RESOLUTION OF THE BOARD OF TRUSTEES OF THE ANGLOVAAL GROUP MEDICAL SCHEME ("Scheme") PASSED IN TERMS OF THE RULES OF THE SCHEME AT THE BOARD OF TRUSTEES' MEETING HELD ON 1 SEPTEMBER 2021

2022 RULE AMENDMENTS

Whereas the Board of Trustees considered the Scheme's benefit changes, contribution increases and rule amendments for 2022, it was therefore resolved that-

1. The benefit structure be amended for 2022, as indicated by the benefit changes summarised below and further detailed in Annexure B to the Scheme Rules;

2. An inflationary benefit limit increase of 4.4% would be applied for 2022;

3. A contribution increase of 4% would be applied for 2022;

4. Rules 27.1.3 and 27.2.4 be amended to make provision for virtual attendance at general meetings; and

5. The Scheme rules be amended in accordance with the above resolutions and submitted to the Registrar for Medical Schemes for approval

Certified as a True Copy

Principal Officer — Date: 29/9/2021

Chairman — Date: 29/09/2021

Trustee — Date: 29/09/2021

REGISTERED BY ME ON

Mashilo Leboho 2021/10/26
03/11/202115:20:32(UTC+02:00)
Signed by Mashilo Leboho,
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REGISTRAR OF MEDICAL SCHEMES

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

26.2.5 a person who is disqualified from acting as an auditor in terms of the Companies Act, 2008.

26.3 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 (thirty) days appoint another auditor to fill the vacancy for the unexpired period.

26.4 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 (thirty) days make such appointment, and if it fails to do so, the Registrar may at any time do so.

26.5 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 other officers of the Scheme such information and explanations as he deems necessary for the performance of his duties.

26.6 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 general meetings.

26.7 The Board must appoint an audit committee of at least 5 (five) members of whom at least 2 (two) must be members of the Board.

27. GENERAL MEETINGS

27.1 Annual General Meeting -

27.1.1 The annual general meeting of members must be held not later than 30 June of each year.

27.1.2 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 (twenty-one) days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceeding at such meeting, provided that the notice procedure followed by the Board was reasonable.

27.1.3 At least 15 (fifteen) members of the Scheme present in person (in respect of which the term "present in person" shall include being present by may be held by means of such electronic or other communication facility or media as permits all persons participating in the meeting to communicate with each other simultaneously and instantaneously and persons so participating shall be deemed to be present at such meeting) shall constitute a quorum. If a quorum

is not present after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting

must be postponed to a date determined by the Board, and members then present constitute a quorum.

27.1.4 The financial statements and reports specified in Rule 27.1.2 must be laid before the meeting.

27.1.5 Notices of motions to be placed before the annual general meeting must reach the principal officer not later than seven days prior to the date of the meeting.

27.2 Special General Meeting -

27.2.1 The Board may call a special general meeting of members if it is deemed necessary.

27.2.2 On the requisition of at least 20 (twenty) members of the Scheme, the Board must cause a special general meeting to be called within 30 (thirty) days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitioners and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

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

27.2.4 Twenty members present in person (in respect of which the term "present in person" shall include being present by may be held by means of such electronic or other communication facility or media as permits all persons participating in the meeting to communicate with each other simultaneously and instantaneously and persons so participating shall be deemed to be present at such meeting) shall form a quorum. If a quorum is not present at a special general meeting called by the Board after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed until the same day and time of the next week and the members then present shall form a quorum provided that if the same day of the next week is a public holiday the meeting will be postponed until the first working day following the public holiday. If a quorum is not present at a special general meeting convened on the request of members after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.

1. ANGLOVAAL GROUP MEDICAL SCHEME RULES

ANNEXURE A

1. CONTRIBUTIONS FROM 1/1/2022

INSURED CONTRIBUTIONS			
INCOME BANDS	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
Below R4 600	R1 994	R1 994	R616
R4 601 – R9 100	R2 333	R2 333	R707
R9 101 – R13 600	R2 536	R2 536	R777
R13 601 – R18 100	R2 687	R2 687	R820
Above R18 101	R2 753	R2 753	R833
MSA CONTRIBUTIONS @ 25% OF TOTAL CONTRIBUTION			
INCOME BANDS	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
Below R4 600	R497	R497	R154
R4 601 – R9 100	R582	R582	R176
R9 101 – R13 600	R633	R633	R193
R13 601 – R18 100	R673	R673	R205
Above R18 101	R687	R687	R207
TOTAL CONTRIBUTIONS			
INCOME BANDS	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
Below R4 600	R2 491	R2 491	R770
R4 601 – R9 100	R2 915	R2 915	R883
R9 101 – R13 600	R3 169	R3 169	R970
R13 601 – R18 100	R3 360	R3 360	R1 025
Above R18 101	R3 440	R3 440	R1 040

For purposes of the contribution table "Adult Dependant" means the member's spouse or partner and any other dependant who is over the age of 21 years irrespective of the person's relationship to the member.

