

Registered under the Medical Schemes Act (No. 131 of 1998)

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1. Name

The name of the Scheme is TeleMed Medical Scheme, hereinafter referred to as the Scheme. The abbreviated name is TeleMed.

2. Legal persona

The Scheme, in its own name, is a body corporate, 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, Regulations and these Rules.

3. Registered office

The registered office of the Scheme is situated at TeleMed Building, 4 Third Street, Marlands, Germiston but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

4. Definitions

In these Rules, a word or expression defined in the Medical Schemes Act (No. 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,
- (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 (No. 131 of 1998) and the regulations framed thereunder.

4.2 "Admission date"

The date on which a person may become a member, or in respect of a dependant, the date on which such a dependant is admitted as a dependant in terms of these Rules or the date on which an employer group or company is entitled to participate in the Scheme.

4.3 "Annual limit"

The maximum benefits to which a member and his registered dependants are entitled in terms of these Rules and shall be calculated annually to coincide with the financial year of the Scheme.

4.4 "Approval"

Prior written approval.

4.5 "Auditor"

An auditor registered in terms of the Public Accountants' and Auditors' Act, 1991 (No. 80 of 1991).

4.6 "Authorisation"

The approval to receive benefits for services as granted by the Scheme (see Annexure D for authorisation process).

- 4.7 "Beneficiary"**
A member or a person admitted as a dependant of a member.
- 4.8 "BHF"**
The Board of Healthcare Funders of Southern Africa.
- 4.9 "Board"**
The Board of Trustees constituted to manage the Scheme in terms of the Act and these Rules.
- 4.10 "Child"**
A member's natural child or a stepchild or legally adopted child or a child who has been placed in the custody of the member or his spouse or partner.
- 4.11 "Chronic disease"**
Denotes a disease of slow progress and persisting over an extended period of time.
- 4.12 "Condition specific waiting period"**
A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made.
- 4.13 "Co-payments"**
Those charges for services, which shall be collected directly by the provider or by the Scheme from the member or his dependant, but excludes the amounts payable by the Scheme in terms of the members' benefit plan.
- 4.14 "Continuation member"**
A member who retains his membership of the Scheme in terms of Rule 6.2 or a dependant who becomes a member of the Scheme in terms of Rule 6.3.
- 4.15 "Contribution"**
In relation to a member, the amount, exclusive of interest, paid by or in respect of the member and his registered dependants if any, as membership fees.
- 4.16 "Cost"**
In relation to a benefit, the net amount payable in respect of a relevant health service.
- 4.17 "Creditable coverage"**
It means any period of verifiable medical scheme membership of the applicant or his or her dependant, but excluding membership as a child dependant, terminating two years or more before the date of the latest application for membership.
- 4.18 "Date of service"**
In the event of a consultation, visit or treatment, the date on which each consultation, visit or treatment took place, whether for the same illness or not.
- 4.18.1** In the event of an operation, procedure or confinement, the date on which such operation, procedure or confinement occurred.
- 4.18.2** In the event of hospitalisation, the date of each discharge from a hospital or nursing home, or date of cessation of membership, whichever date occurs first.

4.18.3 In the event of any other health service the date on which such other service was rendered or requirement obtained.

4.18.4 In the event of an accident or incident as referred in clause 1.1 of Annexure C, the date of the final decision.

4.19 "Dependant"

4.19.1 A member's spouse or partner who is not a member or a registered dependant of a member of a medical scheme.

4.19.2 A member's child who is not a member or a registered dependant of a member of a medical scheme.

4.19.3 The immediate family of a member in respect of whom the member is liable for family care and support ("immediate family" means a blood relative of the member).

4.19.4 Additional spouses.

4.19.5 Minor foster child who has been placed in the member's care by a juvenile court and who is not recognised as a dependant of a member of another medical scheme.

4.19.6 Any other person who is recognised by the Board as a dependant for purposes of these Rules.

4.20 "Dependent"

In relation to a child, a child under the age of 21 or a child under 26 years who is a full time student at a recognised institution, who is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child who, due to a mental or physical disability, is dependent upon the member.

4.21 "Disputes Committee"

The body appointed by the Board of Trustees to mediate the process by which a member can express complaints and seek remedies.

4.22 "Employee"

A person in the employment of an employer.

4.23 "Executive: Managed Healthcare"

A doctor who is authorised by TeleMed to be responsible for administering TeleMed's medical affairs and for serving as the medical liaison to service providers.

4.24 "Formulary"

A defined listing of medicines covered under a member's benefit plan.

4.25 "General waiting period"

A period in which a beneficiary is not entitled to claim any benefits.

4.26 "Guide"

The guide/s to fees determined by the respective healthcare professions.

4.27 "Hospice"

An institution which caters for the terminally ill in the final stages of life.

4.28 "Income"

For the purposes of calculating contributions in respect of:

4.28.1 A member who is an employee – gross monthly salary/ pensionable earnings.

4.28.2 A member who registers a spouse or partner as a dependant – the higher of member or spouse's or partner's salary or earnings.

4.28.3 A continuation member – gross monthly earnings (gross monthly earnings to include pension income and income earned from any other source).

4.28.4 An individual member – gross monthly earnings.

4.29 "Managed Healthcare"

The process through which the utilisation, cost and quality of healthcare services gets monitored and managed.

4.30 "Medically necessary care"

Medical or surgical treatment which is determined by the member's doctor and the Executive: Managed Healthcare to be:

4.30.1 Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition under the professional and technical standards adopted by the relevant Registered Professional Association.

4.30.2 Within the standards of good medical practice accepted by the medical community and as defined by the Utilisation Review Committee.

4.30.3 Not primarily for the convenience of the member, the doctor or any other provider of healthcare services.

4.30.4 In the case of services provided in terms of Prescribed Minimum Benefits in Annexure A of the Regulations to the Act, not different in quality terms to that of publicly funded patient services and which follows predominant public hospital practices.

4.31 "Member"

Any person who is admitted as a member of the Scheme in terms of these Rules.

4.32 "Member family"

The member and all the registered dependants.

4.33 "Minimum benefits"

The benefits in respect of relevant health services as prescribed by the Minister in terms of section 67(1)(g) of the Act.

4.34 "Partner"

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

4.35 "Pre-existing sickness condition"

A sickness 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.

- 4.36 "Quality management"**
A formal set of activities to review and affect the quality of services provided to members, including quality assessment and corrective action to remedy any deficiencies in the quality of direct patient care, administrative and support services.
- 4.37 "Referral"**
The process by which a doctor directs a member to seek and obtain covered health services from a health professional, a hospital or any other provider of covered health services.
- 4.38 "Registrar"**
The Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of section 18 of the Act.
- 4.39 "Scale of benefits"**
The scale of benefits in respect of relevant health services determined and published by BHF from time to time.
- 4.40 "Social pension"**
The appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (No. 89 of 1992).
- 4.41 "Specialist"**
A practicing doctor who is professionally qualified to practice his designated specialty and includes the responsibility for providing covered health services in his designated specialty.
- 4.42 "Spouse"**
The spouse of a member to whom the member is married in terms of any law or custom.
- 4.43 "Utilisation Review Committee"**
A committee appointed by the Board, in consultation with the senior health professionals, which comprises medical doctors and/or other healthcare professionals to direct utilisation review programmes undertaken by TeleMed.

5. Vision, mission & values

Vision

We are a well respected medical scheme of choice and a leader in the innovative provision of excellent, technology enabled and cost-effective services by valuing long-term relationships with our responsible members and strategic partners.

Mission

Our mission is to restore, promote and maintain health ensuring long-term growth, sustainability and peace-of-mind for our members.

Values

- Customer focused product offerings and service delivery
- Employees are motivated to achieve the vision of the organisation and value diversity
- Focusing on rewarding members for managing their health and well-being
- A pro-active and innovative approach to sustain and grow our business
- Service excellence is the foundation of everything we do
- We are ethical and trustworthy – we deliver on our promises

6. Membership

6.1 Eligibility

Subject to Rule 8, membership is open to any person or group of persons.

6.2 Retirees

6.2.1 A member shall retain his membership of the Scheme with his registered dependants, if any, in the event of his retiring from the service of his employer or his employment being terminated by his employer on account of age, ill-health or other disability.

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

6.2.3 Notwithstanding the provisions of Rules 6.2.1 and 6.2.2 above, a member shall not qualify as a continuation member of the Scheme where that member's period of membership of the Scheme is less than five years and the member has not been a member of any other medical scheme for any period which could complete the qualifying five year membership period; provided that a member, whose period of membership of any medical scheme is not sufficient for him to qualify as a continuation member in terms of this Rule, shall qualify as a continuation member upon payment to the Scheme of the contributions for the balance of the qualifying period in respect of which he falls short.

6.3 Dependants of deceased members

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

6.3.2 The Scheme shall inform the dependant of his right to membership and of the contributions payable in respect thereof. Unless such person informs the Board in writing of his intention not to become a member, he shall be admitted as a member of the Scheme.

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

6.3.4 Notwithstanding the provisions of Rules 6.3.1 and 6.3.2 above, a dependant of a deceased member shall not qualify for continued membership of the Scheme where the said member or dependant has been a member of the Scheme for a period of less than five years and whose period of membership of any other medical scheme cannot complete the qualifying five year period; provided that the dependant of a deceased member shall qualify for continued membership if the contributions for the balance of the qualifying period in respect of which the dependant falls short, are paid to the Scheme.

6.3.5 Where a child dependant/s has been orphaned, the youngest child may be deemed to be the member, and the other siblings, the child dependant/s.

7. Registration and de-registration of dependants

7.1 Registration of dependants

- 7.1.1** A member may apply for the registration of his dependants at the time that he applies for membership in terms of Rule 8.
- 7.1.2** If a member applies to register a new born or newly adopted child within 30 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 30 days of the date of such marriage to register his spouse as a dependant, his 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. The spouse shall not qualify for benefits until such time as the member qualifies for benefits.
- 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 8 shall apply *mutatis mutandis*.

7.2 De-registration of dependants

- 7.2.1** A member shall inform the Scheme within 30 days of the occurrence of any event which results in any one of his dependants no longer satisfying the conditions in terms of which he may be a dependant.
- 7.2.2** When a dependant ceases to be eligible to be a dependant, he shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.

8. Terms and conditions applicable to membership

- 8.1** A minor may become a member with the consent of his parent or guardian.
- 8.2** No person may be a member of more than one medical scheme or a dependant:
- 8.2.1** Of more than one member of a particular medical scheme, or
- 8.2.2** Of members of different medical schemes, or
- 8.2.3** Claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member or a dependant of a member.

8.3 Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in respect of himself and his dependants of age, income, state of health and 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 respect of 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.

8.4 Waiting periods

8.4.1 The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application:

8.4.1.1 A general waiting period of up to three months, and

8.4.1.2 A condition specific waiting period of up to 12 months.

8.4.2 The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application, preceding the date of application:

8.4.2.1. A condition-specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits,

8.4.2.2. In respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

8.4.3 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a general waiting period of up to three months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

8.4.4 A general waiting period of three months applies to a member and his dependants. Provided that the general waiting period shall not be imposed on a member or a dependant of a member who has been a member or a dependant of the member of one or more medical schemes for a continuous period of two years or more and applies for membership of the Scheme within a period of three months after termination of such previous membership. No waiting period shall apply in respect of the prescribed minimum benefits.

- 8.5** No waiting periods may be imposed on:
- 8.5.1** A person in respect of whom application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of:
 - 8.5.1.1** Change of employment, or
 - 8.5.1.2** An employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the Scheme to which an application is made for such transfer to occur at the beginning of the financial year.
- Where the former medical scheme had imposed a general or condition-specific waiting period in respect of persons referred to this rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.
- 8.5.2** A beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied.
 - 8.5.3** A child dependant born during the period of membership.
- 8.6** The registered dependants of a member must participate in the same benefit option as the member.
- 8.7** Every member will, on admission to membership, receive a detailed summary of these Rules which shall include contributions, benefits, limitations and the member's rights and obligations. Members and their dependants and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.
- 8.8** A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a member is entitled under these Rules, or any right in respect of such benefit or payment of such benefit to such member, if a member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.
- 8.9** The Scheme shall in no circumstances be obliged to re-establish membership of a member whose membership has been terminated in terms of Rule 12.4 or 12.5.
- 8.10** Where a member terminates his membership with a view to obtain membership of another medical scheme or to become a dependant of his/her spouse's medical scheme, he shall be re-admitted under the same conditions as apply to any new applicant in terms of the Rules of the Scheme.

9. Transfer of employer groups from another medical scheme

If the members of a medical scheme who are members of that scheme by virtue of their employment by a particular employer, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Board will admit as a member, without a waiting period, any member of such first-mentioned scheme who is a continuation member by virtue of his past employment by the particular employer and admit any person who has been a registered dependant of such member, as a dependant.

10. Membership card and certificate of membership

- 10.1** Every member shall be furnished with a membership card, containing such particulars as may be prescribed. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership.
- 10.2** The utilisation of a membership card by any person other than the member or his registered dependants, with the knowledge or consent of the member or his dependants, is not permitted and is construed as an abuse of the privileges of membership of the Scheme.
- 10.3** On termination of membership or on de-registration of a dependant, the Scheme must, within 30 days of such termination, furnish such person with a certificate of membership and cover, containing such particulars as may be prescribed.
- 10.4** A duplicate membership card will only be issued after the payment of an amount which is determined by the Board.

11. Change of address of member

A member must notify the Scheme within 30 days of any change of address. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member's neglecting to comply with the requirements of this Rule. The furnishing of an address on an account which is submitted for payment by the Scheme shall not be accepted as a notice to which this Rule applies.

12. Termination of membership

12.1 Resignation

- 12.1.1** A member who, in terms of his conditions of employment is required to be a member of the Scheme, may not terminate his membership while he remains an employee without the prior written consent of his employer.
- 12.1.2** A member who resigns from the service of the participating employer shall, on the date of such termination, cease to be a member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto. Such member shall on the date of termination, be eligible to individual membership if he so chooses, without the imposition of any new restrictions that did exist at the time of his resignation.

12.2 Voluntary termination of membership.

12.2.1 A member, who is not required in terms of his conditions of employment to be a member, may terminate his membership of the Scheme on giving three months written notice. All rights to benefits cease after the last day of membership.

12.2.2 Such notice period shall be waived in substantiated cases where membership of another medical scheme is compulsory as a result of a condition of employment.

12.2.3 A participating employer may terminate his participation with the Scheme on giving three months written notice.

12.3 Death

Membership of a member terminates on his death.

12.4 Failure to pay amounts due to the Scheme

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

Provided that the membership of a person whose membership has been terminated due to the non-payment of monthly contributions, may be reinstated as a member in the discretion of the Board if they are satisfied that the non-payment of the monthly contributions by such person was due to circumstances beyond his control.

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

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

13. Contributions

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

13.2 Contributions shall, for deductions from salaries, be due monthly in arrears and be payable by no later than the 3rd day of each month. All other contributions shall be due monthly in advance and be payable by no later than the 3rd day of each month. Where contributions or any other debt owing to the Scheme have not been paid by the 3rd of the month, be it for contributions payable in advance or arrears, the Scheme shall have the right to suspend, with immediate effect, all benefit payments which have accrued to such member irrespective of when the claim for such benefit arose, and to give the member and/or employer notice that if contributions or such other debts are not paid up to date within 14 days, membership may be cancelled.

- 13.3** In the event that payments are brought up to date, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the member from the date of default and any such benefit paid may be recovered by the Scheme.
- 13.4** Unless specifically provided for in the Rules in respect of savings accounts, no refund of any assets of the Scheme or 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.
- 13.5** The balance standing to the credit of a member in terms of any option which provides for personal medical savings accounts shall, at all time remain the property of the member.
- 13.6** In the event of the death or termination / resignation of a member during the month, contributions for that month shall become due and payable irrespective of the date of death or termination / resignation.

