LA Health

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RULES

1 January 2022

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LA HEALTH RULES

1. NAME AND CONSTITUTION

The name of the Scheme shall be "LA HEALTH Medical Scheme", hereinafter referred to as "LA HEALTH" and the translated name shall be "LA HEALTH Mediese Skema".

2. LEGAL PERSONA

2.1 The Scheme, is a body corporate, in its own name, capable of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act and Regulations and these rules.

2.2 Any person, whether in the capacity as Member, Beneficiary or Dependant, who intends to sue the Scheme on matters arising solely from the application of the Act or the Rules of the Scheme, shall subject to Rule 27 and Sections 47 to 50 of the Act, and notwithstanding the provisions of any other law, institute such procedures in a court within whose jurisdiction the Scheme's registered office is situated.

3. REGISTERED OFFICE

The registered office of LA HEALTH shall be situated at CRF Building, Unit 7, Level 2, 4 Bridal Close, Tyger Falls, 7530 for the purposes of all legal proceedings, or at any other address in the Republic of South Africa, as the Board may from time to time decide.

4. DEFINITIONS

In these rules, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context -

(a) a word or expression in the masculine gender includes the feminine;

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2021/02/26
Mpho Sehloho
01/03/2021 08:17:09 (UTC+02:00)
Signed by Mpho Sehloho,
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(b) a word in the singular number includes the plural, and *vice versa*; and

(c) the following expressions have the following meanings:

4.1 **"Act",**

the Medical Schemes Act, 131 of 1998, including any regulations under Section 67 thereof.

4.2 **"Admission date",**

4.2.1 in respect of a member, the date on which he/she is admitted as a member.

4.2.2 in respect of a dependant of a member, the date on which such dependant is registered as a dependant in terms of these rules.

4.3 **"Adult dependant",**

A person who has reached the age of twenty-one (21) in terms of these rules.

4.4 **"Application",**

an application on a form approved by the Board.

4.5 **"Approval",**

prior written or telephonic approval by the Board of Trustees or its authorised representative.

4.6 **"Associate employer",**

any organisation associated or affiliated with the local government sector, which has been admitted as an employer by the Board.

4.7 **"Auditor",**

an individual or firm that is a registered auditor as defined in Section 1 of the Auditing Professional Act, 2005 and authorised by the Registrar.

4.8 **"Beneficiary",**

a member or a person admitted as a dependant of a member.

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4.9 **"Benefits",**

the benefits payable by LA HEALTH to its members and their dependants in terms of these rules.

4.10 **"Board",**

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

4.11 **"Case management",**

the process whereby beneficiaries' specific health care needs are identified and utilisation management plans or programmes implemented which efficiently utilise health care benefits to achieve optimum patient care in the most cost-effective manner.

4.12 **"CDL"**

Chronic Disease List being the Prescribed Minimum Benefit (PMB) chronic conditions published from time to time by the Council for Medical Schemes.

4.13 **"Child"**,

A dependant who is under the age of twenty-one (21) or older if he or she is permitted under the rules/policy of the Scheme to be a child dependant.

4.14 **"Claim",**

the amount to which a beneficiary is in terms of these rules entitled in respect of expenses incurred by him/her in connection with any relevant health service rendered or provided to him/her and his/her dependants.

4.15 **"Condition-specific waiting period",**

a period not exceeding twelve (12) months 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 (12) month period ending on the date on which an application for membership was made.

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4.16 **"Continuation member",**

a member who retains his/her membership of the Scheme after his/her retirement or the termination of his/her employment due to age, ill-health or other disability, or a surviving dependant who becomes the principal member after the death of the original principal member (in terms of Rule 6.1; and 6.2).

4.17 **"Contribution",**

Amount payable by a member on a monthly basis as membership fee to the Scheme in return for medical coverage and in accordance with a payment structure in Annexure A of these rules, for the purpose of qualifying for benefits offered by the Scheme in terms of these rules.

4.18 **"Co-payment"**

An amount the member has to pay towards a healthcare service as stipulated in the Benefit Schedules.

4.19 **"Cost",**

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

4.20 **"Council",**

The Council for Medical Schemes established by Section 3 of the Medical Schemes Act.

4.21 **"Councillor",**

4.21.1 in the case of a local government body any Councillor appointed, elected or nominated in terms of any legislation governing the appointment, election or nomination of a Councillor thereof;

4.21.2 in the case of the South African Local Government Association or any other similar body in any province, a member of the Executive thereof;

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4.21.3 in the case of a branch of a union recognised by the employer that has full-time employees who are members of LA HEALTH; or a fund or joint fund referred to in the definition of "local government body", a member of the committee of such a body or such fund;

4.21.4 in the case of any other institution, body, association or fund recognised by LA HEALTH, a member of the committee responsible for controlling the affairs thereof.

4.22 **"Creditable coverage",** any period in which a late joiner was-

4.22.1 a member or a dependant of a medical scheme;

4.22.2 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;

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

4.22.4 a member or a dependant of the Permanent Force Continuation Fund, excluding any period of coverage as a dependant under the age of twenty-one (21) years.

4.23 **"Date of service",**

4.23.1 in respect of a consultation, visit or treatment by a healthcare professional providing a service, the date on which each such consultation, visit or treatment occurred, whether for the same illness or not;

4.23.2 in respect of an operation, procedure or confinement, the date on which any such operation, procedure or confinement occurred;

4.23.3 in respect of hospitalisation, the date of each admission to hospital or similar institution, or the date of cessation of membership, whichever date occurs first, and

4.23.4 in respect of any other healthcare service or supply, the date on which such service or supply was rendered or provided.

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4.24 **"Deductible"**

a specific payment for which a beneficiary is personally liable, the amount of which is specifically stipulated in these rules.

4.25 **"Dependant" –**

4.25.1 the spouse or partner, dependant children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or

4.25.2 any person who, under these rules is recognised as a dependant of a member.

4.26 **"Designated Service Provider (DSP)",**

A healthcare provider or group of healthcare providers selected by the Scheme as its preferred service provider/s to provide its beneficiaries diagnosis, treatment and care in respect of one or more Prescribed Minimum Benefit conditions, or any other relevant healthcare service covered by the Scheme.

4.27 **"Domcilium citandi et executandi",**

4.27.1 the member's chosen physical address at which notices in terms of Rules 10 and 11.2.2, as well as legal process or any action arising there from, may be validly delivered and served;

4.27.2 the Scheme's registered office in terms of Rule 3.

4.28 **"Due date",**

in respect of the payment of contributions in arrears, the last day of each and every month, and in the case of any other moneys owing to LA HEALTH, the date determined by LA HEALTH.

4.29 **"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

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functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

4.30 **"Employee",**

any person who is in the service of an employer.

4.31 **"Employer",**

a local government body, or a municipal entity as defined in the Municipal Systems Act, No. 32 of 2000, including an associate employer and LA HEALTH.

4.32 **"Financial year",**

each period of twelve months ending on 31 December of each year.

4.33 **"Fit and Proper",**

the regulatory eligibility of a person to hold an important position of trust in a medical scheme and the regulated entities with whom it contracts, including that person's character, integrity, competence and ability to do the job.

4.34 **"Fixed Fee",**

a fee that covers all costs incurred by the facility for a specified procedure, including, but not limited to ward, theatre and drug costs, unless otherwise specifically agreed to.

4.35 **"Frail care",**

The assistance required by persons who, due to physical or mental ailment, are wholly or partially incapable of carrying out activities associated with daily living, which activities may include attention to personal hygiene, feeding, dressing, reasonable and due attendance to personal safety and the safety of others.

4.36 **"General waiting period",**

a three (3) month period in which a beneficiary may not be entitled to claim benefits.

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4.37 **"Global Fee",**

a fee that covers all relevant medical expenses including, but not limited to, professional, facility, radiology and pathology expenses.

4.38 **"Immediate family member",**

4.38.1 a member's spouse or life partner;

4.38.2 a member's dependent children;

4.38.3 a member's legally adopted children; or

4.38.4 in the absence of a spouse, life partner or dependent children, the member's siblings and parents in respect of whom the member is liable for family care and support.

4.39 **"Income",**

for the purposes of calculating contributions in respect of -

4.39.1 a member who is an employee, gross monthly pensionable earnings;

4.39.2 an individual member, gross annual income;

4.39.3 a member who registers a spouse, ex-spouse or partner as a dependant, the higher of the member or spouse's or partner's salary or earnings;

4.39.4 a continuation member, gross annual income.

4.40 **"LA HEALTH Rate (LAHR)",**

4.40.1 the maximum fee/rate payable in respect of relevant health services; or

4.40.2 in the absence of a fee/rate contemplated in Rules 4.34 and 4.37, the fee/rate as 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.

4.41 **"LA Medicine Rate (LAMR)",**

The single exit price plus professional fee negotiated with the Scheme's Designated Service Provider Network.

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4.42 **"late joiner",**

an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is thirty-five (35) years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding three (3) consecutive months since 1 April 2001.

4.43 **"Local government body",**

4.43.1 any institution or body contemplated in section 84(1)(f) of the Provincial Government Act, 1961 (Act No. 32 of 1961);

4.43.2 any institution or body contemplated by the Local Government Transitional Act, 1993 (Act 209 of 1993);

4.43.3 a municipality referred to in section 155 (6) of the Constitution of the Republic of South Africa, 1996;

4.43.4 any institution or body established in terms of a law and which is similar to an institution or body contemplated in this definition; or

4.43.5 an institution, body, association or fund recognised by LA HEALTH as an employer by virtue of the service benefits which are provided to employees in the service of a local government body or by virtue of the interests of the local government body it serves or by virtue of the employment of members of LA HEALTH as a result of secondment, transfer or employment of such members arising out of the restructuring, or privatisation of local government functions.

4.44 **"Medically necessary",**

services, care or supplies which are appropriate and necessary, and evidence-based for evaluating or determining the symptoms, diagnosis and/or clinical management of a medical condition and/or is provided for

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the direct care and/or treatment of a medical condition provided that the level of service, care or supply-

4.44.1 meets the standard of good clinical practice amongst relevant medical practitioners in the community within which the Member resides;

4.44.2 is not primarily for the convenience or comfort of the Member, the Scheme and/or the provider; and

4.44.3 is deemed to be appropriate and necessary (relative to and consistent with the Member's diagnosis or condition) to meet the healthcare needs of the Member, as may be determined by the Scheme or a healthcare professional, multi-disciplinary committee or panel of experts appointed by the Scheme to make such a determination.

4.45 **"Medical Savings Account"**

a medical savings account is provided to a member within a specific benefit option offering such benefit. The Scheme allocates an amount not exceeding twenty-five percent (25%) of total contributions to a member's medical savings account at the beginning of the year where after the member repays that amount back to the Scheme through a portion of his/her monthly contributions.

4.46 **"Member"**,

any person who is admitted as a member of the Scheme in terms of these rules.

4.47 **"Member family"**,

the member and all his/her registered dependants.

4.48 **"Month"**,

a period extending from the first day to the last day of any one of the twelve months of the financial year.

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4.49 **"Motion",**

a written proposal formally submitted to a general meeting for discussion and possible adoption as a resolution.

4.50 **"Orphan",**

the child of a deceased member who was, at the time of the death of the member, a registered dependant of the member.

4.51 **"Partner",**

a person with whom the member has a committed and serious relationship akin to a marriage or recognised as a union or partnership by any law, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

4.52 **"Pay(ment) in full",**

in relation to a prescribed minimum benefit (PMB), means payment according to the service provider's invoice (i.e. cost) for relevant healthcare services rendered, subject to the use of protocols, designated service providers (DSP's), formularies, pre-authorisation or such other managed care initiatives in place and provided for in these rules.

4.53 **"Planned Procedures",**

those medical procedures that are non-life threatening that develop over time, are not of sudden onset and where the timing of the procedure is generally discretionary and/or elective.

4.54 **"Pre-existing condition",**

a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve (12) month period ending on the date on which an application for membership was made.

4.55 **"Preferred Provider",**

a healthcare provider or group of providers, selected by the Scheme in terms of an agreement in which the fee/rate is determined in respect of the payment of relevant healthcare services.

4.56 **"Pre-authorisation",**

authorisation in advance, of the medical necessity, efficiency and or appropriateness of health care services and treatment plans for specified services.

4.57 **"Premier rate"**

The rate that the Scheme will pay a Premier Rate provider in accordance with the undertaking referred to in Annexure G pursuant to which such provider's claims will be paid by the Scheme in full and beneficiaries will not be required to make any further payments to the provider, save in the instances of depleted benefits.

4.58 **"Premier Rate provider"**

A healthcare provider who has undertaken in writing *inter alia*, to bill beneficiaries at the Premier rate for procedures and consultations in accordance with the relevant procedure codes and consultation codes in return for direct payment by the Scheme of benefits to which beneficiaries are entitled.

4.59 **"Prescribed minimum benefits",**

Benefits contemplated in Regulation 7 of the Act which are available to beneficiaries on all registered options.

4.60 **"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.

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4.61 **"Registrar",**

the Registrar or Deputy Registrar of Medical Schemes appointed in terms of Section 18 of the Act.

4.62 **"Related Account",**

is any account related to an approved in-hospital admission other than the hospital account.

4.63 **"Relevant health services",**

a service as defined in the Act which is provided for in a Benefit Option.

4.64 **"Rules",**

the rules of Scheme and shall include the Schedules, Annexures and any other provisions relating to contributions payable to LA HEALTH and the benefits payable by LA HEALTH in terms of these rules.

4.65 **"Spouse",**

the spouse of a member to whom the member is married in terms of any law or custom, or with whom the member enjoys a relationship similar to that of legally married spouses.

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4.66 **"Termination date",**

the effective date of termination of a Member's membership, Dependant's registration or an Employer's participation in terms of these Rules.

4.67 **"Treatment",**

provision of healthcare services which would include, but is not limited to hospitalisation benefits and subject to Rule 4.44.

5. BUSINESS OF A MEDICAL SCHEME

The business of the Scheme is to undertake liability, in respect of its members and their dependants, in return for a contribution -

5.1 to make provision for the obtaining of any relevant health service;

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

5.3 where applicable to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme.

6. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

6.1 MEMBERSHIP

6.1.1 Eligibility

Membership of LA HEALTH is restricted to –

6.1.1.1 employees of an employer;

6.1.1.2 members who retire from the service of an employer or whose services are terminated on account of age, ill-health or other disability;

6.1.1.3 members who cease to be employees of an employer in the case of retrenchment or redundancy;

6.1.1.4 the registered dependants of deceased members including widows and orphaned children. Where child dependants have been orphaned, the eldest child may be considered to be the member, and any younger siblings, the child dependants.

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6.1.1.5 councillors and former councillors who were members of the Scheme at the time of expiry of their term of office.

6.1.2 A minor may only become a member with the written consent of his/her parent or guardian.

6.1.3 No person may be a member of a dependant of more than one medical scheme or claim benefits under the name of another beneficiary.

6.1.4 Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in respect of himself and his/her dependants, of age, income, state of health and of any prior membership or

admission as dependant of any other medical scheme. The Scheme may require an applicant to provide the Scheme with a medical report in relation to any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made. The costs of any medical tests or examinations required to provide such medical report will be paid for in full by the Scheme. The Scheme may however designate a provider to conduct such tests or examinations.

6.1.5 Every member will, on admission to membership, have access to the Rules which shall include contributions, benefits, limitation and exclusions, the member's rights and obligations.

6.2 CONTINUATION MEMBERSHIP

6.2.1 Retirees

6.2.1.1 A member shall have the right to retain his/her membership of the Scheme, with his/her registered dependants, if any, in the event of his/her retiring from the service of his/her employer or his/her employment being terminated by his/her employer on account of age, ill-health, disability, retrenchment, or redundancy.

6.2.1.2 The Scheme shall inform the member of his/her right to continue his/her membership and of the contribution payable from the date of retirement or termination of his/her employment. Unless such member informs the Board within sixty (60) days of his/her retirement or termination of service in writing of his/her desire to terminate his/her membership, he/she shall continue to be a member.

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6.2.2 Surviving dependants

6.2.2.1 The surviving dependants who are registered with the Scheme as his/her dependants at the time of such member's death, shall be entitled to membership of the

Scheme without any new restrictions, limitations or waiting periods.

6.2.2.2 The Scheme shall notify the dependant of his/her right to membership and of the contributions payable in respect thereof. Unless such person informs the Board within sixty (60) days of such notice in writing of his/her intention not to become a member, he/she shall be admitted as a member of the Scheme.

6.2.2.3 Such a member's membership terminates if he/she becomes a member or a dependant of a member of another medical scheme.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of dependants

7.1.1 A member may apply for the registration of his/her dependants at the time that he/she applies for membership in terms of Rule 6.

7.1.2 If a member applies to register a new born or newly adopted child within sixty (60) days of the date of birth or adoption of the child, such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption.

7.1.3 If a member who marries subsequent to joining the Scheme, applies within sixty (60) days of the date of such marriage to register his/her spouse as a dependant, his/her spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of marriage.

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7.1.4 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the member may apply to the Scheme for the registration of such person as a dependant, whereupon the provisions of Rule 6 shall apply *mutatis mutandis*.

7.2 **De-registration of Dependants**

7.2.1 A member shall inform the Scheme within thirty (30) days of the occurrence of any event which results in any one of his/her dependants no longer satisfying the conditions in terms of which he/she may be a dependant.

7.2.2 When a dependant ceases to be eligible to be a dependant, he/she 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. WAITING PERIODS

8.1 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; and who was not a beneficiary of a medical scheme for a period of at least ninety (90) days preceding the date of application:

8.1.1 a general waiting period of up to three (3) months; and

8.1.2 a condition-specific waiting period of up to nine (9) months on existing pregnancies in respect of all pregnancy-related services; and

8.1.3 a condition-specific waiting period of up to twelve (12) months where applicable.

8.1.4 PMBs may also be excluded during the waiting period.

8.2 A medical scheme may impose on a person in respect of whom application is made for membership, or for admission as a dependant in a benefit option, and who previously was a beneficiary of a medical scheme for a continuous period of up to twenty-four (24) months terminating less than ninety (90) days before the date of application, a waiting period that is as follows:

8.2.1 a condition-specific waiting period of up to twelve (12) months, except in respect of PMB's

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8.2.2 any unexpired waiting period imposed by the applicant's former medical scheme.

8.3 **The general waiting period shall not apply-**

8.3.1 to a person who has been a beneficiary of a medical scheme for a continuous period of less than twenty-four (24) months immediately preceding his/her application and who applies within ninety (90) days of termination as such beneficiary;

8.3.2 to a child dependant born during his/her parent's membership of the Scheme;

8.3.3 to a person who changes from one benefit option to another;

8.3.4 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/her employer changing medical schemes; and

8.3.5 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/her application.

8.4 **A condition-specific waiting period shall not apply-**

8.4.1 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/her application and who applies within ninety (90) days of termination as such beneficiary;

8.4.2. to a child dependant born during his parent's membership of the Scheme;

8.4.3 to a person who changes from one benefit option to another;

8.4.4. to a person who was previously a beneficiary of a medical scheme and who applies within ninety (90) days of ceasing to be such beneficiary, to become a beneficiary of the Scheme because of a change of employment or of his/her employer changing medical schemes; and

8.4.5. 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/her application.

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8.5 Notwithstanding the provisions of Rules 8.1, 8.2, 8.3 and 8.4, the Scheme may apply only the un-expired duration of a waiting period-

8.5.1 imposed by a previous medical scheme that applied immediately preceding the application of a beneficiary; and

8.5.2 where beneficiaries change from one benefit option to another.

9. PROOF OF MEMBERSHIP AND CERTIFICATE OF MEMBERSHIP

9.1 Every member shall be furnished with valid proof of membership, containing such particulars as may be prescribed. Such proof must be exhibited to the supplier of a health service on request. It remains the property of the Scheme and must be returned to the Scheme or destroyed on termination of membership.

9.2 The utilisation of a membership card or other proof of membership by any person other than the member or his/her registered dependants, with the knowledge or consent of the member or his/her dependants, is not permitted and is construed as an abuse of the privileges of membership of the Scheme and is construed as fraud. The provisions of Rule 11.3 will be instituted.

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

10. CHANGE OF ADDRESS OF MEMBER

A member must notify the Scheme within thirty (30) days of any change of address including his/her *domicilium citandi et executandi*. The Scheme shall not be held liable if a beneficiary's rights are prejudiced or forfeited as a result of the member's neglecting to comply with the requirements of this rule.

11. TERMINATION AND SUSPENSION OF MEMBERSHIP

11.1 **Voluntary termination of membership**

11.1.1 a member may terminate his/her membership of LA HEALTH by giving one (1) months written notice. All rights to benefits cease after the last day of membership.

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11.1.2 where a member elects to become a member of another medical scheme accredited by the South African Local Government Bargaining Council in accordance with any agreement between employers and employees;

11.1.3 where a member elects to become a dependant on his/her spouse's medical scheme;

11.1.4 in the case of a surviving dependant contemplated by Rule 6.2.2.3 on becoming a member or a dependant of a member of any other medical scheme, or if LA HEALTH is requested in writing to cancel such membership;

11.1.5 in the case of a divorced spouse who is a registered dependant of a member, on remarriage, or if by reason of employment, he/she becomes a beneficiary of a medical scheme, or if he/she requests LA HEALTH in writing to cancel his/her enrolment;

11.1.6 in the case of a continuation member, if he/she requests LA HEALTH in writing to cancel his/her membership, or if by reason of his/her re-employment he accepts membership of any medical scheme; and

11.1.7 in accordance with any agreement between LA HEALTH and the local government body and the member concerned.

11.2 Involuntary termination of membership

The Board may in its sole discretion suspend benefits instead of terminating the membership.

11.2.1 **Amounts due to the Scheme**

Where contributions or any other debt owing to the Scheme, have not been paid within thirty (30) days of the due date, the Scheme shall have the right to:

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

11.2.1.2 give the member written notice at his/her *domicilium citandi et executandi* or by means of an electronic means agreed upon, that if contributions or such other debts are not paid within twenty one (21) days of posting of such notice, membership may be cancelled.

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11.2.2 A notice sent by prepaid registered post to the member at his/her *domicilium citandi et executandi* or by any agreed electronic means shall be deemed to have been received by the member on the seventh (7th) day after the date of distribution. In the event that the member fails to nominate a *domicilium citandi et executandi*, or provide an electronic mail address or facsimile, the member's postal or residential address on his/her application form shall be deemed to be his/her *domicilium citandi et executandi*.

11.2.3 In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with Rule 11.2.1.2, benefits shall be reinstated without any break in continuity. 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.

11.2.4 Any amount due and owing to the Scheme in respect of a member or a dependant of the member after reasonable demands for payment have been issued, becomes a debt due to the Scheme and is recoverable by it.

11.3 Submission of fraudulent claims, committing of any fraudulent act and/or non-disclosure of material information

The Board may suspend or terminate the membership of a beneficiary who:

11.3.1 abused his/her benefits/privileges as a member or dependant of the Scheme;

11.3.2 submitted fraudulent claims, committed any fraudulent act;

11.3.3 failed to disclose material information.

11.3.4 An applicant is obliged to disclose all material information to the Scheme with regard to any matter concerning the state of health or medical history of the person concerned, or that of any of his or her dependants, which arose or occurred during the period of twelve (12) months preceding the date of application for membership. In such event, the member must refund the Scheme any claims paid out by the Scheme and the Scheme must refund all the contributions paid to the member.

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11.4 A member who ceases to reside in the Republic of South Africa. Provided that he/she may elect to retain his/her membership in terms of the rules of LA HEALTH if he/she fully complies with the terms and conditions laid down by the rules from time to time. Payment of benefits to such a member shall be made in South African currency into his/her bank account in the Republic: Provided that contributions shall be paid to LA HEALTH in South African currency.

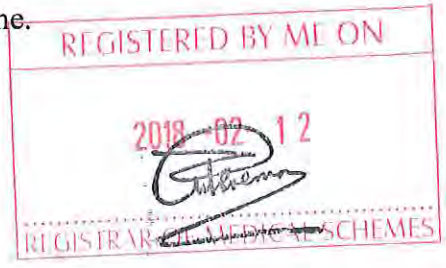
12. CONTRIBUTIONS

12.1 The total monthly contributions payable to the Scheme by or in respect of a beneficiary are as stipulated in Annexure's A appended hereto, depending on the benefit option elected by the member.

12.2 Contributions shall be due monthly in arrears. Contributions shall be payable by not later than the third day of the due date. Where contributions or any other debt owing to the Scheme, have not been paid within thirty (30) days of the due date, the Scheme shall have the right to suspend all benefit payments which have accrued to such member during the period of default, and to give the member and/or employer written notice at his/her *domicilium citandi et executandi* that if contributions or such other debts are not paid up to date within fourteen (14) days, membership may be cancelled.

12.3 Unless specifically provided for in the rules in respect of medical savings accounts, no refund of any portion of a contribution shall be paid to any person where such member's membership or cover in respect of any dependant terminates during the course of a month.

12.4 A member who retires from the service of a local government body and who at the date of such retirement elects to take his/her retirement benefit in cash only, shall have the right to be a continuation member of the Scheme against payment of a contribution in accordance with any contribution schedule not having income as a basis or the maximum contribution determined in any contribution schedule, having income as a basis, as amended from time to time.



13. LIABILITIES OF EMPLOYER AND MEMBER

13.1 The liability of the employer towards the Scheme is limited to any amounts payable in terms of any binding agreement.

13.2 The liability of a member to the Scheme is limited to the amount of his/her unpaid contributions together with any sum disbursed by the Scheme on his/her behalf or on behalf of his/her dependants, which has not been repaid to the Scheme. Such liability may be recoverable from the member by way of legal proceedings, or set off against any amounts due to the member at any time.

13.3 In the event of a member ceasing to be a member, any amount still owing by such member is a debt due to the Scheme and recoverable by it on cancellation of the membership, or when called upon by the Scheme to do so.

14. CLAIMS PROCEDURE

The procedures for dealing with the submission and settlement of claims shall be as detailed in Annexure D or the Major Medical Benefit, Annexure E, appended to these rules.

15. BENEFITS

15.1 Unless membership is suspended in terms of Rule 11.2, beneficiaries shall be entitled to the benefits as detailed in Annexure's B, appended hereto, for the specific benefit option as elected by the member concerned, in respect of relevant healthcare expenses incurred by members and their dependants.

15.2 A member's dependants who are registered as such with the Scheme, must participate in the same benefit option as such member.

15.3 Notwithstanding anything to the contrary in these rules contained, any benefit option offered by the Scheme covers in full, as stipulated in the relevant benefit schedule Annexures B, the diagnosis, treatment and care cost of the prescribed minimum benefit conditions as may be prescribed from time to time if such services are obtained from the Scheme's designated service provider; or if involuntarily obtained from any other service provider. If cover in terms of

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these rules, for a condition specified in the statutory prescribed minimum benefits is involuntarily obtained from another service provider the Scheme will, subject to pre-authorization, provide that patient with the cover prescribed, as detailed in Annexures B hereof.

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

15.5 The Board may consider additional benefits in exceptional circumstances based on the merits of each case. Each case must be fully motivated and accompanied by a document containing the specific clinical data needed for the motivation. The award of any additional benefits remains at the sole discretion of the Board.

15.6 A member is entitled to change from one to another benefit option subject to the following conditions:

15.6.1 The change may be made only with effect from 1 January of any financial year. The Board of Trustees may, in its absolute discretion, permit a member to change from one to another benefit option on any other date.

15.6.2 Application to change from one benefit option to another must be in writing and lodged with the Principal Officer by no later than 30 November prior to the year upon which it is intended that the change will take place, provided that the member has had at least thirty (30) days prior notification of any intended changes in benefits or contributions for the next year.

15.7 The Scheme may, in respect of the financial year in which a member joins the Scheme, reduce annual benefits pro-rata to the period of membership and calculated from the member's admission date to the end of the financial year concerned.

15.8 Any member or dependant obtaining a relevant health service outside the South African monetary area shall not be entitled to any benefits from the Scheme in excess of those to which he would have been entitled had he received the same treatment in the Republic. Costs incurred in effecting such payment, shall be for the cost of the member.

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16. PAYMENT OF ACCOUNTS

16.1 Payment of accounts or reimbursement of claims is restricted to the net amount payable in respect of such benefit and the maximum amount of the benefit to which the member is entitled in terms of the applicable benefit as follows:

16.1.1 up to the relevant benefit limit payable at the LAHR, and

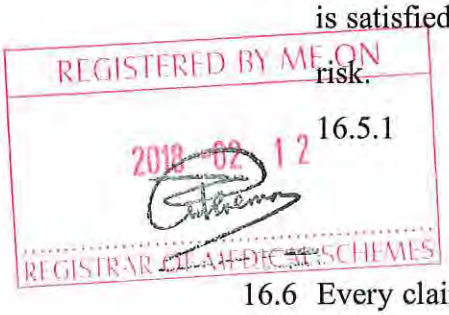
16.1.2 in full for prescribed minimum benefits.

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

16.3 Where the Scheme has paid an account or portion of an account or any benefit to which a beneficiary is not entitled, whether payment is made to the member or to the supplier of service, the amount of any such overpayment is recoverable within three (3) years by the Scheme.

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

16.5 The Scheme may in its sole discretion stop all payments to a provider where it is satisfied on reasonable grounds that such provider has placed the Scheme at risk.



16.5.1 The Scheme shall notify the provider in writing of such decision and the reasons therefor. The provider will be entitled to dispute the decision.

16.6 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement as may be prescribed.

16.7 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 at least the following particulars-

16.7.1 the name and the membership number of the member;

16.7.2 the name of the supplier of service;

16.7.3 the final date of service on the account or statement that is covered by the payment;

16.7.4 the total amount charged for the service concerned; and

16.7.5 the amount of the benefit awarded for such service.

16. 8 In the event that a member or dependant becomes entitled to any benefit for medical services rendered in the treatment of an injury sustained as a result of or arising out of the negligent driving of a motor vehicle by a person within the Republic of South Africa, the member or dependant shall:

16.8.1 be obliged to take all steps which are necessary to timeously submit to the Road Accident Scheme ("RAF") established in terms Act 56 of 1996, a claim for compensation for the costs of any health care services performed and which in the future may be necessitated in connection with such injury; and

16.8.2 advise and keep the Scheme advised of the progress in relation to such claim for compensation; on admission of such claim by the RAF, advise the Scheme of the terms of such admission, including any terms relating to any undertaking by the RAF to make payments of the costs of any future medical expenses, in which event the Scheme shall be entitled to recover payment of any benefit in respect of health care services for which the RAF has undertaken to make payment.

