL PROCEDURES All in-hospital services, namely operations, procedures and consultations.	100% of cost up to a maximum of 100% of the Society Rate	Subject to the Overall Annual Limit	1. Subject to pre-authorisation by the Society's designated agent or hospital DSP. 2. Excludes dental implants, unless indicated as an essential part of another pre-authorised dental procedure. 3. Includes Elective Orthognatic Surgery and Maxillo Facial Surgery.
1.3	IN-HOSPITAL PSYCHIATRIC TREATMENT I. Accommodation. 2. Medicines, materials and hospital equipment. 3. Visits by medical practitioners.	100% of cost up to a maximum of 100% of Society Rate 100% of cost (TTO limited to 7 days) 100% of Society Rate	Limited to 21 days pbpa	1. Includes treatment for substance abuse. 2. Benefit is not pro-rated if member joins during benefit year. 3. Includes treatment on a day patient basis, in lieu of hospitalisation, subject to pre-authorisation. 4. Where the treatment is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 5. The benefits in respect of PMBs will be limited as per Annexure A of the regulations

	SERVICE	**BENEFIT (Subject to Annual Limits)**	**ANNUAL LIMITS**	**CONDITIONS/REMARKS**
1.4	IN - HOSPITAL PHYSIOTHERAPY AND AUXILIARY SERVICES (INCLUDING AUDIOLOGY, OCCUPATIONAL THERAPY AND SPEECH THERAPY)	**PMB**: 100% of cost **Non-PMB:** 100% of Society Rate	Subject to overall annual limit	1. Subject to pre-authorisation.
1.5	SUB-ACUTE FACILITIES / ALTERNATIVES TO HOSPITALISATION: 1. Step-down Nursing Facilities. 2. Private Nursing (in lieu of hospitalisation). 3. Hospice. 4. Post hospitalisation benefit (in lieu of hospitalisation).	100% of Society Rate or Agreed Tariff at DSP whichever is applicable 100% of Society Rate **PMB:** 100% of cost 100% of Society Rate	R 25 000 pfpa 90 days per diagnosis	1. Subject to overall annual limit 2. Excludes frail care facilities 3. Subject to pre-authorisation by the Society's designated agent. 4. Post hospitalisation and/or cardiac rehabilitation benefit must be in accordance with an authorised treatment plan. 5. The Society's designated agent will liaise with the case manager of the hospital and the treating doctor to assess the appropriateness of step