14. Liabilities of employer and member

- 14.1** The liability of the employer towards the Scheme is limited to any amounts payable in terms of any agreement between the employer and the Scheme.
- 14.2** The liability of a member to the Scheme is limited to the amount of his unpaid contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants which has not been repaid to the Scheme or such charges levied in 13.3.
- 14.3** 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.
- 14.4** The necessary monthly contributions of pensioner and dependants of deceased members must be paid monthly to the Scheme directly, provided that they may pay their contributions in advance periodically.
- 14.5** A member who is absent from work on unpaid leave for a period of longer than three months and who does not elect to have his membership suspended in terms of Rule 14.6 must pay his contributions directly to the Scheme.
- 14.6** A member who is absent from work on unpaid leave for a longer period than three months may temporarily suspend his membership for the duration of such leave with the approval of the Board provided that the member informs the Chief Executive Officer beforehand in writing of his intention to temporarily suspend his membership during such period of leave.

15. Claims procedure

- 15.1.** Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement as prescribed by Regulation 5 and must contain the following:
- (a) The surname and initials and postal address of the member.
 - (b) The surname, first name and other initials, if any, of the patient as indicated on the membership card.
 - (c) The name of the Scheme and Scheme option concerned.
 - (d) The membership number of the member and the membership number of the dependant, where applicable.
 - (e) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of the service and, in the case of a group practice, the name of the practitioner who provided the service.
 - (f) The relevant diagnostic and such other item code numbers that relate to such relevant health service in terms of ICD-10 and CPT 4 code systems and/or the code number of the Scale of Benefits as may be required by the Scheme, where applicable.
 - (g) The date on which each relevant health service was rendered.
 - (h) The nature and cost of each relevant service rendered, including the supply of medicine to the member concerned or to a dependant of that member, and the name, quantity and dosage of and net amount payable by the member in respect of the medicine.
 - (i) Where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member, a copy of the original prescription or a certified copy of such prescription.
 - (j) Where mention is made in such account or statement of the use of a theatre:
 - (i) The name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation.
 - (ii) The name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation.
 - (iii) All procedures carried out together with the relevant item code number contemplated in paragraph (f).
 - (k) In the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating:
 - (i) The tariff code number of the treatment.
 - (ii) The expected total amount in respect of the treatment.
 - (iii) The expected duration of the treatment.
 - (iv) The initial amount payable.
 - (v) The monthly amount payable.
 - (l) Where the account is a copy of the original, certification by the supplier of the service by way of a rubber stamp or signature on such photocopy is compulsory. Copies and faxed copies will be accepted subject to verification.
- 15.2** If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme will, 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:

- (a) The name and membership number of the member.
- (b) The name of the supplier of service.
- (c) The final date of service rendered by the supplier of service on the account or statement which is covered by the payment.
- (d) The total amount charged for the service concerned.
- (e) The amount of the benefit awarded for such service.

15.3 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct and must be submitted to the Scheme no later than the last day of the fourth month following the month in which the service was rendered.

15.4 Where a member has paid an account, he shall, in support of his claim, submit an original receipt or certified copy thereof.

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

15.6 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 or the healthcare provider, whichever is applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member or provider the opportunity to return such corrected claim to the Scheme within four months of the notice.

16. Benefits

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the member to his registered dependants. A member must, on admission, elect to participate in any one of the available options, detailed in Annexure B.

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

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

16.2.2 Application to change from one benefit option to another must be in writing and lodged with the Chief Executive Officer by not later than 15 December prior to the year upon which it is intended that the change will take place, provided that the member has had at least 30 days prior notification of any intended changes in benefits or contributions for the next year.

16.3 The Scheme shall, where an account has been rendered, pay any benefit due to a member, either to that member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.

16.4 Any benefit option offered in Annexure B covers in full the cost of the prescribed minimum benefits rendered by a State hospital.

16.5 Benefits are subject to limitations as set out in Annexure B and exclusions as set out in Annexure C to the Rules.

16.6 The Board shall be entitled to withhold payment of any benefit to a member in respect of any service, whose contributions are more than one month in arrear, and where accounts have been paid in accordance with Rule 17, the member will be liable for the full amount.

17. Payment of accounts

17.1 Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected.

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

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

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

18. Governance

18.1 The affairs of the Scheme must be managed according to these Rules by a Board consisting of the following persons who shall be fit and proper to be Trustees:

18.1.1 Elected trustees – seven members of the Scheme, elected by the members by postal ballot.

18.1.2 Appointed trustees – not more than four persons, appointed by the Board of Trustees to enhance diversity of skills and representivity.

18.1.3 The term of office of elected and appointed trustees shall be three years.

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

18.2.1 A person under the age of 21 years.

18.2.2 An employee, director, officer, consultant or contractor of the Scheme or of the holding company, subsidiary, joint venture or associate of the Scheme.

18.2.3 A broker.

18.2.4 The Chief Executive Officer of the Scheme.

18.2.5 The auditors of the Scheme.

18.3 Retiring members of the Board are eligible for re-election or re-appointment.

18.4 Nominations to fill vacancies in terms of clause 18.1.1, signed by the candidate signifying his consent to stand for election, must be submitted to the Scheme by 30 April of the year concerned.

18.4.1 In the case of the number of valid nominations being less or equal to the number of vacancies the nominated persons will be deemed to be duly elected.

- 18.4.2** In the case of the number of valid nominations being more than the number of vacancies ballot papers containing the names and a short resume for each candidate shall be posted to members of the Scheme not less than 30 days prior to the Annual General Meeting.
- 18.4.3** Properly completed and signed ballot papers shall reach the Principal Officer not less than 7 days prior to the Annual General Meeting.
- 18.4.4** The names of the duly elected trustees shall be announced at the Annual General Meeting which will be the first day of their term of office.
- 18.5** The Board may fill by appointment any casual vacancy. In the case of an elected trustee a person so appointed shall retire at the first ensuing Annual General Meeting.
- 18.6** The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.
- 18.7** Half of the members of the Board plus one is a quorum at meetings of the Board.
- 18.8** The Board must elect from its number the chairperson and vice chairperson.
- 18.9** In the absence of the chairperson and vice chairperson, the Board members present must elect one of their members to preside.
- 18.10** Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson has a casting vote in addition to his deliberative vote.
- 18.11** A member of the Board may resign at any time by giving 30 days written notice to the Board.
- 18.12** A member of the Board ceases to hold office if:
- 18.12.1** He becomes mentally ill or incapable of managing his affairs.
 - 18.12.2** He is declared insolvent or has surrendered his estate for the benefit of his creditors;
 - 18.12.3** He is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury.
 - 18.12.4** He is removed by the court from any office of trust on account of misconduct.
 - 18.12.5** He is disqualified under any law from carrying on his profession.
 - 18.12.6** He ceases to be an appointee by the Board of Trustees or being a Board member elected by members of the Scheme or if he ceases to be a member of the Scheme.
 - 18.12.7** He absents himself from three consecutive meetings of the Board without the permission of the chairperson.
 - 18.12.8** He is removed from office by the Council in terms of Section 46 of the Act.

18.12.9 The provisions of Rules 18.12.1 – 18.12.5 apply *mutatis mutandis* to the Chief Executive Officer.

18.13 The Board must meet at least once every three months or at such intervals as it may deem necessary.

18.14 The chairperson may convene a special meeting should the necessity arise. Any five members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting. Upon receipt of the request, the chairperson shall, within 7 days, convene a special meeting of the Board to deal with the matters.

18.15 Members of the Board shall be entitled to emoluments in respect of services rendered in their capacity as members of the Board at an amount to be determined and reviewed annually. The Board in its discretion may decide to reimburse its members for reasonable expenses for the attendance of meetings or other services rendered in their capacity as members of the Board.

19. Duties of the Board of Trustees

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

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

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

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

19.5 The Board shall appoint a Chief Executive Officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme and shall determine the terms and conditions of service and the cover in respect of pension of the Chief Executive Officer and of any person employed by the Scheme.

19.6 The chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

19.7 The Board must keep such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.

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

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

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

- 19.11** The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.
- 19.12** The Board must obtain expert advice on legal, accounting, business matters and risk management as required or on any other matter of which the members of the Board may lack sufficient expertise.
- 19.13** The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.
- 19.14** The Board must take all reasonable steps to protect the confidentiality of medical records concerning any member or dependant's state of health.
- 19.15** The Board must approve all disbursements, provided that such authority may be delegated to the Chief Executive Officer and such person as the Board may approve.
- 19.16** The Board must keep 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.
- 19.17** The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.
- 19.18** The Board shall in respect of every financial year prepare annual financial statements, which comply with Section 37 of the Act, and shall within four months after the end of a financial year, furnish a copy of the audited financial statements together with the annual report of the Board to the Registrar and a summarised version thereof to every member of the Scheme.
- 19.19** The Board shall disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the Scheme.

20. Powers of the Board of Trustees

The Board has the power:

- 20.1** To cause the termination of the services of any employee of the Scheme.
- 20.2** To take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfillment of the Scheme's obligations under such appointments.
- 20.3** To appoint a sub-committee consisting of such Board members and other experts as it may deem appropriate.
- 20.4** To appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the regulations.
- 20.5** To appoint, compensate and contract with any accredited broker for the introduction or admission of a member to the Scheme.

- 20.6** To contract with managed healthcare organisations subject to the provisions of the Act and its regulations.
- 20.7** To purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it.
- 20.8** To let or hire movable or immovable property.
- 20.9** To provide administration services to other medical schemes.
- 20.10** 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.
- 20.11** With the prior approval of the Council, 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.
- 20.12** 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 members of the Scheme.
- 20.13** To donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the beneficiaries.
- 20.14** To contribute to any fund conducted for the benefit of employees of the Scheme.
- 20.15** To reinsure obligations in terms of the benefits provided for in these Rules.
- 20.16** To authorise the Chief Executive 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.
- 20.17** To contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes.
- 20.18** In general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.

21. Duties of the Chief Executive Officer and staff

- 21.1** The staff of the Scheme executes the duties as instructed upon them by the Board and must ensure the confidentiality of all information regarding its members and their dependants.
- 21.2** The Chief Executive Officer is the executive officer of the Scheme and as such shall ensure that:
 - 21.2.1** The decisions and instructions of the Board are executed without unnecessary delay.

- 21.2.2** Where necessary, there is proper and appropriate communication between the Scheme and those parties, affected by the decisions and instructions of the Board.
- 21.2.3** He keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in Section 57(4) of the Act.
- 21.2.4** He keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme to enable the Board to comply with the provisions of Section 57(6) of the Act.
- 21.2.5** He does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.
- 21.3** The Chief Executive Officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.
- 21.4** The Chief Executive Officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Board, and any other duly appointed sub-committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.
- 21.5** The Chief Executive Officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.
- 21.6** The Chief Executive Officer shall keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.
- 21.7** The Chief Executive Officer shall prepare, for approval by the Board, annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.
- 21.8** The following persons are not eligible to be a Chief Executive Officer:
 - 21.8.1** 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.
 - 21.8.2** A broker.
- 21.9** Any person who, immediately prior to commencement of the Medical Schemes Amendment Act, 2001, was a principal officer of a medical scheme in contravention of Section 57(7) of the Act, will be deemed to comply with that section for the period terminating on January 2004.

22. Indemnification and fidelity guarantee

- 22.1** The Board and any officer of the Scheme must be indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim in connection with the Scheme, not arising from their negligence, dishonesty or fraud.
- 22.2** The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers (including members of the Board) having the receipt or charge of moneys or securities belonging to the Scheme.
- 22.3** Nothing in these Rules shall be construed as altering in any way the employer's right to either terminate the service of an employee who is a member of the Scheme or to terminate or amend any agreement between the employer and the employee in regard to conditions of service.

23. Financial year of the Scheme

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

24. Banking account

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

25. Auditor and Audit Committee

- 25.1** An auditor (who must be approved in terms of Section 36 of the Act) must be appointed by resolution at each Annual General Meeting, to hold office from the conclusion of that meeting to the conclusion of the next Annual General Meeting.
- 25.2** The following persons are not eligible to serve as auditor of the Scheme:
 - 25.2.1** A member of the Board.
 - 25.2.2** An employee, officer or contractor of the Scheme.
 - 25.2.3** An employee, director, officer or contractor of the Scheme's administrator or of the holding company, subsidiary joint venture or associate of the administrator.
 - 25.2.4** A person not engaged in public practice as an auditor.
 - 25.2.5** A person who is disqualified from acting as an auditor in terms of the Companies Act 1973.
- 25.3** Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board must within 30 days appoint another auditor to fill the vacancy for the unexpired period.

- 25.4** If the members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this Rule, the Board must within 30 days make such appointment, and if it fails to do so, the Registrar may at any time do so.
- 25.5** 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 duties.
- 25.6** The auditor must report to the members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in a general meeting.
- 25.7** The Board must appoint an Audit Committee of at least five members of whom at least two must be members of the Board.
- 25.8** The objects and duties of the Audit Committee will be determined by the Committee in conjunction with the Board and shall comply with the Act.
- 25.9** The Audit Committee shall meet at least three times per annum.
- 25.10** Members of the Audit Committee may receive remuneration, honorarium, fees and reimbursement of expenses incurred in carrying out their duties as members of the Audit Committee at the discretion of the Board.

26. General meetings

26.1 Annual General Meeting

- 26.1.1** The Annual General Meeting of members must be held not later than the 30th of June of each year.
- 26.1.2** The notice convening the Annual General Meeting, containing the agenda, the annual financial statements, auditor's report and annual report, must be furnished to members at least 21 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such meeting.
- 26.1.3** At least 15 members of the Scheme present in person constitute a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting must be postponed until the same day and time of the next week and members then present shall constitute a quorum. Provided that if the same day of the next week is a public holiday the meeting shall be postponed until the first working day following the public holiday.
- 26.1.4** The financial statements and reports specified in Rule 26.1.2 must be laid before the meeting.
- 26.1.5** Notices of motions to be placed before the Annual General Meeting must reach the Chief Executive Officer not later than seven days prior to the date of the meeting.

26.2 Special general meeting

- 26.2.1** The Board may call a special general meeting of members if it is deemed necessary.
- 26.2.2** On the requisition of at least 15 members of the Scheme, the Board must cause a special general meeting to be called within 21 days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitionists and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.
- 26.2.3** The notice convening the special general meeting, containing the agenda, must be furnished to members at least 14 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such a meeting.
- 26.2.4** At least 15 members present in person constitute a quorum. If a quorum is not present at a special general meeting after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled.

27. Voting at meetings

- 27.1** Every member who is present at a general meeting of the Scheme and whose contributions is not in arrears, has the right to vote, or may, subject to this Rule, appoint another member of the Scheme as proxy to attend, speak and vote in his stead.
- 27.2** The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the member and the person appointed as the proxy. The proxy form must be deposited not later than two days before the meeting at the registered office of the Scheme or at such other place or places as the Board shall decide and of which notice has been given in the notice of the meeting, failing which the proxy shall be deemed invalid. The Chairperson's decision as to whether or not a particular proxy is valid shall be final and binding.
- 27.3** The chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson, if he is a member, has a casting vote in addition to his deliberative vote.

28. Complaints and disputes

- 28.1** Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators shall also provide a dedicated telephone number which may be used for dealing with telephonic complaints.
- 28.2** All complaints received in writing will be responded to by the Scheme in writing within 30 days of receipt thereof.
- 28.3** A Disputes Committee of three members, who may not be members of the Board, employees of the administrator of the Scheme or officers of the Scheme, must be appointed by the Board annually to serve a term of office of one year. At least one of such members shall be a person with legal expertise.

- 28.4** Any dispute, which may arise between a member, prospective member, former member or a person claiming by virtue of such member and the Scheme or an officer of the Scheme, must be referred by the Chief Executive Officer to the Disputes Committee for adjudication.
- 28.5** On receipt of a request in terms of this Rule, the Chief Executive Officer must convene a meeting of the Disputes Committee by giving not less than 14 days notice in writing to the complainant and all the members of the Disputes Committee stating the date, time, and venue of the meeting and particulars of the dispute.
- 28.6** The Disputes Committee may determine the procedure to be followed.
- 28.7** The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.
- 28.8** An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the Disputes Committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than three months after the date on which the decision concerned was made.
- 28.9** A member may appeal to the Council against a decision of a review panel established in terms of Chapter 5 of the regulations to the Act.