16.9 In the event that a member or dependant becomes entitled to any benefit for medical services rendered in the treatment of an injury or disease sustained or contracted in the course of his employment, the member or dependant shall:

16.9.1 be obliged to take all steps which are necessary to timeously submit a claim for compensation to the Compensation Commissioner ("the Commissioner") as provided for in terms of the Compensation for Occupational Injuries and Diseases Act 130 of 1993, a claim for compensation for the costs of any health care services performed and which in the future may be necessitated in connection with such injury or disease and;

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16.9.2 advise and keep the Scheme advised of the progress in relation to such claim for compensation; on submission of such claim to the Commissioner, advise the Scheme of the terms of such submission, including any terms relating to any undertaking by the Commissioner

to make payment of the costs of any future medical expenses, in which event the Scheme shall be entitled to recover payment of any benefit in respect of healthcare services for which the Commissioner has undertaken to make payment, limited to the amount paid by the Scheme.

16.10 In the event that a member or dependant becomes entitled to any benefit for medical services rendered in the treatment of an injury or disease sustained, or for which any other party (excluding the parties mentioned in 17.8 and 17.9) is, or may be held wholly or partly liable in law for damages or indemnification in terms of statute, a contract or otherwise ("the Indemnifier"), then the member or dependant shall be entitled to such benefits as contemplated by his or her chosen benefit option and the Rules of the Scheme. This entitlement does not derogate from the member's or dependant's right to institute a claim against the Indemnifier for compensation for the costs of any healthcare services and/or medical expenses incurred and/or which in future may be necessitated in connection with such injury(ies) and/or disease(s). In the event of submitting such a claim against the Indemnifier, the member or dependant shall:

16.10.1 promptly inform the Scheme of such claim submitted to the Indemnifier;

16.10.2 include in such claim all payments made by the Scheme for healthcare services rendered and/or medical expenses incurred in respect of such injury or disease;

16.10.3 advise the Scheme of any undertaking by the Indemnifier to make payments of the costs of any past and/or future healthcare services and/or medical expenses in connection with such injury(ies) and/or disease(s). In the event of such an undertaking by the Indemnifier, the Scheme shall be absolved from liability to make further payment of any benefit in respect of healthcare services and/or medical expenses for which the Indemnifier has undertaken to make payment;

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16.10.4 reimburse the Scheme with any payment made by the Indemnifier in respect of such injury(ies) or disease(s) which were paid by the Scheme;

16.10.5 ensure that all reimbursements due to the Scheme in terms of 16.10.4 are made within thirty (30) days of receipt of the payment from the Indemnifier, whether the payment was made to the member or the member's appointed agent; and

16.10.6 make all reimbursements due to the Scheme in terms of 16.10.4 without any deductions.

17. GOVERNANCE: MANAGEMENT OF LA HEALTH

17.1 Composition of the Board of Trustees

The Scheme shall be managed in accordance with these rules by a Board of Trustees consisting of a maximum of sixteen (16) Trustees who are fit and proper to be Trustees constituted as follows, provided that a minimum of ten (10) trustees shall constitute the Board at any given time:

17.1.1 Ten (10) persons who are members of the Scheme, nominated and elected by members of the Scheme.

17.1.2 Six (6) persons appointed by the Board of Trustees to address knowledge, skills, experience, diversity and independence.

17.2 Term of Office

17.2.1 All Trustees shall, unless they become disqualified to serve as Trustees in terms of these Rules, serve for a period of six (6) years with effect from 1 July of the year in which an election is to be held, notwithstanding the date of election.

17.2.2 Retiring Trustees shall be eligible for re-election provided that no person shall serve more than two (2) consecutive terms, and no more than three (3) terms altogether.

17.2.3 Trustees referred to in Rules 17.1.1 must be elected in accordance with Rule 17.3.

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17.3 **Election of Trustees**

17.3.1 Any member of the Scheme may nominate a candidate for election to the Board.

17.3.2 A notice inviting nominations shall be sent to all members by 28 February in the year in which an election is to be held.

17.3.3 Nominations to fill vacancies, signed by the candidate signifying his/her consent to stand for election, must be submitted to the Scheme by 31 March of the year concerned and must include the following :-

17.3.3.1 the full name and an abbreviated *curriculum vitae* of the member nominated;

17.3.3.2 the employer by whom he is/was employed or where he is serving as a Councillor;

17.3.3.3 the name, membership number and signature of one member nominating him/her.

17.3.4 The election shall be carried out by a postal and/or any means of electronic ballot of all the members of the Scheme.

17.3.5 The election shall be held before the office of the serving Board expires so as to enable the newly elected Board to assume office on 1 July of the year in which such election was held.

17.3.6 If for any reason whatsoever the aforesaid election cannot be held before 1 July of the year in which such term of office shall expire, the existing members of the Board shall continue to hold office until the election shall have been held and their successors shall have been elected and shall have assumed office.

17.4 **Filling of Vacancies**

17.4.1 The Board of Trustees shall have the power to fill any casual vacancy which may occur during the term of office of an elected member. A person so appointed shall fill the vacancy for the un-expired period of office of the vacating member.

17.4.2 Notwithstanding any vacancy on the Board, the continuing members thereof may act on its behalf: Provided that if and so long as their number is reduced below that fixed for a quorum by these Rules

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such members may act only for the purpose of increasing the number of members to that number, but for no other purpose.

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

17.5.1 A person under the age of twenty (21) years;

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

17.5.3 a broker;

17.5.4 the Principal Officer of the Scheme;

17.5.5 the auditor of the Scheme; or

17.5.6 a person who is or becomes a Trustee of any other employer accredited medical scheme.

17.6 At the Board's first meeting of each new term of office of trustees, it shall elect by secret ballot, if there is more than one nomination, from amongst its number a Chairperson, and a Deputy-Chairperson.

17.7 The Board shall meet not less than once in every three (3) months; provided that the Chairperson may from time to time convene additional meetings.

17.8 Subject to the provisions of Rule 17.1 above, half of the Trustees plus one, personally present at meetings of the Board, shall constitute a quorum. At a meeting of any committee appointed by the Board, this principle shall apply *mutatis mutandis*.

17.9 The Principal Officer shall cause minutes to be kept of every meeting of the Scheme.

17.10 Notwithstanding the provisions of Rule 17.4, the office of a member of the Board shall become vacant whenever he –

17.10.1 ceases to be a member of the Scheme;

17.10.2 absents himself/herself from three (3) consecutive meetings of the Board without an apology;

17.10.3 at any time tenders his/her resignation in writing as a member of the Board;

17.10.4 becomes of unsound mind or is subject to a reception order in terms of the Mental Health Act, 1973 (Act 18 of 1973), or has been

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declared by a competent court to be incapable of managing his/her affairs;

17.10.5 has been declared insolvent or has surrendered or assigned his/her estate for the benefit of his/her creditors;

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

17.10.7 is removed by a competent court from any office of trust on account of misconduct; or

17.10.8 is removed by the Council for Medical Schemes from office in terms of Section 46 of the Act.

17.11 In the event of the office of every member of the Board being vacant, the Principal Officer shall appoint an ad hoc committee of not less than five (5) persons with the approval of the Registrar, to control and manage the Scheme until a new Board is elected in terms of these rules.

17.12 Until the new Board has been elected in terms of these rules, the ad hoc committee shall have the powers and privileges and be subject to the duties and obligations of the Board.

17.13 **Voting**

Matters serving before a meeting of the Board shall be decided by a majority of votes of Board members present at such meeting except in relation to matters contemplated by the proviso hereto. In the event of an equality of votes, the Chairperson will have a casting vote as well as a deliberate vote; Provided that the salaries and conditions of service of the Principal Officer and other persons appointed in terms of these rules for the proper execution of the Scheme's activities shall be determined by a majority of the total number of members of the Board.

17.14 **Remuneration of Board Members**

An honorarium as may from time to time be determined at the annual general meeting may be paid to members of the Board. Members of the Board may also be reimbursed for all reasonable expenses incurred by them in the performance of their duties as trustees, at the rate determined from time to time by the Board. Such honorarium related to the Trustees must be disclosed to the members at the Annual General Meeting (AGM) and included in the annual financial statements.

17.15 If the Board of Trustees suspends or removes the Principal Officer or a trustee from office in terms of Rule 19.1, and that person(s) is aggrieved by the decision, he/she may lodge a complaint with the Registrar.

17.16 On receipt of a written complaint mentioned in Rule 17.15 above:

17.16.1 The Registrar shall investigate the basis of the complaint and;

17.16.2 If he/she finds that the complaint has merit, the Registrar or the Council shall take such steps as may be necessary in terms of the powers provided for by the Act to address the concerns raised in the complaint.

17.17 A member of the Board who acts in a manner which is seriously prejudicial to the interests of the beneficiaries of the Scheme may be removed by members of the Board after following a due process that is consistent with provisions of Section 46 of the Medical Schemes Act or the provisions or just administrative action, by way of a special resolution taken at a special general meeting, provided that:

17.17.1 Special notice shall be lodged with the Board accompanying the requisition at date of lodgement, and on receipt of notice of such proposed resolution, the Board shall forthwith deliver a copy thereof to the trustee concerned, who shall be entitled to be heard on the proposed resolution at the meeting.

17.17.2 The notice convening the special general meeting containing the agenda and proposed special resolution must be furnished to members at least fourteen (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.

17.17.3 Where the trustee concerned makes representation in writing which is of a reasonable length and requests dissemination to members, the Board shall unless the representations are received by it too late for it to do so, state that such representations have been made in its notice to members in terms of Rule 17.17.2 and send a copy of the representations to all members, whether such notice was sent before or after the receipt of representations by the Board.

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17.17.4 Where the representation was not sent due to late receipt, the trustee concerned may require that the representations be read at the meeting.

17.17.5 Fifty percent (50%) + one (1) member of the board of trustees present in person constitute a quorum.

17.17.6 The resolution to remove the trustee/s must be passed by at least two-thirds (⅔) of members present in person or by proxy entitled to vote.

18. FIDUCIARY DUTIES OF BOARD OF TRUSTEES

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

18.2 The Board shall act with due care, diligence, skill and in good faith.

18.3 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.

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

18.5 **Appointment of officers**

18.5.1 The Board shall appoint a principal officer who is fit and proper person, as defined in Section 57, to hold such office and within thirty (30) days of such appointment, give notice thereof in writing to the Registrar. The Board must determine the terms and conditions of employment of the person appointed (Sec 57 (4)(a)).

18.5.2 The Board may authorise the appointment of any staff by the Principal Officer, which in its opinion are required for the proper execution of the business of the Scheme and must determine the terms and conditions of service of any person employed by the Scheme.

18.5.3 The following persons are not eligible to be a principal officer-

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

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18.5.3.2 a broker.

18.6 The Chairperson, or in his/her absence the Deputy-Chairperson, shall preside over meetings of the Board and ensure due and proper conduct at meetings. In the absence of both the Chairperson and the Deputy-Chairperson, the members shall elect from their number a Chairperson to preside at that meeting.

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

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

18.9 The Board must ensure that adequate and appropriate information is communicated to the members of the Scheme regarding their rights, benefits, contributions and duties in terms of the rules.

18.10 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.

18.11 The Board must take out and maintain an appropriate level of professional indemnity insurance, fidelity guarantee insurance and may, as provided for in section 30 (1) (d) of the Act, contribute to any fund of any kind whatsoever, which is conducted for the benefit of the officers of the Scheme or pay for insurance policies on the lives of officers of the Scheme, including Board Group Life Insurance, for the benefit of such officers and their dependents and account for it in terms of section 57 (8) of the Act.

18.12 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.

18.13 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.

18.14 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any member or dependant's state of health in terms of the Protection of Personal Information Act.

18.15 The Board must approve monthly financial statements of income and expenditure submitted by the Principal Officer in accordance with his/her duties outlined in Rule 20.8 hereof.

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

18.17 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.

18.18 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.

18.19 The Board shall cause to be done a "Board effectiveness self-assessment" on an annual basis and an independent assessment every three (3) years with due regard to normal practice and recommended guidelines pertaining to improving the Board's effectiveness.

18.20 The Board shall ensure that every existing and newly appointed/elected Board member undergoes trustee training in the form of induction/advanced training provided by the Council.

18.21 The Board must appoint the authorised auditor and the audit committee annually.

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19. POWERS OF BOARD

The Board has the power -

19.1 to suspend or remove the Principal Officer or a Trustee from office on good cause shown;

19.2 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 under such appointments;

19.3 to appoint a committee consisting of such Board members and other experts, as it may deem appropriate;

19.4 to appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The

terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the Regulations.

19.5 to appoint, compensate and contract subject to the provisions of the Act and the Regulations, with any accredited broker for the introduction or admission of a member to the Scheme and for ongoing broker services if it so deems fit;

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

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

19.8 to let or hire movable or immovable property;

19.9 to co-opt knowledgeable persons to participate in the deliberations of the Board, but such co-opted persons shall not have a vote.

19.10 in respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such moneys upon security and to realise, re-invest or otherwise deal with such monies and investments in accordance with an investment policy approved by the Board from time to time;

19.11 with the prior approval of the Council for Medical Schemes, to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

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

19.13 to make a donation to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the beneficiaries of the Scheme;

19.14 to make additional benefit payments on behalf of beneficiaries in order to assist such members to meet commitments in regard to any matter specified in these rules;

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19.15 to meet legal costs incurred by the Scheme or by members in enforcing or defending any right or interest of the Scheme or of its members, including but not limited to payment by any person of contributions or any other moneys referred to in these rules;

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

19.17 to reinsure obligations in terms of the benefits provided for in these rules;

19.18 to delegate either generally or specifically to a committee appointed by it from its members and/or other experts or to an officer employed by the Scheme, any of its functions, duties and powers;

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

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

19.21 in general, to do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these rules;

19.22 to apply risk management tools in terms of the benefits provided for in these Rules.

20. DUTIES OF PRINCIPAL OFFICER AND STAFF

20.1 The staff of the Scheme must, in terms of the Protection of Personal Information Act, ensure the confidentiality of all information regarding its beneficiaries.

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

20.2.1 he/she acts in the best interests of the members of the Scheme at all times;

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

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

20.2.4 he/she keeps the Board sufficiently and timeously informed of the affairs of the Scheme that relate to the duties of the Board as stated in Section 57(4) of the Act;

20.2.5 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;

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

20.3 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.

20.4 The Principal Officer shall ensure the carrying out of all of his/her duties as are necessary for the proper execution of the business of the Scheme. He/She shall attend all meetings of the Board, and any other duly appointed committee where his/her attendance may be required, and ensure proper recording of the proceedings of all meetings, but shall have no vote.

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

20.6 The Principal Officer shall, with the concurrence of the Board, cause the termination of the services of any employee of the Scheme.

20.7 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.

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

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21. INDEMNIFICATION & FIDELITY GUARANTEE

21.1 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.

21.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers.

22. FINANCIAL YEAR OF THE SCHEME

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

23. BANKING ACCOUNT

The Scheme shall maintain a banking account with a registered commercial bank. All moneys received shall be deposited to the credit of such account and all payments shall 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.

24. AUDITOR & AUDIT COMMITTEE

24.1 The Board shall in compliance with Section 36 of the Act, appoint an auditor for the duration determined by the Board from time to time.

24.2 The following persons are not eligible to serve as auditor of the Scheme—

24.2.1 a member of the Board;

24.2.2 an employee, officer or contractor of the Scheme;

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

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

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

24.3 Whenever for any reason an auditor vacates his/her office prior to the expiration of the period for which he has been appointed, the Board must within thirty (30) days appoint another auditor to fill the vacancy for the un-expired period.

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24.4 If the Board fails to appoint an auditor in terms of this rule, the Registrar may at any time make such appointment.

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

24.6 The auditor must report to the audit committee of the Scheme on the accounts examined by him and on the financial statements to be laid before the Scheme in general meeting.

24.7 The Board shall appoint an audit committee of at least five (5) members of whom two must be members of the Board. The Chairperson of the Audit Committee may not be a member of the Board.

25 GENERAL MEETINGS

25.1 Annual General Meeting

25.1.1 The annual general meeting of members shall be held not later than 31 August of each year, either physically or virtually.

25.1.2 The notice convening the annual general meeting containing the agenda and advising how the annual financial statements, auditor's report and annual report may be obtained, shall be furnished to members at least twenty-one (21) days before the date of the meeting. The non-receipt of such notice by a member shall not invalidate the proceedings at such a meeting.

25.1.3 Thirty (30) members of the Scheme shall constitute a quorum. If a quorum is not present after the lapse of thirty (30) minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed for a further thirty (30) minutes and members then present, constitute a quorum.

25.1.4 The financial statements and reports specified in Rule 20.8 must be laid before the meeting.

25.1.5 Every notice of motion to be placed before the annual general meeting shall reach the Principal Officer not later than seven (7) days prior to the date of the meeting, failing which such notice shall be invalid.

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25.2 **Special General Meeting**

25.2.1 A special general meeting of members may be called at any time by the Board whenever it deems it necessary.

25.2.2 On the written requisition of at least fifty (50) members of the Scheme the Board shall cause a special general meeting to be called within thirty (30) days after the deposit of the requisition, at the Scheme's registered office. The requisition shall state the motions to be proposed at such meeting and shall be signed by the members and only those matters specified therein shall be discussed at such meeting.

25.2.3 The notice convening a special general meeting shall be furnished to members at least fourteen (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.

25.2.4 Fifty (50) members present shall constitute a quorum. If a quorum is not present at a special general meeting after the lapse of thirty (30) minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled.

26 VOTING

26.1 Every member in good standing, who is present at a general meeting of the Scheme has the right to vote at such meeting.

26.2 The Chairperson shall determine whether voting shall be by secret ballot or by a show of hands. In the event of the votes being equal the Chairperson, if he/she is a member of the Scheme, has a casting vote in addition to his/her deliberative vote.

26.3 A member may appoint another member of the Scheme, who is in good standing, as a proxy to attend, speak and vote in his/her stead.

26.4 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.

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27. COMPLAINTS AND DISPUTES

27.1 Members may lodge their complaints, indicating the nature of the complaint in writing, addressed to the Principal Officer. The Scheme shall also provide, a dedicated telephone number, which appears on claim statements, and which may be used for dealing with complaints telephonically.

27.2 All complaints received in writing shall be responded to by the Scheme in writing within thirty (30) days of receipt thereof.

27.3 Two (2) persons, who shall not be members of the Board or officers or employees of the Scheme or of the administrator of the Scheme, shall be appointed by the Board to be the Scheme's disputes committee, to adjudicate upon any dispute declared by a member, prospective member or former member arising from the administration, control or management of the Scheme and existing between the Scheme and such member, prospective member or former member or any person deriving his/her claim from any such member.

27.4 The disputes committee may, before any evidence has been led and with the consent of the Principal Officer, summon not more than two (2) persons who are not members of the Board or officers or employees of the Scheme or of its administrator and who have particular skills or experience in those matters which may have to be considered at the adjudication contemplated by Rule 27.3, to sit with the disputes committee as assessors.

27.5 The disputes committee shall determine the procedures to be followed and applied in settling any dispute.

27.6 The disputes committee shall in addition to any powers vested in it by or under any law, have power to hear such relevant evidence as may be adduced by either party to the dispute and thereafter to arrive at a settlement of the dispute which settlement shall, subject to an appeal to the Council for Medical Schemes be binding on the parties to the dispute.

27.7 Any party to a dispute shall be entitled either personally or through the offices of counsel or an attorney or counsel and an attorney, to appear and to adduce or cause to be adduced evidence before the disputes committee, to examine and cross-examine witnesses and to address the disputes committee at any of its sittings on any matter which, in the opinion of the Chairperson of the disputes committee, is relevant to the dispute.

27.8 The remuneration of the persons serving on the disputes committee shall be as determined by the Board appointing such disputes committee. Any other expenditure which may be deemed to have been necessarily incurred in the proper performance by the disputes committee of its functions, shall be determined by the Principal Officer in consultation with the Chairperson of the disputes committee.

28. DISSOLUTION OF THE SCHEME

28.1 The Scheme shall be dissolved only by order of a competent court or by a decision of members as provided for in Rule 28.3.

28.2 In the event of the dissolution of the Scheme pursuant to an order of court the winding up of the Scheme shall be in accordance with the provisions of the Act, and with the conditions contained in the court order.

28.3 If seventy-five percent (75%) of the members of the Board should decide that the Scheme should be dissolved, the Principal Officer, by direction of the Board shall despatch to every member of the Scheme a memorandum containing the reasons for the proposed dissolution, and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper; provided that the memorandum and the ballot paper shall before dispatch, be forwarded to the Registrar for comment. Every member shall be requested to return his/her ballot paper duly completed before a date stipulated in the said memorandum. If at least fifty percent (50%) of members return their duly completed ballot papers and if the majority thereof are in favour of the proposed dissolution, the Board shall take a formal decision that the Scheme shall be dissolved with effect from a particular date, from which date no further contributions shall be payable to the Scheme. If two successive attempts fail to obtain fifty percent (50%) of the ballot papers, the Registrar may be requested to determine a lower percentage.

28.4 If a decision to dissolve the Scheme has been taken in terms of Rule 28.3, the dissolution shall be effected in accordance with the memorandum and as provided for in the Act. For the purpose of such dissolution the Board shall appoint a professional liquidator in consultation with the Registrar.

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29. AMALGAMATION AND TRANSFER OF BUSINESS

29.1 The Board may propose that the Scheme should, 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 shall arrange for members to decide by ballot whether the proposed amalgamation should be proceeded with or not.

29.2 If at least fifty percent (50%) 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.

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

30. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

30.1 Any beneficiary must on request and on payment of a fee of R50.00 per copy, be supplied by the Scheme with a copy of the following documents -

30.1.1 The rules of the Scheme including any network/preferred providers and DSP's;

30.1.2 the latest audited annual financial statements, returns, Trustees' reports and auditor's report; and

30.1.3 the accompanying management accounts in respect of all of its benefit options.

30.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 30.1 and to make extracts therefrom.

30.3 Any person who is entitled to access information, shall apply to the Scheme and obtain such information in compliance with the Promotion of Access to Information Act, No 2 of 2000.

31. AMENDMENT OF RULES

31.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure and to determine the implementation date thereof.

31.2 No alteration, rescission or addition which affects the objects of the Scheme or which increases the rates of contribution or decreases the extent of benefits of the Scheme or of any particular benefit option by more than twenty five

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percent (25%) during any financial year, is valid unless it has been approved by a majority of members present at an annual general meeting or a special general meeting or by ballot.

31.3 No alteration, rescission or addition to these rules shall be valid unless approved and registered by the Registrar in terms of the act.

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

31.5 Notwithstanding the provisions of Rule 31.1 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.

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ANNEXURE A

LA-HEALTH CONTRIBUTIONS

PREAMBLE

1. Members who have elected to have benefits for themselves and their registered dependants as set out in any one of the relevant benefit schedules of Annexure B, shall pay the contributions as specified in the corresponding contribution schedule hereof.

2. Contributions are due monthly in arrears.

3. Premium penalties may be applied in terms of the Regulations under the Act in respect of persons over the age of 35 years, who were without medical scheme cover for the period indicated hereunder but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001 without a break in coverage exceeding three consecutive months since 1 April 2001 -

Period without cover	Penalty
1 – 4 years	**0.05 multiplied by the relevant contribution**
5 – 14 years	**0.25 multiplied by the relevant contribution**
15 – 24 years	**0.50 multiplied by the relevant contribution**
25 plus years	**0.75 multiplied by the relevant contribution**

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ANNEXURE A (1)

WITH EFFECT FROM 1 JANUARY 2022

LA-Health Comprehensive Option – Contribution Schedule

MONTHLY INCOME R	MEMBER R	ADULT DEPENDANT R	CHILD DEPENDANT R	MAXIMUM FOR CHILD DEPENDANTS R
MONTHLY CONTRIBUTION	R6,981.00	R5,529.00	R1,681.00	R5,043.00
MONTHLY SAVINGS CONTRIBUTION (COMPULSORY)	R 1,082.00	R 628.00	R 274.00	R 822.00

The contribution payable for children referred to in the definition of "Child", shall be limited to 3.

ANNEXURE A (2)

WITH EFFECT FROM 1 JANUARY 2022

LA-Health Core Option – Contribution Schedule

	MEMBER	ADULT DEPENDANT	CHILD DEPENDANT	MAXIMUM FOR CHILD DEPENDANTS
MONTHLY CONTRIBUTION	R5,146.00	R4,671.00	R1,448.00	R4,344.00
MONTHLY SAVINGS CONTRIBUTION (COMPULSORY)	R 871.00	R 761.00	R 350.00	R1,050.00

The contribution payable for children referred to in the definition of "Child", shall be limited to 3.

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ANNEXURE A (3)

WITH EFFECT FROM 1 JANUARY 2022

LA-Health Active Option – Contribution Schedule

	MEMBER	ADULT DEPENDANT	CHILD DEPENDANT	MAXIMUM FOR CHILD DEPENDANTS
MONTHLY CONTRIBUTION	R2,525.00	R1,667.00	R 788.00	R2,364.00
MONTHLY SAVINGS CONTRIBUTION (COMPULSORY)	R 602.00	R 435.00	R 249.00	R 747.00

The contribution payable for children referred to in the definition of "Child", shall be limited to 3.

ANNEXURE A (4)

WITH EFFECT FROM 1 JANUARY 2022

LA-Health Focus Option – Contribution Schedule

	MEMBER	ADULT DEPENDANT	CHILD DEPENDANT	MAXIMUM FOR CHILD DEPENDANTS
MONTHLY CONTRIBUTION	R1,940.00	R1,253.00	R 570.00	R1,710.00
MONTHLY SAVINGS CONTRIBUTION (COMPULSORY)	R 649.00	R 420.00	R 191.00	R 573.00

The contribution payable for children referred to in the definition of "Child", shall be limited to 3.

ANNEXURE A (5)

WITH EFFECT FROM 1 JANUARY 2022

LA-Health Key Plus Option – Contribution Schedule

MONTHLY INCOME R	MEMBER R	ADULT DEPENDANT R	CHILD DEPENDANT R	MAXIMUM FOR CHILD DEPENDANTS R
R 0 – R10 100	R1,239.00	R1082.00	R 453.00	R1,359.00
R10 101 – R14 000	R1,307.00	R1,143.00	R 477.00	R1,431,00
R14 101+	R1,968.00	R1,751.00	R 735.00	R2,205.00

The contribution payable for ch on of "Child", shall be limited to 3.

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LA-HEALTH BENEFITS

PREAMBLE

1

1.1 Subject to the provisions contained in these rules, members paying the contributions as specified in the relevant contribution schedule of Annexure A, are entitled to the benefits for themselves and for their registered dependants, as set out in the corresponding benefit schedule hereof.

1.2 Unless specifically provided otherwise in these Rules the Scheme shall provide beneficiaries with full cover (i.e. at 100% of cost) for services rendered by a designated service provider or subject to paragraph 1.4 and 9.3 at 100% of cost up to the LAHR or LAMR whichever is applicable where services are voluntarily obtained from a non-designated service provider in respect of diagnosis, treatment and care for the conditions specified in the Statutory Prescribed Minimum Benefits in at least one service provider or service provider network which shall at all times include the State Hospital system.

1.3 The diagnosis, treatment and care costs of the statutory prescribed minimum benefit conditions will be paid in full if those services are obtained from the designated service provider, or if involuntarily obtained from a provider who is not the designated service provider.

1.4 If services in respect of the prescribed minimum benefit conditions are voluntarily obtained from a provider who is not a designated service provider;

- where the service is rendered in a non-DSP hospital the co-payment will be equal to the difference between the fees that would have been charged by the DSP and that which were actually charged, unless the benefit schedule indicates otherwise. This provision is applicable to all options.

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- a co-payment shall apply if the cost of providing diagnosis, treatment and care in respect of the prescribed minimum benefit condition exceeds the amount that the DSP would have charged for such service. The co-payment will be equal to the difference between the fees that would have been charged by the DSP and that which were actually charged, unless the benefit schedules indicate otherwise.

- no co-payment shall apply if the cost of providing diagnosis, treatment and care in respect of the prescribed minimum benefit condition is less than the amount that the DSP would have charged for such service except where the relevant DSP agreement is either capitation or volume related discount-based.

1.5 A beneficiary will be deemed to have involuntarily obtained a service from a provider other than the designated service provider, if:

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) 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 the designated service provider; or

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

1.6 If cover, in terms of these rules, for a condition specified in the prescribed minimum benefits is exhausted while the patient is still undergoing or requires diagnosis, care or treatment for that condition, the Scheme will accept liability for all costs incurred, subject to paragraph 1.4 above.

2 Pre-authorization shall be required before non-emergency hospitalization, surgical procedures and other specified items may qualify for benefits. In the case of an emergency the Scheme must be notified thereof within two working days after such an emergency admission or treatment having been initiated, failing which paragraph 3 (c) of this preamble will apply. Notwithstanding anything to the contrary in these rules contained, the Scheme shall not refuse such authorization or pre-authorization for a prescribed minimum benefit in a public hospital.

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3 In respect of benefits set out in this Annexure the following principles shall apply in all cases where pre-authorization is required -

(a) if pre-authorization is obtained and the treatment does not exceed the authorization, the treatment will qualify for the benefits as stated;

(b) if pre-authorization is obtained and the authorization is exceeded, benefits will only accrue for the authorized treatment. The cost pertaining to the treatment in excess of that pre-authorized will be payable by the member. In exceptional cases the Board may agree to a retrospective authorization, subject to such terms and conditions as the Board may determine.

(c) if treatment is undergone without pre-authorization having been obtained, application may be made retrospectively for an authorization. In the event of such authorization being granted the benefit will, except in cases of an emergency medical condition or where from a clinical perspective the required authorization would under normal circumstances have been issued in accordance with the findings of the Scheme's Medical Advisor on the merits of each case, be subject to a co-payment of 30% with a maximum of R1000 per case. If authorization is declined no benefits will accrue: Provided that authorization for prescribed minimum benefits will not be refused, but shall be covered in full as provided for in paragraph 1 above.

4 Claims must be submitted in accordance with the instructions contained in Annexure D.

5 Maximum annual benefits shall be calculated from 1 January to 31 December each year, based on the services rendered during that year.

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

7 The Scheme shall if circumstances so dictate enter into or cause to be entered into such arrangements, agreements or contracts with healthcare professionals, private

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hospitals or hospital groups, including but not limited to per diem reimbursements, as may be considered appropriate. Benefit entitlements shall, unless otherwise indicated in the benefit schedules appended hereto, be 100% of the cost according to the arrangement, agreement or contract.

8 DENTAL SERVICES

8.1 Basic Dentistry

Services include:

(a) consultations, including full mouth examination, charting and treatment planning and visits;

(b) full mouth intra-oral radiographs payable once per beneficiary in a 2 year cycle;

(c) intra-oral periapical and occlusal radiographs;

(d) bitewing radiographs – 1 set of bitewing per beneficiary per annum;

(e) panoramic radiographs – payable once per beneficiary in a 2 year cycle;

(f) prophylaxis – 2 per beneficiary per annum;

(g) topical application of fluoride – 1 treatment per annum for a beneficiary up to 18 years of age;

(h) fissure sealants on children up to 18 years only;

(i) endodontics (root canal treatment);

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(j) dentures (plastic and partial metal base) – limited to 1 set per arch per beneficiary in a 2 year cycle, excluding gold inlays in dentures; and re-lining & re-basing of dentures;

(k) plastic restoration; and

(l) base metal inlays in posterior teeth only.