	5. Hospital Prevention	100% of Society Rate, or cost where no Society Rate exists 100% of Society Rate.	Subject to overall annual limit and pre-authorisation. Managed care protocols apply.	down transfer of certain Beneficiaries. The Society's designated agent will arrange and manage the appropriate alternatives to hospitalisation on discharge such as cardiac rehabilitation programme at an accredited provider, rehabilitation facilities, sub-acute facilities or home nursing in accordance with the Beneficiary's clinical motivation from doctors and case managers.
1.6	REHABILITATION: 1. Following a hospital event (post discharge) 2. Maintenance Therapy 3. Cardiac Rehabilitation Benefit (post discharge)	100% of Society Rate 100% of Society Rate 100% of Society Rate at Accredited Providers	Subject to Overall Annual Limit Limited to R10 400 pfpa Limited to 6 months per cardiac event	1. Subject to pre-authorisation. 2. Includes extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation. 3. Such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital. 4. The Cardiac Rehabilitation Benefit provides for an initial3-month intensive rehabilitation benefit followed by a 3-month continuing care benefit.
1.7	RADIOLOGY. **Basic** All X-rays **Ultrasounds** **Advanced** - MRI & CT Scans - Scopes (Diagnostics) - Angiography - Nuclear Medicine Studies	**PMB:** 100% of cost **Non – PMB:** 100% of Agreed Tariff out of hospital 100% of Agreed Tariff in hospital **Non – PMB** 100% of Society Rate for both in and out of hospital **Non – PMB:** 100% of Society Rate for both in and out of hospital	R1 100 pbpa Subject to Overall Annual Limit Subject to Pre-Authorisation	1. The Society's designated agent must authorise MRI, CAT Scans, Scopes and Angiography, except in emergencies. 2. In the event of an emergency, the Society's designated agent shall be notified on the first working day following the procedure. 3. In respect of PMB conditions, radiology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost. 4. Excludes PET–scans unless authorised as part of a member's Oncology Programme or where it is deemed to be clinically appropriate and medically necessary by the Society's designated agent. 5. Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
1.8	PATHOLOGY	**PMB:** 100% of cost **Non-PMB:** 80% of Agreed Tariff out of hospital 100% of Agreed Tariff in hospital		1. In respect of PMB conditions, pathology must be detailed in the Care Plan for the treatment of the PMB condition to be paid at 100% of cost.
1.9	ORGAN TRANSPLANTS	**PMB:** 100% of cost **Non-PMB:** 100% of Agreed Tariff at DSP	R 170 000 pfpa	1. The Society will pay for both the cost of harvesting the organ from the donor as well as transplanting it into the recipient if both the donor and the recipient are members of the Society. Where the donor is a member of the Society and the recipient is not, the costs of harvesting the organ from the donor will not be covered by the , Society. If the recipient is a member of the Society the harvesting costs will be covered. 2. Subject to pre-authorisation. 3. Benefit includes anti-rejection medication, but excludes hospitalisation and related costs, which are covered under the hospitalisation benefit in 1.1 above. 4. Benefit is not pro-rated if member joins during benefit year.
1.10	KIDNEY DIALYSIS	100% of cost		1. Subject to pre-authorisation.
1.11	BLOOD TRANSFUSIONS	100% of cost		1. Includes the cost of blood, blood equivalents, blood products and the transport of blood. 2. Subject to pre-authorisation.
1.12	AMBULANCE SERVICES (Road and Air)	100% of cost at designated provider except in case of emergency		1. Such transport is to be certified by a medical practitioner as being essential. 2. Subject to authorisation from Society's Designated Service Provider (Netcare 911). 3. Failure to obtain authorisation will render the Member liable for a 30% co-payment.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
1.13	PROSTHESES External and Internal.	100% of Agreed Tariff	R21 100 pbpa, except for PMB and the following prostheses which shall be limited as stated: Hip Replacements: - Bilateral Total R61 200 - Total Hip R35 300 - Partial Hip R19 650 - Revision Hip R67 200 Knee Replacements: - Without Patella R39 050 - With Patella R44 200 - Bilateral Knee R78 400 - Revision Knee R68 050 Shoulder Replacements: - Total Shoulder R46 800 - Bilateral Shoulder R59 550 Spinal Fusion: - Level 1 (without cage) R21 300 - Level 1 (with cage) R40 500 - Level 2 (without cage) R28 450 - Level 2 (with 1 cage) R45 250 - Level 2 (with 2 cages) R66 350 Artificial Limbs: - Below the knee R20 400 - Above the knee R34 150 Artificial Eyes R20 400 Finger Joint Prosthesis R5 000 Pacemakers: - With leads R42 500 - Biventricular R69 650 Intra Cardiac Device R233 100 Cardiac Valves, each R32 100 Cardiac Stents with Delivery System, each R23 050 (maximum 3 pa) Drug Eluting Stents, each (maximum 3 pa) R28 850 Aortic Aneurism Repair Grafts R136 250 Cochlear Implant R213 100 Multiple external and internal prostheses are subject to a joint overall limit of R76 350 pbpa.	1. **External:** Eyes and limbs, e.g. legs and arms. 2. **Internal:** Appliances placed in the body to replace body parts during an operation with the exception of dental implants. 3. Subject to pre-authorisation by Society's designated agent or hospital DSP. 4. Benefit is not pro-rated if member joins during benefit year. 5. Where the prosthesis is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the procedure.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