29. Termination or dissolution

- 29.1** The Scheme may be dissolved by order of a competent court or by voluntary dissolution.
- 29.2** Members in general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by ballot whether the Scheme must be liquidated. Unless the majority of members decide that the Scheme must continue, the Scheme must be liquidated in terms of Section 64 of the Act.
- 29.3** Pursuant to a decision by members taken in terms of Rule 29.2 the Chief Executive Officer must, in consultation with the Registrar, furnish to every member 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.
- 29.4** Every member must be requested to return his ballot paper duly completed before a set date. If at least 50 percent of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

30. Amalgamation and transfer of business

- 30.1** The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person, in which event the Board must arrange for members to decide by ballot whether the proposed amalgamation should be proceeded with or not.
- 30.2** If at least 50 percent plus one ballot of the members' returned ballot papers, duly completed, are in favour of the amalgamation or transfer, then, subject to Section 63 of the Act, the amalgamation or transfer may be concluded.

31. Right to obtain documents and inspection of documents

- 31.1** Any beneficiary must on request and on payment of a R50 fee per copy, be supplied by the Scheme with a copy of the following documents:
- 31.1.1** The Rules of the Scheme.
 - 31.1.2** The latest audited annual financial statements, returns, trustee's reports and auditor's report of the Scheme.
 - 31.1.3** The management accounts in respect of the Scheme and all of its benefit options.
- 31.2** A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 31.1 and to make extracts thereof.

32. Amendment of rules

- 32.1** The Board is entitled to alter or rescind any Rule or annexure or to make any additional Rule or annexure.
- 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 fifty percent during any financial year, is valid unless it has been approved by a majority of members present in a general meeting or a special meeting or by ballot.
- 32.2** Members must be furnished with a copy of such amendment within 14 days after registration thereof. Should a member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.
- 32.3** Notwithstanding the provisions of Rule 32.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any Rule that is inconsistent with the provisions of the Act.
- 32.4** No alteration, reversions or additional shall be valid unless it has been approved and registered by the Registrar in terms of the Act.

33. A member's personal savings account

- 33.1** A personal account in each member's name is opened in the Scheme's books to provide for:
- 33.1.1** That portion of his monthly contributions that must be credited to his personal account in terms of Annexure A.
 - 33.1.2** Those amounts that must be debited to his personal account in respect of payments made on behalf of the member to service providers, in excess of benefits to which the member is entitled in terms of Annexure B and Rule 17.3.
- 33.2** Every member is compelled to contribute towards his personal account at the rate stipulated in Annexure A:
- Provided that a member may, with the permission of the Board, increase his contribution to his personal account or deposit a cash amount in it provided the total contribution to his personal account during a financial year shall not exceed 25% of his annual contributions.
- 33.3** A member's contributions to his personal account as stipulated in Annexure A are payable together with his basic contributions:
- Provided that the contributions to a personal account in the case of a pensioner or a widow member must be sent to the Scheme direct.
- 33.4** The credit balance in a member's personal account which cannot be refunded due to circumstances beyond the Scheme's control, will after three years be deposited into the Guardian's Fund.
- 33.5** A member must repay the debit balance in his personal account when his membership is terminated or when it is temporarily suspended.
- 33.6** The benefits of a member or a member who continues his membership of the Scheme as a pensioner after termination of his services and who fails to pay the debit balance in his personal account may, in the discretion of the Board, be suspended until the debit balance has been paid.
- 33.7** The credit balance in the personal account of a member whose membership has terminated and who is not admitted as a member of another medical scheme which does not provide for a personal account is refunded to the member, subject to applicable laws, within five months of such termination.
- 33.8** Should a member be admitted to membership of another scheme which provides for a similar account, the credit balance due to the member must be transferred to such scheme.
- 33.9** The credit balance in the personal account of a deceased member shall be credited to the account of his registered dependant who continues membership. Failing such dependant the credit balance will be paid to his estate.

34. Managed Healthcare processes

34.1 Introduction

This clause cover particular issues which pertain to managed healthcare processes and must be read in conjunction with the rest of the Rules.

34.2 Referral authorisation and case management

34.2.1 The Scheme requires that all referrals to service providers as per Annexure D hereto, be subject to authorisation before the member and/or dependant visits the specialist doctor or is admitted to the hospital. This is subject to exclusions as listed in Annexure C hereto. Such authorising procedures will be prescribed by the Scheme from time to time.

34.2.2 The Scheme may contract with specialist doctors and hospitals. Referring providers are required to refer to these specialist doctors and hospitals in the first instance. Referrals to non-contracted specialist doctors and hospitals can be made with prior authority from the Scheme, subject to motivation by the referring provider acceptable to the Executive: Managed Healthcare.

34.2.3 The Scheme has case managers to manage hospital cases and high cost procedures. The member and/or dependants receiving these services, as well as the responsible doctors and service providers, will be expected to co-operate with the case managers.

34.3 Acute and chronic medicines

34.3.1 The Scheme requires providers to prescribe medicines according to specific rules. Providers and pharmacists are aware of procedures to be followed where medicines are prescribed outside the rules. Members and/or dependants are expected to comply with these rules.

34.3.2 Special procedures for meeting the costs of chronic medicines are in place as per the benefits Annexure B and members are expected to comply with these requirements.

34.4 Member education, service quality and health status management

The Scheme is concerned for the quality of health services provided to members and for the health status of members. Members and dependants will be encouraged to participate in programmes from time to time and in particular:

34.4.1 Education programmes arranged to familiarise them with the operation of the Scheme's managed healthcare processes or to study literature and information brochures which the Scheme will make available.

34.4.2 Education programmes and seminars regarding specific diseases for which they are receiving medical attention or to study literature and information brochures which the Scheme will make available.

34.4.3 Complete health status questionnaires that may be required when necessary.

34.4.4 Complete service satisfaction questionnaires that may be required when necessary.

- 34.4.5** Complying with the Rules of the Scheme regarding the provision of services, referrals and chronic disease treatment.
- 34.4.6** Understanding and implementing preventative, promotive and self-medication healthcare processes that may be conveyed to members and dependants by the Scheme.

34.5 Member incentives

- 34.5.1** The Scheme may adjust benefit limits as an incentive to members and dependants who meet these requirements as set out in the benefit Annexure B hereto.

34.6 Utilisation Review Committee

- 34.6.1** A Utilisation Review Committee shall be appointed in July of each year by the Board, to direct utilisation review programmes undertaken by TeleMed. The duties of the Utilisation Review Committee will include:
 - 34.6.1.1** To determine the procedures which it will follow in carrying out its duties.
 - 34.6.1.2** To set standards for retrospectively reviewing performance by providers.
 - 34.6.1.3** To set standards for case management processes and to evaluate the effectiveness of these standards.
 - 34.6.1.4** To investigate and advise on alternative care methods which will ensure quality and cost effective healthcare for members.
 - 34.6.1.5** To set referral and dispute procedures to be followed when a provider is in dispute with the Executive Managed Healthcare regarding the authorisation of services or provision of medication.
 - 34.6.1.6** To set standards for the management of chronic diseases and the supply of chronic medicines and evaluate the effectiveness of these standards.
 - 34.6.1.7** To manage the medicine utilisation.
 - 34.6.1.8** To introduce and manage peer review programmes in conjunction with provider group practices, provider networks and hospital groups.
 - 34.6.1.9** Any other business which the committee considers appropriate to the Scheme and its members.

Annexure A – Total monthly contribution for 2009

Total monthly contribution (including employer subsidy):

	Platinum	Gold	Gold Select	Silver		Bronze			
				< R15 500	> R15 500	< R4 000	R4 001 – R6 000	R6 001 – R8 000	> R8 001
Principal member	R2 573	R1 970	R2 004	R1 195	R1 425	R440	R482	R628	R916
Adult dependant	R2 573	R1 970	R2 004	R980	R1 085	R386	R415	R548	R797
Child dependant	R603	R407	R477	R355	R410	R186	R205	R231	R284

Note:

Principal member + spouse + children = the member only pay for a maximum of 3 children

Single parent (Principal member with children) = the member only pay for a maximum of 4 children

All other children are allowed as beneficiaries on the Scheme free of charge

Flexfunder (Silver option only)

Flexfunder is a medical savings account into which a member pays 20% of the total contribution. All valid medical expenses will automatically be covered by funds available in the member's Flexfunder once a benefit is exhausted, except for Prescribed Minimum Benefits (PMB) related expenses not covered by the Scheme.

Annexure B – Annual benefits 2009

TeleMed Platinum

An attractive top-of-the-range traditional option with elements of a new generation product.
Suitable for members who require extensive but flexible in- and out-of-hospital cover.

Maximum Annual Cover (MAC) = Unlimited		
All services covered at the lesser of either the TeleMed Rate (TR), Designated Service Provider's (DSP) rate or cost, unless otherwise stated. Services rendered are subject to Managed Healthcare Protocols (MHP) where applicable.		
Benefit	Cover	Benefit note
In-hospital benefits		All admissions must be pre-authorised R1 100 penalty if no pre-authorisation obtained Emergency – notify Scheme within 48 hours / 1 st working day after admission
Accommodation	General ward, high care, ICU and theatre fees Step down facilities, hospice and private nursing	Covered 100% TR Included: Drugs and equipment Excluded: Frail care services
Procedures	Surgical	Covered 100% TR
	Organ transplants / Renal dialysis	R260 000 / family Covered 100% TR
	Maxillo-facial / Oral surgery	Covered 100% TR
	Maternity / Confinement	Covered 100% TR
	Breast reduction	R9 000 / family Covered 100% TR
	Refractive eye surgery	R10 000 / family Covered 100% TR
Consultations	GP / Specialist	Covered 100% TR
	Physiotherapy / Biokinetics	Covered 100% TR
	Mental health: Psychiatry / Clinical psychology	R25 000 / family Covered 100% TR
Other	Internal surgical prosthesis	R52 000 / family Covered 100% TR
	Pathology	Covered 100% TR

	Radiology (X-rays)	Covered 100% TR	Max. 2 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorisation except for ultrasound scans Included in out-of-hospital benefit
	Oncology: Radiotherapy / Chemotherapy In- and out-of-hospital	Covered 100% TR	Member must enrol in programme or a 50% co-payment will apply to non-PMB cancers and the voluntary use of a non-DSP and non-formulary drugs A co-payment will apply in respect of PMB if the member is not registered on the programme
	Materials and medicines	Covered 100% TR	
	Take Home Medicine (THM)	Covered 100% TR	Day patients: Only after-hours emergency THM will be paid Overnight admission: Patient must obtain script on discharge and submit to pharmacy Subject to acute and chronic medication sub-limits and Scheme Rules
	Blood transfusions	Covered 100% TR	Cost of blood, blood equivalents, blood products and transport of blood
Out-of-hospital benefits			
Flexpenditure	Consultations GP consultations Specialist consultations Registered primary care nursing Maternity / Antenatal / Midwifery		Included: Minor procedures, materials, medicines used and examinations in rooms Excluded: Antenatal classes and oncology PMB conditions fully covered at DSP subject to enrolment in treatment care plan and pre-authorisation Co-payment for non-PMB conditions if member does not enrol in and abide by treatment care plan
	Optometry Eye examinations Lenses Add-ons Frames	Flexpenditure benefit: Member R24 000 Member + 1 R37 000 Member + 2 + R44 000 Covered 100% TR	Subject to Optical Management and clinical necessity 1 Examination / beneficiary / 24 months, subject to PMB 1 Pair spectacle lenses / beneficiary / 24 months OR clear contact lenses. Limited to R1 650 / beneficiary / 24 months Single vision, bi- and varifocal lenses covered 100% of tariff for generic lenses Tints, coatings, designs, materials and branded lenses 100% of tariff for the generic add-on for generic glass photochromic lenses OR 100% of tariff for the generic add-on for generic glass fixed tint not exceeding 35% 1 Frame / beneficiary / 24 months R930 / beneficiary / 24 months

	<p>Auxiliary benefits Dieticians, chiropractors, homeopaths (consultations and medication), acupuncture, speech therapy, audiology, occupational therapy, physiotherapy, podiatry / chiropody, orthotics / prostheses and biokinetics</p>		
	<p>Radiology (Basic X-rays)</p>		Unlimited but subject to pre-authorisation for the PMB / CDL Care Plan
	<p>Pathology</p>		Unlimited but subject to pre-authorisation for the PMB / CDL Care Plan
	<p>Over the counter medicine (OTC)</p>		R1 000 / family; max. R140 / purchase
	<p>Acute medication</p>		Any pharmacy of choice, subject to medicine formulary
	<p>Chronic medication</p>	<p>Chronic medication – Included in Flexpenditure with sub-limits: R13 500 / beneficiary R10 co-payment / item Max. R30 / script</p>	<p>PMB / CDL conditions fully covered at DSP with no co-payment / item / script Co-payment for 60 additional non-PMB chronic conditions – refer to TCL Benefit subject to programme enrolment, authorisation and medicine formulary No co-payment if obtained from DSP pharmacy</p>
Other benefits	<p>Mental health: Psychiatry / Clinical psychology</p>	<p>R25 000 / family Covered 100% TR</p>	<p>Included in in-hospital mental health benefit Treatment for alcoholism / drug addiction subject to PMB Excludes pre-school assessments and psychometric testing Electroconvulsive treatment covered from MAC</p>
	<p>Dentistry Basic dentistry</p>	<p>Covered 100% TR</p>	<p>Children under 12 unlimited Included: Diagnostic examinations, endodontics and preventative treatment and fillings and extractions (including surgical) Excluded: Any complications with removable dentures and MRI and CAT scans for any dento-alveolar procedures</p>
	<p>Specialised dentistry</p>	<p>Member R3 750 Member + 1 R4 600 Member + 2 R5 400 Member + 3 R6 250 Member + 4 + R7 000 Covered 100% TR</p>	<p>Subject to 48 hours pre-authorisation notice Doctor's cost of procedures subject to sub-limits Included: Orthodontics, periodontics and prostodontics, crown and bridgework, plastic dentures, metal-base dentures, bite plates and implant-supported tooth replacement Excluded: Orthodontic therapy for those over 18, MRI and CAT scans for dento-alveolar procedures and complications with removable dentures</p>

	Radiology (Specialised X-rays)	Non-PMB covered 100% TR, DSP rate or cost PMB unlimited at DSP	Max. 2 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorisation except for ultrasound scans Included in in-hospital benefit
	HIV / AIDS	Covered 100% TR, DSP rate or cost	Member enrolment in programme and accesses benefits from the DSP, otherwise a 50% co-payment applies for voluntary use of a non-DSP
	Immunisation	Covered 100% TR	Vaccines limited to one / condition / beneficiary
	Emergency ambulance services	Covered 100% TR	To be obtained from ER24
	Services rendered abroad	Covered 100% TR	Benefit limits and Scheme Rules apply
	External appliances 1 Artificial and electronic aids, orthopaedic appliances / support and shoes, elastic stockings, hearing aids (including repairs), wheelchairs, etc. External appliances 2 Artificial limbs and eyes, dental implants and components	External appliances 1 R13 500 / family / 24 months Covered 100% TR External appliances 2 R14 300 / beneficiary / 24 months Covered 100% TR	Motivation required 3 Month hire expenses for CPAP ventilator, if clinically appropriate, purchase will be considered Stoma bags (disposable bladder and intestinal bags) and other PMB appliances covered from MAC Dental implants and components only applicable to surgical phase of placement

TeleMed Gold

A popular traditional option with elements of a new generation product.
Suitable for members who require both comprehensive hospital and flexible out-of-hospital cover.