(m) extractions and surgical removal of teeth.

8.2 Special Dentistry - subject to pre-authorisation

Services include:

(a) orthodontic treatment;.

(b) periodontic treatment;

(c) prostodontic treatment;

(d) crown and bridge-work.

(e) Gold inlays and gold restorations on permanent teeth only.

8.3 Dental treatment required to be carried out in a Hospital or Day Clinic under general anaesthetic or conscious sedation, shall be subject to the relevant Benefit Schedules.

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9. PRESCRIBED MEDICINE

Services include the cost of medicines and materials for injections and vaccinations, prescribed by a medical practitioner, dentist or any other service provider who is

legally entitled to prescribe medicine for use out of hospital. The benefits provided for in the Annexures appended hereto are subject to:

9.1 The benefit in respect of medicines being restricted per prescription to a maximum of one month's supply of each kind of medicine prescribed or to a maximum of the nearest equivalent standard packaging of each kind of medicine prescribed, as the case may be; and

9.2 If the Maximum Medical Aid Price List of Medicine issued by the Pharmaceutical Society of South Africa contains an equivalent for any medicine prescribed, the benefit in respect of the medicine so prescribed shall be calculated on the maximum medical aid price of such equivalent medicine.

9.3 Chronic Medication

For the purposes hereof the Scheme regards chronic medication, as medicines that are used for the treatment of the chronic disease conditions and for the life threatening conditions which fall within the conditions shown on the CDL. and PMB chronic conditions.

The Chronic Disease List (CDL) appended to the benefit schedules hereto reflects the prescribed minimum benefit conditions. Other chronic conditions where covered by the Scheme are shown in a separate list also, appended to the relevant benefit schedule. This list may be amended by the Board of Trustees from time to time, and any criteria attached to each condition shall be applied in terms of the Scheme's Chronic Medication Programme.

The following further criteria shall pertain:

(a) The medicine must be prescribed by a registered medical practitioner.
(b) The prescribed medicines must, in the opinion of the medical practitioner, be essential to relieve the symptoms or limit the progress of a condition that is ongoing and which could seriously debilitate a person's health.

In Annexure B1 and B2, chronic medication detailed in the CDL is subject to pre-authorisation. PMB conditions have unlimited cover.

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In Annexures B1 to B5, chronic medication detailed in the CDL and PMB is subject to pre-authorisation. PMB conditions have unlimited cover.

PMB conditions and HIV/AIDS treatment is subject to a formulary. Should a beneficiary elect not to use medicine on the formulary or a non-DSP a co-payment equal to the difference between the cost of the formulary medicine and the amount charged for the non-formulary medicine will be applicable.

The DSP for the obtaining of chronic medication is through the Scheme's Pharmacy Networks. Rate of reimbursement as per Annexure G of these Rules.

9.4 Acute Medicines

These are medicines that do not qualify as any of the two aforementioned classifications.

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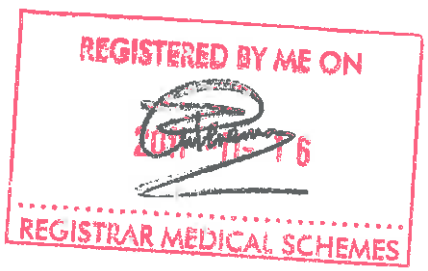

Annexure B(1)

BENEFIT SCHEDULE

LA COMPREHENSIVE OPTION
(With effect from 1 January 2022)

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GENERAL RULES APPLICABLE TO THIS ANNEXURE

(1) In this option, unless otherwise stated, all elective in-hospital PMB treatment and care must be obtained from a hospital in the KeyCare Network of hospitals. Specific treatment and procedures, as per the list provided in Annexure H of these Rules, to be obtained from one of the Scheme's identified Preferred Provider Day Surgery facilities.

(2) In this option, unless otherwise indicated in this schedule, an out of hospital ***NON-PMB*** benefit will be financed first from the Medical Savings Account (MSA) accumulating up to an Annual Threshold. Unless stated differently in the tables below, upon depletion of the MSA all ***NON-PMB*** out of hospital claims must be self-funded by the member. If applicable, the claims will accumulate towards the relevant annual threshold (AT) as specified in the benefit schedule hereunder. Thereafter, benefits so indicated in this schedule, will be paid from the Above Threshold Benefit (ATB) subject to the applicable limits.

(3) The Medical Savings Account (MSA) and the Annual Threshold Benefit (AT) are compulsory levels of cover, in this option, for the day-to-day ***NON-PMB*** expenses up to the following annual limits:

		MSA		AT
Per Member	R	12.984	R	18.084
Per Spouse/Adult Dependant	R	7.536	R	12.336
Per Child (to a maximum of three)	R	3.288	R	5.436

(4) This Option has no overall annual limit.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
A.	**Statutory Prescribed Minimum Benefits subject to paragraph 1.4 of Annexure B**			
	Private Hospital, subject to DSP for elective procedures / treatment	100% of Cost	Unlimited	1. Basis of cover as contained in Annexure G. 2. Diagnosis, treatment and care costs subject to pre-authorisation and the preamble hereto covered from MMB (including Radiology, Pathology and MRI/CT Scans).
	Out of Hospital *Including: ■ Oncology, Chemothery, Radiotherapy, Organ Transplants (including Bone Marrow transplants) and Kidney Dialysis. ■ Psychological, psychiatric treatment and drug and alcohol rehabilitation. ■ Authorised related medicines and TTO. ■ Specialist and general practitioners in and out-of-hospital ■ Confinements and midwives.			3. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 4. Limited up to a maximum of 21 Days in respect of Drug and Alcohol Abuse up to a maximum of the rate contracted with SANCA. 5. Limited up to a maximum of 3 Days in respect of Detoxification up to a maximum of the rate contracted with SANCA.
B.	**In Private Hospitals, Unattached Operating Theatres and Day Clinics**			
	Accommodation in a general ward, high care ward and intensive care unit. Theatre fees. Medicines, materials and hospital equipment. Outpatient services. Confinement and midwives.	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB. 4. Medicines include the completion of a course of treatment specifically related to the event giving rise to hospitalisation. 5. Outpatient/Casualty visits paid from MSA, except in the case of PMB's.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
	In Private Hospitals, Unattached Operating Theatres and Day Clinics			
	In-hospital consultations, surgical and other procedures including maxillo-facial procedures (Severe infections, jaw-joint replacements, cancer-related and trauma-related surgery, cleft-lip and palate repairs)	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB. 4. Medicines include the completion of a course of treatment specifically related to the event giving rise to hospitalization. 5. Outpatient/Casualty visits paid from MSA, except in the case of PMB's.
	Day surgery procedures or treatment Healthcare services reflected in Annexure H at a defined list of preferred facilities	100% of Cost up to LAHR	Unlimited	Subject to pre-authorisation and clinical criteria.
	Endoscopic procedures, gastroscopy and colonoscopy	100% of Cost up to LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Spinal care and surgery In and out of hospital management of spinal care and surgery for a defined list of clinically appropriate procedures, which include Lumbar or Cervical Fusion,Laminectomy or Laminotomy	100% of cost up to LAHR or up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB. 4. Out-of-hospital conservative treatment subject to the Scheme's basket of care.
	Colorectal cancer care and surgery In and out of hospital management of colorectal cancer and related surgery	100% of cost up to LAHR or up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB.
C.	**Out of Hospital Procedures/Operations**			
	1. Surgical procedures	100% of Cost up to LAHR	Unlimited	Subject to pre-authorisation, covered from MMB including the channeling of a clinical procedure or operation from hospital to the doctor's room.
	2. Endoscopic procedures, laser tonsillectomy, gastroscopy, colonoscopy, 24 hour oesophageal pH studies and oesophageal motility studies	100% of Cost up to LAHR	Unlimited	Scope codes only: Covered from MMB. Subject to pre-authorisation. Related accounts paid from and limited to funds in Medical Savings Account/ Above Threshold Benefit.
D.	**Home-based care in lieu of hospitalisation / early discharge from hospital**			
	Home-based care for clinically appropriate chronic and acute treatment and conditions that can be treated at home	100% of cost up to LAHR, subject to PMB	Unlimited in baskets of care	1. Subject to authorisation / approval and paid from MMB. 2. Subject to treatment guidelines and clinical and benefit criteria and services provided by the Scheme's preferred providers, where applicable, and the treatment meeting clinical and benefit entry criteria. 3. Defined services in the Scheme's baskets of care apply.
	Clinically appropriate home monitoring devices for home monitoring of chronic and acute conditions	100% of the cost up to the LAHR	Subject to the Scheme's basket of care	1. Paid from the Major Medical Benefit, subject to basket of care. 2 Subject to approval, the Scheme's protocols and clinical and benefit entry criteria.
E	**Practitioners (Out of Hospital)**			
	GP and Specialists visits in doctor's rooms, virtual and tele consultations	100% of Cost up to LAHR	Limited to funds in MSA/ATB	Covered from MSA/ATB except for PMB's.
	Virtual Paeditrician Consultations children aged 14 and under from a Network Paeditrician consulted in the 6 months immediately prior to the virtual consultation	100% of Cost up to LAHR	Unlimited	Once the MSA has been depleted and before the Threshold is reached, ~~virtual~~ virtual Paediatrician Consultations paid from MMB per qualifying child. Amounts so paid shall not accumulate to Threshold.
	Second-opinion consultation obtained from specialists at the Cleveland Clinic	50% of Cost	Unlimited	Paid from MMB to a maximum of 50% of the cost of the consultation. Subject to pre-authorisation.
	Nurse Practitioners	100% of Cost up to LAHR	R12,330 per family	Covered from MSA. Once the AT has been reached, covered from ATB. Registered nursing services only. Domestic services excluded.
	Trauma related casualty visits for children aged 10 and under (includes consultation, facility fee and consumable codes billed) at a hospital in the Scheme's casualty network	100% of Cost up to LAHR	2 visits per child per annum	1. Paid from MMB once MSA is depleted, but before the annual threshold is reached. 2. Limited to 2 visits per child. 3. Member must be in self-payment GAP. 4. Does not accumulate to Threshold.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
F.	**Dentistry**			
	In-Hospital:			**Subject to pre-authorisation**
	Specialised dentistry	100% of cost up to LAHR	In-hospital account unlimited Related non-hospital accounts limited to R32,700 per beneficiary	1. Deductible payable by the member: Hospital – Younger than 13 years – R2,220 Hospital – Older than 13 years – R5,610 Day Clinics – Younger than 13 years – R1,090 Day Clinics – Older than 13 years – R3,670 2. Balance of Hospital/Day Clinic account (after deductible) paid from MMB. 3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from MMB, subject to joint limit of R32,700 per beneficiary per year for in- and out-of-hospital specialized dentistry.
	Basic dentistry	100% of cost up to LAHR	Joint limit of R16,890 per beneficiary for basic dentistry in- or out-of-hospital	**Subject to pre-authorisation** 1. Deductible payable by the member: Hospital – Younger than 13 years – R2,220 Hospital – Older than 13 years – R5,610 Day Clinics – Younger than 13 years – R1,090 Day Clinics – Older than 13 years – R3,670 2. Balance of Hospital account (after deductible) paid from MMB. 3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from MSA/ATB, subject to joint limit of R16,890 per beneficiary per year for in- and out-of-hospital basic dentistry.
	Out-of-Hospital:			
	Specialised dentistry	100% of cost up to LAHR	Combined overall limit of R32,700 per beneficiary for specialized dentistry in- or out-of-hospital	Paid from and limited to funds in MSA/ATB, subject to joint limit of R32,700 per beneficiary for specialized dentistry performed in-or out-of-hospital.
	Basic dentistry	100% of cost up to LAHR	Combined overall limit of R16,890 per beneficiary for basic dentistry in- or out of hospital	Paid from and limited to funds in MSA/ATB, subject to joint limit of R16,890 per beneficiary for basic dentistry performed in-or out-of-hospital.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
G.	**Prescribed Pharmaceuticals Including TTO**			
	Acute sickness conditions	100% of LAMR for medicine on preferred list and 90% for medicine not on preferred list	M : R11,005 M1 : R14,075 M2 : R16,965 M3 : R19,570 M4+: R22,265	Covered from MSA. Once the AT has been reached, covered from ATB.
	Speciality Medicine and Technology Benefit (SMTB)	100% of cost up to the LAHR	Limited to R228,000 per beneficiary per annum	Paid from MMB. A co-payment up to 20% applies based on the specific condition and medicine as defined for all Non-PMB treatment.
	Over-the-Counter Medication (Schedule 0, 1 and 2, generic or non-generic whether prescribed or not)	100% of cost	Limited to funds in MSA	1. Benefit will not accumulate to the AT. 2. A sub-limit of R1,570 per beneficiary per year applies to certain categories of unscheduled supplements, provided as OTC.
	PMB Chronic conditions (including but not limited to the appended CDL)	100% of cost	Unlimited based on Formulary	1. Subject to pre-authorisation, and the preamble hereto. 2. Full cover based on a formulary. If non-formulary medicine is used voluntarily the Scheme will pay up to the monthly Chronic Drug Amount (CDA). This is subject to Regulations 15 h (c) and 15 i (c). 3. Covered from MMB. 4. In the case of PMB's Annexure G applies. 5. Costs for completion of chronic application form covered from MMB.
	Diabetes Care or Cardio Care Disease Management Programmes	100% of LAHR	Unlimited	Non-PMB GP and other -related services covered in a treatment basket, subject to referral by the Scheme's Network GP and participation on the Chronic Illness Benefit. Paid from MMB.
	Continuous blood glucose monitoring	100% of the LAHR	Limited to R1,560 per beneficiary per month for sensors only	1. Subject to the patient being registered on the Scheme's Diabetes Management Programme, approval, criteria and the sensors obtained from a DSP dispensing Pharmacy. 2 Readers and/or transmitters paid from MSA/ATB, subject to the External Medical Items benefit, limited to R4,350 per device. 3. Purchase of the sensors subject to an annual co-payment: Adult beneficiary: R1,170; Paediatric beneficiary: R1,560
	Other chronic conditions (as per appended list) in so far as they don't form part of the PMB's which will not be subject to the annual limit	Paid up to a monthly Chronic Drug Amount and subject to annual limit	M : R 5,880 M1 : R11,830 M2 : R13,695 M3 : R15,575 M4 : R16,870 M5+: R18,545	1. Subject to pre-authorisation, and the preamble hereto. 2. Full cover based on a formulary. If non-formulary medicine is used voluntarily the Scheme will pay up to the monthly Chronic Drug Amount (CDA). This is subject to Regulations 15 h (c) and 15 i (c). 3. Covered from MMB. 4. In the case of PMB's Annexure G applies. 5. Costs for completion of chronic application form covered from MMB.
H.	**Radiology**			
	In Hospital (x-rays)	100% of cost up to the LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Out of Hospital (x-rays)	100% of cost up to the LAHR	Unlimited one in ATB	Covered from MSA. Once the AT has been reached, unlimited from ATB.
	MRI/CT scans (in hospital and out of hospital)	100% of cost up to the LAHR	Unlimited	Subject to referral by specialist. Covered from MMB. Subject to pre-authorisation in-hospital.
	PET scans	100% of cost up to the LAHR	Unlimited	Subject to clinical criteria, motivation and authorisation. Covered from MMB.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
I.	**Oncology, including Chemotherapy and Radiotherapy**	100% of cost for PMB's at DSP	Unlimited	1. Non-PMB paid up to LAHR from MMB. All oncology benefits accrue to a threshold of R456,000 per beneficiary per 12 month cycle. Once this threshold has been reached member will be liable for 20% co-payment on all further Non-PMB claims. (basis of cover as contained in Annexure E (C) 5.4)
	Oncology-related PET scans	100% of cost up to the LAHR	Unlimited from MMB	1. Services obtained from the Scheme's DSP Network (basis of cover as contained in Annexure E (C) 5.5). 2. Accrues to Oncology threshold of R456,000. Once rhreshold is reached all future claims subject to a 20% co-payment, irrespective of DSP or non-DSP. 3. Voluntary use of non-DSP providers, paid up tp 80% of the LAHR from R1.
	Advanced Illness Benefit and the Oncology member support programme for Oncology patients	100% of cost up to LAHR	Unlimited	Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
	Oncology Innovation Benefit, providing access to cover for a defined list of non-PMB novel and ultra-high cost treatment	75% of the LAMR	Unlimited	1. Accumulates to the 12-month Oncology threshold. 2. Paid at 75% of the Scheme Rate below and above the Oncology threshold. 3. Access to the benefit is subject to: 3.1 Meeting clinical criteria as specified or adopted by the Scheme. 3.2 Peer review by a Scheme appointed panel of specialists.
J.	**Organ Transplants (including Bone Marrow / Stem Cell transplants) and Kidney Dialysis** (includes authorised related medicines)	100% of cost up to LAHR 100% of cost for PMB's at DSP	Unlimited	1. Subject to pre-authorisation and case management (basis for cover as contained in Annexure E (C) 5.2), covered from MMB. 2. Acute and Chronic Dialysis paid from MMB, at National Renal Care Facilities. Subject to approval of treatment plan. If non-DSP is used voluntarily the claim is paid at the agreed LA Health Rate. 3. Locally sourced Stem Cell Transplant benefit subject to authorisation, clinical criteria and review.
K.	**Mental Health Benefit** Psychological, Psychiatric treatment and Drug and Alcohol rehabilitation with due regard to the PMB's (paragraph A)			Refer to Annexure G for PMB's
	In- or Out-of-Hospital PMB related care	100% of cost up to LAHR	Up to a maximum of 21 Days per beneficiary per annum	1. Covered in full from MMB at the DSP. 2. If services of non-DSP is used voluntarily, a 20% co-pay applies to the hospital account. 3. Subject to clinical criteria and protocols. 4. A maxiumum of 21 Days In-Hospital or 15 days Out-of-hospital psychologist or psychiatrist contacts for PMB related conditions, both accruing to the maximum of 21 treatment days. 5. Further limited to a maximum of 21 days for alcohol or drug abuse-related rehabilitation, or treatment and care in the case of an attempted suicide and 3 days for in-hospital detoxification services.
	Out of Hospital non-PMB mental health benefits (including psychologists, psychiatrists, art therapy and social workers)	100% of cost up to LAHR	R21,200 per family	Covered from MSA. Once the AT has been reached, thereafter covered from ATB. (The limit includes a sub-limit of R7,050 per beneficiary for alcohol and drug rehabilitation).
	Disease management for major depression for members registered on the Mental Health Care Programme, including benefits to prevent relapse or recurrence of a major depressive episode	100% of the LAHR	Unlimited.	Non-PMB GP-related services covered in the Scheme's basket of care subject to treatment guidelines and managed care criteria, and referral by the Scheme's Network GP. Paid from MMB. Specific limits apply in the basket of care.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
L.	**Physiotherapy**			
	Pre-Hospital, In-Hospital and Post-Hospital	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation and case management, covered from MMB.
	Out of Hospital	100% of cost up to LAHR	Unlimited	Covered from MSA. Once the AT has been reached, unlimited from ATB.
M.	**Blood Transfusions and Blood Products/Equivalents**	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, covered from MMB.
N.	**Ambulance Services**	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation, covered from MMB. 2. The services of the Scheme's DSP, must be used.
O.	**Alternatives to hospitalisation** Approved Step-down Nursing Facilities Private Nursing	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation and case management, covered from MMB. 2. Private nursing excludes domestic services.
	Hospice (terminal care excluding frail care)	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to clinical entry criteria.
P.	**Auxiliary Services** Audiology Occupational therapy Speech Therapy Chiropody/Podiatry Dietetics Homeopathy Naturopathy Chiropractics Orthoptics Acupuncture Any other registered auxiliary service	100% of cost up to LAHR	Unlimited once in ATB.	Covered from MSA. Once the AT has been reached, unlimited from ATB. Providers of service must be registered with the appropriate professional authority.
	Unani-Tibb therapy	100% of cost up to LAHR	Limited to funds in MSA	Paid from MSA with no accumulation to ATB.
Q.	**Internal Prostheses** Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	100% of cost up to LAHR	Limited to R235,100 per beneficiary per annum	Covered from MMB subject to pre-authorisation.
	Spinal Prostheses/Devices	100% of cost up to LAHR	Unlimited	Paid from MMB. Unlimited, subject to obtaining services from Scheme's Network Provider for prosthetic device, screws, cement and other components used in the surgery. If the Network Provider is not used, an annual limit of R52,500 per beneficiary applies, limited to R26,250 per level. Further limited to two levels per procedure, and one procedure per year.
	Hip, Knee and Shoulder replacement devices	100% of cost up to LAHR	Unlimited Subject to preauthorisation, clinical criteria, obtaining the device from a Preferred Provider, and the use of the DSP hospital for Hip and Knee replacements	Covered from MMB. Shoulder replacement devices limited to R42,950 per prosthesis per admission if from a non-Preferred Provider. Hip and knee replacements limited to R30,900 per device from a non-Preferred Provider. A 20% co-payment of the hospital cost applies for hip/knee replacements when the services of a non-network hospital is used voluntarily.
	Other Internal Prostheses	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation; clinical entry criteria, covered from MMB.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
R.	**Pathology (non-PMB)**			
	In Hospital	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation and DSP for basic pathology.
	Out of Hospital	100% of cost up to LAHR	Unlimited once in ATB.	Covered from MSA except for PMB's. Once the AT has been reached, unlimited from ATB.
	Point of care pathology testing	100% of cost up to LAHR	Unlimited once in ATB	1. Covered from MSA, except for PMB's. Once the AT has been reached, unlimited from ATB. 2. Subject to meeting the Scheme's treatment guidelines and managed care criteria and the results provided by the use of Scheme accredited devices
S.	**External Medical Items**			
	Prosthetic limbs, eyes and other external prostheses, orthopaedic appliances (including wheelchairs and crutches), nebulisers, glucometers, diabetic equipment, diagnostic agents and appliances, stoma bags, bandages, hearing aids and wigs with due regard to the PMB's.	100% of cost	R30,270 per family	Covered from MSA except for PMB's. Once the AT has been reached, covered from ATB. (Subject to monitoring and a sub-limit of R20,240 per family for hearing aids)
	External Medical Items Extender Benefit	100% of the cost	Unlimited	Covered from MMB. Subject to approval and clincial criteria.
	Oxygen rental	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, the use of Scheme's DSP and covered from MMB.
	Bluetooth enabled blood glucose monitoring device	100% of cost up to LAHR	Limited to 1 device per beneficiary per year	Covered from MMB subject to: 1. Beneficiary being registered for Diabetes on the Chronic Illness Benefit. 2. Scheme's protocols, clinical entry criteria and DSPs.
T.	**Optical**			
	Optometry Consultations	100% of cost up to LAHR	Unlimited once in ATB	Covered from MSA. Once the AT has been reached, unlimited from ATB.
	Spectacles, frames, contact lenses and refractive eye surgery (e.g. excimer laser)	100% of cost	R5,020 per beneficiary	Covered from MSA. Once the AT has been reached, covered from ATB.
U.	**Maternity**			
	Maternity Programme			
	Cover during pregnancy			
	Ante-natal visits, scans and selected blood tests and pre- or post-natal classes		8 antenatal consultations with Gyneacologist, GP or Midwife. 1 Nuchal translucency or 1 non-invasive prenatal test (NIPT) or 1 T21 Chromosome test. 2 X 2D Ultrasound scans. A defined basket of blood tests. 5 pre- or post-natal classes or consultations with a registered nurse	Paid from MMB when registered on the Maternity Programme. Limited to the applicable benefits in MSA or ATB if not registered on the Maternity Programme. 3D scans covered up to the cost of a 2D scan only.
	Cover for the newborn baby for 2 years after the birth		2 visits to GP, paediatrician or ENT	
	Cover for the mother of the newborn baby for 2 years after the birth		1 consultation at GP or Gynaecologist for post-natal complications. 1 nutritional assessment at a dietician. 2 mental health consultations with a counsellor or psychologist. 1 lactation consultation with a registered nurse or lactation specialist	
	Antenatal classes (if not registered on the Maternity Programme)	100% of LAHR	Limited to R1,775 per pregnancy.	Paid from MSA or Above Threshold Benefit.
	Doulas	100% of LAHR		Paid from MSA only.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
V.	**HIV/AIDS and related illnesses**	100% of cost	Unlimited	1. Subject to evidence-based managed care protocols/formularies as provided for in regulation 15, and managed by the Scheme's Management Programme. 2. Covered from MMB.
	HIV prophylaxis (rape and mother-to-child transmission)	100% of cost	Unlimited	1. Subject to pre-authorisation. 2. Covered from MMB.
	HIV/AIDS-related GP consultations	100% of cost	Unlimited	Subject to authorisation and obtaining treatment from DSP. A 20% co-payment applies if non-DSP is used voluntarily.
W.	**Screening Tests** Group of tests at a Pharmacy 1. Blood Glucose Test 2. Blood Pressure Test 3. Cholesterol Test 4. Body Mass Index (BMI) OR One Flu vaccination	100% of the LAHR	One or all of the 4 listed screening tests per annum per beneficiary One flu vaccination per beneficiary per year	1. Payable from MMB only if services were obtained in the Scheme's contracted network of pharmacies. 2. Payable from MSA if member voluntarily makes use of a Non-DSP. 3. Once the limit has been reached, tests will be paid for from the MSA/ATB. 4. LDL Cholesterol test, subject to clinical criteria. Paid from MMB. 1. Paid up to the Scheme Rate for Group of Tests at a Pharmacy only.
	Screening tests for children between ages 2 and 18 years of age: 1. Body Mass Index (BMI) and counselling where appropriate 2. Basic Hearing screening 3. Basic Dental screening 4. Milestone tracking for children under the age of 8	100% of the LAHR	One, or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained from the Scheme's contracted DSP. 2. Once the limit has been reached, or if member uses services of a non-DSP, applicable tests will be paid from MSA/ATB.
	Group of age appropriate screening tests for beneficiaries who are 65 years or older	Up to 100% of LAHR	Each of the assessments limited to one per beneficiary per annum	1. Subject to clinical criteria and payable from MMB for hearing, vision or frailty and core seniors assessment 2. Once the limits has been reached, or if non-DSP services are used paid for from the MSA/ATB.
	Additional screening assessment or consultation for at-risk members	up to 100% of LAHR	1 Consultation per person per annum	1. Subject to clinical criteria and treatment guidelines and the services obtained from the Scheme's accredited Network provider
	Other screening tests (subject to PMB) 1. Mammograms 2. Pap Smears 3. Prostate-Specific Antigen (PSA)	100% of the LAHR for the actual test codes only	Limit per beneficiary: One Pap Smear every 3 years. One Mammogram every 2 years. One PSA test per annum	1. The LAHR will be paid from MMB for the actual tests only. Associated consultations and other related procedures will be funded from MSA/ATB. 2. More frequent pap smears and/or mammography, MRI breast scan and once off BRCA testing, subject to clinical criteria and authorisation for at risk members.
	4. Colorectal cancer screenings for persons aged 45 to 75 years	100% of the LAHR	1 Faecal occult blood test or 1 faecal immunochemical test every 2 years	1. A Colonoscopy, subject to clinical criteria and authorisation, for persons identified to be at risk
	Other Vaccinations 1. Other vaccinations	100% of the LAHR	Unlimited	1. Paid from MSA / ATB.
	2. Pneumococcal vaccinations	100% of the LAHR	One Pneumococcal vaccine per person every 5 years for persons younger than 65 and one vaccine per person per lifetime, if older than 65	1. Subject to clinical entry criteria. Paid from MMB.

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REGISTRAR OF MEDICAL SCHEMES

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
	Genetic testing			
	1. Whole Exome screening (subject to licencing)	up to 50% of the cost	Unlimited	1. Must be obtained from Scheme's Preferred Supplier. 2. Up to 50% of the cost paid from MSA, without accumulation to the threshold. 3. Remainder of the account to be paid by the member.
	2. Newborn screening	100% of the LAHR	Unlimited	1. Limited to funds available in MSA, without accumulation to the threshold.
X.	**WHO Outbreak Benefit** Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks:			Basis for cover subject to PMB as defined in **Annexure G** Subject to obtaining the services from the Scheme's preferred providers / DSPs , where applicable. And further subject to the treatment meeting certain clinical criteria and guidelines
	Out of hospital healthcare services related to COVID-19, subject to PMB			
	Screening consultation with a Nurse or GP	100% of cost up to LAHR	Unlimited	1. Defined basket for pathology / x-rays and scans.
	Pathology / X-rays and scans	100% of cost up to LAHR	2 tests per person per year	2. Testing subject to referral.
	Consultations with a GP or nurse	100% of cost	Unlimited	
	Supportive treatment	100% of cost	Unlimited	1. Acute medicine according to a defined list.
	Vaccine, including administration costs	100% of cost	Unlimited	
	Home based care in lieu of hospitalisation	100% of cost	Unlimited	
	Pulse oximeters	100% of cost	1 device per person	
	Treatment of complications and rehabilitation for long COVID-19	100% of cost	Unlimited	1 Oferred for a period of six months if the condition persists 2 Subject to defined basket of care
Y.	**Trauma Recovery Benefit** Day-to-day cover for medical expenses related to a traumatic incident for members after suffering a loss of functionality due to a traumatic incident of an acute nature and who are left with a standard level of residual inability after discharge from hospital or rehabilitation facilities.			
	Allied, Therapeutic and Psychological healthcare services (acousticians, biokineticists, chiropractors, counsellors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and hearing therapists)	up to100% of LAHR	M = R21,900 M+1 = R29,800 M+2 = R36,300 M3+ = R42,100	1. These day-to-day benefits are paid from MMB, per family, up to the end of the year following the one in which the traumatic incident occurred. 2. Benefits will be paid up to the LAHR for day-to-day claims: i. following the traumatic onset of: Paraplegia; Hemiplegia; Quadriplegia and Tetraplegia. ii. for conditions resulting from the following traumatic incidents: Near-drowning; Severe anaphylactic reaction; Poisoning and Crime-related injuries. iii. relating to severe burns. iv. following the traumatic onset of an internal or external head injury. v. due to loss of limb, or part thereof. 3. Benefits are paid according to the general rules applicable to this Benefit Option in terms of protocols, clinical entry criteria and DSP's.
	Prescribed Medicine	up to100% of LAHR	M = R23,900 M+1 = R29,000 M+2 = R34,900 M3+ = R38,100	
	External Medical Appliances	up to100% of LAHR	R42,700	
	Prosthetic Limbs (with no further access to the External Medical Appliances Limit)	up to100% of LAHR	R92,300	
	Hearing Aids	up to100% of LAHR	R22,300	

LEGEND:

ART = Anti Retroviral Treatment
CDL = Chronic Disease List (as appended)
DSP = Designated Service Provider
LAHR = LA Health Rate
LAMR = LA Medicine Rate
MMB = Major Medical Benefit
MSA = Medical Savings Account
PMB = Prescribed Minimum Benefits
M = Member
S = Spouse/Adult
C = Child (maximum of three)

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CHRONIC DISEASE LIST: CDL (AS PER REGULATIONS UNDER THE MEDICAL SCHEMES ACT)

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Obstructive Pulmonary Disease	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus Types 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

OTHER CHRONIC CONDITIONS

(In so far as they don't form part of the PMB which are not subject to the annual limit)

Anticoagulant Therapy (PMB)	Lipidoses and other storage disorders (PMB)
Ankylosing Spondylitis	Major Psychiatric Disorders (motivated by psychiatrist) (PMB)
Arthritis	Meniere's Disease
Attention Deficit Disorder (motivated by specialist)	Migraine (motivated by physician)
Benign Prostatic Hypertrophy (motivated by urologist)	Motor Neurone Disease
Cerebro-vascular Accident (Stroke) (PMB)	Myasthenia Gravis
Chronic Urticaria (motivated by dermatologist)	Narcolepsy (motivated by physician)
Cushing's Disease/Syndrome (PMB)	Osteoporosis (only if confirmed by industry standard BMD readings)
Cystic Fibrosis	Paget's Disease
Depression (according to depression rating scale) (PMB)	Pemphigus (motivated by dermatologist) (PMB)
Eczema (severe, motivated by dermatologist)	Psoriasis (severe, motivated by dermatologist)
GORD (diagnosis confirmed by Gastro-enterologist or surgeon)	Scleroderma and other collagen vascular diseases
Gout (Uric acid levels must be provided, prophylaxis therapy only)	Trigeminal Neuralgia
Haematological disorders e.g. Thalassaemia (PMB)	Urinary Incontinence
Hyperthyroidism (PMB)	Zollinger Ellison Syndrome
Hypoparathyroidism (PMB)	

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Annexure B(2)

BENEFIT SCHEDULE

LA CORE OPTION
(With effect from 1 January 2022)

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GENERAL RULES APPLICABLE TO THIS ANNEXURE

(1) ~~In this option, unless otherwise stated, all elective in-hospital PMB treatment and care must be obtained from a hospital in the KeyCare Network of hospitals.~~ Specific treatment and procedures, as per the list provided in Annexure H of these Rules, to be obtained from one of the Scheme's identified Preferred Provider Day Surgery facilities.