2.	**PRESCRIBED MEDICINE AND INJECTION MATERIAL:**			
2.1	SELF-MEDICATION	100% of cost or 80% of cost, as per the acute medication benefit	R210 per ailment, subject to the acute medication limits	1. See Annexure D to the Society's Rules for details of the self-medication benefit.
2.2	ACUTE MEDICATION Acute sickness conditions.	100% of cost up to R1 280 per beneficiary, thereafter 80% of cost	Limits: M R4 690 M + 1 R7 320 M + 2 R8 290 M + 3 + R9 110	1. Prescribed by a person legally entitled to prescribe. 2. Subject to Metref and MMIRP. 3. Benefit is pro-rated if member joins during benefit year. 4. Acute benefit is subject to an acute exclusion list.
2.3	CHRONIC MEDICATION (EXCLUDING SPECIALISED MEDICATION) Chronic sickness conditions.	100% of Agreed Tariff at DSP Single exit price plus the lower of the dispensing fee, as set out in medicine pricing regulations or that agreed with DSP, at non-DSP.	Limit: R32 300 pbpa subject to Appendix I	1. Includes daily continuous use of oxygen for a chronic ailment excluding the cylinder which is provided for in benefit 3.6 below; subject to pre-authorisation. 2. Prescribed by a person legally entitled to prescribe. 3. Medication in respect of PMB conditions is subject to the Care Plan, Formulary, Metref and MMIRP and Appendix 1. 4. Medication in respect of a condition that is not included in the PMB list of conditions is subject to pre-authorisation on MRM and MMIRP or Metref and Appendix 1. 5.Once the limit is reached, only medication in respect of PMB chronic conditions will be paid in full according to the Careplan, Formulary and MMIRP or Metref. 6. Benefit is pro-rated if member joins during benefit year.
2.4	SPECIALISED MEDICATION	100% of Agreed Tariff at DSP Single exit price plus the lower of the dispensing fee, as set out in medicine pricing regulations or that agreed with DSP, at non-DSP.	Limit: R125 000pbpa	1. Only medication on the Society's Specialised Medicine List will be covered. 2. Subject to authorisation and clinical entry criteria. 3. Benefit is pro-rated if member joins during the year. 4. Once the limit is reached, only medication in respect of PMB Chronic conditions will be paid in full.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
3.	**PRIMARY CARE:**			
3.1	PREVENTATIVE CARE BENEFITS (OUT-OF-HOSPITAL)			
	1. Cardiovascular Screening: Blood Pressure Blood Glucose Screening Cholesterol Screening Body Mass Index	100% of Society Rate	1 per beneficiary per year	Benefits are subject to Society protocols and use of the Society's DSPs. Will be paid by Multiply if tests are conducted by either Clicks or Dis-chem as part of the Starter Multiply Health Assessments.
	2. Cancer Screening: Mammograms	100% of Agreed Tariffs	1 per beneficiary per year	Age limit: 40 years (benefits for beneficiaries younger than 40 subject to motivation and prior approval.
	Pap Smears		1 per beneficiary per year	
	Prostate Specific Antigen (PSA)		1 per beneficiary per year	Age limit: 50 years and older (benefits for beneficiaries younger than 50 subject to motivation and prior approval.
	Faecal Occult Blood	100% of Agreed Tariffs	1 per beneficiary per year	Age limit: 50 years and older (benefits for beneficiaries younger than 50 subject to motivation and prior approval.
	3. Vaccinations: Child and infant Vaccinations	100% of Agreed Tariffs	Maximum of 3 per beneficiary depending on vaccination make	A list of approved vaccinations is available on the Society's website
	Human Papillomavirus (HPV)	100% of Cost	1 per beneficiary per year	Male and Female beneficiaries between the ages of 9 and 18
	Pneumococcal vaccine			
	Flu vaccination	100% of Agreed Tariff	1 per beneficiary per year Subject to a limit of R1 150 if performed in a doctor's rooms	
	4. Male Circumcisions:	100% of Agreed tariff,	1 per beneficiary per year	
	5. HIV Screening: Elisa Test	100% of Agreed Tariff	1 per beneficiary per year	
	6. Bone Density Tests	100% of Agreed Tariff	Limited to R1400 per beneficiary and subject to overall acute medication limit	Age limit: 50 years and older (benefits for beneficiaries younger than 50 subject to motivation and prior approval.
	7. Contraceptives	100% of Agreed Tariff	One per beneficiary per year	
	8.Dental consultation (in addition to dental benefit in 3.10)		One per beneficiary every 2	