Maximum Annual Cover (MAC) = Unlimited			
All services covered at the lesser of either the TeleMed Rate (TR), Designated Service Provider's (DSP) rate or cost, unless otherwise stated. Services rendered are subject to Managed Healthcare Protocols (MHP) where applicable.			
Benefit	Cover	Benefit note	
In-hospital benefits		All admissions must be pre-authorized R1 100 penalty if no pre-authorization obtained Emergency – notify Scheme within 48 hours / 1 st working day after admission	
Accommodation	General ward, high care, ICU and theatre fees Step down facilities, hospice and private nursing	Covered 100% TR Included: Drugs and equipment Excluded: Frail care services	
Procedures	Surgical	Covered 100% TR	
	Organ transplants / Renal dialysis	R155 000 / family Covered 100% TR	Cover for related living donor limited to the cost of a nephrectomy, excluding complications relating to patients who are not members of the Scheme and for non-PMB complications
	Maxillo-facial / Oral surgery	Covered 100% TR	Subject to pre-authorization 48 hours prior to surgery Included: Cysts, tumours, fractures, salivary gland, complicated infections, TM joint pathology, cleft lip and palate, orthognatic surgery and surgical placement of implants Excluded: Orthognatic surgery for patients older than 18
	Maternity / Confinement	Covered 100% TR	Hospitalisation, post-natal services, midwifery and delivery (includes multiple births)
Consultations	GP / Specialist	Covered 100% TR	Includes consultations and ward visits
	Physiotherapy / Biokinetics	Covered 100% TR	Included in out-of-hospital physiotherapy benefit
	Mental health: Psychiatry / Clinical psychology	R15 500 / family Covered 100% TR	Included in out-of-hospital mental health benefit Electroconvulsive treatment covered from MAC Subject to PMB
Other	Internal surgical prosthesis	R37 000 / family Covered 100% TR	Subject to PMB
	Pathology	Covered 100% TR	
	Radiology (X-rays)	Covered 100% TR	Max. 2 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorization except for ultrasound scans Included in out-of-hospital benefit

	Oncology: Radiotherapy / Chemotherapy In- and out-of-hospital	Covered 100% TR	Member must enrol in programme or a 50% co-payment will apply to non-PMB cancers and the voluntary use of a non-DSP and non-formulary drugs A co-payment will apply in respect of PMB if the member is not registered on the programme
	Materials and medicines	Covered 100% TR	
	Take Home Medicine (THM)	Covered 100% TR	Day patients: Only after-hours emergency THM will be paid Overnight admission: Patient must obtain script on discharge and submit to pharmacy Subject to acute and chronic medication sub-limits and Scheme Rules
	Blood transfusions	Covered 100% TR	Cost of blood, blood equivalents, blood products and transport of blood
Out-of-hospital benefits			
Flexpenditure	Consultations GP consultations Specialist consultations Registered primary care nursing Maternity / Antenatal / Midwifery		Included: Minor procedures, materials, medicines used and examinations in rooms Excluded: Antenatal classes and oncology PMB conditions fully covered at DSP subject to enrolment in treatment care plan and pre-authorisation Co-payment for non-PMB conditions if member does not enrol in and abide by treatment care plan

	<p>Optometry</p> <p>Eye examinations</p> <p>Lenses</p> <p>Add-ons</p> <p>Frames</p>	<p>Flexpenditure benefit: Member R11 000 Member + 1 R17 600 Member + 2 + R21 500</p> <p>Covered 100% TR</p>	<p>Subject to Optical Management and clinical necessity</p> <p>1 Examination / beneficiary / 24 months, subject to PMB</p> <p>1 Pair of spectacle lenses / beneficiary / 24 months OR clear contact lenses. Limited to R1 200 / beneficiary / 24 months Single vision, bi- & varifocal lenses covered 100% of tariff for generic lenses</p> <p>Tints, coatings, designs, materials and branded lenses 100% of tariff for the generic add-on for generic glass photochromic lenses OR 100% of tariff for the generic add-on for generic glass fixed tint not exceeding 35%</p> <p>1 Frame / beneficiary / 24 months R575 / beneficiary / 24 months</p>
	<p>Auxiliary benefits Dieticians, chiropractors, homeopaths (consultations and medication), acupuncture, speech therapy, audiology, occupational therapy, physiotherapy, podiatry / chiropody, orthotics / prostheses and biokinetics</p>		
	<p>Radiology (Basic X-rays)</p>		<p>Unlimited but subject to pre-authorisation for the PMB / CDL Care Plan</p>
	<p>Pathology</p>		<p>Unlimited but subject to pre-authorisation for the PMB / CDL Care Plan</p>
	<p>Over the counter medicine (OTC)</p>		<p>R900 / family; max. R100 / purchase</p>
	<p>Acute medication</p>		<p>Any pharmacy of choice, subject to medicine formulary</p>
	<p>Chronic medication</p>	<p>Chronic medication – Included in Flexpenditure with sub-limits: Member R6 500 Member + 1 R8 000 Member + 2 R10 000 Member + 3 + R12 000</p>	<p>PMB / CDL conditions fully covered at DSP Additional 6 chronic conditions covered – refer to TCL Benefit subject to programme enrolment, authorisation and medicine formulary To be obtained from DSP pharmacy</p>

Other benefits	Mental health: Psychiatry / Clinical psychology	R15 500 / family Covered 100% TR	Included in in-hospital mental health benefit Treatment for alcoholism / drug addiction subject to PMB Excludes pre-school assessments and psychometric testing Electroconvulsive treatment covered from MAC
	Dentistry Basic dentistry	 Covered 100% TR	 Children under 12 unlimited Included: Diagnostic examinations, endodontics and preventative treatment and fillings and extractions (including surgical) Excluded: Any complications with removable dentures and MRI and CAT scans for any dento-alveolar procedures
	Specialised dentistry	Member R3 000 Member + 1 R3 900 Member + 2 R4 500 Member + 3 R5 000 Member + 4 + R5 800 Covered 100% TR	Subject to 48 hours pre-authorisation notice Doctor's cost of procedures subject to sub-limits Included: Orthodontics, periodontics and prostodontics, crown and bridgework, plastic dentures, metal-base dentures, bite plates and implant-supported tooth replacement Excluded: Orthodontic therapy for those over 18, MRI and CAT scans for dento-alveolar procedures and complications with removable dentures
	Radiology (Specialised X-rays)	Non-PMB covered 100% TR PMB unlimited at DSP	Max. 2 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorisation except for ultrasound scans Included in in-hospital benefit
	HIV / AIDS	Covered 100% TR	Member enrolment in programme and accesses benefits from the DSP, otherwise a 50% co-payment applies for voluntary use of a non-DSP
	Immunisation	Covered 100% TR	Vaccines limited to one / condition / beneficiary
	Emergency ambulance services	Covered 100% TR	To be obtained from ER24
	Services rendered abroad	Covered 100% TR	Benefit limits and Scheme Rules apply
	External appliances 1 Artificial and electronic aids, orthopaedic appliances / support and shoes, elastic stockings, hearing aids (including repairs), wheelchairs, etc. External appliances 2 Artificial limbs and eyes, dental implants and components	External appliances 1 R9 500 / family / 24 months Covered 100% TR External appliances 2 R7 000 / family / 24 months Covered 100% TR	Motivation required 3 Month hire expenses for CPAP ventilator, if clinically appropriate, purchase will be considered Stoma bags (disposable bladder and intestinal bags) and other PMB appliances covered from MAC Dental implants and components only applicable to surgical phase of placement

TeleMed Gold Select

A popular traditional option, supplied by a provider network, offers comprehensive day-to-day benefits and unlimited hospitalisation in a controlled healthcare environment.

Maximum Annual Cover (MAC) = Unlimited

All services covered at the lesser of either the TeleMed Rate (TR), Designated Service Provider's (DSP) rate or cost, unless otherwise stated.
Services rendered are subject to Managed Healthcare Protocols (MHP) where applicable.

Contracted Provider Network (PN)

Hospital benefits are subject to use of the Scheme's hospital network on referral from a selected network provider (NP)
Other benefits can only be obtained from the selected network provider (NP) or on referral from the selected network provider (NP)
Except in an emergency, benefits will not be paid without the mandatory referral

Benefit	Cover	Benefit note
In-hospital benefits		Pre-authorised hospitalisation Emergency – notify Scheme within 48 hours / 1 st working day after admission A 25% penalty applies if a network hospital is not used The following procedures are restricted to specified providers or treatment facilities: <ul style="list-style-type: none"> • Cardiology • Neurosurgery • Oncology • Day procedures • Orthopaedic surgery • Endoscopic surgery
Accommodation	General ward, high care, ICU and theatre fees Step down facilities, hospice and private nursing	Covered 100% TR Included: Drugs and equipment Excluded: Frail care services Admission to network hospital subject to referral by NP
Procedures	Surgical	Covered 100% TR Subject to authorisation and referral by NP
	Organ transplants / Renal dialysis	R160 000 / family Covered 100% TR Subject to PMB provision Cover for related living donor limited to the cost of a nephrectomy, excluding complications relating to patients who are not members of the Scheme and for non-PMB complications
	Maxillo-facial / Oral surgery	Covered 100% TR Subject to pre-authorisation 48 hours prior to surgery Included: Cysts, tumours, fractures, salivary gland, complicated infections, TM joint pathology, cleft lip and palate, orthognatic surgery and surgical placement of implants Excluded: Orthognatic surgery for patients older than 18
	Maternity / Confinement	Covered 100% TR Hospitalisation, post-natal services, midwifery and delivery (includes multiple births)

Consultations	GP / Specialist	Covered 100% TR	Referral by NP Specialist visits must be pre-authorized by PN
	Physiotherapy / Biokinetics	Covered 100% TR	Included in out-of-hospital physiotherapy benefit
	Mental health: Psychiatry / Clinical psychology	R16 000 / family Covered 100% TR	Included in out-of-hospital mental health benefit Electroconvulsive treatment covered from MAC Subject to PMB
Other	Internal surgical prosthesis	R37 000 / family Covered 100% TR	Subject to PMB
	Pathology	Covered 100% TR	
	Radiology (X-rays)	Covered 100% TR	Referral by NP Max. 2 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorization except for ultrasound scans Included in out-of-hospital benefit
	Oncology: Radiotherapy / Chemotherapy In- and out-of-hospital	Covered 100% TR	Member must enrol in programme or a 50% co-payment will apply to non-PMB cancers and the voluntary use of a non-DSP and non-formulary drugs A co-payment will apply in respect of PMB if the member is not registered on the programme
	Materials and medicines	Covered 100% TR	
	Take Home Medicine (THM)	Covered 100% TR	Supply for 7 days post hospitalisation Day patients: Only after-hours emergency THM will be paid Overnight admission: Patient must obtain script on discharge and submit to pharmacy Subject to acute and chronic medication sub-limits and Scheme Rules
	Blood transfusions	Covered 100% TR	Cost of blood, blood equivalents, blood products and transport of blood
Medication benefit	Chronic medication	R7 000 / beneficiary Covered 100% TR Subject to PMB provision	Prescribed by NP / specialist PMB / CDL conditions plus 42 additional chronic conditions covered – refer to TCL To be obtained from a NP / DSP pharmacy Benefit subject to programme enrolment, authorisation and medicine formulary A co-payment will apply in respect of PMB if the member is not registered on the programme
Out-of-hospital benefits			
Flexpenditure	Consultations GP consultations Maternity / Antenatal / Midwifery	Flexpenditure benefit: Member R11 800 Member + 1 R18 800 Member + 2 + R23 000	Only from selected NP at network approved tariff or on referral from NP If approved, minor procedures performed in providers' rooms will be covered PMB conditions fully covered at cost subject to treatment care plan enrolment and pre-authorization ICD-10 codes obligatory on claim A 50% co-payment if no treatment plan or adherence thereto
	Registered primary care nursing	Covered 100% TR	Subject to pre-authorization

<p>Out of town / Emergency consultations</p>		<p>2 Bona fide out of town / emergency consultations Max. R900 / family Included in Flexpenditure Member pays upfront and claims back from the Scheme</p>
<p>Specialist consultations</p>		<p>Referred by NP and approved by PN Included in Flexpenditure with sub-limits Member R1 250 Member + 1 R1 750 Member + 2 + R2 500 No benefit will be paid without a referral or authorisation</p>
<p>Acute medication</p>		<p>Prescribed / dispensed by NP GP / specialist, subject to acute medicine formulary Pharmacy as specified by PN</p>
<p>Dentistry (Basic / Primary care)</p>		<p>Network approved tariff list for primary care dentistry Consultation, primary extractions, fillings, scaling and polishing at PN specified dentist Basic dentistry and plastic dentures included</p>
<p>Optometry</p> <p>Eye examinations</p> <p>Lenses</p> <p>Add-ons</p> <p>Frames</p>		<p>Subject to Optical Management and clinical necessity</p> <p>1 Examination / beneficiary / 24 months, subject to PMB</p> <p>1 Pair spectacle lenses / beneficiary / 24 months OR clear contact lenses. Limited to R1 250 / beneficiary / 24 months Single vision, bi- and varifocal lenses covered 100% of tariff for generic lenses</p> <p>Tints, coatings, designs, materials and branded lenses 100% of tariff for the generic add-on for generic glass photochromic lenses OR 100% of tariff for the generic add-on for generic glass fixed tint not exceeding 35%</p> <p>1 Frame / beneficiary / 24 months R600 / beneficiary / 24 months</p>
<p>Over the counter medicine (OTC)</p>		<p>R900 / family; max. R120 / purchase Subject to acute medicine formulary</p>

	<p>Auxiliary benefits Dieticians, chiropractors, homeopaths (consultations and medication), acupuncture, speech therapy, audiology, occupational therapy, physiotherapy, podiatry / chiropody, orthotics / prostheses and biokinetics</p>		
	<p>Radiology (Basic X-rays / Primary care radiology)</p>		<p>Subject to pre-authorisation for PMB related services as approved per the treatment care plan according to protocols and condition specific ICD-10 codes Primary care radiology as requested by NP according to network approved tariff list Covers black & white X-rays of limbs, spinal column and abdomen Covers single or 2 views (more than 2 views not covered)</p>
	<p>Pathology</p>		<p>Subject to pre-authorisation for PMB related services as approved per the treatment care plan according to protocols and condition specific ICD-10 codes Primary care pathology as requested by NP according to network approved tariff list</p>
Other benefits	<p>Mental health: Psychiatry / Clinical psychology</p>	<p>R16 000 / family Covered 100% TR, DSP rate or cost Subject to PMB provision</p>	<p>Included in in-hospital mental health benefit Treatment for alcoholism / drug addiction subject to PMB Excludes pre-school assessments and psychometric testing Electroconvulsive treatment covered from MAC</p>
	<p>Dentistry (Specialised)</p>	<p>Member R3 050 Member + 1 R4 000 Member + 2 R4 600 Member + 3 R5 200 Member + 4 + R6 000 Covered 100% TR</p>	<p>Subject to 48 hours pre-authorisation notice Included: Orthodontics, periodontics and prostodontics, crown and bridgework, metal-base dentures, bite plates and implant-supported tooth replacement Excluded: Orthodontic therapy for those over 18, MRI and CAT scans for dento-alveolar procedures and complications with removable dentures</p>
	<p>Radiology (Specialised X-rays)</p>	<p>Covered 100% TR</p>	<p>Max. 2 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorisation except for ultrasound scans Included in in-hospital benefit</p>
	<p>HIV / AIDS</p>	<p>Covered 100% TR</p>	<p>Member enrolment in programme and accesses benefits from the DSP, otherwise a 50% co-payment applies for voluntary use of a non-DSP</p>
	<p>Immunisation</p>	<p>Covered 100% TR</p>	<p>Vaccines limited to one / condition / beneficiary</p>
	<p>Emergency ambulance services</p>	<p>Covered 100% TR</p>	<p>To be obtained from either Netcare 911 (Prime Cure) or ER24 (ONECARE)</p>
	<p>Services rendered abroad</p>	<p>Covered 100% TR</p>	<p>Benefit limits and Scheme Rules apply</p>

	<p>External appliances 1 Artificial and electronic aids, orthopaedic appliances / support and shoes, elastic stockings, hearing aids (including repairs), wheelchairs, etc.</p> <p>External appliances 2 Artificial limbs and eyes, dental implants and components</p>	<p>External appliances 1 R10 000 / family / 24 months Covered 100% TR</p> <p>External appliances 2 R7 200 / beneficiary / 24 months Covered 100% TR</p>	<p>Motivation required 3 Month hire expenses for CPAP ventilator, if clinically appropriate, purchase will be considered Stoma bags (disposable bladder and intestinal bags) and other PMB appliances covered from MAC</p> <p>Dental implants and components only applicable to surgical phase of placement</p>
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TeleMed Silver

An appealing new generation product for young, healthy members with moderate healthcare needs.