(2) In this option, unless otherwise indicated in this schedule, an out of hospital ***NON-PMB*** benefit will be financed first from the Medical Savings Account (MSA) and thereafter from the Extended Day-to-day Benefit (EDB).

(3) The Extended Day-to-day Benefit (EDB) is a compulsory level of cover, in respect of out of hospital expenses, for GP's, Specialists, Acute Medication, Dentistry, Optical, Radiology and Pathology, up to the following annual joint limits:

Per Member	R6,976
Per Spouse/Adult Dependant	R4,871
Per Child (to a maximum of three)	R1,898

(4) The MSA is a compulsory level of cover, for the NON-PMB day-to-day expenses up to the following annual limits:

Per Member	R10,452
Per Spouse/Adult Dependant	R9,132
Per Child (to a maximum of three)	R4,200

(5) This Option has no overall annual limit.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
A.	**Statutory Prescribed Minimum Benefits subject to paragraph 1.4 of Annexure B**			
	Private Hospital, subject to DSP for elective procedures / treatment	100% of Cost	Unlimited	1. Basis of cover as contained in Annexure G. 2. Diagnosis, treatment and care costs subject to pre-authorisation and the preamble hereto covered from MMB (including Radiology, Pathology and MRI/CT Scans). 3. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 4. Limited up to a maximum of 21 Days in respect of Drug and Alcohol Abuse up to a maximum of the rate contracted with SANCA. 5. Limited up to a maximum of 3 Days in respect of Detoxification up to a maximum of the rate contracted with SANCA.
	Out of Hospital *Including: ■ Oncology, Chemothery, Radiotherapy, Organ Transplants (including Bone Marrow transplants) and Kidney Dialysis. ■ Psychological, psychiatric treatment and drug and alcohol rehabilitation. ■ Authorised related medicines and TTO. ■ Specialist and general practitioners in and out-of-hospital. ■ Confinements and midwives.			
B.	**In Private Hospitals, Unattached Operating Theatres and Day Clinics**			
	Accommodation in a general ward, high care ward and intensive care unit. Theatre fees. Medicines, materials and hospital equipment. Outpatient services. Confinement and midwives.	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB. 4. Medicines include the completion of a course of treatment specifically related to the event giving rise to hospitalization. 5. Outpatient/Casualty visits paid from MSA, except in the case of PMB's.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
	In Private Hospitals, Unattached Operating Theatres and Day Clinics			
	In-hospital consultations, surgical and other procedures including maxillo-facial procedures (Severe infections, jaw-joint replacements, cancer-related and trauma-related surgery, cleft-lip and palate repairs).	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB. 4. Medicines include the completion of a course of treatment specifically related to the event giving rise to hospitalization. 5. Outpatient/Casualty visits paid from MSA, except in the case of PMB's.
	Day surgery procedures or treatment Healthcare services reflected in Annexure H at a defined list of preferred facilities	100% of Cost up to LAHR	Unlimited	Subject to pre-authorisation and clinical criteria.
	Endoscopic procedures, gastroscopy and colonoscopy	100% of Cost up to LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Spinal care and surgery In and out of hospital management of spinal care and surgery for a defined list of clinically appropriate procedures, which include Lumbar or Cervical Fusion,Laminectomy or Laminotomy	100% of cost up to LAHR or up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB. 4. Out-of-hospital conservative treatment subject to the Scheme's basket of care.
	Colorectal cancer care and surgery In and out of hospital management of colorectal cancer and related surgery	100% of cost up to LAHR or up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB.
C.	**Out of Hospital Procedures/Operations**			
	1. Surgical procedures	100% of Cost up to LAHR	Unlimited	Subject to pre-authorisation, covered from MMB including thechanneling of a clinical procedure or operation from hospital to the doctor's room by the Scheme.
	2. Endoscopic procedures, laser tonsillectomy, gastroscopy, colonoscopy, 24 hour oesophageal pH studies and oesophageal motility studies	100% of Cost up to LAHR	Unlimited	Scope codes only: Covered from MMB. Subject to pre-authorisation. Related accounts paid from and limited to funds in Medical Savings Account/ Extended Day-to-day Benefit.
D.	**Home-based care in lieu of hospitalisation / early discharge** Home-based care for clinically appropriate chronic and acute treatment and conditions that can be treated at home	100% of cost up to LAHR, subject to PMB	Unlimited in baskets of care	1. Subject to authorisation / approval and paid from MMB. 2. Subject to treatment guidelines and clinical and benefit criteria and services provided by the Scheme's preferred providers, where applicable, and the treatment meeting clinical and benefit entry criteria. 3. Defined services in the Scheme's baskets of care apply.
	Clinically appropriate home monitoring devices for home monitoring of chronic and acute conditions	100% of the cost up to the LAHR	Limited to benefits in basket of care	1. Paid from the Major Medical Benefit, subject to basket of care. 2. Subject to approval, the Scheme's protocols and clinical and benefit entry criteria.
E.	**Practitioners (Out of Hospital)**			
	GP and Specialists visits in doctor's rooms, virtual and tele consultations	100% of Cost up to LAHR	Joint Limit	Covered first from MSA and thereafter from EDB, except for PMB's.
	Virtual Paeditrician Consultations children aged 14 and under from a Network Paeditrician consulted in the 6 months immediately prior to the virtual consultation	100% of Cost up to LAHR	Unlimited	Once the MSA/EDB have been depleted, Virtual Paeditrician Consultations paid from MMB per qualifying child.
	Second-opinion consultation obtained from specialists at the Cleveland Clinic	50% of Cost	Unlimited	Paid from MMB to a maximum of 50% of the cost of the consultation. Subject to pre-authorisation.
	Nurse Practitioners	100% of Cost up to LAHR	Unlimited	Covered from MSA. Registered nursing services only. Domestic services excluded.
	Trauma related casualty visits for children aged 10 and under (includes consultation, facility fee and consumable codes billed) at a hospital in the Scheme's casualty network	100% of Cost up to LAHR	2 visits per child per annum	1. Paid from MMB once MSA and EDB are depleted. 2. Limited to 2 visits per child.

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<table>
<tr><th></th><th>SERVICE</th><th>% BENEFIT</th><th>ANNUAL LIMITS</th><th>CONDITIONS/REMARKS</th></tr>
<tr><td>F.</td><td>Dentistry

In-Hospital:
Specialised dentistry</td><td>100% of cost
up to LAHR</td><td>In-hospital costs
unlimited

Related non-hospital
accounts limited to
R32,700 per beneficiary</td><td>Subject to pre-authorisation
1. Deductible payable by the member:
<table><tr><td rowspan="2">Hospital</td><td>Younger than 13 years</td><td>R2,220</td></tr><tr><td>Older than 13 years</td><td>R5,610</td></tr><tr><td rowspan="2">Day Clinics</td><td>Younger than 13 years</td><td>R1,090</td></tr><tr><td>Older than 13 years</td><td>R3,670</td></tr></table>2. Balance of Hospital/Day Clinic account (after deductible) paid from MMB.

3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from MMB, subject to joint limit of R32,700 per beneficiary.</td></tr>
<tr><td></td><td>Basic dentistry</td><td>100% of cost
up to LAHR</td><td>Unlimited</td><td>Subject to pre-authorisation
1. Deductible payable by the member:
<table><tr><td rowspan="2">Hospital</td><td>Younger than 13 years</td><td>R2,220</td></tr><tr><td>Older than 13 years</td><td>R5,610</td></tr><tr><td rowspan="2">Day Clinics</td><td>Younger than 13 years</td><td>R1,090</td></tr><tr><td>Older than 13 years</td><td>R3,670</td></tr></table>2. Balance of Hospital account (after deductible) paid from MMB.

3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from and limited to funds in MSA/EDB.</td></tr>
<tr><td></td><td>Out-of-Hospital:
Specialised dentistry</td><td>100% of cost
up to LAHR</td><td>Unlimited</td><td>Paid from and limited to funds in MSA/EDB.</td></tr>
<tr><td></td><td>Basic dentistry</td><td>100% of cost
up to LAHR</td><td>Unlimited</td><td>Paid from and limited to funds in MSA/EDB.</td></tr>
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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
G.	**Prescribed Pharmaceuticals Including TTO**			
	Acute sickness conditions	100% of LAMR for medicine on preferred list and 90% for medicine not on preferred list	Joint Limit	Covered first from MSA and thereafter from EDB.
	Over-the-Counter Medication (Schedule 0, 1 and 2, generic or non-generic whether prescribed or not)	100% of cost	Joint Limit	1. Covered first from MSA and thereafter from EDB. 2. A sub-limit of R1,570 per beneficiary per year applies to certain categories of unscheduled supplements, provided as OTC.
	PMB Chronic conditions (including but not limited to the appended CDL)	100% of cost	Unlimited based on Formulary	1. Subject to pre-authorisation, and the preamble hereto. 2. Full cover based on a formulary. If non-formulary medicine is used voluntarily the Scheme will pay up to the monthly Chronic Drug Amount (CDA). This is subject to Regulations 15 h (c) and 15 i (c). 3. Covered from MMB. 4. In the case of PMB's Annexure G applies. 5. Costs for completion of chronic application form covered from MMB.
	Diabetes Care or Cardio Care Disease Management Programmes	100% of LAHR	Unlimited	Non-PMB GP and other -related services covered in a treatment basket, subject to referral by the Scheme's Network GP and participation on the Chronic Illness Benefit. Paid from MMB.
	Continuous blood glucose monitoring	100% of the LAHR	Limited to R1,560 per beneficiary per month for sensors only	1. Subject to registration on the Scheme's Diabetes Management Programme, approval, criteria and obtaining sensors from DSP pharmacy 2. Readers and/or transmitters paid from MSA, limited to R4350 per device. 3. Purchase of the sensors subject to an annual co-payment: Adult beneficiary: R1,170; Paediatric beneficiary: R1,560
	Other chronic conditions (as per appended list) in so far as they don't form part of the PMB's which will not be subject to the annual limit	Paid up to a monthly Chronic Drug Amount and subject to annual limit	M : R12,025 M1+ : R23,860	1. Subject to pre-authorisation, and the preamble hereto. 2. Full cover based on a formulary. If non-formulary medicine is used voluntarily the Scheme will pay up to the monthly Chronic Drug Amount (CDA). This is subject to Regulations 15 h (c) and 15 i (c). 3. Covered from MMB. 4. In the case of PMB's Annexure G applies. 5. Costs for completion of chronic application form covered from MMB.
H.	**Radiology**			
	In Hospital (x-rays)	100% of cost up to the LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Out of Hospital (x-rays)	100% of cost up to the LAHR	Joint Limit	Covered first from MSA and thereafter from EDB.
	MRI/CT scans (in hospital and out of hospital)	100% of cost up to the LAHR	Unlimited	Subject to referral by specialist. Covered from MMB. Subject to pre-authorisation in-hospital.
	PET scans	100% of cost up to the LAHR	Unlimited	Subject to clinical criteria, motivation and authorisation. Covered from MMB.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
I.	**Oncology including Chemotherapy and Radiotherapy**	100% of cost for PMB's at DSP	Unlimited	1. Non-PMB paid up to LAHR from MMB. All oncology benefits accrue to a threshold of R456,000 per beneficiary per 12 month cycle. Once this threshold has been reached member will be liable for 20% co-payment on all further Non-PMB claims. (basis of cover as contained in Annexure E (C) 5.4)
	Advanced Illness Benefit and the Oncology member support programme for Oncology patients	100% of cost up to LAHR	Unlimited	Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
	Oncology-related PET scans	100% of cost up to the LAHR	Unlimited from MMB	1. Services obtained from the Scheme's DSP Network (basis of cover as contained in Annexure E (C) 5.5). 2. Accrues to Oncology threshold of R456,000. Once threshold is reached all future claims subject to a 20% co-payment irrespective of DSP or non-DSP. 3. Voluntary use of non-DSP providers, paid up to 80% of the LAHR from R1.
	Oncology Innovation Benefit, providing access to cover for a defined list of non-PMB novel and ultra-high cost treatment	75% of the LAMR	Unlimited	1. Accumulates to the 12-month Oncology threshold. 2. Paid at 75% of the Scheme Rate below and above the Oncology threshold. 3. Access to the benefit is subject to: 3.1 Meeting clinical criteria as specified or adopted by the Scheme. 3.2 Peer review by a Scheme appointed panel of specialists.
J.	**Organ Transplants (including Bone Marrow / Stem Cell transplants) and Kidney Dialysis** (includes authorised related medicines)	100% of cost up to LAHR 100% of cost for PMB's at DSP	Unlimited	1. Subject to pre-authorisation and case management (basis for cover as contained in Annexure E (C) 5.2), covered from MMB. 2. Acute and Chronic Dialysis paid from MMB, at National Renal Care Facilities. Subject to approval of treatment plan. If non-DSP is used voluntarily the claim is paid at the agreed LA Health Rate. 3. Locally sourced Stem Cell Transplant benefit subject to authorisation, clinical criteria and review.
K.	**Mental Health Benefit** Psychological, Psychiatric treatment and Drug and Alcohol rehabilitation with due regard to the PMB's (paragraph A)			Refer to Annexure G for PMB's
	In- or Out-of-Hospital PMB related care	100% of cost up to LAHR	Up to a maximum of 21 Days per beneficiary per annum	1. Covered in full from MMB at the DSP. 2. If services of non-DSP is used voluntarily, a 20% co-pay applies to the hospital account. 3. Subject to clinical criteria and protocols. 4. A maxiumum of 21 Days In-Hospital or 15 days Out-of-hospital psychologist or psychiatrist contacts for PMB related conditions, both accruing to the maxumim of 21 treatment days. 5. Further limited to a maximum of 21 days for alcohol or drug abuse related rehabilitation, or treatment and care in the case of an attempted suicide . and 3 days for in-hospital detoxification services
	Out of Hospital non-PMB mental health benefits (including psychologists, psychiatrist art therapy and social workers)	100% of cost up to LAHR	Unlimited	Covered from MSA, except for PMB's.
	Disease management for major depression for members registered on the Mental Hea Care Programme, including benefits to prevent relapse or recurrence of a major depressive episode	100% of the LAHR	Unlimited.	Non-PMB GP-related services covered in the Scheme's basket of care subject treatment guidelines and managed care criteria and referral by the Scheme's Network GP. Paid from MMB. Specific limits apply in the basket of care.
L.	**Physiotherapy** Pre-Hospital, In-Hospital and Post-Hospital	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation and case management, covered from MMB.
	Out of Hospital	100% of cost up to LAHR	Unlimited	Covered from MSA.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
M.	**Blood Transfusions and Blood Products/Equivalents**	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, covered from MMB.
N.	**Ambulance Services**	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation, covered from MMB. 2. The services of the Scheme's DSP, must be used.
O.	**Alternatives to hospitalisation** Approved Step-down Nursing Facilities Private Nursing	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation and case management, covered from MMB. 2. Private nursing excludes domestic services.
	Hospice (terminal care excluding frail care)	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to clinical entry criteria.
P.	**Auxiliary Services** Audiology Occupational therapy Speech Therapy Chiropody/Podiatry Dietetics Homeopathy Naturopathy Chiropractics Orthoptics Acupuncture Unani-Tibb therapy Any other registered auxiliary service	100% of cost up to LAHR	Unlimited	Covered from MSA. Providers of service must be registered with the appropriate professional authority.
Q.	**Internal Prostheses** Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	100% of cost up to LAHR	Limited to R235,100 per beneficiary per annum	Covered from MMB subject to pre-authorisation.
	Spinal Prostheses/Devices	100% of cost up to LAHR	Unlimited	Paid from MMB. Unlimited, subject to obtaining services from Scheme's Network Provider for prosthetic device, screws, cement and other components used in the surgery. If the Network Provider is not used, an annual limit of R52,500 per beneficiary applies, limited to R26,250 per level. Further limited to two levels per procedure, and one procedure per year.
	Hip, Knee and Shoulder replacement devices	100% of cost up to LAHR	Unlimited Subject to preauthorisation, clinical criteria, obtaining the device from a Preferred Provider, and the use of the DSP hospital for Hip and Knee replacements	Covered from MMB. Shoulder replacement devices limited to R42,950 per prosthesis per admission if from a non-Preferred Provider. Hip and knee replacements limited to R30,900 per device from a non-Preferred Provider. A 20% co-payment of the hospital cost applies for hip/knee replacements when the services of a non-network hospital is used voluntarily.
	Other Internal Prostheses	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation; clinical entry criteria, covered from MMB.
R.	**Pathology (non-PMB)** In Hospital	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation and DSP for basic pathology.
	Out of Hospital	100% of cost up to LAHR	Joint Limit	Covered from MSA and thereafter from EDB.
	Point of care pathology testing	100% of cost up to LAHR	Joint Limit	1. Covered from MSA/EDB except for PMB's. 2. Subject to meeting the Scheme's treatment guidelines and managed care criteria and the results provided by the use of Scheme accredited devices

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
S.	**External Medical Items** Prosthetic limbs, eyes and other external prostheses, orthopaedic appliances (including wheelchairs and crutches), nebulisers, glucometers, diabetic equipment, diagnostic agents and appliances, stoma bags, bandages, hearing aids and wigs with due regard to the PMB's.	100% of cost	Unlimited	Covered from MSA except for PMB's.
	Oxygen rental	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, the use of Scheme's DSP and covered from MMB.
	Bluetooth enabled blood glucose monitoring device	100% of cost up to LAHR	Limited to 1 device per beneficiary per year	Covered from MMB subject to: 1. Beneficiary being registered for Diabetes on the Chronic Illness Benefit. 2. Scheme's protocols; clinical entry criteria and DSPs.
T.	**Optical** Optometry Consultations	100% of cost up to LAHR	Joint Limit	Covered first from MSA and thereafter from EDB.
	Spectacles, frames, contact lenses and refractive eye surgery (e.g. excimer laser)	100% of cost	Joint Limit	Covered first from MSA and thereafter from EDB.
U.	**Maternity** Maternity Programme Cover during pregnancy: Ante-natal visits, scans and selected blood tests and pre- or post-natal classes	100% of LAHR	8 antenatal consultations with Gyneacologist, GP or Midwife. 1 Nuchal translucency or 1 non-invasive prenatal test (NIPT) or 1 T21 Chromosome test. 2 X 2D Ultrasound scans. A defined basket of blood tests. 5 pre- or post-natal classes or consultations with a registered nurse.	Paid from MMB when registered on the Maternity Programme. Limited to the applicable benefits in MSA or EDB if not registered on the Maternity Programme. 3D scans covered up to the cost of a 2D scan only.
	Cover for the newborn baby for 2 years after the birth	100% of LAHR	2 visits to GP, paediatrician or ENT	
	Cover for the mother of the newborn baby for 2 years after the birth	100% of LAHR	1 consultation at GP or Gynaecologist for post-natal complications. 1 nutritional assessment at a dietician. 2 mental health consultations with a counsellor or psychologist. 1 lactation consultation with a registered nurse or lactation specialist.	
	Antenatal classes (if not registered on the Maternity Programme)	100% of LAHR	Unlimited	Paid from MSA only.
	Doulas	100% of LAHR	Unlimited	Paid from MSA only.
V.	**HIV/AIDS and related illnesses**	100% of cost	Unlimited	1. Subject to evidence-based managed care protocols/ formularies as provided for in regulation 15, and managed by the Scheme's Management Programme. 2. Covered from MMB.
	HIV prophylaxis (rape and mother-to-child transmission)	100% of cost	Unlimited	1. Subject to pre-authorisation. 2. Covered from MMB.
	HIV/AIDS-related GP consultations	100% of cost	Unlimited	Subject to authorisation and obtaining treatment from DSP. A 20% co-payment applies if non-DSP is used voluntarily.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
W.	**Screening Tests**			
	Group of tests at a Pharmacy			
	1. Blood Glucose Test 2. Blood Pressure Test 3. Cholesterol Test 4. Body Mass Index (BMI)	100% of the LAHR	One or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained in the Scheme's contracted network of pharmacies. 2. Payable from MSA if member voluntarily makes use of a Non-DSP. 3. Once the limit has been reached, tests will be paid for from the MSA. 4. Paid from MMB.
	OR			
	One Flu vaccination		One flu vaccination per beneficiary per year	1. Paid up to the Scheme Rate for Group of Tests at a Pharmacy only.
	Screening tests for children between ages 2 and 18 years of age:			
	1. Body Mass Index (BMI) and counselling where appropriate 2. Basic Hearing screening 3. Basic Dental screening 4. Milestone tracking for children under the age of 8	100% of the LAHR	One, or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained from the Scheme's contracted DSP. 2. Once the limit has been reached, or if member uses services of a non-DSP, applicable tests will be paid from MSA.
	Group of age appropriate screening tests for beneficiaries who are 65 years or older	Up to 100% of LAHR	Each of the assessments limited to one per beneficiary per annum	1. Subject to clinical criteria and payable from MMB for hearing, vision or frailty and core seniors assessment 2. Once the limits has been reached, or if non-DSP services are used paid for from the MSA/EDB.
	Additional screening assessment or consultation for at-risk members	up to 100% of LAHR	1 Consultation per person per annum	1. Subject to clinical criteria and treatment guidelines and the services obtained from the Scheme's accredited Network provider
	Other screening tests (subject to PMB)			
	Group of tests at Healthcare Professionals:			
	1. Mammograms 2. Pap Smears 3. Prostate-Specific Antigen (PSA)	100% of the LAHR for the actual test codes only	Limit per beneficiary: One Pap Smear every 3 years. One Mammogram every 2 years. One PSA test per annum	1. The LAHR will be paid from MMB for the actual tests only. Associated consultations and other related procedures will be funded first from MSA and thereafter from EDB. 2. More frequent pap smears and/or mammography, MRI breast scan and once off BRCA testing, subject to clinical criteria and authorisation for at risk members.
	4. Colorectal cancer screenings for persons aged 45 to 75 years	100% of the LAHR	1 Faecal occult blood test or faecal immunochemical test every 2 years	1. A Colonoscopy, subject to clinical criteria and authorisation, for persons identified to be at risk
	Other Vaccinations			
	1. Other vaccinations	100% of the LAHR	Unlimited	1. Paid from MSA.
	2. Pneumococcal vaccinations	100% of the LAHR	One Pneumococcal vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons older than 65.	1. Subject to clinical entry criteria. Paid from MMB.
	Genetic testing			
	1. Whole Exome screening (subject to licencing)	up to 50% of the cost of the LAHR	Unlimited	1. Must be obtained from Scheme's Preferred Supplier. 2. Up to 50% of the cost paid from MSA. 3. Remainder of the account to be paid by the member.
	2. Newborn screening	100% of the LAHR	Unlimited	1. Limited to funds available in MSA.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
X.	**WHO Outbreak Benefit** Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks:			Basis for cover subject to PMB as defined in **Annexure G** Subject to obtaining the services from the Scheme's preferred providers / DSPs , where applicable. And further subject to the treatment meeting certain clinical criteria and guidelines
	Out of hospital healthcare services related to COVID-19, subject to PMB			
	Screening consultation with a Nurse of GP	100% of cost	Unlimited	1. Defined basket for pathology / x-rays and scans.
	Pathology / X-rays and scans	100% of cost	2 tests per person per year, unless PMB	2. Testing subject to referral.
	Consultations with a GP or nurse	100% of cost	Unlimited	
	Supportive treatment	100% of cost	Unlimited	1. Acute medicine according to a defined list.
	Vaccine, including administration costs	100% of cost	Unlimited	
	Home-based care in lieu of hospitalisation	100% of cost	Unlimited	
	Pulse oximeter	100% of cost	1 device per person	
	Treatment of complications and rehabilitation for long COVID-19	100% of cost	Unlimted	1 Oferred for a period of six months if the condition persists 2 Subject to defined basket of care
Y.	**Trauma Recovery Benefit** Day-to-day cover for medical expenses related to a traumatic incident for members after suffering a loss of functionality due to a traumatic incident of an acute nature and who are left with a standard level of residual inability after discharge from hospital or rehabilitation facilities.			
	Allied, Therapeutic and Psychological healthcare services (acousticians, biokineticists, chiropractors, counsellors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and hearing therapists)	100% of the LAHR	M = R21,900 M+1 = R29,800 M+2 = R36,300 M3+ = R42,100	1. These day-to-day benefits are paid from MMB, per family up to the end of the year following the one in which the traumatic incident occurred. 2. Benefits will be paid up to the LAHR for day-to-day claims: i. following the traumatic onset of: Paraplegia; Hemiplegia; Quadriplegia and Tetraplegia. ii. for conditions resulting from the following traumatic incidents: Near-drowning; Severe anaphylactic reaction; Poisoning and Crime-related injuries. iii. relating to severe burns. iv. following the traumatic onset of an internal or external head injury. v. due to loss of limb, or part thereof. 3. Benefits are paid according to the general rules applicable to this Benefit Option in terms of protocols, clinical entry criteria and DSP's.
	Prescribed Medicine	100% of the LAHR	M = R23,900 M+1 = R29,000 M+2 = R34,900 M3+ = R38,100	
	External Medical Appliances	100% of the LAHR	R42,700	
	Prosthetic Limbs (with no further access to the External Medical Appliances Limit)	100% of the LAHR	R92,300	
	Hearing Aids	100% of the LAHR	R22,300	

LEGEND:

ART = Anti Retroviral Treatment
CDL = Chronic Disease List (as appended)
DSP = Designated Service Provider
EDB = Extended Day-to-day Benefit
LAHR = LA Health Rate
LAMR = LA Medicine Rate
MMB = Major Medical Benefit
MSA = Medical Savings Account
PMB = Prescribed Minimum Benefits
M = Member
S = Spouse/Adult
C = Child (maximum of three)

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CHRONIC DISEASE LIST: CDL (AS PER REGULATIONS UNDER THE MEDICAL SCHEMES ACT)

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Obstructive Pulmonary Disease	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus Types 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

OTHER CHRONIC CONDITIONS

(In so far as they don't form part of the PMB which are not subject to the annual limit)

Anticoagulant Therapy (PMB)	Lipidoses and other storage disorders (PMB)
Ankylosing Spondylitis	Major Psychiatric Disorders (motivated by psychiatrist) (PMB)
Arthritis	Meniere's Disease
Attention Deficit Disorder (motivated by specialist)	Migraine (motivated by physician)
Benign Prostatic Hypertrophy (motivated by urologist)	Motor Neurone Disease
Cerebro-vascular Accident (Stroke) (PMB)	Myasthenia Gravis
Chronic Urticaria (motivated by dermatologist)	Narcolepsy (motivated by physician)
Cushing's Disease/Syndrome (PMB)	Osteoporosis (only if confirmed by industry standard BMD readings)
Cystic Fibrosis	Paget's Disease
Depression (according to depression rating scale) (PMB)	Pemphigus (motivated by dermatologist) (PMB)
Eczema (severe, motivated by dermatologist)	Psoriasis (severe, motivated by dermatologist)
GORD (diagnosis confirmed by Gastro-enterologist or surgeon)	Scleroderma and other collagen vascular diseases
Gout (Uric acid levels must be provided, prophylaxis therapy only)	Trigeminal Neuralgia
Haematological disorders e.g. Thalassaemia (PMB)	Urinary Incontinence
Hyperthyroidism (PMB)	Zollinger Ellison Syndrome
Hypoparathyroidism (PMB)	

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Annexure B(3)

BENEFIT SCHEDULE

LA ACTIVE OPTION
(With effect from 1 January 2022)

GENERAL RULES APPLICABLE TO THIS ANNEXURE

(1) ~~In this option, unless otherwise stated, all elective in-hospital PMB treatment and care must be obtained from a hospital in the KeyCare Network of hospitals.~~ Specific treatment and procedures, as per the list provided in Annexure H of these Rules, to be obtained from one of the Scheme's identified Preferred Provider Day Surgery facilities.

(2) In this option, unless otherwise indicated in this schedule, an out of hospital ***NON-PMB*** benefit will be financed first from the Medical Savings Account (MSA) and thereafter from the Extended Day-to-day Benefit (EDB).