	9. Eye test (Acuity, pressure and other) 10. Dietician consultation		year cycle at DSP One per beneficiary per year	
3.2	SPECIALIST AND GENERAL PRACTITIONER SERVICES: 1. Consultations and visits (out of hospital). 2 All other services unless stated otherwise in this Annexure. Specialist services: General Practitioner Services:	**PMB:** 100% of cost **Non-PMB:** 100% of Society Rate for first 2 consultations pbpa, thereafter 80% of Society Rate. If a network provider is used, 120% of Society rate **PMB:** 100% of cost at a network provider **Non-PMB:** If a network provider is used, 100% of Agreed Tariff If non network provider is used, 80% of Society Rate	**Combined limit:** **PMB:** Unlimited **Non-PMB Limits:** M R6 150 M + 1 R8 220 M + 2 R10 260 M + 3 + R12 340 Limited to combined limit for Specialist and General Practitioner Services detailed above Limited to combined limit for Specialist and General Practitioner Services detailed above	1.Consultations in respect of a PMB condition are subject to the Care Plan and Appendix 1 of the Society's rules.. 2.Includes consultations out of hospital (including, but not limited to chiropractor, homeopath, biokineticist, ante-natal visits and midwifery, osteopaths, naturopaths, dieticians, podiatrists, chiropodists, ayurvedic and traditional healers, therapeutic massage therapists and outpatient facilities; subject to registration with the HPCSA and AHPCSA). 3.Once the limit is reached, only consultations in respect of PMB chronic conditions will be paid in full. 4. Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 5.Benefit is pro-rated if member joins during benefit year.
3.3	MATERNITY	100% of Society Rate	Subject to Overall annual limit and subject to Society's protocols	1.Subject to pre-authorisation and Society's protocols. 2. Care plan includes the following: a. 10 Obstetric consultations b. 10 Antenatal visits c. 2 ultrasound scans, limited to 2D d. Basic pathology tests 3. Additional services, such a Toco-Cardiography, External Cephalic Version, Lecithin-Sphingomyelin and Amniocentesis may be granted where clinically appropriate and medically necessary
3.4	OUT-OF-HOSPITAL AUXILIARY SERVICES 1. Audiology. 2. Audiomotry. 3. Occupational therapy. 4. Speech therapy. 5. Orthoptic Services. 6. Physiotherapy	80% of Society Rate	R7 500 pfpa	1. Only treatment / procedures to be paid from this benefit. 2. Consultations are to be paid in accordance with benefits defined in 3.2. 3. Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. Benefit is pro-rated if member joins during benefit year.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
3.5	APPLIANCES AND CONSUMABLES RELATING TO CHRONIC DISEASE AND / OR MEDICAL CONDITIONS: 1. Wheelchairs, Crutches, Braces, Walking Frames and similar equipment. 2. Appliances relating to Chronic Disease and Medical Conditions, eg. Oxygen Cylinders and Nebulisers (includes either hire or purchase). 3. Consumables relating to Chronic Disease and Medical Conditions, eg. Colostomy kits and other incontinence materials / equipment. 4. Diabetic Consumables and Appliances, including needles, strips & glucometers.	100% of cost 100% of cost 100% of cost 100% of cost	R10 250 pbpa R10 250 pbpa R20 100 pbpa R40 40 pbpa	1. Excludes: • daily continuous use of oxygen, which is included under the chronic medication benefit in 2.3 above. • hearing aids, which are provided for in a separate benefit under 3.7 below. 2. Benefit is pro-rated if member joins during benefit year. 3. Where the appliance or consumable is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. All benefits, except for nebulisers, are subject to pre-authorisation.
36	ACUTE MEDICAL AND SURGICAL APPLIANCES	80% of cost	R6 910 pfpa	1. This benefit is for appliances of an acute nature. 2. Prescribed by a person legally entitled to prescribe. 3. Examples of acute appliances, include, but are not limited to braces, slings, splints and corsets; cervical collars; thermo-moulded shoes and post-operative sandals, including bunionectomy Arco-pedico shoes; air casts; pressure garments; compression hose; cushions; mastectomy breast prosthesis; TED compression stockings; the hiring of sleep apnoea monitors for infants; and the hiring of wheelchairs, walking frames, crutches, traction equipment, toilet and bath raisers and bath swivel stools.
3.7	HEARING AIDS Includes repairs to hearing aids.	100% of cost	R17 980 pb per cycle	1. "Cycle" shall mean a 2 year cycle: 2017/2018.
3.8	PSYCHOLOGICAL and PSYCHIATRIC TREATMENT	**PMB:** 100% of cost **Non-PMB:** 80% of Society Rate	R6 910 pfpa	1. Consultations in respect of a PMB condition are subject to the Care Plan and Appendix 1. 2. Once the limit is reached, only consultations and services in respect of PMB conditions will be paid in full. 3. Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 4. Benefit is pro-rated if member joins during benefit year.
3.9	CLINICAL and TECHNICAL TECHNOLOGISTS: In-Hospital services Out-of-Hospital services	 100% of cost to a maximum of 2 times Society Rate 100% of Society Rate		1. All in-hospital services are subject to pre-authorisation.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
3.10	DENTAL SERVICES 1. Conservative and Restorative Dentistry (includes plastic dentures and extractions under conscious sedation). 2. Special dentistry (Including metal base dentures). 3. Implants.	100% of Society Rate or Agreed Tariff	Limited to: M: R9 660 M+1 R14 420 M+2:R17 860 M+3+: R19 290	1 All orthodontic services are subject to prior approval. Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered. 2. General anesthetic and hospitalisation for conservative dental work excluded except in the case of trauma and impacted 3rd molars. 3. In-hospital Dentistry subject to pre-authorisation by Society's designated agent or hospital DSP. 4. Benefit is pro-rated if member joins during benefit year.
3.11	OPTICAL SERVICES 1. Comprehensive Consultation (inclusive of Tonometry (glaucoma) screening and visual screening). **Plus** 2. Spectacles 2.1 Lenses 2.2 Frames and/or Prescription Lens enhancements **Or**	100% of cost if obtained from Iso Leso 100% of cost for one pair of clear single vision spectacle lenses including charges for extra lenses and prismatic correction when obtained from Iso Leso pb per cycle **Or** 100% of cost for one pair of clear AQUITY bifocal spectacle lenses when obtained from Iso Leso pb per cycle 100% of cost in and out of network 100% of cost limited to network	One pb per cycle Consultations outside the network will be limited to a maximum of R350 pb per cycle. One pair of clear single vision spectacle lenses limited to R170 per lens when obtained outside of Network pb per cycle One pair of clear bifocal lenses, limited to R375 per lens when obtained outside of Network pb per cycle One pair of clear multi -focal lensesof any prescription. Limited to R800 per lens Limited to R800 per beneficiary per cycle. 100% of cost out of network limited to R750 per beneficiary per cycle Limited to R1 175 per beneficiary per cycle. 100% of cost outside of network limited to R1 125	1. "Cycle" shall mean a 2 year cycle: 2017/2018. 2. Iso Leso is the Society's Designated Service Provider for providing optical care to its members. 3.. A list of Iso Leso affiliated optometrists may be obtained from the Society's website.