Maximum Annual Cover (MAC) = Unlimited

All services covered at the lesser of either the TeleMed Rate (TR), Designated Service Provider's (DSP) rate or cost, unless otherwise stated.

Services rendered are subject to Managed Healthcare Protocols (MHP) where applicable.

All valid medical expenses will automatically be covered by funds available in the member's Flexfunder once a benefit is exhausted, except for PMB related expenses not covered by the Scheme.

Benefit		Cover	Benefit note
In-hospital benefits			All admissions must be pre-authorised R1 100 penalty if no pre-authorization obtained, payable from Flexfunder Emergency – notify Scheme within 48 hours / 1 st working day after admission Co-payment not applicable to PMB admissions All benefits paid from MAC unless otherwise stated
Accommodation	General ward, high care, ICU and theatre fees Step down facilities, hospice and private nursing	Covered 100% TR	Included: Drugs and equipment Excluded: Frail care services
Procedures	Surgical	Covered 100% TR	
	Organ transplants / Renal dialysis	Covered 100% TR PMB / CDL only	Only available at DSP otherwise a co-payment will apply for voluntary use of a non-DSP Subject to PMB
	Maxillo-facial / Oral surgery	Covered 100% TR	Subject to pre-authorization 48 hours prior to surgery Included: Cysts, tumours, fractures, salivary gland, complicated infections, TM joint pathology, cleft lip and palate and orthognatic surgery Excluded: Orthognatic surgery for patients older than 18 and surgical placement of implants
	Maternity / Confinement	Covered 100% TR	Hospitalisation, post-natal services, midwifery and delivery (includes multiple births)
Consultations	GP / Specialist	Covered 100% TR	Includes consultations and ward visits
	Physiotherapy / Biokinetics	R4 000 / family Covered 100% TR	
	Mental health: Psychiatry / Clinical psychology	R12 600 / family Covered 100% TR	Electroconvulsive treatment covered from MAC Subject to PMB
Other	Internal surgical prosthesis	R30 000 / family Covered 100% TR	Subject to PMB
	Pathology	Covered 100% TR	

	Radiology (Specialised X-rays)	Covered 100% TR	Max. 1 each per beneficiary of MRI, CT, PET scan, ultrasound scan and angiogram 2 Ultrasound scans per pregnancy Subject to pre-authorisation except for ultrasound scans
	Oncology: Radiotherapy / Chemotherapy	PMB / CDL only Covered 100% TR	Only available at DSP Member must enrol in programme or a 50% co-payment will apply to non-PMB cancers and the voluntary use of a non-DSP and non-formulary drugs
	Materials and medicines	Covered 100% TR	
	Take Home Medicine (THM)	Covered 100% TR	Supply for 5 days post hospitalisation thereafter payable from available Flexfunder
	Blood transfusions	Covered 100% TR	Cost of blood, blood equivalents, blood products and transport of blood
Out-of-hospital benefits			
Flexfunder	Consultations GP consultations Specialist consultations Registered primary care nursing Maternity / Antenatal / Midwifery	Covered 100% Cost Flexfunder benefit:	Covered from available Flexfunder
	Chronic, acute and over the counter medicine (OTC)	Gross monthly income less than R15 500: R2 868 / Principal member R2 352 / Adult dependant R852 / Child dependant	Covered from available Flexfunder
	Dentistry (Basic and specialised)	Gross monthly income of R15 500 or more:	Specialised dentistry subject to pre-authorisation 48 hours prior to treatment / surgery Covered from available Flexfunder
	Radiology (Basic and specialised)	R3 420 / Principal member R2 604 / Adult dependant R984 / Child dependant	Covered from available Flexfunder
	Pathology		Includes immunisation Covered from available Flexfunder

	Optometry		Tints, coatings, designs, materials and branded lenses 100% of cost for the generic add-on for generic glass photochromic lenses OR 100% of cost for the generic add-on for generic glass fixed tint not exceeding 35%
	Auxiliary benefits Dieticians, chiropractors, homeopaths (consultations and medication), acupuncture, speech therapy, audiology, occupational therapy, podiatry / chiropody, orthotics / prostheses and biokinetics		
Other benefits	HIV / AIDS	Covered 100% TR	Member enrolment in programme and accesses benefits from the DSP, otherwise a 50% co-payment applies for voluntary use of a non-DSP Covered from available Flexfunder
	Emergency ambulance services	Covered 100% TR	To be obtained from ER24
	Services rendered abroad	Covered 100% TR	Benefit limits and Scheme Rules apply

TeleMed Bronze

An entry level product for young, healthy members with moderate healthcare needs.

Maximum Annual Cover (MAC) = R600 000 per family

All services covered at the lesser of either the TeleMed Rate (TR), Designated Service Provider's (DSP) rate or cost, unless otherwise stated.
Services rendered are subject to Managed Healthcare Protocols (MHP) where applicable.

All services from contracted Provider Network (PN) = Prime Cure

All services to be obtained from the network provider's contracted practitioners

Sub-limits subject to MAC, except for PMB, when a PMB / DSP applies. R1 100 penalty if no pre-authorization obtained.

PN will arrange the transfer of a patient to a DSPN facility should any healthcare related services be required that are in excess of sub-limits

	Benefit	Cover	Benefit note
In-hospital benefits			
Accommodation	General ward, high care, ICU and theatre fees	ICU and high care: Limited to 10 days or R53 500 / beneficiary at PN facilities	Drugs included Should additional ICU cover be required, the PN will arrange the transfer of the patient to a DSPN facility (subject to the patient's clinical condition) Subject to case management
Procedures <i>(Limits not applicable to PMB procedures)</i>	Surgical	Subject to MAC	
	Organ transplants	100% DSP rate R100 000 / family	Only at DSPN facility Subject to confirmed PMB condition and current public sector protocols
	Renal dialysis	100% DSP rate R100 000 / family	Only at DSP facility Subject to confirmed PMB condition and current public sector protocols Collective acute and chronic
	Oncology: Radiotherapy / Chemotherapy	100% DSP rate R100 000 / family	Only at DSP facility Subject to confirmed PMB condition and current public sector protocols
	Burns	100% DSP rate R100 000 / family	Only at DSPN facility Admission if >30% of body surface
	Neonatal	R29 700 / family	Subject to current public sector protocols
	HIV / AIDS	Unlimited cover in general ward	Only at DSP facility Subject to pre-authorization, case management and enrolment in Disease Management Programme
	Alcoholism / Drug dependency: In- and out-of-hospital	100% AT	PMB rules apply Only at DSP facility
	Infertility: In- and out-of-hospital	100% AT	PMB rules apply Only at DSP facility

	Mental health	100% DSP rate R5 000 / family	Hospitalisation, consultations and procedures Public hospitals only Subject to registration on Disease Management Programme
	Blood transfusions	R5 350 / family	Includes transport costs
	Dental services	100% NHRPL / SADA rates	Hospitalisation restricted to trauma and impacted 3rd molars Children 7 years and younger Day theatres and DSPN hospitals only
	Maxillo-facial / Oral surgery	R10 000 / family	Excludes surgical placement of implants
	Maternity	100% AT	Hospitalisation, post-natal services, midwifery and delivery (includes multiple births) Special pre-authorisation required
Consultations	GP / Specialist	100% AT	Consultations and ward visits
	Occupational therapy / Physiotherapy	100% NHRPL rate Combined benefit of R5 550 / family	Included in out-of-hospital physiotherapy benefit Post-operative and post traumatic
Other	Internal surgical prosthesis	R17 600 / family	Should any healthcare related service be required in excess of the sub-limit, the PN will arrange the transfer of the patient to a DSPN facility (subject to the patient's clinical condition) Subject to special motivation, pre-authorisation and case management
	In-hospital equipment	R5 350 / family	Subject to pre-authorisation and case management
	Clinical technologists	R10 800 / family	Subject to pre-authorisation and case management
	Take Home Medicine (THM)	Supply for 7 days post-hospitalisation	Subject to PN medication formulary
	Medical / Surgical appliances	R5 550 / family	Dispensed in-hospital
	Radiology	R17 600 / family	Included: MRI and CAT scans Subject to case management and pre-authorisation Included in out-of-hospital radiology benefit
	Pathology	R12 800 / family	Subject to case management
	Alternatives to hospitalisation	R12 000 / family	Included: Step down facilities Subject to pre-authorisation and case management
	Casualty / Emergency consultation	Covered	Unlimited for emergency visits – no co-payment by member Any registered emergency facility Facility fees not covered
Out-of-hospital benefits			
Medication benefit	Services only provided by PN / DSP or on referral by Network Provider (NP)		
	Chronic medication	PMB / CDL medication only	Prescribed by Network Provider (NP) Subject to formulary, registration and pre-authorisation To be obtained from DSP pharmacy

	Acute medication	Covered	Prescribed by NP / specialist Specialist prescriptions – any pharmacy of choice, subject to medicine formulary
	Over the counter medicine (OTC)	R165 = Max. R55 / purchase Limited to 3 purchases per annum	Network medicine formulary applies To be obtained from DSP pharmacy only
Consultations	Services only provided by PN / DSP or on referral by Network Provider (NP)		
	GP	100% AT	Network GP's only Minor procedures in rooms
	Specialist	3 Consultations = R1 800 / beneficiary OR 5 Consultations = R2 450 / family	100% Benefit if involuntary use of non-DSP specialist 30% Co-payment if voluntary use of non-DSP specialist No benefit will be paid for self-referral without a GP consultation Unlimited for PMB conditions, managed according provider network protocol Pre-authorisation required for each visit and any other referral or procedure Specialist referral form must be completed by a network GP or accredited network provider
	Out of town / Emergency consultations	1 Consultation / beneficiary OR 2 Consultations / family Limited to R600 with a 20% co-payment	Member pays upfront and claims back from the Scheme Unlimited if PMB Facility fees not covered
	Antenatal care / Maternity	2 Additional gynaecological consultations / pregnancy 2 Ultrasound scans / pregnancy Selected blood tests	Authorisation is required for selected blood tests Midwifery consultations included
	Mental health	PMB / CDL only	Only available at DSP Treatment for alcoholism / drug addiction subject to PMB

Other benefits	Optometry		
	Eye examinations	100% Covered 1 examination / beneficiary / 12 months	A quality range of modern approved frames to choose from Criteria for qualifying norms Excess payment for non-range frames, lenses and accessories
	Spectacles	100% Covered every 24 months	Tests, single vision, clear lenses and standard frames No benefit for contact lenses
	Dentistry		
	Basic dentistry	Covered	
	Dentures	1 Standard set / beneficiary / 24 months	20% Co-payment required for dentures
	Emergency dentistry	Limited to 1 event / beneficiary / 12 months	Pain treatment and sepsis intervention covered
Radiology / Pathology	100% AT	Basic black & white X-rays and pathology Referral by network GP and within list of approved codes	
Auxiliary services Physiotherapy, dieticians, occupational therapy, audiology, speech therapy, podiatry, social workers and other allied professionals registered with HPCSA	100% AT R1 125 / beneficiary R1 685 / family	Subject to pre-authorisation and case management Referral by contracted PN GP	
HIV / AIDS	Anti-retroviral treatment and any other HIV related condition covered	Member must enrol in programme otherwise a co-payment will apply Approved treatment plan according to PMB guidelines	
Immunisation	100% AT	Flu vaccinations for members at risk	

	<p>Emergency transport</p> <p>Ambulance services</p> <p>Inter hospital transfer</p>	<p>100% AT DSP – Netcare 911</p> <p>100% AT</p>	<p>Emergency roadside assistance and transport to nearest / appropriate healthcare facility Excludes cover for non-emergency transport</p> <p>Transfer to DSPN facility if emergency admission was obtained at a non-DSPN facility Includes Netcare 911 arm band Excludes cover for voluntary admission for non-PMB condition</p>
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Annexure C – Exclusions and limits 2009

1. Exclusions on benefits

Unless the service in question is related to a Prescribed Minimum Benefits condition, or unless the Board of Trustees decide otherwise, the Scheme will not pay a claim if, in the opinion of the Clinical Committee as constituted by the Board of Trustees, the health service in respect of which the claim has been submitted is, in view of the condition, not applicable and at an acceptable and reasonable level of care and is not medically necessary or not in accordance with evidence based medicine principles.

Furthermore, expenses incurred in connection with any of the following will not be paid by the Scheme, unless the Board decides otherwise:

- 1.1 All costs of whatever nature incurred for treatment of sickness, conditions or injuries sustained by a member or dependant and for which any other party is liable, including costs associated with occupational injuries and diseases. The member will be entitled to such benefits as would have applied under normal conditions provided that on receipt of payment in respect of medical expenses the member will reimburse the Scheme any money paid out by the Scheme in respect of this benefit.
 - 1.1.1 If the Scheme pays an amount towards costs and the member or dependant proceeds with an action against any party liable for his/her injuries or the associated costs, then, if the action is completely or partially successful, the member or dependant is obliged to ensure that:
 - the amount in respect of medical costs recovered from each party shall firstly be used to repay all amounts paid by the Scheme; and
 - the Scheme is immediately advised of the exact amount of any award in respect of future medical costs.
 - 1.1.2 If the member or dependant does not proceed with an action and the Scheme has incurred costs:
 - the member or dependant must, if required by the Scheme, cede any right of action to the Scheme, so that the Scheme can recover all costs in the member's name.
 - 1.1.3 Complications resulting from the treatment of any excluded condition (except for PMB conditions).
- 1.2 Alternative medicine, ayurveda aromatherapy, reflexology, magnetic therapy, hypnotherapy, phytotherapy, etc.
- 1.3 Antenatal classes
- 1.4 Applicators, toiletries and beauty preparations
- 1.5 Appointments not kept
- 1.6 Artificial insemination

- 1.7 Autopsies
- 1.8 Cosmetic treatment and procedures
- 1.9 Dental
 - Hospitalisation for periodontal therapy
 - MRI and CAT scans for dental implants
- 1.10 Domestic and biochemical remedies
- 1.11 Food and nutritional supplements including baby foods and special milk preparations
- 1.12 Frail care and general nursing care
- 1.13 Holidays for recuperative purposes
- 1.14 In respect of infertility, medical and surgical management shall be limited to the following procedures or interventions:
 - Hysterosalpingogram
 - The following blood tests:
 - ❖ Day 3 FSH/LH
 - ❖ Oestradiol
 - ❖ Thyroid function (TSH)
 - ❖ Prolactin
 - ❖ Rubella
 - ❖ HIV
 - ❖ VDRL
 - ❖ Chlamydia
 - ❖ Day 21 Progesterone
 - Laparoscopy
 - Hysteroscopy
 - Surgery (uterus and tubal)
 - Manipulation of ovulation defects and deficiencies
 - Semen analysis (volume, count, mobility, morphology, MAR-test)

- Basic counselling and advice on sexual behaviour, temperature charts, etc.
 - Treatment of local infections
- 1.15 Medical examinations (insurance and sport related)
- 1.16 Obesity treatment
- 1.17 Occupational injuries (injury on duty) subject to 1.1
- 1.18 Optometrical services:
- Plastic photochromic / transitional lenses
 - Sunglasses (including prescribed sunglasses)
 - Repairs
 - Coloured and one-day contact lenses
 - Lens polishing
 - UV 400 coating, hard coating, etc.
 - Colorimetry
- 1.19 Complications resulting from the harvesting of organs from living donors if not members of the Scheme.
- 1.20 Psychometric evaluation and testing for pre-school assessment
- 1.21 Sexual dysfunction
- 1.22 Slimming preparations
- 1.23 Travelling expenses – The travelling costs of a member or his dependant to and from medical practitioners or hospitals (excluding ambulances for medically necessary transport).
- 1.24 Uvulopalatopharyngoplasty, unless for PMB.
- 1.25 Unregistered medication (if not registered with the Medicines Control Council)
- 1.26 Wilful self inflicted injuries / conditions except for PMB (expenses other than psychiatric treatment incurred by a member or his/her dependant in the case of, or arising out of, wilful self-injury which include costs incurred as a result of partaking in professional sporting activities).
- 1.27 All expenses that exceed the maximum yearly limitation on benefits to which a member of the Scheme is entitled in terms of the Rules of the Scheme, except for PMB conditions.
- 1.28 Purchase of medicines that were prescribed by a person not legally authorised to do so.