(3) The Extended Day-to-day Benefit (EDB) is a compulsory level of cover, in respect of out of hospital expenses, for GP's, Specialists, Acute Medication, Dentistry, Optical, Radiology and Pathology, up to the following annual joint limits:

Per Member	R5,256
Per Spouse/Adult Dependant	R3,674
Per Child (to a maximum of three)	R1,060

(4) The MSA is a compulsory level of cover, for the NON-PMB day-to-day expenses up to the following annual limits:

Per Member	R7,224
Per Spouse/Adult Dependant	R5,220
Per Child (to a maximum of three)	R2,988

(5) This Option has no overall annual limit.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
A.	**Statutory Prescribed Minimum Benefits subject to paragraph 1.4 of Annexure B**			
	Private Hospital, subject to DSP for elective procedures / treatment	100% of Cost	Unlimited	1. Basis of cover as contained in Annexure G. 2. Diagnosis, treatment and care costs subject to pre-authorisation and the preamble hereto covered from MMB (including Radiology, Pathology and MRI/CT scans).
	Out of Hospital *Including: ■ Oncology, Chemothery, Radiotherapy, Organ Transplants (including Bone Marrow transplants) and Kidney Dialysis. ■ Psychological, psychiatric treatment and drug and alcohol rehabilitation. ■ Authorised related medicines and TTO. ■ Specialist and general practitioners in and out-of-hospital ■ Confinements and midwives.			3. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 4. Limited up to a maximum of 21 Days in respect of Drug and Alcohol Abuse up to a maximum of the rate contracted with SANCA. 5. Limited up to a maximum of 3 Days in respect of Detoxification up to a maximum of the rate contracted with SANCA.
B.	**In Private Hospitals, Unattached Operating Theatres and Day Clinics**			
	Accommodation in a general ward, high care ward and intensive care unit. Theatre fees. Medicines, materials and hospital equipment. Confinement and midwives.	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
B.	**In Private Hospitals, Unattached Operating Theatres and Day Clinics**			
	In-Hospital consultations, surgical and other procedures- including maxillo-facial procedures (Severe infections, jaw-joint replacements, cancer-related and trauma-related surgery, cleft-lip and palate repairs)	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB.
	Day surgery procedures or treatment Healthcare services reflected in Annexure H in a defined list of preferred facilities	100% of Cost up to LAHR	Unlimited	Subject to pre-authorisation and clinical criteria.
	Spinal care and surgery In and out of hospital management of spinal care and surgery for a defined list of clinically appropriate procedures, which include Lumbar or Cervical Fusion,Laminectomy or Laminotomy	100% of cost up to LAHR up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB. 4. Out-of-hospital conservative treatment subject to the Scheme's basket of care.
	Colorectal cancer care and surgery In and out of hospital management of colorectal cancer and related surgery	100% of cost up to LAHR up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB.
C.	**Investigative procedures**			Co-payments do not apply to PMB's.
	In Hospital Endoscopic procedures, gastroscopy, colonoscopy, sigmoidoscopy and protoscopy (Actual hospital costs related to ward and theatre fees, etc where procedure is performed in hospital)	100% of cost up to LAHR	Unlimited	First R3,100 of hospital costs covered from MSA and the remainder from MMB. Subject to pre-authorisation. Related accounts paid from MSA/EDB.
	Hospital realted costs (e.g. those charged by surgeon, anaesthetist and other related costs)	100% of cost up to LAHR	Unlimited	Covered from MSA and thereafter from EDB.
	Out of Hospital Endoscopic procedures, gastroscopy, colonoscopy, sigmoidoscopy and protoscopy	100% of cost up to LAHR	Unlimited	Scope codes only. Covered from MMB. Subject to pre-authorisation. Related accounts paid from and limited to funds in Medical Savings Account/ Extended Day-to-day Benefit.
D.	**Home-based care in lieu of hospitalisation / early discharge from hospital** Home-based care for clinically appropriate chronic and acute treatment and conditions that can be treated at home	100% of cost up to LAHR, subject to PMB	Unlimited in baskets of care	1. Subject to authorisation / approval and paid from MMB. 2. Subject to treatment guidelines and clinical and benefit criteria and services provided by the Scheme's preferred providers, where applicable, and the treatment meeting clinical and benefit entry criteria. 3. Defined services in the Scheme's baskets of care apply.
	Clinically appropriate home monitoring devices for home monitoring of chronic and acute conditions	100% of the cost up to the LAHR	Limited to benefits in basket of care	1. Paid from the Major Medical Benefit, subject to basket of care. 2 Subject to approval, the Scheme's protocols and clinical and benefit entry criteria.
E.	**Practitioners (Out of Hospital)**			
	GP and Specialists visits in doctor's rooms, virtual and tele consultations	100% of cost up to LAHR	Joint Limit	Covered first from MSA and thereafter from EDB, except for PMB's.
	Virtual Paeditrician Consultations children aged 14 and under from a Network Paeditrician consulted in the 6 months immediately prior to the virtual consultation	100% of cost up to LAHR	Unlimited	Once the MSA/EDB have been depleted, Virtual Paeditrician Consultations paid from MMB per qualifying child.
	Second-opinion consultation obtained from specialists at the Cleveland Clinic	50% of Cost	Unlimited	Paid from MMB to a maximum of 50% of the cost of the consultation. Subject to pre-authorisation.
	Nurse Practitioners	100% of cost up to LAHR	Unlimited	Covered from MSA. Registered nursing services only. Domestic services excluded.
	Trauma related casualty visits for children aged 10 and under (includes consultation, facility fee and consumable codes billed) at a hospital in the Scheme's casualty network.	100% of Cost up to LAHR	2 visits per child per annum	Paid from MMB once MSA and EDB are depleted. Limited to 2 visits per child.

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<table>
<tr><th></th><th>SERVICE</th><th>% BENEFIT</th><th>ANNUAL LIMITS</th><th>CONDITIONS/REMARKS</th></tr>
<tr><td>F.</td><td>Dentistry

In-Hospital:
Specialised dentistry</td><td>100% of cost up to LAHR</td><td>In-hospital costs unlimited

Related non-hospital accounts limited to R24,750 per annum per beneficiary</td><td>Subject to pre-authorisation
1. Deductible payable by the member:
<table><tr><td rowspan="2">Hospital</td><td>Younger than 13 years</td><td>R2,220</td></tr><tr><td>Older than 13 years</td><td>R5,610</td></tr><tr><td rowspan="2">Day Clinics</td><td>Younger than 13 years</td><td>R1,090</td></tr><tr><td>Older than 13 years</td><td>R3,670</td></tr></table>2. Balance of Hospital/Day Clinic account (after deductible) paid from MMB.

3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from MMB, subject to limit of R24,750 per beneficiary per year.</td></tr>
<tr><td></td><td>Basic dentistry</td><td>100% of cost up to LAHR</td><td>Unlimited</td><td>Subject to pre-authorisation
1. Deductible payable by the member:
<table><tr><td rowspan="2">Hospital</td><td>Younger than 13 years</td><td>R2,220</td></tr><tr><td>Older than 13 years</td><td>R5,610</td></tr><tr><td rowspan="2">Day Clinics</td><td>Younger than 13 years</td><td>R1,090</td></tr><tr><td>Older than 13 years</td><td>R3,670</td></tr></table>2. Balance of Hospital account (after deductible) paid from MMB.

3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from and limited to funds in MSA/EDB.</td></tr>
<tr><td></td><td>Out-of-Hospital:
Specialised dentistry</td><td>100% of cost up to LAHR</td><td>Unlimited</td><td>Paid from and limited to funds in MSA/EDB.</td></tr>
<tr><td></td><td>Basic dentistry</td><td>100% of cost up to LAHR</td><td>Unlimited</td><td>First R4,015 per family payable from MMB. Thereafter paid from and limited to funds in MSA/EDB.</td></tr>
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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
G.	**Prescribed Pharmaceuticals Including TTO**			
	Acute sickness conditions	100% of LAMR for medicine on preferred list and 90% for medicine not on preferred list	Joint Limit	Covered first from MSA and thereafter from EDB.
	Over-the-Counter Medication (Schedule 0, 1 and 2, generic or non-generic whether prescribed or not)	100% of cost	Joint Limit	1. Covered first from MSA and thereafter from EDB. 2. A sub-limit of R1,570 per beneficiary per year applies to certain categories of unscheduled supplements, provided as OTC
	PMB Chronic conditions (including the CDL as per Appendix 1) and other PMB chronic conditions as per DTP pairs	100% of cost	Unlimited	1. Subject to pre-authorisation, and the preamble hereto. 2. Full cover based on a formulary. If non-formulary medicine is used voluntarily the Scheme will pay up to the monthly Chronic Drug Amount (CDA). This is subject to Regulations 15 h (c) and 15 i (c). 3. Covered from MMB. 4. In the case of PMB's Annexure G applies. 5. Costs for completion of chronic application form covered from MMB.
	Diabetes Care or Cardio Care Disease Management Programmes	100% of LAHR	Unlimited	Non-PMB GP- and other related services covered in a treatment basket, subject to referral by the Scheme's Network GP and participation on the Chronic Illness Benefit. Paid from MMB.
	Continuous blood glucose monitoring	100% of the LAHR	Limited to R1,560 per beneficiary per month for sensors only	1. Subject to registration on the Scheme's Diabetes Management Programme, approval, criteria and obtaining sensors from DSP pharmacy 2 Readers and/or transmitters paid from MSA, limited to R4350 per device. 3. Purchase of the sensors subject to an annual co-payment: Adult beneficiary: R780; Paediatric beneficiary: R1,560
H.	**Radiology**			
	In Hospital (x-rays)	100% of cost up to the LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Out of Hospital (x-rays)	100% of cost up to the LAHR	Joint Limit	Covered first from MSA and thereafter from EDB.
	MRI/CT scans on referral by a specialist			
	In hospital	100% of cost up to the LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Out of Hospital	100% of cost up to the LAHR	Unlimited	First R3,100 covered from MSA thereafter from MMB.
	PET scans	100% of cost up to the LAHR	Unlimited	Subject to clinical criteria, motivation and authorisation. Covered from MMB.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
I.	**Oncology including Chemotherapy and Radiotherapy**	100% of cost for PMB's at DSP	Unlimited	1. Non-PMB paid up to LAHR from MMB. All oncology benefits accrue to a threshold of R228,000 per beneficiary per 12 month cycle. Once this threshold has been reached member will be liable for 20% co-payment on all further Non-PMB claims. (basis of cover as contained in Annexure E (C) 5.4)
	Advanced Illness Benefit and the Oncology member support programme for Oncology patients	100% of cost up to LAHR	Unlimited	Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
	Oncology-related PET scans	100% of cost up to the LAHR	Unlimited from MMB	1. Services obtained from the Scheme's DSP Network (basis of cover as contained in Annexure E (C) 5.5). 2. Accrues to Oncology threshold of R228,000. Once threshold is reached all future claims subject to a 20% co-payment irrespective of DSP or non-DSP. 3. Voluntary use of non-DSP providers, paid up to 80% of the LAHR from R1.
J.	**Organ Transplants (including Bone Marrow / Stem Cell transplants) and Kidney Dialysis** (includes authorised related medicines)	100% of cost up to LAHR 100% of cost for PMB's at DSP	Unlimited	1. Subject to pre-authorisation and case management (basis for cover as contained in Annexure E (C) 5.2), covered from MMB. 2. Acute and Chronic Dialysis paid from MMB, at National Renal Care Facilities. Subject to approval of treatment plan. If non-DSP is used voluntarily the claim is paid at the agreed LA Health Rate. 3. Locally sourced Stem Cell Transplant benefit subject to authorisation, clinical criteria and review.
K.	**Mental Health Benefit** Psychological, Psychiatric treatment and Drug and Alcohol rehabilitation with due regard to the PMB's (paragraph A)			Refer to Annexure G for PMB's
	In- or Out-of-Hospital PMB related care	100% of cost up to LAHR	Up to a maximum of 21 Days per beneficiary per annum	1. Covered in full from MMB at the DSP. 2. If services of non-DSP is used voluntarily, a 20% co-pay applies to the hospital account. 3. Subject to clinical criteria and protocols. 4. A maxiumum of 21 Days In-Hospital or 15 days Out-of-hospital psychologist or psychiatrist contacts for PMB related conditions, both accruing to the maxumim of 21 treatment days. 5. Further limited to a maximum of 21 days for alcohol or drug abuse related rehabilitation, or treatment and care in the case of an attempted suicide and 3 days for in-hospital detoxification services
	Out of Hospital non-PMB mental health benefits (including psychologists, psychiatrists, art therapy and social workers)	100% of cost up to LAHR	Unlimited	Covered from MSA, except for PMB's.
	Disease management for major depression for members registered on the Mental Health Care Programme, including benefits to prevent relapse or recurrence of a major depressive episode	100% of the LAHR	Unlimited	Non-PMB GP-related services covered in the Scheme's basket of care subject to treatment guidelines and managed care criteria and referral by the Scheme's Network GP. Paid from MMB. Specific limits apply in the basket of care.
L.	**Physiotherapy** In-Hospital	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation and case management, covered from MMB.
	For acute non-hospital related conditions	100% of cost up to LAHR	Unlimited	Covered from MSA.
M.	**Blood Transfusions and Blood Products/Equivalents**	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, covered from MMB.
N.	**Ambulance Services**	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation, covered from MMB. 2. The services of the Scheme's DSP, must be used.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
O.	**Alternatives to hospitalisation** Approved Step-down Nursing Facilities & Private Nursing	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation and case management, covered from MMB. 2. Private nursing excludes domestic services.
	Terminal care excluding frail care	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to clinical entry criteria.
P.	**Auxiliary Services** Audiology Occupational therapy Speech Therapy Chiropody/Podiatry Dietetics Homeopathy Naturopathy Chiropractics Orthoptics Acupuncture Unani-Tibb theraphy Any other registered auxiliary service	100% of cost up to LAHR	Unlimited	Covered from MSA. Providers of service must be registered with the appropriate professional authority.
Q.	**Internal Prostheses**			
	Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	100% of cost up to LAHR	Limited to R235,100 per beneficiary per annum	Covered from MMB subject to pre-authorisation.
	Spinal Prostheses/Devices	100% of cost up to LAHR	Unlimited	Paid from MMB. Unlimited, subject to obtaining services from Scheme's Network Provider for prosthetic device, screws, cement and other components used in the surgery. If the Network Provider is not used, an annual limit of R52,500 per beneficiary applies, limited to R26,250 per level. Further limited to two levels per procedure, and one procedure per year.
	Hip, Knee and Shoulder replacement devices	100% of cost up to LAHR	Unlimited Subject to preauthorisation, clinical criteria, obtaining the device from a Preferred Provider, and the use of the DSP hospital for Hip and Knee replacements	Covered from MMB. Shoulder replacement devices limited to R42,950 per prosthesis per admission if from a non-Preferred Provider. Hip and knee replacements limited to R30,900 per device from a non-Preferred Provider. A 20% co-payment of the hospital cost applies for hip/knee replacements when the services of a non-network hospital is used voluntarily.
	Other Internal Prostheses	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation; clinical entry criteria, covered from MMB.
R.	**Pathology (non-PMB)** In Hospital	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation and DSP for basic pathology.
	Out of Hospital	100% of cost up to LAHR	Joint Limit	Covered first from MSA and thereafter from EDB.
	Point of care pathology testing	100% of cost up to LAHR	Joint Limit	1. Covered from MSA/EDB except for PMB's. 2. Subject to meeting the Scheme's treatment guidelines and managed care criteria and the results provided by the use of Scheme accredited devices.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
S.	**External Medical Items**			
	Prosthetic limbs, eyes and other external prostheses, orthopaedic appliances (including wheelchairs and crutches), nebulisers, glucometers, diabetic equipment, diagnostic agents and appliances, stoma bags, bandages, hearing aids and wigs with due regard to the PMB's.	100% of cost	Unlimited	Covered from MSA except for PMB's.
	Oxygen rental	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, the use of Scheme's DSP and covered from MMB.
	Bluetooth enabled blood glucose monitoring device	100% of cost up to LAHR	Limited to 1 device per beneficiary per year	Covered from MMB subject to: 1. Beneficiary being registered for Diabetes on the Chronic Illness Benefit. 2 Scheme's protocols; clinical entry criteria and DSPs.
T.	**Optical**			
	Optometry Consultations	100% of cost up to LAHR	Joint Limit	Covered first from MSA and thereafter from EDB.
	Spectacles, frames, contact lenses and refractive eye surgery (e.g. excimer laser)	100% of cost	Joint Limit	Covered first from MSA and thereafter from EDB.
U.	**Maternity**			
	Maternity Programme Cover during pregnancy: Ante-natal visits, scans and selected blood tests and pre- or post-natal classes		8 antenatal consultations with Gyneacologist, GP or Midwife. 1 Nuchal translucency or 1 non-invasive prenatal test (NIPT) or 1 T21 Chromosome test. 2 X 2D Ultrasound scans. A defined basket of blood tests. 5 pre- or post-natal classes or consultations with a registered nurse.	Paid from MMB when registered on the Maternity Programme. Limited to the applicable benefits in MSA or EDB if not registered on the Maternity Programme. 3D scans covered up to the cost of a 2D scan only.
	Cover for the newborn baby for 2 years after the birth		2 visits to GP, paediatrician or ENT	
	Cover for the mother of the newborn baby for 2 years after the birth		1 consultation at GP or Gynaecologist for post-natal complications. 1 nutritional assessment at a dietician. 2 mental health consultations with a counsellor or psychologist. 1 lactation consultation with a registered nurse or lactation specialist.	
	Antenatal classes (if not registered on the Maternity Programme)	100% of LAHR	Unlimited	Paid from MSA only.
	Doulas	100% of LAHR	Unlimited	Paid from MSA only.
V.	**HIV/AIDS and related illnesses**	100% of cost	Unlimited	1. Subject to evidence-based managed care protocols/formularies as provided for in regulation 15, and managed by the Scheme's Management Programme. 2. Covered from MMB.
	HIV prophylaxis (rape and mother-to-child transmission)	100% of cost	Unlimited	1. Subject to pre-authorisation. 2. Covered from MMB.
	HIV/AIDS-related GP consultations	100% of cost	Unlimited	Subject to authorisation and obtaining treatment form DSP. A 20% co-payment applies if non-DSP is used voluntarily.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
W.	**Screening Tests** Group of tests at a Pharmacy 1. Blood Glucose Test 2. Blood Pressure Test 3. Cholesterol Test 4. Body Mass Index (BMI) OR	100% of the LAHR	One or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained in the Scheme's contracted network of pharmacies. 2. Payable from MSA if member voluntarily makes use of a Non-DSP. 3. Once the limit has been reached, tests will be paid for from the MSA. 4. LDL Cholesterol test, subject to clinical criteria. Paid from MMB.
	One Flu vaccination	100% of the LAHR	One flu vaccination per beneficiary per year	1. Paid up to the Scheme Rate for Group of Tests at a Pharmacy only.
	Screening tests for children between ages 2 and 18 years of age: 1. Body Mass Index (BMI) and counselling where appropriate 2. Basic Hearing screening 3. Basic Dental screening 4. Milestone tracking for children under the age of 8	100% of the LAHR	One, or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained from the Scheme's contracted DSP. 2. Once the limit has been reached, or if member uses services of a non-DSP, applicable tests will be paid from MSA.
	Group of age appropriate screening tests for beneficiaries who are 65 years or older	Up to 100% of LAHR	Each of the assessments limited to one per beneficiary per annum	1. Subject to clinical criteria and payable from MMB for hearing, vision or frailty and core seniors assessment 2. Once the limits has been reached, or if non-DSP services are used paid for from the MSA.
	Additional screening assessment or consultation for at-risk members	up to 100% of LAHR	1 Consultation per person per annum	1. Subject to clinical criteria and treatment guidelines and the services obtained from the Scheme's accredited Network provider .
	Other screening tests (subject to PMB) Group of tests at Healthcare Professionals: 1. Mammograms 2. Pap Smears 3. Prostate-Specific Antigen (PSA)	100% of the LAHR for the actual test codes only	Limit per beneficiary: One Pap Smear every 3 years. One Mammogram every 2 years. One PSA test per annum	1. The LAHR will be paid from MMB for the actual tests only. Associated consultations and other related procedures will be funded first from MSA and thereafter from EDB. 2. More frequent pap smears and/or mammography, MRI breast scan and once off BRCA testing, subject to clinical criteria and authorisation for at risk members.
	4. Colorectal cancer screenings for persons aged 45 to 75 years		1 Faecal occult blood test or faecal immunochemical test every 2 years	1. A Colonoscopy, subject to clinical criteria and authorisation, for persons identified to be at risk.
	Other Vaccinations			
	1. Other vaccinations	100% of the LAHR	Unlimited	1. Paid from MSA.
	2. Pneumococcal vaccinations	100% of the LAHR	One Pneumococcal vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons older than 65.	1. Subject to clinical entry criteria. Paid from MMB.
	Genetic testing Whole Exome screening (subject to licencing)	up to 50% of the cost of the LAHR	Unlimited	1. Must be obtained from Scheme's Preferred Supplier. 2. Up to 50% of the cost paid from MSA. 3. Remainder of the account to be paid by the member.
	New born screening	100% of the LAHR	Unlimited	1. Limited to funds available in MSA.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
X.	**WHO Outbreak Benefit** Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks:			Basis for cover subject to PMB as defined in **Annexure G** Subject to obtaining the services from the Scheme's preferred providers / DSPs, where applicable. And further subject to the treatment meeting certain clinical criteria and guidelines ceiteria and protocols.
	Out of hospital healthcare services related to COVID-19, subject to PMB			
	Screening consultation with a Nurse of GP	100% of cost	Unlimited	1. Defined basket for pathology / x-rays and scans.
	Pathology / X-rays and scans	100% of cost	2 tests per person per year, unless PMB	2. Testing subject to referral.
	Consultations with a GP or nurse	100% of cost	Unlimited	
	Supportive treatment	100% of cost	Unlimited	1. Acute medicine according to a defined list.
	Vaccine, including administration costs	100% of cost	Unlimited	
	Home-based care in lieu of hospitalisation	100% of cost	Unlimited	
	Pulse oximeter	100% of cost	1 device per person	
	Treatment of complications and rehabilitation for long COVID-19	100% of cost	Unlimted	1 Oferred for a period of six months if the condition persists 2 Subject to defined basket of care
Y.	**Trauma Recovery Benefit** Day-to-day cover for medical expenses related to a traumatic incident for members after suffering a loss of functionality due to a traumatic incident of an acute nature and who are left with a standard level of residual inability after discharge from hospital or rehabilitation facilities.			
	Allied, Therapeutic and Psychological healthcare services (acousticians, biokineticists, chiropractors, counsellors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and hearing therapists)	100% of the LAHR	M = R8,700 M+1 = R13,100 M+2 = R16,200 M3+ = R19,600	1. These day-to-day benefits are paid from MMB, per family up to the end of the year following the one in which the traumatic incident occurred. 2. Benefits will be paid up to the LAHR for day-to-day claims: i. following the traumatic onset of: Paraplegia; Hemiplegia; Quadriplegia and Tetraplegia. ii. for conditions resulting from the following traumatic incidents: Near-drowning; Severe anaphylactic reaction; Poisoning and Crime-related injuries. iii. relating to severe burns. iv. following the traumatic onset of an internal or external head injury. v. due to loss of limb, or part thereof. 3. Benefits are paid according to the general rules applicable to this Benefit Option in terms of protocols, clinical entry criteria and DSP's.
	Prescribed Medicine	100% of the LAHR	M = R16,900 M+1 = R20,000 M+2 = R23,800 M3+ = R28,900	
	External Medical Appliances	100% of the LAHR	R28,700	
	Prosthetic Limbs (with no further access to the External Medical Appliances Limit)	100% of the LAHR	R92,300	
	Hearing Aids	100% of the LAHR	R15,900	

LEGEND:

CDL = Chronic Disease List (as appended)
DSP = Designated Service Provider
EDB = Extended Day-to-day Benefit
LAHR = LA Health Rate
LAMR = LA Medicine Rate
MMB = Major Medical Benefit
MSA = Medical Savings Account
PMB = Prescribed Minimum Benefits
M = Member
S = Spouse/Adult
C = Child (maximum of three)

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CHRONIC DISEASE LIST: CDL (AS PER REGULATIONS UNDER THE MEDICAL SCHEMES ACT)

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Obstructive Pulmonary Disease	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus Types 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

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Annexure B(4)

BENEFIT SCHEDULE

LA FOCUS OPTION
(With effect from 1 January 2022)

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GENERAL RULES APPLICABLE TO THIS ANNEXURE

(1) ~~In this option, unless otherwise stated, all elective in-hospital PMB treatment and care must be obtained from a hospital in a LA Focus Network hospital in the Coastal areas and at a KeyCare Network hospital in the inland provinces.~~ Specific treatment and procedures, as per the list provided in Annexure H of these Rules, to be obtained from one of the Scheme's identified Preferred Provider Day Surgery facilities.

(2) In this option, unless otherwise indicated in this schedule, an out of hospital ***NON-PMB*** benefit will be financed from the Medical Savings Account (MSA).

Per Member	R7,788
Per Spouse/Adult Dependant	R5,040
Per Child (to a maximum of three)	R2,292

(3) This Option has no overall annual limit.

(4) The Scheme's appointed DSP for hospitalisation for this option is the LA Focus Hospital Network.

This LA Focus Network Hospital consists of:

(a) This option provides benefits at 100% of cost up to the LAHR for hospital-related services as indicated in this schedule and rendered within all hospitals located in the provinces:
Eastern Cape
KwaZulu Natal
Northern Cape
Western Cape

(b) This option provides benefits at 100% of cost up to the LAHR for hospital-realted services as indicated in this schedule and rendered in a network of selected private hospitals in the following Provinces:
Gauteng
North West
Limpopo
Mpumalanga and
Free State

(5) A 30% deductible will apply to **NON-EMERGENCY** hospitalisation **EXCEPT FOR PMB'S** within all hospitals not in Scheme's Focus Hospital Network for this option