	3. Contact lenses in lieu of spectacles	100% cost in network	per beneficiary per cycle. Lens Enhancements of R500 per beneficiary per cycle.	
	4. Refractive Surgery		Benefits provided for under hospitalisation	4. Refractive eye surgery is provided for under the hospitalisation benefit and subject to pre-authorisation and guidelines laid down by the Scheme's designated agent.

	SERVICE	BENEFIT (Subject to Annual Limits)	ANNUAL LIMITS	CONDITIONS/REMARKS
4.	**GENERAL**			
4.1	HIV/AIDS AND RELATED ILLNESSES	100% of Single Exit Price (SEP) plus the lower of the agreed or regulated dispensing fee at DSP 100% of Agreed Tariff at DSP or 90% of cost at other providers	Subject to Prescribed Minimum Benefits, Appendix Iand Society protocols In respect of pathology, medication and consultations. In respect of hospitalisation and related services.	1. Medicine and hospital pre-authorisation is required. 2. Subject to PMBs, pre-authorisation and Society protocols. 3. Use of a DSP and formulary medication is required. Failing which a co-payment for the voluntary use of a non-DSP and non-formulary medication will apply. 4. Subject to Appendix I. 5. Post Exposure Prophylactics: Members will be covered for 28 days on Triple Therapy.
4.2	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above	Subject to Prescribed Minimum Benefits and Appendix I	1. Subject to pre-authorisation. 2. Where the treatment is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.
4.3	INFERTILITY	Prescribed Minimum Benefits only		1. Prescribed minimum benefits will be paid in respect of services obtained in the DSP and from State/Public Hospitals.
4.4	ONCOLOGY PROGRAMME/ CHEMOTHERAPY AND RADIOTHERAPY	100% of Agreed Tariff at DSP Claims in respect of medication obtained from a non-DSP will be paid at single exit price plus the lower of the dispensing fee, as set out in medicine pricing regulations or that agreed with DSP.	Limit: R500 000 pbpa, subject to Prescribed Minimum Benefits and Appendix 1.	1. Subject to pre-authorisation and once-off registration on the programme and use of a specialist affiliated to ICON. 2. These benefits apply to in and out of hospital chemotherapy and radiotherapy. 3. Medication to treat side effects of chemotherapy and radiotherapy are to be paid from this benefit. 4. Not subject to chronic medication limits. 5. Includes all treatment in terms of the care plans. 6. Consultations are subject to authorised treatment plans and not the limits set out in benefit 3.2 above. 7. Where the treatment is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered.

Benefits are not transferable from one financial year to another or from one category to another.

PMB conditions referred to in this Annexure are the minimum benefits which the Society must provide for it's members with regard to diagnosis and treatment of approximately 270 illness conditions (as stipulated in the Act) and the diagnosis, medical management and medication for 26 chronic disease conditions (listed below).

EXPLANATION OF PMB (CDL)

The diagnosis, treatment and care costs for relevant health care services rendered at DSPs will be paid in full for the Prescribed Minimum Benefits (PMB), Chronic Disease List Conditions (CDL). There are no limits on these services, provided these are within the Care Plans and obtained from the designated service provider (DSP), where applicable and subject to Appendix 1.

PMB Chronic Disease List:

Addison's Disease	Asthma
Bipolar Mood Disorder (not implemented as yet)	Bronchiectasis
Cardiac Failure	Cardiomyopathy
Chronic Renal Disease	Chronic Obstructive Pulmonary Disease
Coronary Artery Disease	Crohn's Disease
Diabetes Insipidus	Diabetes Mellitus Types 1 & 2
Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
Hyperlipidaemia	Hypertension
Hypothyroidism	Multiple Sclerosis
Parkinson's Disease	Rheumatoid Arthritis
Schizophrenia	Systemic Lupus Erythematosus
Ulcerative Colitis	HIV-Infedtion

The HIV/AIDS benefit provided will be in accordance with the National Antiretroviral Treatment Guidelines and the algorithms specified within the Prescribed Minimum Benefits for the treatment and management of HIV/AIDS