- 1.29 Expenses for services rendered by:
- a person who is not registered with a recognised professional body constituted in terms of an Act of Parliament; or
 - any institution, except a state or provincial hospital, that is not registered in terms of any Act.
- 1.30 Services rendered without a registered tariff code
- 1.31 Services which are payable by and can be claimed from the Compensation Commissioner or an employer (subject to 1.1).

2. Limits on benefits

- 2.1 In the case of prolonged illness, the Board of Trustees is authorised to insist that a member or a dependant consult a specific specialist nominated by the Board in consultation with the consulting doctor. Should the specialist's proposed treatment in such a case not be acted upon, no further benefits will be permitted in respect of the specific illness.
- 2.2 The maximum benefits to which a member or a dependant is entitled during a financial year are limited as specified, subject to PMB.
- 2.3 Members who join during a financial year are entitled to benefits as specified in the Rules. The maximum benefits are adjusted in proportion to the period of membership from the date of admission to the end of the relevant financial year.
- 2.4 If a specialist is consulted without referral by a general practitioner, the Board may at its discretion, limit the benefits that the Scheme allows to the amount that would have been paid to a general practitioner for the same service. This does not apply to the TeleMed Gold Select and TeleMed Bronze network options.
- 2.5 Unless the Board decides otherwise, benefits in respect of prescription medicines are limited to one month's supply or the nearest packaging for every such prescription or repeat prescription.
- 2.6 Semi-private and private wards – no benefit unless such wards are medically necessary.
- 2.7 Lodging mothers – no benefit unless motivated by the doctor.
- 2.8 Electronic pain therapy equipment – only if motivated and recommended by a doctor, after prior approval by the Scheme and limited to one apparatus per lifetime.
- 2.9 Dermatological laser procedures require clinical motivation.
- 2.10 Reconstructive breast surgery after carcinoma requires clinical motivation.

Annexure D – Pre-authorisation policy and procedures 2009

1. Pre-authorisation of clinical services

Pre-authorisation must be obtained for the following clinical services and will be subject to benefit availability:

Discipline	Service
1. Psychiatry	Consultations require benefit confirmation Admissions require pre-authorisation
2. Psychology	Only benefit confirmation It is not necessary to pre-authorise every visit
3. Radiology	MRI, CT, PET scans, isotope studies as well as any invasive procedure by a radiologist, e.g. spirals for aneurysms, stents, etc.
4. Plastic and reconstructive surgery	All procedures require pre-authorisation according to Scheme Rules
5. Dermatology	All procedures and laser treatment
6. Ophthalmology	Radial keratotomy, laser procedures, refractive surgery and all other eye procedures Ophthalmology Society guidelines will apply
7. Oncology	Treatment plan required and all treatment to be pre-authorised. Member must enrol on programme otherwise a co-payment will apply.
8. Registered nursing services	All services
9. Home care, step down facilities, hospice	All services Frail care excluded
10. Ambulance services	All services through ER24 except Netcare 911 for members on TeleMed Gold Select – Prime Cure and TeleMed Bronze. No other ambulance services will be covered except in the case of an emergency.
11. Transplant surgery	All transplants and donor harvesting
12. Rehabilitation	Accommodation and treatment as per PMB guidelines
13. Dentistry	All specialised dentistry Implants (Phase 1, 2 and 3) Orthognatic surgery Orthodontics Periodontics and prostodontics Crown and bridgework Dentures Mouth plates All dental hospitalisation and general anaesthetics
14. Specialist consultations	All visits / consultations on TeleMed Gold Select and TeleMed Bronze

Obtaining authorisation for the above services

Where applicable the member must obtain a motivation from the healthcare provider that includes:

- The patient's full name, date of birth and membership number
- The service requested and the procedure and estimated costs
- The relevant diagnosis and CPT / ICD-10 codes
- All relevant medical / clinical information
- The name, address, contact number and practice number of the relevant healthcare provider
- Name and practice number of referring general practitioner

Although TeleMed prefers the healthcare provider to obtain pre-authorisation, the member may do so, provided that he/she obtains all the relevant medical information from the doctor.

- The member may obtain an authorisation number by phoning, faxing or e-mailing the information to TeleMed or TeleMed's Designated Service Provider Network.
- All relevant clinical and financial implications will be considered and, if necessary, the request will be reviewed by the TeleMed medical advisor or TeleMed's Designated Service Provider Network.
- Once the TeleMed medical advisor or TeleMed's Designated Service Provider Network has reviewed and approved the request, the member or admitting healthcare provider will be issued an authorisation number.
- The member should present the authorisation number to the healthcare provider when scheduling and obtaining the requested service.
- In a medical emergency when the member is unable to contact TeleMed or TeleMed's Designated Service Provider Network, an authorisation must be obtained within 48 hours or on the 1st working day after the service has been rendered.
- In order to expedite payment of the account, the healthcare provider should state the authorisation number on his/her account when presenting it to TeleMed or TeleMed's Designated Service Provider Network for payment.

2. Pre-authorisation of hospitalisation

2.1 All hospital admissions (public and private) must be pre-authorised

- If no pre-authorisation is obtained, a penalty of R1 100 will be applied to the hospital account.
- Payment to a hospital is subject to pre-authorisation, clinical necessity, appropriate treatment, the Maximum Annual Cover (MAC) and PMB.
- If the member requests care over-and-above that agreed to by the Scheme, the cost will be for the member's account.
- The hospital must motivate, every 72 hours, accommodation in intensive care units (ICU) and high-care wards (HCW).

- Where a hospital network applies, pre-authorisation is subject to referral by the Scheme's selected network provider (GP/specialist), otherwise no benefit will be available except for PMB.
- Refer to above table for all in-hospital services that require pre-authorisation.

2.2 Pre-authorisation procedure for hospitalisation (for certain options a hospital network will apply)

Obtain a hospital authorisation number by phoning, faxing or e-mailing the following information to TeleMed or TeleMed's Designated Service Provider Network:

- Name of patient
- Date of birth of patient
- Membership number with relevant dependant code
- Date of admission
- Name and practice number of hospital
- Name and practice number of referring doctor
- Name and practice number of treating doctor
- Reason for admission, tariff code, ICD-10 codes and CPT4 coding

An authorisation is only valid for 30 days.

In an emergency, the member must notify the Scheme within 48 hours or on the 1st working day after treatment/admission.

It is important to obtain a separate pre-authorisation number for each medical service (e.g. hospitalisation, radiology, etc.) so that benefits are correctly confirmed and allocated.

Important: An authorisation does not guarantee payment.

3. Pre-authorisation of dentistry

It is not necessary to obtain an authorisation for routine procedures, e.g. extractions or fillings.

3.1 Basic dentistry

- The Scheme must authorise dental procedures that require general anaesthesia.
- Procedures done under general anaesthesia are only permitted for children under the age of seven or in the case of the surgical removal of impacted wisdom teeth.

3.2 Specialised dentistry

- All specialised dentistry services and procedures must be pre-authorised.
- If any of the procedures involve hospitalisation, the member must obtain a pre-authorisation number from TeleMed or TeleMed's Designated Service Provider Network.

3.3 Maxillo-facial and oral surgery conditions

Dento-alveolar procedures are limited to the removal of impacted wisdom teeth.

4. Pre-authorisation for PMB CDL conditions – consultations and investigations

- 4.1 The TeleMed PMB CDL Care Plan Programme will allow each registered beneficiary a certain number of consultations and investigations annually according to protocol.

The beneficiary will be notified about these benefits at the beginning of each calendar year or shortly after they have been diagnosed with the condition.

- 4.2 To ensure payment, a pre-authorisation is required if the beneficiary needs further consultations, investigations or referral to a specialist for these chronic conditions.

5. Pre-authorisation for specialist consultations and referral to treatment facilities for members on TeleMed Gold Select

The following day procedures and endoscopic procedures / surgery to be performed in doctors' rooms where such facilities exist:

- Any minor surgical procedure
- Breast biopsy
- Fine needle biopsy
- Circumcision
- Endometrial treatment – limited lithotripsy
- Removal of impacted wisdom teeth
- Laser tonsillectomy
- Removal of lipomas, solar keratosis, moles
- Thyroid cyst / nodule / biopsy
- Closed reduction and application of plaster of paris to simple fracture
- Closed reduction simple fracture of toes and fingers
- Yag laser post lens implant
- Suturing of simple wounds
- Bone marrow biopsy
- Intravenous therapy
- Sigmoidoscopy
- Proctoscopy
- Nasal endoscopy
- Cystoscopy
- Gastroscopy
- Hysteroscopy

The following day procedures and endoscopic procedures / surgery to be performed in day-clinics where such facilities exist:

- Arthroscopy – knee, shoulder
- Breast biopsy – lumpectomy
- Circumcision
- Colonoscopy
- Cystoscopy
- D & C / Evacuation
- Removal of impacted wisdom teeth
- Endometrial treatment
- Lithotripsy
- Excision meibomian cysts
- Excimer laser – lasik

- Functional endoscopic sinus surgery
- Gastroscopy
- Hysteroscopy
- Intra-ocular lens extraction and implant
- Laparoscopy – diagnostic, sterilisation
- Wedge resection of cervix
- Lymph node excision
- Myringotomy / myringoplasty
- Pterygium / keratectomy
- Removal of wisdom teeth
- Septoplasty
- Squint repair / strabismus
- Sub-total nasal reconstruction
- Tonsillectomy / adenoidectomy
- Laser tonsillectomy
- Varicocelectomy
- Vasectomy
- Removal of lipomas, solar keratosis, moles
- Thyroid cyst / nodule / biopsy
- Deep proof puncture of sinus

Obtaining authorisation for the above services

The member must provide the following information when requesting a pre-authorisation from TeleMed or TeleMed's Designated Service Provider Network:

- The patient's full name, date of birth and membership number
- The service requested and the procedure and estimated costs
- The relevant diagnosis and CPT / ICD-10 codes
- All relevant medical / clinical information
- The name, address, contact number and practice number of the relevant healthcare provider
- Name and practice number of referring general practitioner

Annexure E – Chronic medication benefit

Note: Mediscor Reference Pricing (MRP) will apply to ALL prescriptions except for TeleMed Gold Select – ONECARE where the Maximum Medical Aid Price (MMAP) will apply. PMB and CDL medicine will be covered at MRP / MMAP plus the relevant dispensing fee.

MRP and MMAP are lists of generic equivalent medicines that cost substantially less than the original medicine. MRP and MMAP set a maximum refundable reference price for the list of generically equivalent products. The member will be liable for the difference in price should he/she elect to use medicines that are more expensive than the MRP or MMAP.

1. Acute medication – TeleMed Platinum, TeleMed Gold and TeleMed Silver

Acute medication refers to all medicine prescribed by a doctor or specialist that:

- does not require pre-authorisation by TeleMed
- is not chronic medication, and
- is not excluded by TeleMed.

Acute medication can be obtained from any pharmacy or doctor of the member's choice and is subject to benefit availability, formularies and MRP.

Acute medication – TeleMed Gold Select

Acute medication refers to all medicine prescribed by a doctor or specialist that is on the provider network's acute medicines formulary.

Payment for any prescribed medication that is not on the provider network's acute medicines formulary may be subject to a limit based upon the MRP / MMAP reference price, or may be payable by the member in full, at the point-of-sale.

Acute medication can be obtained from any pharmacy or doctor of the member's choice.

2. Over the counter medicine (OTC) – TeleMed Platinum and TeleMed Gold

TeleMed offers a benefit for OTC medicines that the member may obtain without prescription. The benefit covers schedule 0, schedule 1, schedule 2 and certain schedule 3 products.

TeleMed will pay for OTCs up to certain annual sub-limits.

All medicine rules and exclusions apply to OTC medication. The pharmacy will electronically submit the OTC claim via the clearing house. The member may also elect to pay the provider and later claim from the Scheme by submitting a valid receipt with the relevant purchase details. The benefit excludes payment for vitamins and supplements.

Over the counter medicine (OTC) – TeleMed Gold Select

TeleMed Gold Select offers its members a benefit for OTC medicines. This benefit includes schedule 0, schedule 1, schedule 2 and certain schedule 3 products that do not require a doctor's prescription.

TeleMed will pay for OTCs up to certain annual sub-limits.

Over the counter medicine (OTC) – TeleMed Silver

This benefit allows schedule 0, schedule 1, schedule 2 and certain schedule 3 products that do not require a doctor's prescription; to be paid from available Flexfunder.

All medicine rules and exclusions apply to OTC medication. The pharmacy will submit the OTC claim on-line via the clearing house. The payment of vitamins and minerals are excluded from this benefit.

3. Chronic medication

TeleMed Platinum

All chronic treatment must be pre-authorized, under the chronic benefit, by the PBM and Chronic Medicine Programme. The member may obtain chronic medicines from any pharmacy, doctor or courier pharmacy of their choice OR from the Scheme's DSP for chronic medication.

1. Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) medication

No Scheme co-payment is payable for the treatment of a PMB CDL condition if the member registers with and use formulary medicines authorised by the PBM and Chronic Medicine Programme.

The MRP and medicine formulary authorisation rules apply to all medication dispensed.

The following applies when medication is dispensed:

The MRP system and medicine formulary authorisation rules stipulate that the dispensed product may not exceed the specified MRP maximum price and must be formulary medicines authorised by the PBM and Chronic Programme.

- If a more expensive product is dispensed, the member will be liable for the difference between the MRP price and that of the more expensive product.
- The member will be liable for the co-payment of 30% of the cost of the medicine for voluntary use of non-formulary medicine.

2. Chronic (non-PMB) medication / TeleMed Chronic List (TCL) – Chronic conditions covered (in addition to the PMB CDL conditions)

The member will pay the difference between the MRP listed price and the price of the medicines elected as well as a Scheme co-payment of R10 per chronic item, to a maximum of R30 per prescription (as well as any administration and dispensing fee levied).

Note: The R10 Scheme co-payment and administration fee is not applicable if obtained from the Scheme's DSP for chronic medication.

Chronic medication will only be authorised for the PMB / CDL list and the 60 diseases listed below.

Chronic (non-PMB) medication / TeleMed Chronic List (TCL) is subject to Managed Healthcare Protocols, registration and formulary.

- Acne – severe recalcitrant nodular
- Allergic rhinitis – chronic
- Alzheimer's disease
- Anaemia – chronic
- Ankylosing spondylitis
- Anorexia nervosa
- Arthritis – osteoarthritis
- Attention Deficit Disorder (ADD)
- Barrett's oesophagus
- Behcet's disease
- Benign prostatic hypertrophy
- Bulimia nervosa
- Chronic cystitis
- Chronic pancreatic steatorrhea
- Cushing's syndrome
- Cystic fibrosis
- Delusional disorder
- Depression
- Disorder of vestibular function
- Dystonia
- Eczema – severe chronic
- Endometriosis
- Gastro-oesophageal reflux disease
- Generalised anxiety disorder
- Gout
- Haematological disorders – thalassaemia, aplastic anaemia, etc.
- Huntington's disease
- Hyperthyroidism
- Hypoparathyroidism
- Hypopituitarism
- Major psychiatric disorders
- Meniere's disease
- Menopause – treatment for flushes
- Migraine – chronic
- Motor neurone disease
- Muscular dystrophy and other inherited myopathies

- Myasthenia gravis
- Narcolepsy
- Neuropathy
- Obsessive compulsive disorder
- Oncology pain control management
- Osteoporosis
- Paget's disease
- Panic disorder
- Paraplegia/quadriplegia (medicines associated with managing)
- Pemphigus
- Peptic ulcer
- Peripheral vascular disease
- Polyarteritis nodosa
- Post traumatic stress disorder
- Psoriasis
- Pulmonary interstitial fibrosis
- Scleroderma
- Sjogren's syndrome
- Stroke
- Systemic sclerosis
- Trigeminal neuralgia
- Tourette's syndrome
- Urinary incontinence
- Zollinger Ellison syndrome

TeleMed Gold

1. Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) medication

No Scheme co-payment is payable if the member register with and uses formulary medicines authorised by the PBM and Chronic Medicine Programme.