(6) Refer to Annexure G for benefits in respect of PMB's

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
A.	**Statutory Prescribed Minimum Benefits subject to paragraph 1.4 of Annexure B**			
	Private Hospital, subject to DSP for elective procedures / treatment	100% of Cost	Unlimited	1. Basis of cover as contained in Annexure G. 2. Diagnosis, treatment and care costs subject to pre-authorisation and the preamble hereto covered from MMB (including Radiology, Pathology and MRI/CT scans).
	Out of Hospital *Including: ■ Oncology, Chemothery, Radiotherapy, Organ Transplants (including Bone Marrow transplants) and Kidney Dialysis. ■ Psychological, psychiatric treatment and drug and alcohol rehabilitation. ■ Authorised related medicines and TTO. ■ Specialist and general practitioners in and out-of-hospital ■ Confinements and midwives.			3. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 4. Limited up to a maximum of 21 Days in respect of Drug and Alcohol Abuse up to a maximum of the rate contracted with SANCA. 5. Limited up to a maximum of 3 Days in respect of Detoxification up to a maximum of the rate contracted with SANCA.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
B.	**In Private Hospitals, Unattached Operating Theatres and Day Clinics**			
	Accommodation in a general ward, high care ward and intensive care unit Theatre fees Medicines, material and hospital equipment	100% of Cost up to LAHR	Unlimited	1. Subject to pre-authorisation. 2. Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient. 3. Covered from MMB.
	Hospital related costs for: Confinement and midwives In-hospital consultations, procedures	100% of Cost up to LAHR	Unlimited	
	Maxillo-Facial procedures Severe infections, jaw-joint replacements, cancer-related and trauma-related surgery, cleft-lip and palate repairs	100% of Cost up to LAHR	Unlimited	
	Day surgery procedures or treatment Healthcare services reflected in Annexure H in a defined list of preferred facilities	100% of Cost up to LAHR	Unlimited	Subject to pre-authorisation and clinical criteria.
	Spinal care and surgery In and out of hospital management of spinal care and surgery for a defined list of clinically appropriate procedures, which include Lumbar or Cervical Fusion,Laminectomy or Laminotomy	100% of cost up to LAHR or up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB. 4. Out-of-hospital conservative treatment subject to the Scheme's basket of care.
	Colorectal cancer care and surgery In and out of hospital management of colorectal cancer and related surgery	100% of cost up to LAHR or up to 80% of LAHR at non-Network facility	Unlimited	1. Subject to the use of the services of the Scheme's Network of providers. 2. Subject to pre-authorisation, treatment guidelines and clinical criteria. 3. Related accounts paid from MMB.
C.	**Investigative procedures**			Co-payments do not apply to PMB's.
	In Hospital Endoscopic procedures, gastroscopy, colonoscopy, sigmoidoscopy and protoscopy (Actual hospital costs related to ward and theatre fees, etc where procedure is performed in hospital)	100% of cost up to LAHR	Unlimited	First R3,100 of hospital costs covered from MSA and the remainder from MMB. Subject to pre-authorisation. Related accounts paid from MSA.
	Hospital realted costs (e.g. those charged by surgeon, anaesthetist and other related costs)	100% of cost up to LAHR	Unlimited	Covered from MSA.
	Out of Hospital Endoscopic procedures, gastroscopy, colonoscopy, sigmoidoscopy and protoscopy	100% of cost up to LAHR	Unlimited	Scope codes only. Covered from MMB. Subject to pre-authorisation. Related accounts paid from and limited to funds in Medical Savings Account.
D.	**Home-based care in lieu of hospitalisation / early discharge from hospital** Home-based care for clinically appropriate chronic and acute treatment and conditions that can be treated at home	100% of cost up to LAHR, subject to PMB	Unlimited in baskets of care	1. Subject to authorisation / approval and paid from MMB. 2. Subject to treatment guidelines and clinical and benefit criteria and services provided by the Scheme's preferred providers, where applicable, and the treatment meeting clinical and benefit entry criteria. 3. Defined services in the Scheme's baskets of care apply.
	Clinically appropriate home monitoring devices for home monitoring of chronic and acute conditions	100% of the cost up to the LAHR	Limited to benefits in basket of care	1. Paid from the Major Medical Benefit, subject to basket of care. 2 Subject to approval, the Scheme's protocols and clinical and benefit entry criteria.
E.	**Practitioners (Out of Hospital)** GP and Specialists visits in doctor's rooms, virtual and tele consultations.	100% of cost up to LAHR	Unlimited	Covered first from MSA, except for PMB's.
	Virtual Paeditrician Consultations children aged 14 and under from a Network Paeditrician consulted in the 6 months immediately prior to the virtual consultation	100% of cost up to LAHR	Unlimited	Once the MSA has been depleted, Virtual Paeditrician consultation paid from MMB per qualifying child.
	Second-opinion consultation obtained from specialists at the Cleveland Clinic	50% of Cost	Unlimited	Paid from MMB to a maximum of 50% of the cost of the consultation. Subject to pre-authorisation.
	Nurse Practitioners	100% of cost up to LAHR	Unlimited	Covered from MSA. Registered nursing services only Domestic services excluded.
	Trauma related casualty visits for children aged 10 and under (includes consultation, facility fee and consumable codes billed) at a hospital in the Scheme's casualty network	100% of cost up to LAHR	2 visits per child per annum	1. Paid from MMB once MSA is depleted. 2. Limited to 2 visits per child.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
F.	**Dentistry**			
	In-Hospital:			**Subject to pre-authorisation**
	Specialised dentistry	100% of cost up to LAHR	Hospital costs unlimited Related non-hospital accounts limited to R24,750 per annum per beneficiary	1. Deductible payable by the member: Hospital – Younger than 13 years: R2,220 Hospital – Older than 13 years: R5,610 Day Clinics – Younger than 13 years: R1,090 Day Clinics – Older than 13 years: R3,670 2. Balance of Hospital account (after deductible) paid from MMB. 3. Related non-hospital accounts (for dentists, anaesthetists, etc) paid from MMB, subject to limit of R24,750 per beneficiary per year. If member makes use of DSP Network Dentist and obtains basic dental services as part of the Specialised Dentistry event, the codes for these basic services will be paid from MMB, without accumulation to the limit.
	Basic dentistry	100% of cost up to LAHR	Hospital costs unlimited	**Subject to pre-authorisation** 1. Deductible payable by the member: Hospital – Younger than 13 years: R2,220 Hospital – Older than 13 years: R5,610 Day Clinics – Younger than 13 years: R1,090 Day Clinics – Older than 13 years: R3,670 2. Balance of Hospital account (after deductible) paid from MMB. 3. Related, non-hospital accounts (for dentists, anaesthetists, etc) limited to funds in MSA. If member makes use of DSP Network Dentist, the basic dentistry services will be paid from MMB.
	Out-of-Hospital:			
	Specialised dentistry	100% of cost up to LAHR	Unlimited	Paid from and limited to funds in MSA. Any basic dentistry services that are included as part of these Sepcialised Dental services that are provided by a Dentist in the Scheme's DSP network, will be paid from MMB.
	Basic dentistry (including 1 set of plastic dentures every four years per beneficiary)	100% of cost up to LAHR	Unlimited	Paid from MMB for all services obtained from a Dentist in the Scheme's DSP Network. Payable from MSA if member makes use of a non-DSP for these basic dental services.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
G.	**Prescribed Pharmaceuticals Including TTO**			
	Acute sickness conditions	100% of LAMR for medicine on preferred list and 90% for medicine not on preferred list	Unlimited	Covered from MSA.
	Over-the-Counter Medication (Schedule 0, 1 and 2, generic or non-generic whether prescribed or not)	100% of cost	Unlimited	1. Covered from MSA. 2. A sub-limit of R1,570 per beneficiary per year applies to certain categories of unscheduled supplements, provided as OTC.
	PMB Chronic conditions (including the CDL as per Appendix 1) and other PMB chronic conditions as per DTP pairs	100% of cost	Unlimited	1. Subject to pre-authorisation, and the preamble hereto. 2. Full cover based on a formulary. If non-formulary medicine is used voluntarily the Scheme will pay up to the monthly Chronic Drug Amount (CDA). This is subject to Regulations 15 h (c) and 15 i (c). 3. Covered from MMB. 4. In the case of PMB's Annexure G applies. 5. Costs for completion of chronic application form covered from MMB.
	Diabetes Care or Cardio Care Disease Management Programmes	100% of LAHR	Unlimited	Non-PMB GP-related services covered in a treatment basket, subject to referral by the Scheme's Network GP and participation on the Chronic Illness Benefit. Paid from MMB.
	Continuous blood glucose monitoring	100% of the LAHR	Limited to R1,560 per beneficiary per month for sensors only	1. Subject to registration on the Diabetes Management Programme approval, criteria and obtaining sensors from DSP pharmacy 2. Readers and/or transmitters paid from MSA, limited to R4350 per device. 3. Purchase of the sensors is subject to the following annual co-payment: Adult beneficiary: R780; Paediatric beneficiary: R1,560
H.	**Radiology**			
	In Hospital (x-rays)	100% of cost up to the LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Out of Hospital (x-rays)	100% of cost up to the LAHR	Unlimited	Covered from MSA.
	MRI/CT scans on referral by a specialist			
	In hospital	100% of cost up to the LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation.
	Out of Hospital	100% of cost up to the LAHR	Unlimited	First R3,100 covered from MSA thereafter from MMB.
	PET scans	100% of cost up to the LAHR	Unlimited	Subject to clinical criteria, motivation and authorisation. Covered from MMB.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
I.	**Oncology including Chemotherapy and Radiotherapy**	100% of cost up to the LAHR 100% of cost for PMB's at DSP	Unlimited	1. Non-PMB paid up to LAHR from MMB. All oncology benefits accrue to a threshold of R228,000 per beneficiary per 12 month cycle. Once this threshold has been reached member will be liable for 20% co-payment on all further Non-PMB claims. (basis of cover as contained in Annexure E (C) 5.4)
	Advanced Illness Benefit and the Oncology member support programme for Oncology patients	100% of cost up to LAHR	Unlimited	Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
	Oncology-related PET scans	100% of cost up to the LAHR	Unlimited from MMB	1. Services obtained from the Scheme's DSP Network (basis of cover as contained in Annexure E (C) 5.5). 2. Accrues to Oncology threshold of R228,000. Once threshold is reached all future claims subject to a 20% co-payment irrespective of DSP or non-DSP. 3. Voluntary use of non-DSP providers, paid up to 80% of the LAHR from R1.
J.	**Organ Transplants (including Bone Marrow / Stem Cell transplants) and Kidney Dialysis** (includes authorised related medicines)	100% of cost up to LAHR 100% of cost for PMB's at DSP	Unlimited	1. Covered from MMB. Subject to pre-authorisation and case management (basis for cover as contained in Annexure E (C) 5.2). 2. Acute and Chronic Dialysis paid from MMB, at National Renal Care Facilities. Subject to approval of treatment plan. If non-DSP is used voluntarily the claim is paid at the agreed LA Health Rate. 3. Locally sourced Stem Cell Transplant benefit subject to authorisation, clinical criteria and review.
K.	**Mental Health Benefit** Psychological, Psychiatric treatment and Drug and Alcohol rehabilitation with due regard to the PMB's (paragraph A)			Refer to Annexure G for PMB's
	In- or Out-of-Hospital PMB related care	100% of cost up to LAHR	Up to a maximum of 21 Days per beneficiary per annum	1. Covered in full from MMB at the DSP. 2. If services of non-DSP is used voluntarily, a 20% co-pay applies to the hospital account. 3. Subject to clinical criteria and protocols. 4. A maxiumum of 21 Days In-Hospital or 15 days Out-of-hospital psychologist or psychiatrist contacts for PMB related conditions, both accruing to the maxumim of 21 treatment days. 5. Further limited to a maximum of 21 days for alcohol or drug abuse related rehabilitation, or treatment and care in the case of an attempted suicide and 3 days for in-hospital detoxification services.
	Out of Hospital non-PMB mental health benefits (including psychologists, psychiatrists, art therapy and social workers)	100% of cost up to LAHR	Unlimited	Covered from MSA.
	Disease management for major depression for members registered on the Mental Health Care Programme, including benefits to prevent relapse or recurrence of a major depressive episode	100% of the LAHR	Unlimited	Non-PMB GP-related services covered in the Scheme's basket of care subject to treatment guidelines and managed care criteria and referral by the Scheme's Network GP. Paid from MMB. Specific limits apply in the basket of care.
L.	**Physiotherapy** In-Hospital	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation and case management, covered from MMB.
	For acute non-hospital related conditions	100% of cost up to LAHR	Unlimited	Covered from MSA.
M.	**Blood Transfusions and Blood Products/Equivalents**	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, covered from MMB.
N.	**Ambulance Services**	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation, covered from MMB. 2. The services of the Scheme's DSP, must be used.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
O.	**Alternatives to hospitalisation** Approved Step-down Nursing Facilities & Private Nursing	100% of cost up to LAHR	Unlimited	1. Subject to pre-authorisation and case management, covered from MMB. 2. Private nursing excludes domestic services.
	Terminal care excluding frail care	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to clinical entry criteria.
P.	**Auxiliary Services** Audiology Occupational therapy Speech Therapy Chiropody/Podiatry Dietetics Homeopathy Naturopathy Chiropractics Orthoptics Acupuncture Unani-Tibb therapy Any other registered auxiliary service	100% of cost up to LAHR	Unlimited	Covered from MSA. Providers of service must be registered with the appropriate professional authority.
Q.	**Internal Prostheses** Cochlear implants, implantable defibrillators, internal nerve stimulators and auditory brain implants	100% of cost up to LAHR	Limited to R235,100 per beneficiary per annum	Covered from MMB subject to pre-authorisation.
	Spinal Prostheses/Devices	100% of cost up to LAHR	Unlimited	Paid from MMB. Unlimited, subject to obtaining services from Scheme's Network Provider for prosthetic device, screws, cement and other components used in the surgery. If the Network Provider is not used, an annual limit of R52,500 per beneficiary applies, limited to R26,250 per level. Further limited to two levels per procedure, and one procedure per year.
	Hip, Knee and Shoulder replacement devices	100% of cost up to LAHR	Unlimited Subject to preauthorisation, clinical criteria, obtaining the device from a Preferred Provider, and the use of the DSP hospital for Hip and Knee replacements	Covered from MMB. Shoulder replacement devices limited to R42,950 per prosthesis per admission if from a non-Preferred Provider. Hip and knee replacements limited to R30,900 per device from a non-Preferred Provider. A 20% co-payment of the hospital cost applies for hip/knee replacements when the services of a non-network hospital is used voluntarily.
	Other Internal Prostheses	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation; clinical entry criteria, covered from MMB.
R.	**Pathology (non-PMB)** In Hospital	100% of cost up to LAHR	Unlimited	Covered from MMB. Subject to pre-authorisation and DSP for basic pathology.
	Out of Hospital	100% of cost up to LAHR	Unlimited	Covered from MSA.
	Point of care pathology testing	100% of cost up to LAHR	Unlimited	1. Covered from MSA except for PMB's. 2. Subject to meeting the Scheme's treatment guidelines and managed care criteria and the results provided by the use of Scheme accredited devices.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
S.	**External Medical Items** Prosthetic limbs, eyes and other external prostheses, orthopaedic appliances (including wheelchairs and crutches), nebulisers, glucometers, diabetic equipment, diagnostic agents and appliances, stoma bags, bandages, hearing aids and wigs with due regard to the PMB's.	100% of cost	Unlimited	Covered from MSA except for PMB's.
	Oxygen rental	100% of cost up to LAHR	Unlimited	Subject to pre-authorisation, the use of Scheme's DSP and covered from MMB.
	Bluetooth enabled blood glucose monitoring device	100% of cost up to LAHR	Limited to 1 device per beneficiary per year	Covered from MMB subject to: 1. Beneficiary being registered for Diabetes on the Chronic Illness Benefit. 2 Scheme's protocols; clinicial entry criteria and DSPs.
T.	**Optical** Optometry Consultations	100% of cost up to LAHR	Unlimited	Covered from MSA.
	Spectacles, frames, contact lenses and refractive eye surgery (e.g. excimer laser)	100% of cost	Unlimited	Covered from MSA.
U.	**Maternity** Maternity Programme Cover during pregnancy: Ante-natal visits, scans and selected blood tests and pre- or post-natal classes	100% of LAHR	8 antenatal consultations with Gyneacologist, GP or Midwife. 1 Nuchal translucency or 1 non-invasive prenatal test (NIPT) or 1 T21 Chromosome test. 2 X 2D Ultrasound scans. A defined basket of blood tests. 5 pre- or post-natal classes or consultations with a registered nurse.	Paid from MMB when registered on the Maternity Programme. Limited to the applicable benefits in MSA if not registered on the Maternity Programme. 3D scans covered up to the cost of a 2D scan only.
	Cover for the newborn baby for 2 years after the birth	100% of LAHR	2 visits to GP, paediatrician or ENT	
	Cover for the mother of the newborn baby for 2 years after the birth	100% of LAHR	1 consultation at GP or Gynaecologist for post-natal complications. 1 nutritional assessment at a dietician. 2 mental health consultations with a counsellor or psychologist. 1 lactation consultation with a registered nurse or lactation specialist.	
	Doulas	100% of LAHR		Paid from MSA only.
V.	**HIV/AIDS and related illnesses**	100% of cost	Unlimited	1. Subject to evidence-based managed care protocols/ formularies as provided for in regulation 15, and managed by the Scheme's Management Programme. 2. Covered from MMB.
	HIV prophylaxis (rape and mother-to-child transmission)	100% of cost	Unlimited	1. Subject to pre-authorisation. 2. Covered from MMB.
	HIV/AIDS-related GP consultations	100% of cost	Unlimited	Subject to authorisation and obtaining treatment from DSP. A 20% co-payment applies if non-DSP is used voluntarily.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
W.	**Screening Tests** Group of tests at a Pharmacy 1. Blood Glucose Test 2. Blood Pressure Test 3. Cholesterol Test 4. Body Mass Index (BMI)	100% of the LAHR	One or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained in the Scheme's contracted network of pharmacies. 2. Payable from MSA if member voluntarily makes use of a Non-DSP. 3. Once the limit has been reached, tests will be paid for from the MSA. 4. LDL Cholesterol test, subject to clinical criteria. Paid from MMB.
	OR One Flu vaccination		One flu vaccination per beneficiary per year	1. Paid up to the Scheme Rate for Group of Tests at a Pharmacy only.
	Screening tests for Children between ages 2 and 18 years of age: 1. Body Mass Index (BMI) and counselling where appropriate 2. Basic Hearing screening 3. Basic Dental screening 4. Milestone tracking for children under the age of 8	100% of the LAHR	One, or all of the 4 listed screening tests per annum per beneficiary	1. Payable from MMB only if services were obtained from the Scheme's contracted DSP. 2. Once the limit has been reached, or if member uses services of a non-DSP, applicable tests will be paid from MSA.
	Group of age appropriate screening tests for beneficiaries who are 65 years or older	Up to 100% of LAHR	Each of the assessments limited to one per beneficiary per annum	1. Subject to clinical criteria and payable from MMB for hearing, vision or frailty and core seniors assessment 2. Once the limits has been reached, or if non-DSP services are used paid for from the MSA.
	Additional screening assessment or consultation for at-risk members	up to 100% of LAHR	1 Consultation per person per annum	1. Subject to clinical criteria and treatment guidelines and the services obtained from the Scheme's accredited Network provider
	Other screening tests (subject to PMB) Group of tests at Healthcare Professionals: 1. Mammograms 2. Pap Smears 3. Prostate-Specific Antigen (PSA)	100% of the LAHR for the actual test codes only	Limit per beneficiary: One Pap Smear every 3 years. One Mammogram every 2 years. One PSA test per annum	1. The LAHR will be paid from MMB for the actual tests only. Associated consultations and other related procedures will be funded first from MSA and thereafter from EDB. 2. More frequent pap smears and/or mammography, MRI breast scan and once off BRCA testing, subject to clinical criteria and authorisation for at risk members.
	4. Colorectal cancer screenings for persons aged 45 to 75 years	100% of the LAHR	1 Faecal occult blood test or faecal immunochemical test every 2 years	1. A Colonoscopy, subject to clinical criteria and authorisation, for persons identified to be at risk.
	Other Vaccinations 1. Other vaccinations	100% of the LAHR	Unlimited	1. Paid from MSA.
	2. Pneumococcal vaccinations	100% of the LAHR	One Pneumococcal vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons older than 65.	1. Subject to clinical entry criteria. Paid from MMB.
	Genetic testing 1. Whole Exome screening (subject to licencing)	up to 50% of the cost	Unlimited	1. Must be obtained from Scheme's Preferred Supplier. 2. Up to 50% of the cost paid from MSA. 3. Remainder of the account to be paid by the member.
	2. Newborn screening	100% of the LAHR	Unlimited	1. Limited to funds available in MSA.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
X.	**WHO Outbreak Benefit** Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks:			Basis for cover subject to PMB as defined in **Annexure G** Subject to obtaining the services from the Scheme's preferred providers / DSPs , where applicable. And further subject to the treatment meeting certain clinical criteria and guidelines ceiteria and protocols.
	Out of hospital healthcare services related to COVID-19, subject to PMB			
	Screening consultation with a Nurse of GP	100% of cost	Unlimited	
	Pathology / X-rays and scans	100% of cost	2 tests per person per year, unless PMB	1. Defined basket for pathology / x-rays and scans. 2. Testing subject to referral.
	Consultations with a GP or nurse	100% of cost	Unlimited	
	Supportive treatment	100% of cost	Unlimited	1. Acute medicine according to a defined list.
	Vaccine, including administration costs	100% of cost	Unlimited	
	Home-based care in lieu of hospitalisation	100% of cost	Unlimited	
	Pulse oximeter	100% of cost	1 device per person	
	Treatment of complications and rehabilitation for long COVID-19	100% of cost	Unlimted	1. Oferred for a period of six months if the condition persists 2. Subject to defined basket of care
Y.	**Trauma Recovery Benefit** Day-to-day cover for medical expenses related to a traumatic incident for members after suffering a loss of functionality due to a traumatic incident of an acute nature and who are left with a standard level of residual inability after discharge from hospital or rehabilitation facilities.			
	Allied, Therapeutic and Psychological healthcare services (acousticians, biokineticists, chiropractors, counsellors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and hearing therapists)	100% of the LAHR	M = R8,700 M+1 = R13,100 M+2 = R16,200 M3+ = R19,600	1. These day-to-day benefits are paid from MMB, per family up to the end of the year following the one in which the traumatic incident occurred. 2. Benefits will be paid up to the LAHR for day-to-day claims: i. following the traumatic onset of: Paraplegia; Hemiplegia; Quadriplegia and Tetraplegia. ii. for conditions resulting from the following traumatic incidents: Near-drowning; Severe anaphylactic reaction; Poisoning and Crime-related injuries. iii. relating to severe burns. iv. following the traumatic onset of an internal or external head injury. v. due to loss of limb, or part thereof. 3. Benefits are paid according to the general rules applicable to this Benefit Option in terms of protocols, clinical entry criteria and DSP's.
	Prescribed Medicine	100% of the LAHR	M = R16,900 M+1 = R20,000 M+2 = R23,800 M3+ = R28,900	
	External Medical Appliances	100% of the LAHR	R28,700	
	Prosthetic Limbs (with no further access to the External Medical Appliances Limit)	100% of the LAHR	R92,300	
	Hearing Aids	100% of the LAHR	R15,900	

LEGEND

CDL = Chronic Disease List (as appended)
DSP = Designated Service Provider
LAHR = LA Health Rate
LAMR = LA Medicine Rate
MMB = Major Medical Benefit
MSA = Medical Savings Account
PMB = Prescribed Minimum Benefits
M = Member
S = Spouse/Adult
C = Child (maximum of three)

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CHRONIC DISEASE LIST: CDL (AS PER REGULATIONS UNDER THE MEDICAL SCHEMES ACT)

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Obstructive Pulmonary Disease	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus Types 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

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Annexure B(5)

BENEFIT SCHEDULE

LA KEYPLUS OPTION
(With effect from 1 January 2022)

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GENERAL RULES APPLICABLE TO THIS ANNEXURE

(1) The Scheme's appointed DSP for this option is the KeyCare Primary Care Network. Members are requested to select their network doctor, through the Scheme's appointed DSP(s) when they join this option.

(2) The Scheme's DSP for in-hospital care is the KeyCare Hospital network. Members are required to undergo treatment for all elective PMB's and non-PMB elective treatment at the KeyCare Network Hospitals. Certain treatment / procedures, stipulated in Annexure H of these Rules, must be performed at one of the Scheme's DSP Day Surgery facilities

(3) This option has no overall annual limit for Major Medical Benefits (MMB).

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
1.	**Statutory Prescribed Minimum Benefits subject to paragraph 1.4 of Annexure B**			Prescribed Minimum Benefits accumulate to the available limits first
	Network Hospital: non-elective and emergency PMB's	100% of cost	Unlimited	1. Basis of cover as contained in Annexure G. 2. Diagnostic, treatment and care costs subject to relevant clinical and managed care criteria, covered from MMB. 3. Subject to PMB and pre-authorisation. For non-emergency PMB admissions, claims in Network Hospitals paid at cost. 4. In the event of an **emergency** any private hospital may be used to stabilise the patient. Once stabilised the patient must be transferred to a network hospital.
	Network Hospital: elective PMB	100% of the cost		
	Out of Hospital (All health services relevant to **PMB's**)	100% of Cost	Unlimited	Diagnostic, treatment and care costs subject to Scheme's relevant treatment protocols. Covered from MMB.
2.	**Network Hospitals** Accommodation in a general ward, high care ward and intensive care unit, theatre fees, medicine, material and hospital equipment, visits by medical medical practitioners, confinement and midwives.	100% of Cost up to LAHR	Unlimited	Subject to PMB, authorisation / approval and the treatment meeting the Scheme's clinical and managed care criteria.
	Non-Network Hospitals Emergency admissions in a Non-Network Hospital	Up to 100% of the cost		Patient to be transferred to a network hospital as soon as stabilised, unless otherwise agreed by the Scheme. Subject to PMB.
	Non-emergency, PMB admissions in a Non-Network Hospital	Up to 80% of the cost		A 20% co-payment applies for all elective PMB's performed in a Non-Network Hospital.
	Elective, non-PMB treatment in a Non-Network Hospital		Not applicable	No benefit for Non-PMB's.
	Day-surgery care Healthcare services reflected in **Annexure H** in a defined list of Network facilities	Up to 100% of the LAHR	Unlimited	1. Subject to authorisation and/or approval and clinical criteria.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
3.	**HIV/Aids and related treatment**	100% of Cost	Unlimited	1. Subject to evidence-based managed care protocols/ formularies as provided for in regulation 15, and managed by the Scheme's Management Programme. (refer Annexure G)
	Post-exposure HIV-prophylaxis following occupational or traumatic exposure, sexual assault or mother-to-child transmissions	Up to 100% of the cost	Unlimited	
	HIV/AIDS-related GP consultations	Up to 100% of the cost	Unlimited	Subject to authorisation and obtaining treatment from DSP GP. A 20% co-payment applies if non-Network GP is used voluntarily.
4.	**Administration of defined intravenous infusions from a Network Provider**	Up to 100% of the LAHR	Unlimited	1. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria. 2. A 20% payable in respect of the hospital account for treatment obtained at a non-Network Provider.
	Medicine used during these procedures	Paid up to 100% of the LAMR		
5.	**Hospitalisation for select members suffering from one or more significant chronic conditions** **Non-emergency admissions**	Paid up to 100% of the LAHR	Unlimited	For members on the Scheme's Disease Management Programme and further subject to authorisation and the patient meeting the clinical criteria. 1. Paid up to a maximum of 80% of the LAHR of the hospital and related accounts for beneficiaries who are not on the Programme for non-PMB conditions
6	**Home-based healthcare for clinically appropriate chronic and acute treatment and conditions that can be treated at home** (Subject to PMB)	Paid up to 100% of the LAHR	Unlimited	1. Subject to the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit criteria. 2. Subject to benefits defined in a basket of care.
	Home-monitoring devices for clinically appropriate chronic and acute conditions	Paid up to 100% of the LAHR from MMB	Limited to R4 000 per person per year	1. Subject to approval of the use of the device and subject to protocols and clinical and benefit criteria.
7.	**Drug and alchohol rehabilitation**	Up to 100% of the LAHR	21 days rehab 3 days detox	Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria. Subject to PMB's
8.	**Cardiac Stents**	Up to 100% of the LAHR	Unlimited if stent is supplied by Network Provider	Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical criteria. 1. If stent is supplied by non-Network supplier: Limited to R7,350 per drug-eluting stent per admission; and R6,200 per bare metal stent per admission. 2. The device accumulates to the limit when non-Network suppliers are used. The costs of the hospital and related accounts do not accumulate to the stent limit. 3. Subject to PMB's

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
9.	**Mental Health**			
	• In- or Out-of-Hospital PMB related care	100% of cost up to LAHR	Up to a maximum of 21 Days per beneficiary per annum, subject to PMB	1. Covered in full from MMB at the DSP. 2. If services of non-DSP is used voluntarily, a 20% co-payment applies to the hospital account. 3. Subject to clinical criteria and protocols. 4. A maxiumum of 21 Days In-Hospital or 15 days Out-of-hospital psychologist or psychiatrist contacts for PMB related conditions, both accruing to the maxumim of 21 treatment days.
	• Out of Hospital Treatment by psychiatrists only	100% of LAHR	R4,730 joint limit per beneficiary	Subject to the Specialist benefit limit.
	Mental Health Care Programme Disease management for major depression for members registered on the Mental Health Care Programme, including benefits to prevent relapse or recurrence of a major depressive episode	Up to 100% of the LAHR, from MMB	Limited	1 Non-PMB GP-related services, on referral from the Scheme's Network GP. 2 Limited to services in the Scheme's basket of care. 3 Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria.
10.	**Surgical procedures (In Hospital)**	100% of LAHR		Subject to authorisation at a Network hospital.
	Major Maxillo Facial Surgery (In Hospital) Severe infections, jaw-joint replacements, cancer-related and trauma-related surgery, cleft-lip and palate repairs	100% of LAHR	Unlimited	Subject to authorisation.
11.	**Practitioners** **Specialists**			PMB benefits subject to Annexure G paragraph A.
	• In Hospital KeyCare Direct Payment Arrangement (DPA) Specialists	Up to 100% of the DPA Rate	Unlimited	1. Member must be referred by his/her chosen GP.
	Other specialists who work in a Network Hospital	Up to 100% of the LAHR		1. Member must be referred by his/her chosen GP.
	• Out of Hospital KeyCare Direct Payment Arrangement Specialists	Up to 100%of the DPA Rate	Limited to R4,730 per beneficiary per year	Require referral by the members chosen DSP GP. 1. Basic x-rays obtained from a network of radiographers, MRI and CT Scans covered only if requested by a member's chosen DSP doctor.
	Other Specialists working in the Network Hospitals	Up to 100% of the LAHR	Subject to the Specialist limit of R4,730 per person per year	2. Basic blood tests available if requested by member's chosen DSP doctor, from the DSP pathologist only.
	International clinical review consultations	50% of Cost	Unlimited	Subject to the use of the services of the Scheme's Preferred Provider, clinical and managed care criteria.
	Other Providers in hospital	Up to 100% of the LAHR	Unlimited	
	Out of Hospital Preoperative Anaesthetist Assessment	Up to 100% of the LAHR	Limited to specific benefits as defined in a basket of care	1. Available to members undergoing Breast, Prostate or Colorectal cancer surgery or coronary artery bypass grafting surgery. 2. Subject to authorisation and the use of the services of DSP Specialist. 3. Paid once per hospital admisssion from the Major Medical Benefit.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
12.	**General Practitioners (GP)**			
	• In Hospital	Up to 100% of the LAHR	Unlimited	
	• Out of Hospital GP visits and selected minor procedures	Up to 100% of the LAHR	Unlimited, but authorisation required after 15th GP visit per person for in the year	1. Payment limited to visits and minor procedures obtained from member's chosen Network GP. 2. Beneficiaries can elect to change GP selection 3 times per year. 3. Benefits subject to selected consultation and procedure codes. 4. If authorisation is not obtained after 15th visist for any one person in the year, no further GP benefits except those for PMB's, will be paid.
	Unscheduled, after-hour GP visits	Up to 100% of the LAHR	Limited to 3 visists per person per year	
	Out of network GP visists	Up to 100% of the LAHR	Limited to 4 GP, 4 pathology 4 radiology and four pharmacy claims per person per year	Treatment must be requested by a General Practitioner. Includes cost of selected blood tests, selected x-rays and acute medicines, according to the Scheme's formulary. Subject to PMB.
13.	**Casualty Visists**			
	Visits to casualty units at KeyCare Network hospitals	Up to 100% of the LAHR	Limited to one Non-PMB casualty visit per person per year	Subject to authorisation 1. First R425 of the casualty unit's account payable by the beneficiary. 2. Balance of the Account paid from MMB. 3. Pathology, radiology or medicine will be subject to applicable clinical guidelines. 4. Specialist consultations subject to the Specialist Benefit limit. 5. No benefit, for non-PMB treatment at a non-Keycare Network Hospital. 6. Subject to PMB's
14.	**Nurse Practitioners**	-		No benefit **except for PMB's**.
15.	**Dental Services** **In-Hospital or Specialised Dentistry**	-	No benefit Subject to PMB's	No benefit. Subject to PMB's
	Out-of-hospital Basic dentistry (fillings, extractions and other basic procedures only)	Up to 100% of the LAHR	Unlimited	1. Subject to meeting the Scheme's treatment guidelines and managed criteria. 2. Subject to a list of procedures, only at a Keycare Network dentist.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
16.	**Prescribed Pharmaceuticals**			
	PMB Chronic sickness conditions and other PMB chronic conditions as per DTP pairs and Annexure G	100% of cost	Unlimited	1. Subject to pre-authorisation 2. Chosen DSP doctor to prescribe medicine in terms of formulary and clinical entry criteria at selected DSP. 3. If the beneficiary involuntarily does not use the Scheme's DSP courier pharmacy or the formulary medicine, a clinical appeals process will apply in line with regulation 15 (h) (c) and 15 (i) (c). 4. Refer to Annexure G for the co-payment applicable for the voluntary use of a non-DSP GP, Pharmacy or a non-formulary medicine. 5. Costs for completion of chronic application form covered from MMB.
	Diabetes Care or Cardio Care Disease Management Programmes	Up to 100% of the LAHR	Unlimited, subject to basket of care	Non-PMB GP-related services covered in a treatment basket, subject to referral by the Scheme's Network Provider and participation on the Chronic Illness Benefit. Paid from MMB.
	Blood glucose monitoring device	Up to 100% of the LAHR	Limited to 1 device per person per year	1. Subject to being registered for Diabetes on the Chronic Illness Benefit. 2. Paid from MMB, subject to PMB's. 3. Limited to the home monitoring device limit, as stipulated.
	Acute and non-PMB chronic sickness conditions	Up o 100% of the LAMR from DSP	Unlimited	Must be prescribed and supplied by the chosen DSP doctor. 1. Subject to the KeyCare acute medicine formulary and protocols
	TTO medicine as prescribed while in hospital.	100% of LAMR	R190 per admission	1. Payable from MMB if included in the Hospital account. 2. PMB TTO at cost.
	Over-the-Counter Medication (Schedule 0, 1 and 2, generic or non-generic, whether prescribed or not)	-	No benefit	No benefit.
17.	**Chronic Kidney Dialysis and organ transplants (includes authorised related medicines)**	Up to100% of LAHR 100% of cost for PMB's Up to 100%of LAMR	Unlimited	1. Co-payment of 20% if performed by a non-Network DSP. **Subject to PMB's and Annexure G.** 2. Subject to authorisation and/or approval and treatment meeting the Scheme's clinical criteria. 3. Medicine for Immuno suppressive therapy covered according to PMB formulary, subject to authorisation.
18.	**Oncology including Chemotherapy and Radiotherapy (including stem cell transplants and Brachytherapy for Prostate cancer)**	100% of LAHR 100% of cost for PMB's at DSP	Unlimited, save as provided for elsewhere in these Rules	Paid from MMB if obtained from -the Scheme's DSP provider(s), subject to PMB requirements and clinical protocols. If member voluntarily makes use of a non-DSP then a 20% co-payment will apply Locally sourced Stem Cell Transplant benefit subject to authorisation, clinical criteria and review.
	Advanced Illness Benefit for Oncology patients	100% of cost up to LAHR	Unlimited	Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
	Oncology-related Positron Emission Tomography (PET) Scans	Up to 100% of LAHR from MMB	Up to maximum of 4 scans per person per treatment cycle	Subject to authorisation and clinical criteria, co-payment of 20% at a non-DSP Network provider or non-Keycare hospital. Subject to peer-review by a designated panel of external specialists.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
19.	**Radiology and Pathology**			
	• In Hospital	Up to 100% of the LAHR	Unlimited	1. Pathology services in hospital subject to Preferred Provider Network. 2. Where the services of a non-Preferred Provider is used, the claim will be paid directly to the member 3. Point of care Pathology testing subject to the Scheme's treatment guidelines and managed care criteria
	• Out of Hospital Selected basic x-rays obtained from the Network of radiographers	Up to 100% of the LAHR	Unlimited	Covered only if requested by a member's chosen DSP doctor 1. Subject to a list of procedure codes and PMB
	Selected basic blood tests	Up to 100% of the LAHR	Unlimited	Covered only if requested by a member's chosen DSP doctor 1. Point of care Pathology testing subject to the Scheme's treatment guidelines and managed care criteria
	MRI or CT Scans			
	• In Hospital	Up to 100% of the LAHR	Unlimited Limited to the Specialist limit of R4,730 per person per year if scan is not related to the admission	Subject to authorisation and treatment meeting the Scheme's treatment guidelines and managed care criteria.
	• Out of hospital	Up to 100% of the LAHR	Subject to the Specialist limit of R4,730 per person per year	Covered only if performed by one of the Scheme's Network providers for non-PMB's. Requires referral by KeyCare Network GP. Co-payment of 20% for elective PMB's performed at a non-KeyCare provider
	Scopes			
	• In Hospital Endoscopic procedures, gastroscopy, colonoscopy, sigmoidoscopy and protoscop	Up to 100% of the LAHR	Unlimited	PMB cover, and cover for children 12 years and under. Subject to preauthorisation and a defined list o Network facilities. Covered from the Major Medical Benefit
	• Out of Hospital Endoscopic procedures, gastroscopy, colonoscopy, sigmoidoscopy and protoscop	Up to 100% of the LAHR	Unlimited	Subject to PMB's and pre-authorisation. Paid from MMB
20.	**Optometry**			
	• In hospital Opthalmology	100% of LAHR	Unlimited at DSP	Paid from MMB if obtained from the Scheme's DSP provider(s), subject to PMB requirements and clinica criteria.
	• Out of hospital Lenses, frames, examinations, contact lenses	100% of LAHR	One pair of spectacles or contact lenses per person every two years from last date of service	Limited to one eye test and one pair of white mono- or bifocal lenses with basic frame, or one pair of contac lenses, at an Optometrist in the DSP Optometry Network
21.	**Maternity**			
	• In hospital Confinement	Up to 100% of LAHR from MMB	Unlimited	Subject to authorisation. In a Network hospital
	• Out of hospital **Maternity Programme** **Cover during pregnancy**			Subject to registration on the Maternity Programme.
	Antenatal consultations with the chosen GP, gynaecologist or midwife		Limited to 8 consultations, subject to applicable limits	1. Services of KeyCare Network GP or Specialist must be used.
	Prenatal screening or Non Invasive Prenatal Testing (NIPT		1 Nuchal translucency test or 1 non-invasive prenatal test (NIPT) or 1 T21 Chromosome test	
	Pregnancy scans		Limited to 2 X 2D Ultrasound scans	1. 3D or 4D Sans will be paid up to the maximum cost of a 2D scan
	A defined routine basket of pregnancy-related blood tests		Limited to the defined basket of tests	
	Antenatal classes and / or postnatal visits with a registered nurse		Limited to 5 pre- or post-natal visits	
	Cover for the newborn baby for 2 years after the birth			
	Visits to GP or Gynaecologist or ENT	Up to 100%of LAHR	Limited to 2 visits	1. Services of KeyCare Network GP or Specialist must be used
	Cover for the mother of the newborn baby for 2 years after the birth	Up to 100% of LAHR		
	GP or Gyneacologist consultation		Limited to 1 consultation	1. Benefit related to post-natal complications
	Nutritional assessment at a dietitian		Limited to 1 assessment	
	Postnatal mental health consultation with a chosen GP, psychologist or counsellor		Limited to 2 consultations	
	Lactation consultation with a registered nurse or lactation specialis		Limited to 1 consultation	