2. PREMIUM PENALTIES FOR PERSON JOINING LATE IN LIFE

2.1 Premium penalties may be applied to a late joiner. Such penalties shall be applied only to that portion of the contribution relative to the late joiner and shall not exceed the following bands:

PENALTY BANDS	MAXIMUM PENALTY
1-4 years	0.05 x contribution
5-14 years	0.25 x contribution
15-24 years	0.5 x contribution
25+ years	0.75 x contribution

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

A = B minus (35 + C) where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of the application

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

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

2.3 If an applicant is unable to obtain documentary proof to substantiate periods of creditable coverage, he/she shall be entitled to produce a sworn affidavit declaring such detailed information and that reasonable efforts to obtain documentary evidence of such periods of creditable coverage were unsuccessful.

ANGLOVAAL GROUP MEDICAL SCHEME RULES

ANNEXURE B
BENEFITS AND LIMITATIONS

Members and their registered dependants shall, subject to the provisions of Annexure C and other limitations imposed by the Rules of the Scheme, be entitled to the following benefits in 2022:

1. PRESCRIBED MINIMUM BENEFITS (PMB'S)

1.1. Definitions

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

- The Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and
- Any emergency medical condition.

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

1.2. Designation of Service Providers

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

Category	Designated Service Provider
General Practitioner	Any GP participating in the Discovery Health GP Network
Specialist	All Premier Rate providers who are part of the Direct Payment Arrangement and/or working in a state hospital contracted to the Scheme

Medication	Any dispensing provider or pharmacy that has contracted with the Scheme
Radiology	Any provider that has contracted with the Scheme
Pathology	Any provider that has contracted with the Scheme
Hospital	Any hospital contracted with the Scheme
Mental Illness	Drug Abuse – any SANCA facility contracted to the Scheme Other – any hospital with psychiatric ward facilities that is contracted to the Scheme
Terminal Care	Hospice
Renal Dialysis	Any provider contracted with the Scheme
HIV/AIDS	OptiPharm, or any provider contracted with the Scheme

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

1.3. Prescribed Minimum Benefits Obtained from Designated Service Providers

100% of the cost in respect of diagnosis, treatment and care costs of prescribed minimum benefits.

1.4. Prescribed Minimum Benefits Voluntarily Obtained from Other Providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to a co-payment equal to the difference between the actual cost incurred and the Scheme Rate.

1.5. Prescribed Minimum Benefits Involuntarily Obtained from Other Providers

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

1.5.2 For the purposes of paragraph 1.5.1, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if:

- The service was not available from the designated service providers or would not be provided without unreasonable delay;
- Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
- There was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

1.5.3 Except in the case of an emergency medical condition, preauthorization shall be obtained by a member prior to involuntarily obtaining a service from a provider other than the designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in Rule 1.5.2 of Annexure B are applicable.

1.6. Medication

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

- The medication is included on the applicable formulary in use by the Scheme; or
- The formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

1.6.2 Where a prescribed minimum benefit includes medication and that medication is voluntarily obtained from a provider other than a designated service provider, a co-payment equal to the difference between the cost of the drug and the Scheme Medicine Rate of the formulary drug will apply.

1.7. Prescribed Minimum Benefits Obtained from Public Hospitals

Notwithstanding anything to the contrary contained in these rules, the Scheme shall pay 100% of the costs of prescribed minimum benefits obtained in a public hospital, without limitation.

1.8. Diagnostic Tests for an Unconfirmed PMB Diagnosis

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

1.9. Co-Payments

Co-payments in respect of the costs for PMB's obtained from providers other than designated service providers may not be paid out of medical savings accounts.

1.10. Chronic Conditions

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

1.11 Insofar as the terms of any other clause in this Annexure B may conflict with the provisions of this clause 1, the terms of this Clause 1 shall prevail.

2. PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)

2.1 On admission to the Scheme, a PMSA, held by the Scheme, shall be established in the name of the member concerned into which the contributions allocated by the Scheme in respect of the PMSA shall be credited and benefits in respect thereof, shall be debited.

Although the full annual (or pro-rated) PMSA allocation shall be available for the payment of claims at any time during the year, the monthly balance in a member's PMSA shall be calculated on the basis of contributions actually received, less any expenditure incurred.

Interest does not accrue to positive PMSA balances.

2.2 The amount allocated to the PMSA by the Scheme for the benefit of the member will be set at 20% of the total gross contributions in respect of the member during the financial year concerned.