Key:

Agreed Tariff	= The tariff agreed between the Society and the service provider, whether designated or preferred provider.
Formulary	= A list of preferred medicines for the treatment of the 26 PMB (CDL) conditions. It includes original, branded and generic medicines and is administered by the Society's designated agent.
Metref	= Metropolitan Health Reference Price. The maximum price that the Society pays for medication, based on the cost of any original product. (Also referred to as generic reference pricing)
MMIRP / TRP	= Therapeutic Reference Pricing. The maximum price that the Society pays for medication for a particular chronic condition, based on a range of medications that have the same therapeutic effect and pharmacological mode of action. (Also referred to as MMIRP)
PMB	= Prescribed Minimum Benefits as stipulated in the Regulations to the Medical Schemes Act.
Society Rate	= The Society Rate is determined by the 2014 Society rate plus a 6% inflationary increase. In respect of claims from Namibian service providers, the Society Rate will be the NAMAF tariff.
TTO	= To-take-out Medicine – Medicine taken home after being hospitalised.
UPFS	= Uniform Patient Fee Structure (Tariff charged by State/Public Facilities).
pfpa	= per family per annum (family is defined as the member plus his/her registered dependants).
pbpa	= per beneficiary per annum.
PPN	= Preferred Provider Network – the Societys Designated Agent that provides Optical Care to the Scheme's members.
MRM	= Medicine Risk Management Programme provided by the Society's Designated agent.
HPCSA	= Health Professions Council of South Africa.
AHPCSA	= Allied Health Professions Council of South Africa.
M	= Single Member.
M+	= Member with dependants.
Care Plan	= A list of services for the specific PMB CDL conditions, based upon protocols / guidelines as published by the Minister of Health. The services may include GP and Specialist consultations as well as pathology and other diagnostic services, such as radiology and physiotherapy.

DSP = Designated Service Provider. A designated service provider is a provider that the Society has chosen as its preferred provider for specific services for the members of the Society.

BP MEDICAL AID SOCIETY
EXCLUSION AND LIMITATIONS

Notwithstanding the exclusions and limitations provided herein, the Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, the scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

1.1 Cost of consultations, investigations, examinations and the treatment for sterility, infertility and the artificial insemination of a person as defined in the Human Tissue Act, 1983 (Act 65 of 1983) unless such costs are defined as prescribed minimum benefits.

1.2 Expenses incurred by a Member or Dependant of a Member in the case of or arising out of wilful self-injury; attempted suicide if attempted more than once unless such costs are within the limits of Prescribed Minimum Benefits.

1.3 Expenses incurred by a Member or Dependants of a Member in the case of injury or disease incurred while engaged in professional sport, motorized speed contests and motorized speed trials.

1.4 Treatments or operations for cosmetic purposes, including but not limited to impotence, breast augmentation, breast reduction, etc.

1.5 The purchase of spectacle cases and the tinting of contact lenses.

1.6 Purchase of medicines, other than medicines on the written prescription of a person legally entitled to prescribe except a pharmacist acting in terms of the Self-Medication Benefit (refer Annexure D).

1.7 Holidays for recuperative purposes.

1.8 Services rendered by:

1.8.1 Any person not registered with a recognised professional body constituted in terms of an Act of Parliament, or

1.8.2 Any institution, nursing home or similar institution except a State/Public or Provincial Hospital, not registered in terms of any law, or

1.8.3 Any person not registered with the Dental Technicians Board as a dental technician.

1.9 Purchase of:

1.9.1 medicines not registered with the Medicines Control Council;

1.9.2 bandages and aids, dressings, and cotton wool and other consumable items not supplied as part of hospital treatment;

1.9.3 patent foods, including baby foods;

1.9.4 contraceptives unless prescribed by a medical practitioner;

1.9.5 any device intended to induce, enhance, maintain and promote penile erection or to address erectile dysfunction such as erectile appliances and auto injectors;

1.9.6 domestic and herbal remedies not included in a prescription from a registered naturopath or herbalist;

1.9.7 slimming preparations, appetite suppressants, food supplements, vitamins and tonics unless prescribed and medically necessary;

1.9.8 household and biochemical remedies;

1.9.9 devices and material such as dental floss, toothbrushes and tooth paste;

1.9.10 sun-screening and tanning agents;

1.9.11 soaps, shampoos and other non-medical topical applications.