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
22.	**Ambulance Services**	100% of the cost up to the LAHR	Unlimited	Subject to authorisation from the DSP for ambulance services and inter-hospital transfers.
23.	**Prostheses** Internal	Up to 100% of the LAHR	Unlimited	Covered from MMB. Subject to authorisation.
24.	**Compassionate Care Benefit for non-oncology patients (in-patient care and home visits)**	100% of cost up to LAHR	Limited to R49,650 per person per lifetime for all claims	Unlimited for PMB-scope and level of care. PMB claims first accumulate to this threshold; thereafter unlimited.
25.	**Medical Equipment Benefit**			
	Mobility Devices Wheelchairs, long leg calipers, crutches, etc	Up to 100% of the LAHR	R5,400 per family per year	Subject to authorisation: 1. Payable from MMB only if requested by the member's chosen KeyCare Network GP. 2. Covered in full up to the limit, only if obtained at DSP. If DSP is not used then a 20% co-payment will apply. 3. This benefit will be prorated if the member joins during the year.
	Oxygen rental	100% of cost up to LAHR	Unlimited	1. Covered in full only if obtained at DSP. If DSP is not used then a 20% co-payment will apply.
26.	**Auxiliary Services** Audiology, Occupational or Speech Therapy, Chiropody/Podiatry Dietetics, Homeopathy, Naturopathy, Chiropractics, Acupuncture and any other registered Aucilliary service	-	No Benefit, Subject to PMB's	No Benefit, Subject to PMB's
28.	**Screening Tests** **Group of screening tests at a Pharmacy** 1. Blood Glucose Test 2. Blood Pressure Test 3. Cholesterol Test 4. Body Mass Index (BMI)	Up to 100% of the LAMR	Paid once per beneficiary per year for one or all of the 4 listed screening tests	1. Payable from MMB only if services were obtained in the Scheme's contracted network of pharmacies.
	Screening tests for children between ages 2 and 18 years of age: 1. Body Mass Index (BMI) and counselling where appropriate 2. Hearing screening 3. Dental screening 4. Milestone tracking for children under the age of 8	Up to 100% of the LAHR	Paid once per beneficiary per year for one or all of the 4 listed screening tests	1. Paid from MMB only if services were obatined from the Scheme's DSP.
	Seniors screening benefit Group of age appropriate screening tests for persons 65 years and older	Up to 100% of the LAHR	Each of the listed assessments paid once per beneficiary per annum	1. Payable from MMB only if services were obtained from the Scheme's contracted DSP.
	Additional comprehensive screening assessment for at risk persons after having undergone any of the above screening tests	Up to 100% of the LAHR	One consultation per beneficiary per year at an accredited Network GP	Subject to clinical entry criteria. Paid from MMB.
	Defined Diabetes and Cholesterol screening tests	Up to 100% of the LAHR	Apply to specific test codes	Subject to meeting the Scheme's clinical criteria.

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	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
	Other screening tests			
	Mammogram, Pap Smear and Prostrate-Specific Antigen (PSA)	Up to 100% of the LAHR	1 Mammogram every 2 years 1 Pap smear every 3 years 1 PSA test person/year	Subject to meeting the Scheme's clinical criteria. 1. Consultation paid from available day-to-day benefits or member's own pocket when benefits are exhausted. PMB paid from MMB. 2. Subject to PMB's
	Colorectal cancer screenings for persons aged 45 to 75 years		1 Faecal occult blood test or immunochemical test every 2 years per person	
	Additional cover for Mammogram, Breast MRI, BRCA or repeat Pap Smear or one Colonoscopy (for persons identified by the colorectal screening to be at risk)	Up to 100% of LAHR	Unlimited, but once off BRCA testing allowed One colonoscopy per person	Subject to meeting the Scheme's clinical criteria. Consultation paid from available day-to-day benefits or members own pocket when benefits are exhausted.
29.	**Preventative Care**			
	Flu vaccination	Up to 100% of the LAHR	1 flu vaccination per beneficiary per year	1. Subject to meeting the Scheme's clinical criteria. 2. Seasonal flu vaccines in excess of the annual limit payable by the member. 3. Consultation and other services to administer the vaccine paid from MMB.
	Pneumococcal vaccination	Up to 100% of the LAHR LAHR	One Pneumococcal vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons older than 65	Paid from MMB. Subject to meeting the Scheme's clinical criteria. Vaccines in excess of the limit, consultation and other healthcare services to administer the vaccine, paid by the member.
30.	**WHO Outbreak Benefit** Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks:			Basis for cover subject to PMB as defined in **Annexure G** Subject to obtaining the services from the Scheme's preferred providers / DSPs , where applicable. Subject to the condition and treatment meeting certain clinical criteria and protocols.
	Out of hospital healthcare services related to COVID-19, subject to PMB			
	Screening consultation with a Nurse of GP	100% of cost	Unlimited	1. Defined basket for pathology / x-rays and scans.
	Pathology / X-rays and scans	100% of cost	2 tests per person per year, unless PMB	2. Testing subject to referral.
	Consultations with a GP or nurse	100% of cost	Unlimited	
	Supportive treatment	100% of cost	Unlimited	1. Acute medicine according to a defined list.
	Home-based care in lieu of hospitalisation (requires authorisation)	100% of cost	Unlimited	1. Subject to authorisation and the use of the Scheme's DSP providers, where relevant.
	Vaccine, including the administration of the vaccine	100% of cost	Unlimited	
	Treatment of complications and rehabilitation for long COVID-19	100% of cost	Subject to basket of care	1. Subject to clinical criteria and guidelines.
31.	**Trauma Recovery Benefit** Benefits are over and above any that may be granted under DTPMB			
	Day-to-day cover for medical expenses related to a traumatic incident of an acute *nature* that resulted in a loss of functionality, leaving the beneficiary with *a standard level of residual inability* after discharge from hospital or rehabilitation facilities.			Paid in respect of the affected beneficiary following the traumatic onset of, or due to: i. Paraplegia; Hemiplegia; Quadriplegia and Tetraplegia. ii. conditions resulting from the following traumatic incidents: Near-drowning; Severe anaphylactic reaction; Poisoning and Crime-related injuries. iii. severe burns. iv. an internal or external head injury v. loss of limb, or part thereof.
	Allied, Therapeutic and Psychological healthcare services (acousticians, biokineticists, chiropractors, counsellors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers,speech and hearing therapists)	Up to 100% of the LAHR or LAMR	M = R8,700 M+1 = R13,100 M+2 = R16,200 M3+ = R19,600	Subject to authorisation and the treatment meeting the Scheme's clinical criteria
	Prescribed Medicine		M = R16,900 M+1 = R20,000 M+2 = R23,800 M3+ = R28,900	1. Excludes OTC Medicines (inclusive of Schedule 0,1 and 2 drugs whether prescribed or not, optometry, antenatal classes and dentistry (other than severe maxillio facial dental and oral procedures).
	External Medical Appliances		R28,700	2. Cover applies to 31 December of the year after the trauma occurred.
	Prosthetic Limbs (with no further access to the External Medical Appliances Limit)		R92,300	3. Cover is not restricted to the Scheme's DSPs
	Hearing Aids		R15,900	
	Counselling sessions with a psychologist or social worker	Up to 100% of the LAHR	Limited to 6 sessions per person	1. Paid in respect of each of the beneficiaries registered on the affected membership to the end of the year after the year in which the trauma occurred

LEGEND:

DSP = Designated Service Provider
LAHR = LA Health Rate
LAMR = LA Medicine Rate
MMB = Major Medical Benefit
PMB = Prescribed Minimum Benefits

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LIMITATION AND EXCLUSION OF BENEFITS

With due regard to the Prescribed Minimum Benefits, the exclusions listed in Annexure C of the Main Body to these Rules will automatically apply to the LA KeyPlus Option. In addition, the following exclusions will apply to these plans:

1. All cosmetic treatment including, but not limited to, septoplasties, osteotomies and nasal tip surgery
2. Benign breast disease
3. All costs relating to cochlear implants, processors and hearing aids
4. All costs relating to auditory brain implants
5. All costs relating to internal nerve stimulators
6. All costs relating to joint replacements
7. Back surgery
8. Neck surgery
9. Knee and shoulder surgery
10. In-hospital management of:
    - Conservative back treatment
    - Conservative neck treatment
    - Dentistry (services of surgical procedures which involve the hard or soft tissues of the mouth)
    - Skin disorders (non- life-threatening) including benign growths and lipomas
    - Nail disorders
    - Investigations and diagnostic work-up
    - Endoscopic procedures
    - Functional nasal problems and functional sinus problems
11. Surgery for oesophaegeal reflux and hiatus hernia repairs
12. Removal of Varicose Veins
13. Correction of Hallux Valgus/Bunion and Tailor's Bunion/Bunionette
14. Surgery and other healthcare services to correct refractive errors of the eye
15. Elective Caesarean Section except in cases where it is medically necessary

The Scheme will also not cover any healthcare expenses related directly or indirectly to these healthcare services.

Nothing contained in this Annexure will be construed to exclude the application of the general exclusions set out in Annexure C.

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CHRONIC DISEASE LIST: CDL (AS PER REGULATIONS UNDER THE MEDICAL SCHEMES ACT)

Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Obstructive Pulmonary Disease	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus Types 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

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REGISTRAR OF MEDICAL SCHEMES

ANNEXURE C

LIMITATION AND EXCLUSION OF BENEFITS

Preamble

1. 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.

2. The limitations and exclusions in the KeyPlus Option as listed in Appendix 1 to Annexure B5 must be read with this Annexure, where applicable.

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A. Limitation of Benefits

1. The maximum benefits to which a member and his dependants are entitled to in any financial year, are limited as set out in Annexure B.

2. In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending practitioner, at the cost of the Scheme. In such cases, if such specialist`s advice is not acted upon, no further benefits will be allowed for that particular illness subject to evidence based managed care protocols/formularies, as provided for in Regulation 15.

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

4. Where the cost of generic medicine exceeds the cost of the original (ethical) brand equivalent of such medicine, the Scheme's funding liability for such medicine shall not exceed the cost of the original (ethical) brand equivalent.

5. Except for benefits in respect of the PMB's, expenses for allowable benefits that are in excess of that which the member is entitled to in terms of the rules of the Scheme may be paid from a member's MSA but shall not accumulate to the AT.

6. Except for the circumstances contemplated in Rules 16.8, 16.9 and 16.10 (including all their respective sub-clauses) of the Main Body of the Rules, if any other party is liable for the cost incurred by the member for any past or future healthcare service and/or medical expense, the Scheme's liability towards the member or dependant, as the case may be, shall be limited in total to the difference between the amount which the member would be entitled to in terms of the Rules and the amount of the liability undertaken by such other party in respect of such healthcare service and/or medical expense. In this regard, where payment has been made by the Scheme to the member for such healthcare service and/or medical expense, the member or the other party concerned, shall reimburse the Scheme, or the Scheme shall be entitled to recover from the member:
   6.1 only from monies due and payable or paid by such party to the member in respect of such healthcare service and/or medical expense; and
   6.2 such reimbursement and/or recovery shall be applicable irrespective of the lapse of time since the Scheme funded, or the healthcare service and /or medical expense was incurred by the member.

7. In the event of any other party (including a manufacturer or supplier) being liable, whether in part or in full, for the cost incurred for the recall, replacement or repair of any defective product used or device/implant inserted in respect of a member or his dependant, the Scheme shall be entitled to be reimbursed or may recover from the other party concerned or the member, if payment has been made to the member by the other party concerned, the full cost of the product used or the cost associated with the initial insertion of the device/implant (including the cost of diagnostic work-up and follow-up interventions) incurred by the Scheme, provided that the quantum of the reimbursement or recovery may not exceed what was actually paid for by the Scheme in respect of such product, device or implant.

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B. Exclusion of Benefits

Expenses incurred in connection with any of the following shall not be paid by the Scheme.

1. Any sickness condition that was specifically excluded from benefit during any applicable waiting periods when a member/dependant joined the Scheme.

2. All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules of the Scheme, taking into consideration that beneficiaries admitted during the year are entitled to benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

3. Costs for services rendered by:
   - 3.1 persons not registered in terms of appropriate legislation for whom registration is a prerequisite to render relevant health services; or
   - 3.2 any institution, nursing home or similar institution except a state or provincial hospital, not registered in terms of any law; or
   - 3.3 persons who have not been registered as a provider by the Board of Healthcare Funders

4. Health care services and/or claims received for medicine not registered, or approved for use in a specific instance by the Health Products Regulation Authority.

5. Healthcare services of an experimental, unproven nature, or those rendered by an unregistered provider.

6. Recuperative or convalescent holidays.

7. Search and rescue.

8. Travel and subsistence for members other than emergency transport provided by or via the Scheme's Designated Service Provider.

9. Healthcare services relating to any complications that may arise from any exclusion except insofar as these services are PMB-related.

10. Healthcare costs associated with a Prescribed Minimum Benefit, if such costs are incurred outside of the borders of South Africa.

11. All costs associated with medical reports, unless the report is requested by the Scheme.

12. All costs associated with medical examinations for life assurance, insurance, employment, lawsuits and similar purposes.

13. Healthcare services that do not meet the Scheme's clinical protocols, provided that such protocols are in accordance with evidence-based medicine, taking into account considerations of cost-effectiveness and affordability and international and/or industry best practice.

14. Any and all costs related to claims fraudulently made and related to making material misrepresentation or non-disclosure of factual information.

15. Interest charges claimed by the member or healthcare provider, as the case may be, in respect of:

    15.1 late payment of claims caused by a delay in submission of claims or re-submission of corrected claims, or delays in the submission of statements, particulars or proof required in support of such claims;

    15.2 delays by a member in payment to a healthcare provider for services rendered in circumstances where the claim was submitted, processed and paid to the member in conformance with the Act and the Rules; or

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15.3 delays in payment of a claim or part thereof, where the delay was occasioned as a result of an active complaint and/or dispute process initiated in terms of the Act or Rules.

16 Healthcare services relating to:

16.1 injuries sustained resulting from participation in a wilful and material violation of the law, except for those included under the PMBs;

16.2 injuries sustained resulting from wilful participation in war, terrorist activity, riot, civil commotion, rebellion or insurrection, except for those included under the PMBs.

17 Appointments which members or dependants of member fail to keep with a provider of service.

18 All costs for operations, medicine, treatment and procedures for:

18.1 Cosmetic purposes which shall, without limitation, be deemed to include health care services related to:

18.1.1 obesity, except PMB; or

18.1.2 hair removal; or

18.1.3 scars; or

18.1.4 nasal tip surgery; or

18.1.5 otoplasty for bat ears; or

18.1.6 keloids, except for functional impairment; or

18.1.7 Blepharoplasties (eyelid surgery); and

18.1.8 Portwine stains.

The Scheme shall, based on the clinical motivation received, decide whether a particular operation, treatment or procedure is cosmetic in nature, taking into consideration evidence-based studies that are based on cost-effectiveness and affordability.

18.2 Healthcare services related to gender reassignment.

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18.3 The purchase of the following, unless prescribed by a person who is registered with a recognised professional body constituted in terms of an Act of Parliament:

18.3.1 applicators, toiletries and beauty preparations;

18.3.2 bandages, cotton wool and other consumable items;

18.3.3 patented foods, including baby foods;

18.3.4 vitamins, mineral supplements, tonics, stimulants slimming preparations and drugs as advertised to the public and healthcare providers;

18.3.5 household and biochemical remedies;

18.3.6 anabolic steroids;

18.3.7 aphrodisiacs;

18.3.8 anti-smoking preparations and devices;

18.3.9 sunscreen agents.

Unless otherwise decided by the Scheme, benefits in respect of medicines obtained under this clause, on a prescription, are limited to one month's supply (or to the nearest unbroken pack) for every prescription or repeat thereof.

18.4 Healthcare services relating to:

18.4.1 any complication that may arise from any exclusion listed in this annexure, except PMB; or

18.4.2 assisted reproductive therapy, including any work-up and complications thereof, other than those covered by the Prescribed Minimum Benefits (PBM); or

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18.4.3 obesity, except PMB; or

18.4.4 acute and/or long term alcohol, drug or solvent abuse, except PMB; or

18.4.5 breast reductions or enlargements; or

18.4.6 Gynaecomastia; or

18.4.7 frail care; or

18.4.8 sclerotherapy, other than that approved by the Scheme for the treatment of varicose veins; or

18.4.9 synvisc intra-articular injections, except PMB; or

18.4.10 hyperbaric oxygen treatment, except PMB.

19. Osseo-integrated implants and implant-related procedures.

20. Accommodation in old-age homes or similar institutions, except where such has been approved by the Scheme as a recognised as a step-down facility.

21. All desensitization treatment and allergy tests unless motivated and funded from the member's MSA.

22. Any treatment, devices or therapy that are deemed to be alternative, or homeopathic for which cover is sought from the MMB, except where provision is therefore is made in the ATB or EDB.

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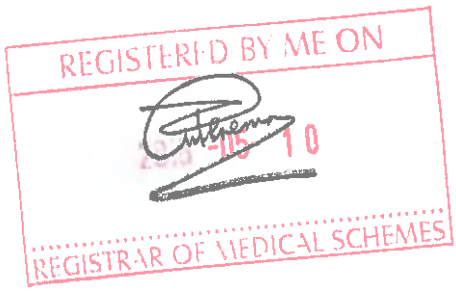

ANNEXURE D

CLAIMS PROCEDURE

(1) Claims in respect of a relevant health service may be submitted to the Scheme electronically.

(2) A claim bearing the ICD10 diagnostic code and/or any other legitimate claim submitted to the Scheme electronically shall be paid to the provider of the relevant health service directly in accordance with the relevant benefit schedule of Annexure B, limited to the LAHR OR LAMR or to the cost in terms of any contract agreement or arrangement between the Scheme and the supplier, as the case may be.

(3) For the purpose of expediting settlement of claims relating to the chronic disease list of the prescribed minimum benefits, the ICD10 diagnostic code that relates to the relevant health service must be reflected on the claim: Provided that any other coding recognizable by the Scheme's systems will also be accepted .

(4) In respect of a claim relating to the prescribed minimum benefits other than that in the chronic disease list, diagnosis information by description or coding must be reflected on the claim. Otherwise the claim will be treated like that for ordinary benefits.

(5) Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the health care provider accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member and provider the opportunity to return such corrected claim to the Scheme within sixty days of the notice.

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(6) On receipt by a member of an account in respect of medical expenses, he shall forthwith submit to the Scheme such account duly certified by him as being a true and correct statement of the expenses so incurred by him or his dependants.

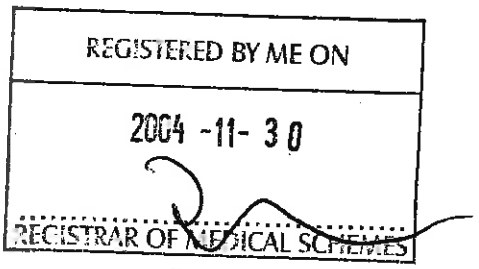
(7) A member shall ensure that any account forwarded by him to the Scheme shall embody –

(a) the name and membership number of such member;

(b) the name of the patient;

(c) the date and nature of the service rendered;

(d) the cost of the service rendered; and



(e) the name and qualifications of the provider of any relevant health service by whom the service was rendered.

(8) Subject to the provisions of paragraph (10) –

(a) the documents specified in paragraph (6) must be submitted to the Scheme on or before the last day of the fourth month following the date on which the service in respect whereof the claim is being made was rendered; and

(b) any request by a member for payment of benefits payable in respect of an account fully settled by him shall be accompanied by an account duly certified as correct and fully specified in terms of paragraph (7) and the receipt for payment thereof, and must be submitted to the Scheme on or before the last day of the fourth month following the date on which the service in respect whereof the claim in being made, was rendered.

(c) A corrected account claim or statement must be resubmitted to the Scheme within 60 days following the date on which it is returned for correction.

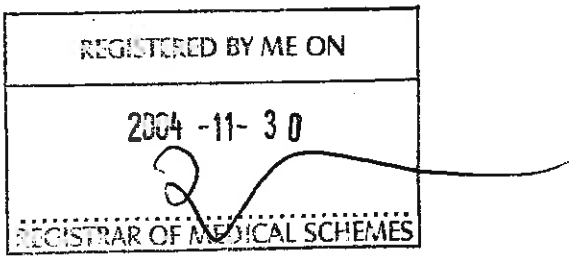
Also provided for in (5)

(9) Should the documents specified in paragraph (8)(a), (b) or (c) not reach the Scheme before the last day contemplated by paragraph (8)(a) or (c), but subject to the provisions of paragraph (10), no benefits shall be payable and the documents shall be returned to the member concerned.

(10) (a) On receipt of an account which has not been fully settled by a member, the Scheme shall pay the benefit in respect of such account, as determined in the Benefit Schedules of these Rules.

(b) Any portion of an account in excess of the applicable benefit and which is not payable by the Scheme shall remain the personal liability of the member concerned.

(11) On receipt of an account which has been fully settled by a member the Scheme shall pay to the member an amount equal to the amount which would have been payable had such account not been fully settled by such member.



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ANNEXURE E

LA-HEALTH MAJOR MEDICAL BENEFIT
(MMB)

(A) GENERAL

1. Effective date

   The MMB shall with effect from 1 January 2005 be applicable to all the benefit options as per Annexure B1 – B5.

2. Annual Maximum

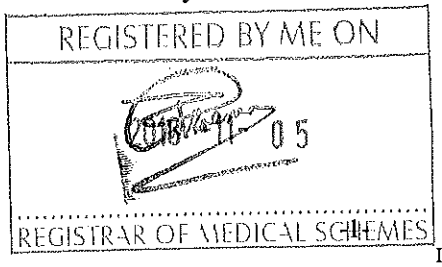
   No annual maximum is applicable to benefits provided in terms of this Annexure.

3. The benefits granted in terms of this Annexure is referred to in the Rules as the Major Medical Benefit (MMB).

4. The benefits offered in terms of this Annexure shall neither be available in respect of the Limitations and Exclusions in Annexure C nor in Appendix 1 to the LA KeyPlus option.

(B) PRESCRIBED MINIMUM BENEFITS

Members and their registered dependants are entitled to the prescribed minimum benefits (PMB). The cost of diagnosis, treatment and care of all PMB will be covered in full, i.e. without a co-payment and not subject to any maximums or exclusions stated in this Annexure but subject to waiting periods, if applicable, through Scheme DSP only and if involuntarily obtained from a non-DSP.



Diagnosis, treatment and care in a private hospital, of the sickness conditions prescribed in terms of the Regulations, excluding procedures/conditions specified in Schedule 1, hereof or diagnosis, treatment and care in a public hospital of sickness conditions not prescribed in terms of the Regulations, do not qualify for PMB, but qualify for additional benefits as stipulated by paragraph (C) below.

(C) ADDITIONAL BENEFITS

1. Hospitals

Subject to the provisions of paragraph D of this Annexure, benefits are granted for hospitalization, treatments and the associated clinical procedures and will be subject to a 20% co-payment if pre-authorisation is not obtained.

1.1 Private Hospitals

The use of Designated Service Providers (DSP) qualifies for benefits stipulated below. (The benefits for the use of Non-DSP are in accordance with the relevant Benefit Schedules).

1.1.1 Accommodation

Except where indicated to the contrary in the relevant Benefit Schedules 100% of the cost or LAHR for:

- accommodation in a general ward;
- accommodation in a private ward where medically necessary (e.g. as a result of a contagious disease);
- accommodation in an intensive care unit and/or high care ward;
- the use of the recovery room.

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1.1.2 Operating theatre

Except where indicated to the contrary in the relevant Benefit Schedules 100% of theatre cost or LAHR, including the use of registered unattached theatres. In the case of after hours surgery, the normal tariff for the theatre will apply, unless in an emergency.

1.1.3 Medicine, material, hospital apparatus and out-patient treatment
Except where indicated to the contrary in the relevant Benefit Schedules 100% of the cost or LAHR / LAMR of disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used during stay in the hospital, including the cost of procedures and the use of hospital apparatus.

1.1.4 Internal Prostheses (Medical and surgical accessories)
Except where indicated to the contrary in the relevant Benefit Schedules, 100% of the cost or LAHR of medical and surgical accessories placed in the body as an internal supporting mechanism during an operation and/or which for functional medical reasons are implanted as a prosthesis to replace parts of the body.

2. Secondary facilities

The following benefits are payable in cases managed as part of a Case Management Program only, subject to the provisions of paragraph (D) of this Annexure:

2.1 100% of cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for sub-acute facilities, hospice, nursing services or practicing nurses and rehabilitation services.

2.2 Benefits for clinical procedures and treatment during stay in a secondary facility will be subject to the same Benefits that apply to hospitalization.

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3. General Practitioners and Specialists

3.1 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for clinical procedures and operations, if pre-authorisation was obtained for hospitalization. In addition, 100% of the applicable tariff as per the benefit schedules of Annexure B for the following clinical procedures performed out of hospital (no pre-authorisation required for these):

3.1.1 Upper gastro-intestinal endoscopy;
3.1.2 Lower gastro-intestinal endoscopy (excluding sigmoidoscopy and anoscopy);
3.1.3 Laser tonsillectomy;
3.1.4 24 hour oesophageal pH studies;
3.1.5 Oesophageal motility.

Should the Scheme channel a clinical procedure or operation from hospital to the doctor's room (at the pre-authorisation stage), such procedure or operation will be covered by MMB.

3.2 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for apparatus used during surgical procedures and operations, if pre-authorisation was obtained for hospitalization.

3.3 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for anaesthetic, where the anaesthetic is administered during surgical procedures and operations, if a pre-authorisation was obtained for hospitalization.

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3.4 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for visits after admission and during a patient's stay in hospital, if pre-authorisation was obtained for hospitalization.

3.5 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for radiology and pathological services rendered during a patient's stay in hospital, if pre-authorisation was obtained for hospitalization.

3.6 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for MRI-scans, computer tomography, bone density scans and radio-isotope studies, irrespective of whether treatment was done during and/or not during hospitalization.

3.7 Maxillo-facial and oral surgery

3.7.1. The conditions listed below will be covered at 100% of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for the services rendered during a patient's stay in-hospital, if pre-authorisation was obtained for hospitalisation:

- **Severe life threatening infections** in the mouth, face and neck area. The infection manifests itself by acute symptoms of sufficient severity that the absence of immediate hospital admission with medical and surgical intervention could result in serious jeopardy to the person's health. This definition specifically excludes procedures such as Apicectomy.

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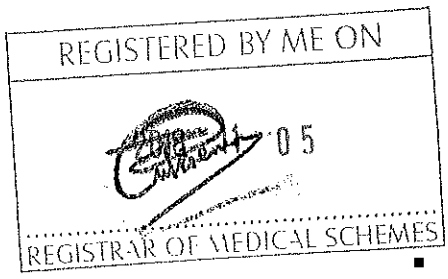
- **Jaw / TM joint replacements** referring to surgical reconstruction to the Temporomandibular joint (the joint that connects the lower jaw to the scull)

- **Cancer related surgery** done to remove cancer of the oral cavity and will include reconstruction surgery of the bone as part of the cancer related surgery. (This will not include periodontal soft tissue procedures, orthodontics and placement of dental implants and superstructures, crowns, bridges or dentures to replace lost teeth or previous dental restorative appliances and restorations.)