The MRP and medicine formulary authorisation rules are applied to all medication dispensed.

The following applies when medication is dispensed:

The MRP system and medicine formulary authorisation rules require that the dispensed product may not exceed the specified MRP maximum price and must be authorised by the PBM and Chronic Programme.

- If a more expensive product is dispensed, the member will be liable for the difference between the MRP price and that of the more expensive product.
- If a non-formulary medicine is supplied, the member will be liable for the co-payment of the non-PMB chronic conditions.
- If a member voluntarily uses non-formulary medicine, the member will be liable for the co-payment.

2. Chronic (non-PMB) medication / TeleMed Chronic List (TCL) – Chronic conditions covered (in addition to the PMB CDL conditions)

The member pays the difference between the MRP listed price and the price of the medicines elected. No Scheme co-payment applies if obtained from the Scheme's DSP for chronic medication.

- If a non-formulary medicine is supplied, the member will be liable for the co-payment of the non-PMB chronic conditions.
- If a member voluntarily uses non-formulary medicine, the member will be liable for the co-payment.

Chronic medication will only be authorised for the PMB / CDL list and the 6 diseases listed below.

Chronic (non-PMB) medication / TeleMed Chronic List (TCL) is subject to Managed Healthcare Protocols, registration and formulary.

- Acne – severe recalcitrant nodular
- Attention Deficit Disorder (ADD)
- Allergic rhinitis – chronic
- Depression
- Eczema – severe chronic
- Menopause – treatment for flushes

All conditions, except those listed above, will be paid from the acute benefit.

Chronic medicine must be obtained from the DSP only, except in emergencies or involuntary use of a non-DSP.

TeleMed Gold Select

1. Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) medication

No Scheme co-payment is payable if the member register with and use formulary medicines authorised by the PBM and Chronic Medicine Programme.

The MRP / MMAP and medicine formulary authorisation rules are applied to all medication dispensed.

The following applies when medication is dispensed:

The MRP / MMAP system and medicine formulary authorisation rules require that the dispensed product may not exceed the specified MRP / MMAP maximum price and must be authorised by the PBM and Chronic Programme.

- If a more expensive product is dispensed, the member will be liable for the difference between the MRP price and that of the more expensive product.
- If a non-formulary medicine is supplied, the member will be liable for the co-payment.

2. Chronic (non-PMB) medication / TeleMed Chronic List (TCL) – Chronic conditions covered (in addition to the PMB CDL conditions)

The member pays the difference between the MRP / MMAP drug price and the cost of the ethical drug. No Scheme co-payment is applicable if obtained from the Scheme's DSP for chronic medication.

- If a non-formulary medicine is supplied, the member will be liable to pay the co-payment, which may be subject to a special motivation and pre-authorisation.
- If a non-formulary medicine is supplied, the member will be liable for the co-payment.

Chronic medication will only be authorised for the PMB / CDL list and the 42 diseases listed below.

Chronic (non-PMB) medication / TeleMed Chronic List (TCL) is subject to Managed Healthcare Protocols, registration and formulary.

- Acne – severe recalcitrant nodular
- Allergic rhinitis – chronic
- Amyloidosis
- Anaemia – chronic
- Ankylosing spondylitis
- Anorexia nervosa
- Attention Deficit Disorder (ADD)
- Benign prostatic hypertrophy
- Bulimia nervosa
- Cerebral palsy
- Chronic cystitis
- Conns syndrome
- Cushing's syndrome
- Eczema – severe chronic
- Embolism
- Endometriosis
- Generalised anxiety disorder
- Gout
- Hyperprolactinaemia
- Hyperthyroidism
- Hypoparathyroidism
- Hypopituitarism
- Idiopathic thrombocytopaenia
- Major psychiatric disorders
- Meniere's disease
- Menopause – treatment for flushes
- Migraine
- Neuropathy
- Obsessive compulsive disorder
- Oncology pain control management
- Panic disorder
- Peripheral vascular disease
- Polycystic ovarian syndrome
- Post traumatic stress disorder

- Psoriasis
- Scleroderma
- Stroke
- Trigeminal neuralgia
- Urinary incontinence
- Urticaria
- Valvular heart disease
- Vestibular functional disorder

All conditions not listed above will be covered from the acute benefit on TeleMed Gold Select, subject to the network provider's acute medicines formulary. Treatment for the above chronic conditions must be pre-authorized by the PBM and Chronic Medicine Programme.

Chronic medicine must be obtained from the DSP only, except in emergencies or involuntary use of a non-DSP.

TeleMed Silver

ONLY Prescribed Minimum Benefits (PMB) medication will be covered.

All PMB medicines must be pre-authorized under the PMB Programme.

PMB medicines must be obtained from the DSP only.

Prescribed Minimum Benefits (PMB) medication

No Scheme co-payment is payable if the member registers with and uses formulary medicines authorised by the PMB Medicine Programme.

The MRP and medicine formulary authorisation rules are applied to all medication dispensed.

The following applies when medication is dispensed:

The MRP system and medicine formulary authorisation rules require that the dispensed product may not exceed the specified MRP maximum price and must be authorised by the PMB Medicine Programme.

- If a more expensive product is supplied, the member will be liable for the difference between the MRP price and that of the more expensive product.
- No non-formulary medicine will be supplied unless in accordance with Regulation 15(1)c which states: "Provision must be made for appropriate substitution of drugs, without penalty to the beneficiary, where a formulary drug has been ineffective or causes / would cause adverse reactions".

Chronic medication – TeleMed Gold, TeleMed Gold Select and TeleMed Silver

Chronic medication obtained from the DSP

The following special rules apply if the member obtains medication from the DSP:

- If a member on TeleMed Gold, TeleMed Gold Select or TeleMed Silver requires emergency chronic / PMB medicine after hours, the member may obtain it from any local retail pharmacy. The member, or the pharmacy, must however notify TeleMed within 24 hours / 1st working day after the medicines are dispensed as well as provide their / the member's details. The DSP will provide TeleMed and the clearing house with authorisation to enable payment to the pharmacy or to refund the member.
- Exceptional cases will be evaluated by the DSP and dealt with accordingly.
- High cost medication: If treatment is not for a chronic condition, but is authorised by the Scheme, it will be dispensed to the member by the DSP and reimbursed by TeleMed from the Maximum Annual Cover (MAC). This also applies for treatment of less than three months, e.g. Zyvoxid out-of-hospital for two months.

TeleMed chronic medication payment guidelines

Options	Benefit	MRP / MMAP	Medicine formulary applicable plus relevant dispensing fee	Co-payment (30% of cost of non-PMB non-formulary drugs)	DSP applicable	Scheme co-payment at a non-DSP for PMB formulary medicine
Platinum	PMB	MRP	Yes	Yes	DSP	Yes R10 (max R30)
	Chronic	MRP	Yes	Yes	DSP	Yes R10 (max R30)
Gold	PMB	MRP	Yes	Yes	DSP only	Yes
	Chronic	MRP	Yes	Yes	DSP only	Yes
Gold Select	PMB	MRP / MMAP	Yes	Yes	DSP only	Yes
	Chronic	MRP / MMAP	Yes	Yes	DSP only	Yes
Silver	PMB	MRP	Yes	Yes	DSP only	Yes

Yes	Applicable
No	Not applicable
PMB	Prescribed Minimum Benefits / Chronic Disease List
Chronic	Non-PMB chronic medication
MRP	The member pays the difference between MRP and ethical brand price
MMAP	The member pays the difference between MMAP and ethical brand price
Formulary	The member pays 30% of the cost of the drug should the prescribed product not be on the formulary
DSP	TeleMed Gold and TeleMed Gold Select member may ONLY obtain medication from the DSP. TeleMed Platinum members may use the DSP or any supplier of their choice in which case a R10 co-payment per item to a maximum of R30 per script will apply.

PMB and/or chronic medication authorisation on TeleMed Platinum, TeleMed Gold, TeleMed Gold Select and TeleMed Silver

Chronic medicines must be authorised before they can be reimbursed from the member's chronic medicine benefit and supplied by the service provider. The cost of unauthorised medicine will be deducted from the member's acute benefit only once, after which the member must obtain authorisation.

1. The member should ask their service provider (doctor or pharmacist) to contact the PBM and the Chronic Medicine Programme to verify whether their condition, and the prescribed medicine, will be authorised for payment from the chronic medicine benefit. If the medicine complies with the Scheme's rules governing chronic medicines, the PBM and Chronic Medicine Programme will authorise the medication and the member can immediately claim the cost. If the condition and/or the medicines do not comply with the Scheme Rules, or require further investigation, then the PBM and Chronic Medicine Programme pharmacists will discuss this with the member's service provider and advise the member and provider of the outcome.

OR

2. The member may contact the PBM and Chronic Medicine Programme and ask that the prescription medicines be considered for authorisation and reimbursement from the chronic medicine benefit. It may be necessary for the member to fax the prescription to the PBM and Chronic Medicine Programme for identification of the prescribed medicine. If the medicines comply with the Scheme's rules governing chronic medicines, the medicines will be authorised.

The PBM and Chronic Medicine Programme pharmacists will contact the doctor if any additional information is required and inform the member of the outcome.

3. The member must give the original prescription to the dispenser (the pharmacist, doctor or courier pharmacy) they are authorised to use.
4. The cost of the authorised medicine will be deducted from the appropriate benefit if the member has sufficient funds available. If the member is on TeleMed Platinum, he/she may use authorised formulary medicine and prefer to make use of the DSP (the member may do so and no co-payment or administration fee will apply).

The member's doctor must renew their chronic prescriptions every six months.

Important note:

It is to the member's advantage to ask their doctor to prescribe medication that will be fully reimbursed (MRP / MMAP) or to write "or generic equivalent" on the script.

- The member must ask their pharmacist to substitute with a generic equivalent that falls within the MRP / MMAP price limit to avoid extra payments.
- A copy of the applicable formulary can be obtained from TeleMed.

TeleMed Bronze

Application for chronic medication

ONLY Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) medication will be covered.

All PMB CDL medicines must be pre-authorized under the PMB and Chronic Medicine Programme and is subject to a formulary and registration. PMB medicines must be obtained from the Designated Service Provider (DSP) or associated network general practitioners contracted to the provider network. Chronic medication must be registered and pre-authorized by the Designated Service Provider Network (DSPN). The Scheme / DSP should be contacted to apply for chronic medication.

Annexure F – Optometry benefit 2009

Optical benefits are subject to the Optical Benefit Management Programme and are limited to the supply of either spectacles or contact lenses, not both.

1. Eye refractions / tests

TeleMed Platinum, TeleMed Gold and TeleMed Gold Select

100% of the tariff of an eye test subject to one (1) test per beneficiary per 24 month period.

TeleMed Silver

Limited and paid at 100% of cost from available Flexfunder.

TeleMed Bronze

100% of the provider network contracted tariff of an optometric examination subject to one (1) optometric examination per beneficiary per 12-month period.

2. Frames

TeleMed Platinum, TeleMed Gold, TeleMed Gold Select and TeleMed Bronze

100% of the cost of frames, limited as per the Rules, per beneficiary every 24 months. A further limit of one (1) frame per beneficiary every 24-month period commencing from the date the beneficiary last obtained a spectacle frame and further limited to the frame benefit.

TeleMed Silver

Unlimited but paid at 100% of cost from available Flexfunder.

3. Spectacle lenses

Subject to the clinical necessity for lenses and further limited to either lenses (spectacles) or contact lenses subject to one (1) pair per beneficiary per 24-month period.

3.1 TeleMed Bronze

Lenses:

- Single vision or bi-focal lenses (please refer to the qualifying norms below).
- Includes standard CR39 lenses (high quality clear plastic lenses).

Qualifying norms apply:

- An unaided visual acuity of worse than 6/9 on the Snellen scale for distance vision and near vision.
- A refraction requirement exceeding 0,5 dioptre and/or 0,5 dioptre cylinder on distance vision and 1,25 dioptre sphere on near vision.

3.2 Single vision

100% of the tariff, as adopted by the Board from time to time, when prescribed or supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner. Limited to glass photochromic lenses or organic photochromic lenses but further limited to the cost of equivalent glass photochromic lenses and glass or organic lenses with a tint not exceeding 35% and further limited to:

- either one (1) pair of lenses per beneficiary every 24-month period commencing from the date a beneficiary obtains a first pair of lenses; or
- instead of a pair of bifocal or multifocal lenses and subject to pre-authorisation by the Board and on the recommendation of an approved registered optometrist or ophthalmologist, two (2) pairs of single vision lenses per beneficiary every 24-month period commencing from the date a beneficiary obtains a pair of lenses.

3.3 Bifocal lenses

100% of the tariff for generic lenses, as adopted by the Board from time to time, when prescribed or supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner. Limited to the cost of two (2) appropriate bifocal lenses with a diameter of 65mm and a reading segment of 28mm, further limited to glass photochromic lenses or organic photochromic lenses but further limited to the cost of equivalent glass photochromic lenses and glass or organic lenses with a tint not exceeding 35% and further limited to one (1) pair of lenses per beneficiary every 24-month period commencing from the date a beneficiary obtains a pair of lenses.

3.4 Multifocal lenses

100% of the tariff for generic lenses, as adopted by the Board from time to time, when prescribed or supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner. Limited to glass photochromic lenses or organic photochromic lenses but further limited to the cost of equivalent glass photochromic lenses and glass or organic lenses with a tint not exceeding 35% and further limited to one (1) pair of lenses per beneficiary every 24-month period commencing from the date a beneficiary obtains a pair of lenses.

3.5 Lens additions

No benefit for additions, apart from those items referred to in paragraphs 3.2 to 3.4, except if the member obtains pre-authorisation from the Board on clinical or medical grounds, on the recommendation of a registered optometrist or ophthalmologist and is further limited to an overall lens limit as set out.

3.6 Sunglasses and repairs to frames and lenses

No benefit.

3.7 TeleMed Silver

Unlimited but paid at 100% of cost from available Flexfunder.

4. Contact lenses

4.1 Non-clinically essential contact lenses

100% of the tariff of two (2) glass photochromic single vision lenses of 65mm and a sphere of 2 diopters plus the frame benefit referred to above.

4.2 Clinically essential contact lenses

Subject to approval of the Board. 100% of the cost of clear contact lenses according to the tariff, as adopted by the Board from time to time, when recommended by a registered optometrist, ophthalmologist or supplementary optical practitioner. Limited to one (1) pair of permanent contact lenses per beneficiary every 24-month period OR 52 pairs of fortnightly disposable contact lenses per beneficiary every 24-month period OR 24 pairs of monthly disposable contact lenses per beneficiary every 24-month period.

4.3 TeleMed Silver

Unlimited but paid at 100% of cost from available Flexfunder.

4.4 TeleMed Bronze

No benefit for contact lenses.

5. Eye examinations

TeleMed Platinum, TeleMed Gold and TeleMed Gold Select

100% of the tariff, as adopted by the Board from time to time. The benefit is limited to one (1) eye examination per beneficiary every 24-month period commencing from the date the beneficiary last obtained an eye examination, except if pre-authorisation is obtained from the Health Risk Management Board (OptiClear) on clinical or medical grounds on the recommendation of a registered optometrist or ophthalmologist.

TeleMed Silver

Unlimited but paid at 100% of cost from available Flexfunder.

TeleMed Bronze

100% of the Prime Cure contracted tariff of an optometric examination subject to one (1) optometric examination per beneficiary per 12-month period.