2.3 Subject to sufficient funds being available at the date on which the claim is processed, members shall be entitled to claim for all health care services from the PMSA at 100% of the cost.

2.4 Funds allocated to the members' PMSA shall be available for the exclusive benefit of the member and his/her dependants. Any credit balance in the PMSA at the end of the financial year accumulates for the benefit of the member.

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

2.6 On transfer to any other available benefit option of the Scheme, which does not provide for such an account, any balance standing to the credit of the member in the PMSA will be refunded to the member, not later than 4 months after such transfer and subject to applicable taxation laws.

2.7 Should a member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme or option which does not provide for a PMSA, the balance due to the member must be refunded to the member not later than 4 months after termination of membership, and subject to applicable taxation laws.

2.8 Should a member transfer to another benefit option or be admitted to membership of another medical scheme, which provides for a similar account, the balance due to the member must be transferred to such benefit option or scheme not later than 4 months after transfer to the benefit option or termination of membership, as the case may be.

2.9 The funds in the member's medical savings account may not be used to pay costs of a prescribed minimum benefit or to offset contributions.

2.10 Where the Scheme pays a claim or claims, which, in aggregate, exceed/s the aggregate amount of those portions of the member's contributions which have been allocated to the member's PMSA, as at the date of such payment by the scheme, the scheme shall, at its option, be entitled:

20.10.1 to debit the unfunded claim amount against the member's PMSA; or
20.10.2 to recover the unfunded claim from the member.

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

3. MAJOR MEDICAL EXPENSES (INSURED BENEFITS)

3.1 Hospitalisation

3.1.1 Subject to prior approval for all elective (non-emergency) cases, one hundred percent (100%) of the Scheme rate, while admitted to a private or public hospital, registered unattached operating theatre or day clinic, of:

- Accommodation in a general, high care and intensive care ward;
- Theatre fees;
- Medicines, materials and equipment used in the hospital;
- Consultations, visits and procedures performed by medical and dental practitioners;
- Confinements;
- Internal prosthesis;
- Clinical technologies;
- Radiology excluding CT, MR and radio-isotope scans;
- Physiotherapy;
- Blood transfusions, and
- Pathology.

3.1.2 The Scheme may, as part of the pre-authorisation process, in its sole discretion and after consultation with appropriate experts determine the medical necessity of the proposed hospitalisation and/or procedure.

3.1.3 Where the Scheme has entered into a Preferred Provider Arrangement with a hospital or group of hospitals and/or medical practitioners, members and their dependants will have the option of obtaining services from such providers at no additional cost to themselves.

3.1.4 Where a member or his dependant, who could reasonably have obtained a required service from a preferred provider, chooses to use another provider of his choice, the Scheme's liability for the cost of such services will be limited to that for which it would have been liable in terms of the preferred provider agreement contemplated in Rule 3.1.3 of Annexure B, with the member being liable for any additional costs that are incurred.

3.1.5 In the event of an emergency admission, the Scheme shall be notified of an event within one working day after admission.

3.1.6 The Scheme may refuse to accept liability for any or all of the costs referred to in Rule 3.1.1 if the member fails to obtain prior authorisation or to notify the Scheme as provided for in Rules 3.1.1 and 3.1.5 of this Annexure.

3.1.7 There shall not be an annual limit for in-hospital costs, but the Scheme shall have the right to monitor and manage any such costs and this may, in addition to preferred provider arrangements include prospective, concurrent and retrospective utilisation review and management.

3.1.8 In cases of true medical emergencies where a beneficiary could not reasonably have made use of another provider, the professional fees directly associated with such an emergency will be covered at cost.

3.2. CHRONIC CONDITIONS

3.2.1 The Scheme will cover in full the diagnosis, medical management and medication for the prescribed chronic conditions to the extent that this is provided for by way of a therapeutic algorithm for a special condition, published by the Minister by notice in the Government Gazette.

A member and his/her dependants will also be entitled to medication for other (non-prescribed) chronic conditions as indicated in the following schedule. The cover for non-prescribed chronic conditions does not include the cost of diagnosis or medical management. These costs may be funded from the members' Medical Savings Accounts.

Cover for chronic conditions (prescribed and non-prescribed) will only be provided subject to pre-authorisation, diagnostic and treatment protocols, a formulary and/or reference prices and chronic drug amount as set by the Scheme and the use of designated services providers.