1.10 Hospitalisation for mental disease for more than 12 consecutive months.

1.11 Costs relating to telephone consultations.

1.12 Costs pertaining to scripts and motivations for procedures/treatment excluded by the Society.

1.13 Examinations for insurance, employment, law suits, visas and similar purposes.

1.14 Accommodation and/or treatment in headache and stress-relief clinics, spas and resorts for health, slimming, recuperative or other similar purposes. For the purposes of this Rule, "accommodation" shall include all related expenses and meals, and "treatment" shall include any of the following: examinations, consultations, investigations, diagnosis, tests, procedures, operations, the supply of any pharmacological or pharmaceutical product or food, the supply and/or fitting of any prosthesis, splint or device, and generally shall include any service or supply by any such enterprise or practice intended to confer a health benefit.

1.15 Costs involving treatment/procedures due to any and all body piercing.

1.16 Sclerotherapy treatment unless a surgeon is responsible for the treatment where it forms part of the surgical removal of varicose veins.

2. LIMITATIONS

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

2.2 Members admitted during the course of a financial year are entitled to the benefits set out in the Annexures appended hereto, with certain benefits being adjusted, as stipulated in the Annexure, in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

2.3 Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply or nearest unbroken pack for every such prescription or repeat thereof.

2.4 In cases of illness of a protracted nature the Board may insist that a Member or a Dependant must consult a particular specialist that the Board may nominate in consultation with the attending practitioner. If such specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

SELF MEDICATION BENEFIT AS REFERRED TO IN ANNEXURE B OF THE RULES OF THE BP MEDICAL AID SOCIETY

METHOD OF OPERATION

The member, having diagnosed the ailment, consults the pharmacist for treatment. The pharmacist will then dispense medicine, which may not exceed the amount stipulated in Annexure B (including VAT, and dispensing fees where applicable). Claims must be endorsed "supplied on request of Member, condition self-diagnosed" and the Member's signature and medical aid number recorded thereon. If the treatment is unsuccessful the patient must be referred to the doctor as no ongoing treatment will be allowed.

Only one ailment will be treated at a time.

The self-medication benefit will cover the cost of medication supplied by the pharmacist for specified minor ailments detailed below.

This service is limited to a supply of medication initiated by the pharmacist for the particular condition requested to be treated. The Scheme will not cover the costs of household medicines requested by the Member.

The Scheme may suspend this benefit in cases of abuse.

The self-medication benefit is subject to the acute medication benefit, which is also subject to Metropolitan Health Reference Price (MetRef).

The following are the ailments for which a Member may request medication:

1.	Coryza (Cold)	
2.	Influenza (Flu)	
3.	Diarrhoea (upset stomach)	
4.	Constipation (not chronic)	7 days
5.	Dyspepsia & Oesophagitis (indigestion and or throat)	
6.	Muscular aches	
7.	Dysmenorrhoea (period pains)	7 days
8.	Hay Fever	

9. Minor Skin Conditions: Insect Stings, Minor Rashes, Athlete's Foot and Ringworm 5 days
10. Headache and Backache
11. Worm Infestation
12. Bladder discomfort
13. Congested Eyes, including epidemic "Pink Eye" but excluding any condition where photophobia (light sensitiveness) exists.
14. Travel Sickness
15. Abdominal cramps where no pre-existing condition is apparent
16. Transitory vaginal irritations
17. Scabies
18. Mouth Ulcers
19. Ano-rectal discomfort

The Scheme will pay for the medication provided that the following conditions are complied with:

1. The total value of the prescription must not exceed the amount stipulated in Annexure B (including VAT).
2. A maximum of three days supply may be obtained or as otherwise indicated.
3. Only one ailment is to be treated at a time.

Specialised medication benefit

The Society has introduced a Specialised Medication Benefit from 1 January 2016 for a defined list of high-cost specialised medicines. The benefit will provide members with access to specific high-cost medicines up to the limit of R125 000 per beneficiary per annum and is in addition to the routine chronic medication benefit. Beneficiaries must meet the clinical entry requirements and obtain pre-authorisation to gain access to this benefit.

The list of medicines to be funded from this benefit and the corresponding conditions are provided in the table below.

Drug	**Disease**
Revellex	Ankylosing spondylitis Psoriatic arthritis Rheumatoid arthritis Crohn's disease Ulcerative colitis
MabThera	Rheumatoid arthritis
Enbrel	Ankylosing spondylitis Psoriatic arthritis Rheumatoid arthritis
Actemra	Rheumatoid arthritis Juvenile idiopathic arthritis
Humira	Ankylosing spondylitis Psoriatic arthritis Rheumatoid arthritis Crohn's disease Juvenile idiopathic arthritis
Tysabri	Multiple sclerosis
Pradaxa	Artrial fibrillation
Victoza	Diabetes Type 2
Sensipar	Chronic renal disease
Forteo	Osteoporosis
TOBI	Cystic fibrosis
Pegasys	Hepatitis C
PegIntron	Hepatitis C
Ozdurdex	Retinal vein occlusion

In the event of the anticipated annual cost for the medication exceeding the benefit limit, the beneficiary may submit an ex-gratia application for consideration of additional funding. Please note that the additional ex gratia benefit is not guaranteed. In the event of a PMB condition, the cost of the specialised medication will accrue to, but is not limited to the R125 000 limit.