- **Trauma** defined as acute sudden unforeseen physical trauma / injury of the facial bones and oral tissues (both soft and hard), which manifests itself by acute symptoms of sufficient severity that the absence of hospital admission with surgical intervention at least within the first 24 hours thereafter could result in serious jeopardy to the person's health or serious impairment to bodily functions.

- **Severe trauma** related surgery will include surgery done within the initial trauma admission as well as admission related to post-traumatic reconstruction surgery of the bone. (This will not include periodontal soft tissue procedures, orthodontics and placement of dental implants and superstructures, crowns, bridges or dentures to replace lost teeth or previous dental restorative appliances and restoration related surgery.)



- **Surgical removal of permanent teeth.**

- **Orthognatic surgery.**

- **Cleft lip and palate repairs**

4. Auxiliary Services

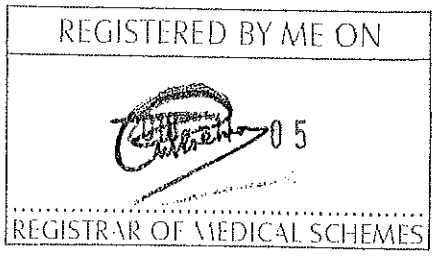
These services are supplementary to hospital care and qualify for benefits if rendered during hospitalisation and/or case management.

4.1 100 % of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for services rendered during a patient's stay in hospital, if pre-authorisation was obtained for hospitalization.

4.2 100 % of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules for approved step down services rendered outside of hospital, if the treatment forms part of case management. Subject to pre-authorisation and case management.

4.3 Blood transfusions

100% of the cost of blood transfusions (i.e. the cost of the blood products and/or equivalents, apparatus and the operator's fee) (Note: Bone marrow transplants are not covered under this section but under organ transplants).



5. Special Clauses

5.1 Maternity Benefits

Covered services are as per the relevant benefit schedules in Annexure B. Confinement benefits are as per paragraphs 1 and 3 of this Annexure but subject to pre-authorisation.

5.2 Organ transplants and Bone Marrow transplants (including immunosuppressant drugs)

100 % of the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules in respect of bone marrow transplants, organ transplants will only be allowed if the treatment forms part of the PMB or a Case Management Program (and occurs within South

Africa). The costs involved in harvesting the organ, bone marrow or stem cells, determining compatibility and disease markers, local registry costs (but specifically excluding foreign registries), and transport of the harvested organ for use by a beneficiary of the Scheme are all covered by the Scheme but only when all of the above donor costs are incurred within the borders of South Africa and in the cases where the donor's costs are not payable by a third party.

Donor costs will be covered by the Scheme if the donor is a beneficiary of the Scheme and the recipient is not, unless such donor costs are covered by any other party.

5.3 **Acute/Chronic Dialysis**

100% of the cost up to LAHR paid from MMB, subject to approval of treatment plan, at National Renal Care Facilities. If non-DSP is used voluntarily, the claim is paid as the agreed LA Health Rate. PMB's paid at cost.

5.4 **Oncology**

Apart from the benefits as in paragraphs 1 and 3 of this Annexure, benefits for treatment and services rendered outside a hospital are covered at the cost or LAHR except where indicated to the contrary in the relevant Benefit Schedules but subject to the condition that the treatment is subject to authorization and/or approval and the treatment meeting the Scheme's clinical criteria and protocols. Also subject to review by an external panel of specialists. Subject to generic substitution and cost-effective therapeutic equivalent substitution, where applicable. Tests and scans prior to positive diagnosis of cancer are not covered, except for those covered under paragraph 3.6 above and tests and scans leading to the determination of the diagnosis as a PMB.

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No co-payment will apply to the first R456,000 in respect of the LA-Comprehensive and LA Core Options and R228 000 in respect of LA Active and LA Focus Options of the benefit per person of approved oncology- related claims, after which all further claims will be subject to a 20% deductible per claim, per 12 month cycle, save for PMB's which are subject to SAOC Tier 1 regimens and baskets of care for supportive requirements.

The treatment of side effects of chemo- and radiotherapy will be covered subject to obtaining pre-authorisation.

Long-term chronic conditions that develop as a result of chemo- and radiotherapy will not be covered under this provision.

5.5 **PET scans**

100% of cost up to LAHR. Subject to authorization and/or approval and the treatment meeting the Scheme's clinical criteria. No co-payment will apply at the Scheme's Designated Service Provider. A deductible of R3,440 will apply per scan should a Designated Service Provider not be used. Oncology-related PET scans also accumulate to the first R456,000 in respect of the LA Comprehensive and LA Core Options and R228 000 in respect of LA Active and LA Focus Options of the benefit per beneficiary of approved oncology- related claims, per 12 month cycle. After all approved oncology- related claims have accumulated to an amount of R456,000 per person in respect of the LA Comprehensive and LA Core Options and R228 000 in respect of LA Active and LA Focus Options. All further PET scan claims will be subject to a 20% co-payment or R3,440 per scan, whichever is greater. Limited to a maximum of 4 scans per beneficiary per 12-month cycle. In instances where the condition is a PMB condition. payment of this benefit will be subject to PMB cover.

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5.6 **Stem Cell Transplants**

100% of cost up to LAHR for Stem Cell Transplants. The Scheme will only pay for the procedure, the search for, and the sourcing of the stem cells in South Africa subject to authorization and/or approval and the treatment meeting the Scheme's clinical criteria. In instances where the condition is a PMB condition, payment of this benefit will be subject to PMB cover.

5.7 **Speciality Medicine and Technology Benefit (SMTP)**

100% of cost. Limited to R228,000 per beneficiary per annum. A co-payment of 20% of each claim applies to all non-PMB treatment.

5.8 **Ambulance service and emergency transport**

100% of the cost or LAHR except where indicated to the contrary in Annexures B1 – B5.

5.9 **Refractive surgery, breast reduction surgery (reduction Mammoplasty), protruding ears and keloids (and other scars that cause functional problems).**

Benefits as in paragraphs 1 and 3 of this Annexure, subject to the Scheme's clinical guidelines and pre-authorisation.

5.10 **Foreign claims**

Benefits in respect of foreign claims are granted in accordance with the benchmark determined by the Scheme for a similar treatment in RSA. Such benefits shall be paid in ZAR.

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(D) PRE-AUTHORISATION

Access to the MMB shall be achieved by procurement on the part of the attending General Medical Practitioner/General Dental Practitioner/Specialist, or the relevant hospital or, as a last resort, the member/dependant, of pre-authorisation from the Scheme, except in the case of medical emergencies and/or life threatening situations where a system of post-confirmation as contemplated in paragraph 2 and 3(c) of Annexure B will apply.

1. Pre-authorisation is required for the services specified in this Annexure except as specified in paragraph C 3.1 herein, as well as any other procedures or treatment decided upon by the Scheme from time to time and provided for in the rules, and of which members will be informed.

2. When the Scheme grants pre-authorisation, it is merely a confirmation that the proposed clinical procedure or treatment is medically necessary.

3. Payment of benefits for a clinical procedure or treatment in respect of which pre-authorisation was granted, will always be subject to the:

    3.1 Rules of the Scheme – in particular any maximum, exclusions and waiting periods;

    3.2 Beneficiary qualifying for benefits – in particular the valid membership of the member, valid registration of any dependant, and fully paid contributions;

    3.3 Beneficiaries submitting such additional information regarding their conditions and the proposed clinical procedure or treatment, or obtaining such second opinions as the Scheme may reasonably request.

4. Conditions applicable to pre-authorisation:

    4.1 If a pre-authorisation is obtained and the clinical procedure or treatment does not exceed the authorisation, the clinical procedure or treatment qualifies for benefits.

    4.2 If a pre-authorisation is obtained and the authorisation is exceeded, benefits are paid only for the authorised clinical procedure or treatment. The excess costs are for the account of the member.

    4.3 If a clinical procedure or treatment is undergone after a pre-authorisation has been refused, no benefits are payable.

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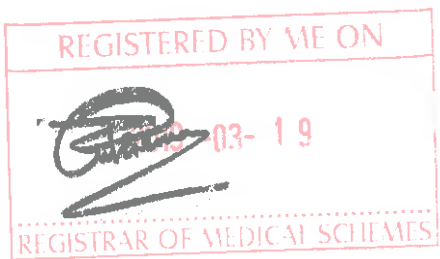
(E) CASE MANAGEMENT PROGRAM

1. If the health problems of beneficiaries are of such a nature that they qualify for admittance to the Scheme's Case or Disease Management Program, the Scheme may enter such beneficiaries on such a program – either on request of a beneficiary, or by referral by the member's treating General Practitioner or Specialist, or automatically.

2. If the Scheme uses a Case or Disease Management Program, the Scheme may, in its sole discretion grant amounts in excess of the benefits specified and which are not subject to the exclusions, provided it falls within the treatment plan of the case manager.

3. Notwithstanding the entitlement to benefits, if a beneficiary refuses participation in a Case or Disease Management Program, the Scheme may, subject to PMB, limit further benefits insofar as they are related to the specific complaint, or only pay benefits for a lower level of service.

4. Notwithstanding the entitlement to benefits, if a Beneficiary does not co-operate with the relevant Case or Disease Management Program, the Scheme may, subject to PMB, limit further benefits insofar as it is related to the specific condition.



Schedule 1

CLINICAL GUIDELINES AS DETERMINED BY LA-HEALTH:

1. **Breast Reduction Surgery:**

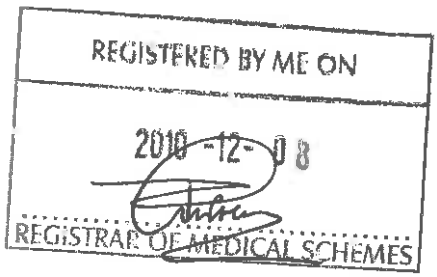
   Criteria -

- Overall mass of patient must not exceed a body mass index of 27.
- Bra size must be D or bigger.
- Sternal notch to nipple length must be 28 cms or more.
- Estimated amount of breast tissue to be removed must be more than 500 grams per side.
- Acceptable photos must accompany request.
- Orthopaedic report re. backache etc is optional.
- Post menopausal and adolescent women to be evaluated by a medical practitioner.
- Psychological and emotional reasons are not acceptable.

2. **LASIK Procedures:**

   Criteria -

   - Myopia > 3,0 diopter.
   - Astigmatism > 2,5 diopter.
   - Spherical equavalent > 4,0
   - Same *criteria* applies for re-do's.
   - PHAKIC-IOL - not acceptable.



3. **GYNECOMASTIA**

   Criteria -

   - Only young adults after puberty (18 to 22 years)
   - Acceptable photos must accompany request.
   - Full clinical motivation by attending doctor.
   - Cosmetic reasons are not acceptable.

4. **BLEPHAROPLASTY**

Criteria -

- Only when the visual fields are affected.
- Ophthalmologist's evaluation if the request comes from a plastic surgeon.
- Acceptable photos must accompany request.

5. **OTOPLASTY** (Bat ears).

Criteria -

- Only children under the age of 12 years.
- Clinical motivation by a medical practitioner.
- Acceptable photos must accompany request.

6. **TOTAL NOSE RECONSTRUCTION**

Criteria -

- Only code 1085 is covered in cases where the bony and/or cartilaginous structure of the nose is distorted.
- Acceptable photos must accompany the request.
- Full clinical motivation from the ENT- or plastic surgeon.
- Second opinion is required.

7. **CIRCUMCISION**

Criteria -

- Full clinical motivation required.

8. **SCARRING** (Keloids)

Criteria -

- Clinically motivated by a medical practitioner as part of the treatment process relating to the cause of the scarring.
- Only for functional reasons.

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9. LASER TONSILLECTOMY

Criteria -

- In doctor's rooms as an office procedure.
- No cover under general anaesthetic in hospital.

10. BREAST RECONSTRUCTION AFTER MASTECTOMY

- Benefits are allowed in respect of reconstructive surgery after mastectomy for proven breast cancer. Benefits will be paid once only for full reconstruction by whichever method, as well as for reduction surgery on the unaffected side for symmetry, where indicated, as per motivation. Only complications of a true medical nature will be considered for benefits and not failed cosmesis.

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ANNEXURE F

MEDICAL SAVINGS ACCOUNT (MSA)

1. On admission to the Scheme, ~~and should the member so elect~~, a MSA held by the Scheme in accordance with regulation 10 under the ACT, ~~may~~ shall be established in the name of the member concerned into which the contributions payable in respect of the MSA shall be credited and benefits in respect thereof, shall be debited. This does not apply to the Keyplus option.

2. The Scheme ~~may from time to time~~ shall pay into a member's MSA an amount as provided for in the Act. and rules.

3. Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to claim, according to the relevant benefit schedule.

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

5. Upon the death of the member, the balance due to the member will be transferred to his dependants who continue membership of the Scheme or paid into his estate in the absence of such dependants.

6. On transfer to another benefit option of the Scheme, which provides for such account, a member's MSA will be transferred to that other benefit option. On transfer to another option of the Scheme, which does not provide for such an account, any balance in the MSA account will be refunded to the member, 5 months after such transfer and subject to applicable taxation laws.

7. Should a member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme which does not provide for a MSA account, the balance due to the member will subject to paragraph 10 be refunded to the member, 5 months after termination of membership, and subject to applicable taxation laws.

8. Should a member be admitted to membership of another medical scheme which provides for a similar account, the balance due to the member will subject to paragraph 10 be transferred to such scheme, 5 months after termination of membership.

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9. Any negative balance in a member's MSA shall be recoverable from him by the Scheme upon his termination of membership, or in the event of his death, from his estate.

10. On termination of membership, any debt due to the Scheme by the member shall be offset against any amount payable in terms of paragraphs 7 and 8.

11. Where the Scheme pays a claim or claims, which, in the aggregate, exceed the aggregate amount of those portions of the member's contributions (including any interest paid to the member) which have been allocated to the member's MSA, as at the date of such payment by the Scheme, the Scheme shall at its option, be entitled:

    11.1 to debit the unfunded claim amount to the member's MSA; or

    11.2 to recover the unfunded claim amount from the member.

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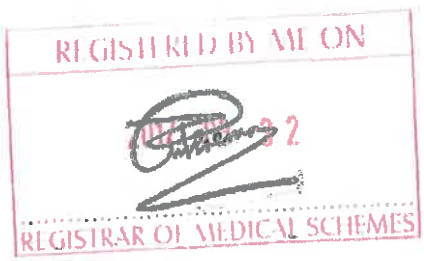

Annexure G

COVER FOR PRESCRIBED MINIMUM BENEFITS

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
Chronic Disease List ("CDL") – Out-of-Hospital Consultations	**Specialists** ***LA KeyPlus*** Any specialist in a KeyCare Specialist Network except where there is no KeyCare Specialist, in which case any Specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate.	Paid in full.	Up to a maximum of the LAHR. Any co-payment, which the member is liable for, is equal to any amount the provider charges above the LAHR
	All other Options Any specialist participating in the KeyCare Specialist network and/or all Specialists who have agreed to charge the Premier Rate.	Paid in full.	Up to a maximum of the LAHR. Any co-payment, which the member is liable for, is equal to any amount the provider charges above the LAHR
	GPs ***LA KeyPlus*** The member's chosen GP participating in the KeyCare Primary Network.	The Scheme shall pay the costs of PMB in full for involuntary use of non-DSP and up to the agreed rate for the services obtained from a DSP	Up to a maximum of the LAHR. Any co-payment, which the member is liable for, is equal to any amount the provider charges above the LAHR
	All other Options All GP's participating in the Discovery Health GP Network and/or the member's nominated Premier Plus GP, who has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of non-DSP and up to the agreed rate for the services obtained from a DSP	Up to a maximum of the LAHR. Any co-payment, which the member is liable for, is equal to any amount the provider charges above the LAHR

REGISTERED BY ME ON
2020/12/08
Mashilo Leboho
09/12/2020 15:15:05 (UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
CDL – Diagnosis	***Specialists***		
	LA KeyPlus Any specialist participating in a KeyCare Specialist Network except where there is no KeyCare Specialist, in which case any Specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate.	The Scheme shall pay healthcare treatment in full, subject to Scheme's diagnostic basket and the member making application to the Scheme.	The Scheme shall pay healthcare treatment up to a maximum of the LAHR, subject to Scheme's diagnostic basket and the member making application to the Scheme.
	All other Options Any Specialist participating in the KeyCare Specialist network and/or all Specialists who have agreed to charge the Premier Rate.	The Scheme shall pay health care treatment in full, subject to Scheme's diagnostic basket and the member making application to the Scheme	The Scheme shall pay healthcare treatment up to a maximum of the LAHR, subject to Scheme's diagnostic basket and the member making application to the Scheme
	GPs		
	LA KeyPlus The member's chosen GP participating in the KeyCare Primary network. Includes services rendered for: Diabetes, HIV, Cardio and Mental Health care	The Scheme shall pay health care treatment in full, subject to Scheme's diagnostic basket and the member making application to the Scheme	The Scheme shall pay healthcare treatment up to a maximum of the LAHR, subject to Scheme's diagnostic basket and the member making application to the Scheme
	All other Options All GP's participating in the Discovery Health GP Network. Diabetes, HIV, Cardio and Mental Health: The member's nominated Premier Plus GP who has contracted with the Scheme	The Scheme shall pay health care treatment in full, subject to Scheme's diagnostic basket and the member making application to the Scheme	The Scheme shall pay healthcare treatment up to a maximum of the LAHR, subject to Scheme's diagnostic basket and the member making application to the Scheme

REGISTERED BY ME ON
2020/12/08
Mashilo Leboho
09/12/2020 15:15:21 (UTC+02:00)
Signed by Mashilo Leboho
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
CDL – Medicine	**GPs** ***LA KeyPlus*** The Designated Service Provider is defined as listed, contracted pharmacies or the member's chosen GP participating in the KeyCare Primary Care Network ***All other Options*** Any dispensing provider or the Designated Service Provider contracted pharmacies	For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the lowest cost formulary listed drug (the chronic drug amount). Subject to Regulations 15 H (c) and 15I (c). For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the lowest cost formulary listed drug (the chronic drug amount) Subject to Regulations 15 H (c) and 15 I (c).	The Scheme will pay the maximum of the lowest cost formulary listed drug (the chronic drug amount) as specified per Option. Subject to Regulations 15 H (c) and 15 I (c). The Scheme will pay the maximum of the lowest cost formulary listed drug (chronic drug amount) as specified per Option. Subject to Regulations 15 H (c) and 15I (c).
CDL – Pathology	**All options** A defined list of providers that has contracted with the Scheme.	Paid in full.	Up to a maximum of the LAHR
CDL - Radiology	***LA KeyPlus*** A defined list of providers that has contracted with the Scheme ***All other Options*** Any provider charging the LA Health Rate	Paid in full. Paid in full.	Up to a maximum of the LAHR Up to a maximum of the LAHR
Diagnostic Treatment PMB ("DTPMB") – Out-of-Hospital Consultations	**Specialists** ***LA KeyPlus*** Any specialist participating in a KeyCare Specialist Network, except where there is no KeyCare specialist in which case any specialist practicing in a KeyCare Network hospital who has agreed to charge the Premier Rate. Subject to regulation 8 (3) (a) (b).	Paid in full.	Up to a maximum of the LAHR.

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REGISTRAR OF MEDICAL SCHEMES

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
Diagnostic Treatment PMB ("DTPMB") – Out-of-Hospital Consultations	***All other Options*** Any Specialist participating in the KeyCare Specialist network and / or Specialists who have agreed to charge the Premier Rate. Subject to regulation 8 (3) (a) (b). **GPs** ***LA KeyPlus*** The member's chosen GP participating in the KeyCare Primary Care Network. ***All other Options*** Any GP participating in the Discovery Health GP Network	Paid in full. Paid in full. Paid in full.	Up to a maximum of the LAHR. Up to a maximum of the LAHR. Up to a maximum of the LAHR.
DTPMB – Diagnosis	**All options** Any provider that has contracted with the Scheme in respect of member's chosen benefit option and where it is appropriate for such diagnosis to be made by the provider	The Scheme shall pay the healthcare treatment in full, subject to the Scheme's diagnostic basket. This is subject to the member making application to the Scheme.	Health care treatment paid to a maximum of the LAHR subject to the Scheme's diagnostic basket and the member making application to the Scheme. Any co-payment, which the member is liable for will be equal to the difference between the amount charged and the LAHR.
DTPMB – In-Hospital Consultations	**Specialists** **LA KeyPlus** Any specialist participating in a KeyCare Specialist Network, except where there is no KeyCare Specialist, in which case any Specialist participating in a KeyCare Network Hospital who has agreed to charge the Premier Rate. Subject to Regulation 8(3)(a) and (b). **All other Options** Any Specialist participating in the KeyCare Specialist Network and /or all Specialists who has agreed to charge the Premier Rate. Subject to Regulation 8 (3) (a) (b).	Paid in full. Paid in full.	Up to a maximum of the LAHR. Up to a maximum of the LAHR.

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REGISTRAR OF MEDICAL SCHEMES

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
DTPMB – In-Hospital Consultations	**GPs** **<u>LA KeyPlus</u>** Any GP participating in the KeyCare Primary Care Network GP and practicing in a KeyCare Network Hospital, and/or any GP Designated by the Scheme. Subject to Regulation 8 (3) (a) (b).	Paid in full.	Up to a maximum of the LAHR.
	All other Options Any GP practicing in the Discovery Health GP Network. Subject to Regulation 8 (3) (a) (b).	Paid in full	Up to a maximum of the LAHR
DTPMB – Medicine	***<u>LA KeyPlus</u>*** The DSP is a defined list of pharmacies or the member's chosen dispensing GP practicing in a KeyCare Primary Network.	For drugs on the Scheme's formulary, the Scheme will pay in full up to the LAMR. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the lowest cost formulary listed drug (chronic drug amount). This is subject to Regulations 15 (H) (c) and 15 (I) (c).	A co-payment equal to the difference between what would have been charged by the DSP and what was actually charged will be applicable.
	<u>All other options</u> The DSP is a list of pharmacies and/or dispensing providers	For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay to the maximum of the chronic drug amount as specified per option subject to the LAMR. This is subject to Regulations 15 (H) (c) and 15 (I) (c).	A co-payment equal to the difference between what would have been charged by the DSP and what was actually charged will be applicable.

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REGISTRAR OF MEDICAL SCHEMES

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
DTPMB – Pathology	**All options** Any LA Health-contracted provider.	Paid in full.	The Scheme will pay up to the maximum of the LAHR.
DTPMB Radiology	***LA KeyPlus*** A defined list of providers that has contracted with the Scheme ***All other Options*** Any provider charging the LAHR	Paid in full Paid in full	The Scheme will pay up to the maximum of the LAHR. The Scheme will pay up to the maximum of the LAHR
DTPMB – Hospital Admissions	**All options** Any KeyCare Network hospital. Subject to Regulation 8 (3) (a) (b)	Paid in full.	The Scheme will pay up to the maximum of the LAHR A co-payment equal to the difference between the fees that would have been charged by the DSP and that which were actually charged, will be payable by the member.
DTPMB – Mental Illness	**All options** Drug and Alcohol abuse facilities. Any facility or provider contracted with the Scheme. **All other conditions**: Any provider contracted with the Scheme and / or a defined list of hospitals with a psychiatric ward that is contracted with the Scheme. Subject to the condition meeting clinical entry criteria and the Scheme's baskets of care.	Up to a maximum of 21 days paid in full. Equivalent of up to a maximum of 21 days in-hospital, or 12 or 15 out-of-hospital consultations, for conditions as defined in Annexure A of the Regulations. Paid in full.	Up to a maximum of 21 days subject to a maximum of the lowest contracted rate payable by the Scheme. A co-payment equal to the difference between the fees that would have been charged by the lowest rate at a contracted DSP, and what was actually charged will be payable by the member.

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REGISTRAR OF MEDICAL SCHEMES

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
DTPMB – Terminal Care	**All options** Hospice and any other compassionate care facility	100% of cost.	A co-payment equal to the difference between the fees that would have been charged by the Hospice and what was actually charged will be payable by the member.
Oncology (out-of-hospital treatment)	**Specialists** ***LA KeyPlus*** The DSP is a defined list of Oncology providers contracted with the Scheme and/or the State. ***All other options*** Any Oncologist who has agreed to charge the Premier rate. **GPs** ***LA KeyPlus*** The DSP is a defined list of Oncology providers contracted with the Scheme ***All other Options*** Any Discovery Network GP who is a SAOC member.	100% of cost. 100% of cost. 100% of cost.	The Scheme will pay up to the maximum of the LAHR. The Scheme will pay up to the maximum of the LAHR. The Scheme will pay up to the maximum of the LAHR.
Oncology - Chemotherapy	***LA KeyPlus*** The DSP is a defined list of Oncology providers contracted with the Scheme. ***All other Options*** A defined list of contracted pharmacies and/or providers	Paid in full Paid in full	The Scheme will pay up to the maximum of the LAHR. The Scheme will pay up to the maximum of the LAHR.
Oncology – Pathology and Radiology	**All options** Any provider that has contracted with the Scheme	100% of cost.	The Scheme will pay up to the maximum of the LAHR.
HIV out-of-hospital consultations	**Specialists** ***LA KeyPlus Option*** Any Specialist participating in a KeyCare Specialist Network except where there is no KeyCare specialist, in which case any specialist practicing in a KeyCare Network Hospital who has agreed to charge the Premier Rate.	100% of cost.	The Scheme will pay up to the maximum of the LAHR.

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REGISTRAR OF MEDICAL SCHEMES

Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
HIV out-of-hospital consultations	***Specialists*** ***All other options*** Any Specialist participating in the KeyCare Specialist Network and / or all Specialists who have agreed to charge the Premier Rate. **GP's** ***LA KeyPlus*** The member's chosen KeyCare Primary Care Network GP participating in the in the Premier Plus GP Network. ***All other options*** Any Premier Plus GP participating in the Discovery Health GP Network	100% of cost. 100% of cost. 100% of cost.	The Scheme will pay up to the maximum of the LAHR. The Scheme will pay up to the maximum of the LAHR The Scheme will pay up to the maximum of the LAHR.
HIV – Pathology	**All options** A defined list of providers that has contracted with the Scheme.	100% of cost	The Scheme will pay up to the maximum of the LAHR.
HIV – Radiology	***LA KeyPlus*** A defined list of providers that has contracted with the Scheme. ***All other Options*** Any provider charging the LAHR.	100% of cost 100% of cost	The Scheme will pay up to the maximum of the LAHR. The Scheme will pay up to the maximum of the LAHR.
HIV - Medicine	***LA KeyPlus*** The DSP is defined as listed contracted pharmacies or the member's chosen dispensing GP participating in the KeyCare Primary Network of GPs ***All other Options*** The DSP is a defined list of contracted pharmacies and/or providers	For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay up to the maximum of lowest cost formulary drug listed. This is subject to Regulations 15 (H) (c) and 15 (I) (c). For drugs on the Scheme's formulary, the Scheme will pay in full. If the drug is not listed on the formulary, the Scheme will pay up to the maximum of the chronic drug amount as specified per Option and subject to the LAMR. This is subject to Regulations 15 (H) (c) and 15 (I) (c).	A co-payment equal to the difference between the cost that would have been charged by the DSP and what was actually charged will be payable by the member. A co-payment equal to the difference between the cost that would have been charged by the DSP and what was actually charged will be payable by the member.

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Type	*Designated Service Provider ("DSP")*	Reimbursement rate if the beneficiary uses the DSP or involuntarily uses a non-DSP	Reimbursement rate if the beneficiary voluntarily does not use the DSP
HIV - VCT	**All options** Any vendor that has contracted with the Scheme.	100% of cost.	The Scheme will pay up to the maximum of the LAHR.
Renal – specifically as regard to chronic renal dialysis, pathology and drugs	**All options** Any provider contracted with the Scheme in respect of chronic renal dialysis and/or the State.	100% of cost.	The Scheme will pay up to the maximum of the LAHR.

Notes:

1. "SAOC" means the South African Oncology Consortium Limited.
2. In accordance with what is stated in paragraph (D) of Annexure E of the main body of these Rules, the beneficiary must authorise all voluntary DTPMB hospital admissions, which admissions include but are not limited to Mental Illness admissions, HIV and Oncology admissions, within 48 hours of the required elective procedure / treatment. Failure to so authorise will result in a co-payment of 30% with a maximum of R1000 as stated in Clause 3(c) of Annexure B of these Rules.
3. For the approved PMB condition, all ICD-10 codes and procedure codes must accord with the Scheme's baskets of care.
4. The Chronic Disease List includes HIV/AIDS.
5. Where claims are paid in full up to a maximum of the contracted rate, beneficiaries will not be required to make any payments not reimbursable by the Scheme.

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ANNEXURE H

DEFINED LIST OF PROCEDURES IN THE DAY SURGERY NETWORK

Applicable to the LA KeyPlus Option only

Save for Prescribed Minimum Benefit entitlement, the following healthcare services will be covered subject to authorisation, and the treatment meeting the Scheme's clinical criteria, for Non-PMB's only if the services were obtained from one of the Scheme's defined list of day-surgery providers. A clinical exceptions process applies to all cases with complex presentations and those procedures that may require an extended length of stay. Members will be transferred to the appropriate facility where required.

A co-payment of 20% for elective PMB's if obtained at a non-DSP Day Surgery Network.

1. Ear, Nose and Throat Procedures
   - Tonsillectomy and/or adenoidectomy
   - Excision of throat lesions
   - Repair ear fistula
   - Simple procedures for nose bleed (extensive cautery)
   - Scopes (laryngoscopy)
   - Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, stapedectomy, myringotomy and/or grommets)

2. Gastrointestinal Procedures
   - Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy)
   - Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

3. Urological Procedures
   - Cystoscopy
   - Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele vasectomy)

4. Orthopaedic Procedures
   - Amputation of digit
   - Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Funded only if not first done via an endoscopic procedure, subject to individual case review.
   - Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review.

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5. Gynaecological Procedures

- Colposcopy with LLETZ
- Diagnostic Dilatation and Curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Examination under anaesthesia

6. Eye Procedures
   - Cataract surgery
   - Treatment of glaucoma
   - Other eye procedures: (removal of foreign body, conjunctivital surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair). (Note: no refractive eye surgery is funded)

7. Ganglionectomy

8. Simple superficial lymphadenectomy

9. Approved breast procedures
   - Mastectomy for gynaecomastia*
   - Lumpectomy* (fibroadenoma

10. Skin Procedures
    - Debridement
    - Simple repair of superficial wounds

11. Biopsies: subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

12. Incision and drainage of abscess and/or cyst: subcutaneous tissue, soft tissue, bone, bursa, mouth, tonsil, pilonidal, ovary, Bartholin's gland, vagina

13. Removal of foreign body (subcutaneous tissue, muscle, external auditory canal under general anaesthesia)

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