Annexure G – Dental policy and procedures 2009

The Scheme has appointed Prime Cure and Supplementary Health Services for dental risk management for TeleMed Bronze and Supplementary Health Services for dental risk management for the other options.

1. Basic dentistry

- Routine procedures, e.g. extractions and fillings do not need to be authorised before the procedure.
- The clinical protocols of the Scheme, or its appointed agent's protocols, will take precedence and apply in all cases.
- Procedures done under general anesthesia will only be considered in the case of children up to the age of seven (7) years.
- TeleMed Silver – The limitations reflected above do not apply as 100% of the cost is paid from the member's available Flexfunder.

2. Specialised dentistry

- All specialised dentistry services and procedures must be pre-authorised.
- Members must request comprehensive quotations for all aspects and phases of a treatment plan, especially in instances where more than one provider is concerned.
- With the exception of orthodontic treatment, an authorisation is valid for three (3) months.
- An authorisation is not a guarantee of payment and is issued subject to benefits being available at the time when the claim/s is received. The authorisation includes a summary of benefit allocation, but the member should always consider dental services already received but not yet paid for by the Scheme.
- The clinical protocols of the Scheme, or its appointed agent's protocols, will take precedence and apply in all cases.
- Elective procedures, such as orthodontic treatment, are either excluded entirely or in any event for anyone older than 18. Clinical protocols are applied for these procedures.
- TeleMed Silver – The limitations reflected above do not apply as 100% of the cost is paid from the member's available Flexfunder.
- TeleMed Bronze – there is no specialised dental benefit.

3. Dentistry in-hospital

- All in-hospital dental services and procedures must be pre-authorised.
- In all instances, the clinical protocols of the Scheme, or its appointed agent's protocols, take precedence and will apply.
- The member will be liable for the cost if they request care over-and-above that agreed to by the Scheme.
- For further information, please refer to Annexure D: Pre-authorisation policy and procedure.

4. Maxillo-facial and oral surgery procedures

- If the dental procedure requires hospitalisation, the procedures must be pre-authorised.
- The Scheme distinguishes between different procedures as follows:
 - ❖ Procedures for conditions of a life-threatening nature or serious impairment. These procedures are listed under the benefits for each option. They are paid from the Maximum Annual Cover (MAC).
 - ❖ Elective procedures, such as orthognatic surgery, are either excluded entirely or in any event for anyone older than 18. Clinical protocols are applied for these procedures.
 - ❖ Dento-alveolar procedures, i.e. procedures involving surgery to teeth and supportive structures (gum and bone). Benefits for such procedures are limited and clinical protocols are applied.

** Protocols are available on request.*

List of dental inclusions & exclusions

TeleMed Platinum

Maxillo-facial surgical admissions		Basic dentistry		Specialised dentistry	
Includes	Excludes	Includes	Excludes	Includes	Excludes
Cysts Tumours Fractures Salivary gland Complicated infections TM joint pathology Cleft lip and palate Orthognatic surgery Surgical placement of implants	Orthognatic surgery above 18 years	Diagnostic examinations Endodontics and preventative treatment Fillings Extractions (including surgical)	MRI and CAT scans for any dento-alveolar procedure	Orthodontics Periodontics & prostodontics Crown and bridgework Metal-base dentures Bite plates Implant-supported tooth replacement Removal of wisdom teeth for orthodontic reasons Plastic dentures	Any complications with removable dentures Orthodontic therapy above 18 years MRI and CAT scans for any dento-alveolar procedure

TeleMed Gold

Maxillo-facial surgical admissions		Basic dentistry		Specialised dentistry	
Includes	Excludes	Includes	Excludes	Includes	Excludes
Cysts Tumours Fractures Salivary gland Complicated infections TM joint pathology Cleft lip and palate Orthognatic surgery Surgical placement of implants	Orthognatic surgery above 18 years	Diagnostic examinations Endodontics and preventative treatment Fillings Extractions (including surgical)	MRI and CAT scans for any dento-alveolar procedure	Orthodontics Periodontics and prostodontics Crown and bridgework Metal-base dentures Bite plates Implant-supported tooth replacement Removal of wisdom teeth for orthodontic reasons Plastic dentures	Any complications with removable dentures Orthognatic surgery and orthodontic therapy above 18 years MRI and CAT scans for any dento-alveolar procedure

TeleMed Gold Select

Maxillo-facial surgical admissions		Basic dentistry		Specialised dentistry	
Includes	Excludes	Includes	Excludes	Includes	Excludes
Cysts Tumours Fractures Salivary gland Complicated infections TM joint pathology Cleft lip and palate Orthognatic surgery Surgical placement of implants	Orthognatic surgery above 18 years	Diagnostic examinations Endodontics and preventative treatment Fillings Extractions (including surgical)	MRI and CAT scans for any dento-alveolar procedure	Orthodontics Periodontics and prostodontics Crown and bridgework Metal-base dentures Bite plates Implant-supported tooth replacement Removal of wisdom teeth for orthodontic reasons Plastic dentures	Any complications with removable dentures Orthognatic surgery and orthodontic therapy above 18 years MRI and CAT scans for any dento-alveolar procedure

TeleMed Silver

Limitations in respect of basic and specialised dentistry do not apply to TeleMed Silver as 100% of the cost is paid from the member's available Flexfunder.

The following limitations apply in respect of maxillo-facial surgical admissions:

Maxillo-facial surgical admissions	
Includes	Excludes
Cysts Tumours Fractures Salivary gland Complicated infections TM joint pathology Cleft lip and palate Orthognatic surgery	Orthognatic surgery above 18 years Surgical placement of implants

TeleMed Bronze

Maxillo-facial surgical admissions in-hospital		Basic dentistry	Specialised dentistry	Emergency dentistry	Dentures
Includes	Excludes	Includes			
Cysts Tumours Fractures Salivary gland Complicated infections TM joint pathology Cleft lip and palate Orthognatic surgery Hospitalisation for trauma only and impacted 3 rd molars Only children aged 7 years and younger Day theatres and DSPN hospitals only	Surgical placements of implants	Examinations Fillings Extractions (only local anaesthetics) Cleanings Preventative treatment Fluoride treatment Basic interventions	No benefit	Only pain treatment and sepsis intervention covered Limited to one (1) event / beneficiary / 12 months Subject to PMB	One standard set / beneficiary / 24 months 20% Co-payment required for dentures

Policy and procedures

1. General principles

- 1.1 Procedure codes in the National schedule of Recommended Fees and Guidelines will apply.
- 1.2 Supplementary Health Services Tariff apply.
- 1.3 All dental procedures are covered as detailed in the Rules for the specific scheme option concerned.
- 1.4 The clinical protocols of Supplementary Health Services will take precedence and apply in all cases.
- 1.5 All treatment rendered by a dental specialist is regarded as specialised treatment regardless of the scope of treatment with the exception of treatment defined as falling within PMB.
- 1.6 All specialised dentistry and hospitalisation for dental procedures are subject to pre-authorization by Supplementary Health Services before treatment commences. Penalties are levied for late authorisation – specialised dentistry R500 and hospitalisation R1 100, except in the case of emergency hospital admissions. *In an emergency, authorisation must be obtained within 48 hours or on the 1st working day after admission.*
- 1.7 Scheme members are required to obtain comprehensive quotations for all aspects and phases of a treatment plan especially in instances where more than one provider is involved.
- 1.8 A written authorisation is not a guarantee of payment and is issued subject to available benefits at the time when the claim/s is received. The authorisation includes a summary of benefit allocation.
- 1.9 With the exception of orthodontic treatment and implant therapy, where longer periods may apply, an authorisation is valid for three (3) months. Hospital authorisations are only valid for one (1) month.
- 1.10 All treatment deemed to form part of Prescribed Minimum Benefits is managed and covered in accordance with general Scheme Rules pertaining to the Scheme option and is payable by the Scheme.

2. Limitations, exclusions and restrictions

2.1 Procedures

- 2.1.1 Cosmetic procedures such as bleaching and anterior tooth laminate veneers and posterior tooth porcelain or resin inlays are not covered.
- 2.1.2 Benefits for crowns will be granted once per tooth every five (5) years except where clinically motivated and assessed by Supplementary Health Services. Bridges are limited to pontics for permanent incisors, canines and pre-molars. The cost of metal will be in accordance to the tooth type.

- 2.1.3 Laboratory fabricated crowns are not covered on primary teeth or third molars.
- 2.1.4 Acrylic and temporary crowns, including laboratory aspects, placed for any reason are excluded from benefits.
- 2.1.5 Cover for periodontal disease management is limited to conservative (non-surgical) management once every two (2) years and is subject to pre-authorisation using the CPITN index. Surgical periodontal treatment is not covered.
- 2.1.6 Orthodontic treatment:
- Orthodontic treatment is limited to patients who are 18 years or younger
 - Benefits for all orthodontic treatment is subject to prior appraisal using the Index of Complexity, Outcome and Need (ICON – copyright University of Wales College of Medicine) or other such recognised clinical index as determined by Supplementary Health Services
 - Platinum option – fixed orthodontics: The maximum benefit amount allocated per case is R10 000 and is determined by the level of severity of the upper and lower jaw discrepancy as defined by the index and subject to the Supplementary Health Services Tariff
 - Gold option – only two removable appliances are covered
 - Silver option – no benefit for orthodontic treatment
 - Repeat treatment is not covered and should the patient transfer to another provider, only the balance of the treatment plan will be covered
 - Replacement of orthodontic appliances and remounting of orthodontic brackets are not covered
 - Removable appliances are limited to two (2) appliances
 - Retainers are limited to one (1) per jaw and subject to the Supplementary Health Services Tariff
 - Invisible retainer material is not covered.
- 2.1.7 Orthognathic (jaw correction) surgery is not covered except to treat severe facial abnormalities in patients younger than 18 and if specifically authorised by Supplementary Health Services. Cover for preparatory orthodontic therapy, prior to orthognathic surgery, will be limited to treatment required to achieve a non-surgical outcome.
- 2.1.8 Tempero-mandibular joint therapy is limited to non-surgical procedures. Appliances for such therapy are limited to a bite-plate and will qualify for benefits every two (2) years.
- 2.1.9 Apisectomies will not be covered unless a reasonable attempt has been made to drain the peri-apical infection via endodontic procedures and further treatment where applicable. Please see 3.1.3.

2.1.10 Implantology and all procedures associated with implantology:

- Silver option – no cover
- Gold and Platinum options – cover is limited to lower denture stabilisation with simple abutments on two (2) implants. For Platinum members only – cover is limited to a single tooth replacement per jaw. Authorised procedures, including the laboratory cost and the cost of the implant components invoiced by the dentist are subject to Supplementary Health Services Tariff
- The prosthodontic portion of implant treatment is subject to the option rules governing that treatment (e.g. crown or denture)
- Failed implant replacement is not covered
- Surgery associated with implant therapy is not covered.

2.1.11 Plastic dentures are limited to one (1) per jaw (i.e. two (2) per beneficiary) within a four (4) year period except if clinically justified and authorised by Supplementary Health Services. Complicated dentures are covered at the basic denture rate.

2.1.12 Partial metal denture frames are limited to one (1) per jaw (i.e. two (2) per beneficiary) within a five (5) year period. Gold option – no cover.

2.1.13 Metal base to full dentures or soft base to new dentures including laboratory cost is not covered.

2.1.14 Endodontic procedures are not covered on third molars unless clinically motivated and assessed by Supplementary Health Services.

2.1.15 Repeat endodontic treatment is not covered within three (3) years of initial treatment.

2.1.16 Not covered:

- oral hygiene instructions
- nutritional counselling
- tobacco counselling
- caries-susceptibility and microbial tests
- pulp capping (direct or indirect)
- root canal treatment on primary and wisdom teeth
- implant tooth replacement on wisdom teeth
- crowns on primary or wisdom teeth
- polishing of restorations
- ozone therapy
- fixed prosthodontics used to repair occlusal wear

- diagnostic dentures
 - provisional and emergency crowns including lab costs
 - snoring appliances
 - perio chip
 - gingivectomy
 - cost of gold, precious metal, semi-precious metal and platinum foil
 - metal substitute coping material for laboratory cost for crowns
 - inlays and onlays regardless of material used, will not be covered
 - pontics on first and second molars
 - connecting bars such as Dolder bars for implants
 - mouth guards (including material and laboratory cost)
 - bonding of restorations as a separate charge
 - therapy of healed extraction sites
 - electrognatographic recordings
 - vascular surgery for treatment of headaches
 - lab costs where the associated dental procedure is not covered
 - high impact acrylic
 - bleaching of teeth
 - cost of mineral trioxide
 - mouthwash and toothpaste
- 2.1.17 Benefits for conservative dental restorations fillings will be granted once per tooth every two (2) years except if clinically motivated and approved by Supplementary Health Services. Supplementary Health Services Tariff for amalgam fillings will apply for the filling of posterior teeth (molar and pre-molars) regardless of the material used.
- 2.1.18 Benefits for dental restorations are limited to a maximum of five (5) restorations per dependant per year.
- 2.1.19 Benefits for dental "check-ups" as described in the schedule under code 8101 are allowed once every six months per dependant, per practitioner. Additional dental consultations during this period will be covered as code 8104. Clinical motivation and assessment by Supplementary Health Services is required for patients who require additional "check-ups" before benefits will be paid.
- 2.1.20 Preventive treatment is limited to one consultation every six (6) months. Benefits will only be paid for additional visits if clinically motivated and assessed by Supplementary Health Services.
- 2.1.21 Fissure sealants on permanent molars and pre-molars are covered once every two (2) years for patients younger than 14.
- 2.1.22 Two (2) intra-oral radiographs per year except for root canal therapy and clinically motivated and assessed by Supplementary Health Services.

- 2.1.23 One (1) extra-oral radiograph per year, except for orthodontic treatment planning where two (2) extra-oral radiographs will be covered.
- 2.1.24 MRI and CAT scans for any dento-alveolar procedures will not be covered.

2.2 Option specific exclusions – Refer to Scheme Rules

- 2.2.1 Gold option – metal denture frames excluded.
- 2.2.2 Gold option – comprehensive (fixed) orthodontic treatment is excluded.

2.3 Exclusions payable by Scheme

PMB's and hospital / sedation / anaesthetic.

3. Hospitalisation

Hospitalisation for dentistry is not automatically covered and is subject to pre-authorisation and the following protocols:

- 3.1 Hospital cover is provided when an underlying medical condition increases the risk of complications if treatment is provided in the rooms or if a higher level of care is required. The sole need for a sterile facility is not an acceptable reason for hospitalisation for dental treatment.
- 3.2 Hospital cover is provided if the discomfort associated with the treatment cannot be tolerated by the average person without general anaesthesia.
- 3.3 Apisectomies on molars and lower pre-molars in hospital are only covered as per 2.1.9.
- 3.4 Frenectomies in hospital.
- 3.5 In-hospital periodontal procedures are not covered.
- 3.6 The extraction of an impacted tooth, as radiologically verified and not for orthodontic reasons, will be covered when associated with pathology or severe pain and the extraction cannot be reasonably performed without being admitted to hospital.
- 3.7 Hospital benefits may not be claimed for dental implantology and associated procedures, e.g. sinus lift, bone harvest, etc.
- 3.8 Bone and tissue regeneration procedures.
- 3.9 Multiple restorative visits to theatre for children younger than seven (7) will not be covered, i.e. a single hospital visit should suffice to stabilise the dentition until the child is old enough for routine dental treatment in dentist's rooms.
- 3.10 Theatre visits and extractions for patients older than seven (7) for conservative dentistry will not be covered.

4. Patient anxiety control

- 4.1 Should a dental practitioner require the assistance of a medical colleague to administer sedatives intravenously (not general anaesthetic) in the dental rooms, the fee charged by the second professional will only be covered once pre-authorized by Supplementary Health Services. Approval will only be granted if the use of nitrous oxide has been unsuccessful.
- 4.2 Cover for the use of oral sedatives or nitrous oxide administered by dental practitioners in their rooms is unlimited.