Preventative Vaccination Benefits:

Child and Infant Vaccinations

The Board of Trustees approved the implementation of a comprehensive vaccination programme for infants and children, with effect 1 January 2016. These vaccinations are not paid from your Acute Medication limit but rather from your Overall Annual Limit. Please note: Only the vaccinations will be paid from the Overall Annual Limit. Consultations charged to administer the vaccinations will be paid from the routine consultation benefit.

The Proposed Vaccination Programme is provided below:

Age	**Vaccination**
Birth	Polio BCG
6 weeks	Diphtheria, Tetanus, Acellular Pertussis Haemophillis Influenza Type B Inactivated Polio vaccine Hepatitis B Rotavirus Pneumococcal Conjugated
10 weeks	Diphtheria, Tetanus, Acellular Pertussis Haemophillis Influenza Type B Inactivated Polio vaccine Hepatitis B Rotavirus Pneumococcal Conjugated
14 weeks	Diphtheria, Tetanus, Acellular Pertussis Haemophillis Influenza Type B Inactivated Polio vaccine Hepatitis B Rotavirus Pneumococcal Conjugated
9 months	Measles Pneumococcal Conjugated
12 months	Hepatitis A Varicella Pneumococcal Conjugated
15 to 18 months	Measles, Mumps, Rubella
18 months	Diphtheria, Tetanus, Acellular Pertussis Haemophillis Influenza Type B Inactivated Polio vaccine Measles Hepatitis A booster
6 years	Measles, Mumps, Rubella Diphtheria, Tetanus, Acellular Pertussis Inactivated Polio vaccine
12 years	Measles, Mumps, Rubella Diphtheria, Tetanus, Acellular Pertussis Inactivated Polio vaccine

Other Vaccinations covered by the Society:

Vaccination:	Benefit (paid from Overall Annual Limit):	Limitations:
Human Papillomavirus (HPV)	100% of Agreed Tariff	Limited to one per beneficiary per year for female beneficiaries between the ages of nine and 18 years of age.
Pneumococcal Vaccine	100% of Agreed Tariff	Limited to one per beneficiary per year.
Influenza Vaccination	100% of Agreed Tariff	Limited to one per beneficiary per year.

Out of Hospital Preventative screening benefit

Cancer Screening:	100% of agreed tariffs, subject to OAL	Limitations:
Mammograms	one per beneficiary per annum	Limited to one per beneficiary per annum age 40 years and older (benefits for beneficiaries younger than 40 years subject to motivation and prior approval)
Pap Smears	one per beneficiary per annum	Limited to one per beneficiary per annum
Prostate Specific Antigen (PSA)	one per beneficiary per annum	Limited to one per beneficiary per annum age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)
Faecal Occult Blood	one per beneficiary per annum	Limited to one per beneficiary per annum age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)

Other Screening:	Benefits (subject to Overall Annual Limit):	Limitations:
Bone Density Tests	one per beneficiary per annum paid at 100% of agreed tariffs	Limited to one per beneficiary per annum age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)
Cardiovascular Screening Blood Pressure Blood Glucose Cholesterol Body Mass Index	100% of Scheme Rate	Will be paid by Multiply if tests are conducted by either Clicks or Dis-Chem as part of the Base Multiply Health Assessments.

Other Screening (cont):	Benefits (subject to Overall Annual Limit):	Limitations:
HIV Screening Elisa Test	100% of Agreed Tariff	Limited to one per beneficiary per year
Dental Consultation (not paid from routine dental benefit, ie in addition to the annual dental benefit)	100% of Scheme Rate	Limited to one per beneficiary per annum. Consultation only. Additional consultations and services will be paid from the dental benefit sub-limit.
Eye Test Acuity, pressure and other	100% of Agreed Tariff	Limited to one per beneficiary every two year cycle if undertaken at a PPN provider. New Cycle: 2015/2016.
Dietician Consultation	100% of Scheme Rate	Limited to one per beneficiary per year

Other Preventative Care Benefits:

Other Preventative Care Benefits:	Benefits:	Limitations:
Male Circumcisions	100% of Cost	Subject to a limit of R1 000 paid from the OAL if performed in a doctor's rooms. Motivation and prior approval required for in-hospital procedures.
Contraceptives	100% of Agreed tariff	Limited to R1 200 per beneficiary per annum. Paid from the routine acute medication limits (ie 100% of cost up to R1 110, thereafter 80% of cost, subject to acute medication limits)