PRESCRIBED CHRONIC CONDITIONS

1.	Addison's Disease	14.	Epilepsy
2.	Asthma	15.	Glaucoma
3.	Bipolar Mood Disease	16.	Haemophilia
4.	Bronchiectasis	17.	Hyperlipidaemia

5.	Cardiac Failure	18.	Hypertension
6.	Cardiomyopathy Disease	19.	Hypothyroidism
7.	Chronic Renal Disease	20.	HIV/AIDS
8.	Coronary Artery Disease	21.	Multiple Sclerosis
9.	Crohn's Disease	22.	Parkinson's Disease
10.	Chronic Obstructive Pulmonary Disorder	23.	Rheumatoid Arthritis
11.	Diabetes Insipidus	24.	Schizophrenia
12.	Diabetes Mellitus Type 1 & 2	25.	Systemic Lupus Erythromatosis
13.	Dysrhythmias	26.	Ulcerative Colitis

OTHER (NON-PRESCRIBED) CHRONIC CONDITIONS COVERED

For the conditions listed in the following table, benefits will be provided above the PMB entitlement, in accordance with the Scheme benefits and managed care protocols.

1.	Allergic Rhinitis	8.	Menopausal symptoms (HRT)
2.	Alzheimer's Disease	9.	Motor Neuron Disease
3.	Ankylosing Spondilitis	10.	Myasthenia Gravis
4.	Cancer Treatment: Side-effects of chemotherapy	11.	Osteoarthritis
		12.	Osteoporosis
5.	Cystic Fibrosis	13.	Paget's Disease of the Bone
6.	Gout	14.	Psoriasis
7.	Major Depressive Disorders		

3.2.2 Benefits under Rule 3.2.1 shall only be paid under the following circumstances and conditions:

3.2.2.1 Suitable motivation, acceptable to the Scheme, must be provided by the member's attending practitioner indicating that the condition is a chronic disorder requiring continuous medicinal treatment.

3.2.2.2 The Scheme shall have the right to authorise, in consultation with the attending practitioner, a suitable generic equivalent or alternative medication for the condition being treated or to include the patient in a disease management programme.

3.2.2.3 The Scheme shall have the right to call for subsequent reports whenever so deemed necessary. Failure to provide such reports within 30 days of such request will cause benefits under this section to cease; and

3.2.2.4 Where the Scheme's formulary or reference price system includes a drug that is clinically appropriate and effective for the treatment of a chronic condition suffered by the beneficiary, and the beneficiary knowingly declines the formulary/reference priced drug and opts to use another drug instead, the Scheme's liability will be limited to that for which it would have been liable in terms of the formulary and/or reference price system. The beneficiary shall be liable for any additional costs.

3.3.1 OTHER SERVICES (INSURED PROCEDURE BENEFITS)

One hundred percent (100%) of the cost of the following services in accordance with the Scheme rate, provided that prior approval has been obtained from the Scheme and subject to the annual limits per member family as indicated:

- Emergency evacuation (road or air): R75 044;
- Oncology (including chemotherapy and radiotherapy): R396 583;
- Stoma therapy and hospice: R12 143;
- Audiology including hearing aids: R24 287;
- Ambulance service: R9 208;
- External surgical appliances, artificial limbs and medical apparatus such as glucometers: R9 208;
- CT, MR and radio-isotope scans: R21 351;
- Out-patient surgical and endoscopic procedures (vasectomy, gastroscopy, colonoscopy, cystoscopy, etc.): R18 358;
- Post-hospitalisation home nursing or accommodation in a nursing home or step-down facility: No limit – managed through the Care Coordination Programme;
- Advanced Illness Benefit for oncology patients: unlimited, but subject to the patient meeting clinical entry criteria and the authorization of the treatment plan;
- Screening and Prevention benefit which includes:

- Screening Benefit A: one per year for a group of tests consisting of blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), up to a maximum of the Scheme rate for group of tests at a network provider; and
- Screening Benefit B: one mammogram, one pap smear, one prostate-specific antigen test, and HIV blood tests; and
- one seasonal flu vaccine per year for beneficiaries who are over the age of 65 or are registered one of the following chronic conditions – asthma, bronchiectasis, cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease, chronic renal failure, coronary artery disease, diabetes (type 1 and 2), or HIV; and

- Conservative Dentistry: R690 per beneficiary.
- Mental health management and relapse prevention. Subject to the member meeting the clinical entry criteria and use of the Scheme's designated services providers.
- Continuous Glucose Monitoring devices for Type 1 diabetics.
- Oncology member support, providing a pre-AIB basket of care for early Oncology management.
- Member Care Programme: subject to the member meeting the clinical entry criteria and use of the Scheme's designated services providers.
- Re-admissions benefit for members admitted with specific qualifying conditions
- Conservative spinal care provided within a network and a spinal centre of excellence for the management of spinal surgeries performed by qualifying surgeons
- Hospital at Home, giving members access to home-based healthcare for eligible health conditions
- GP Virtual house call for members registered on the Chronic Illness Benefit (excluding Oncology) – Limit of 1 per annum

Subject to Rule 3.4.1 and 3.4.2 of Annexure B, the Scheme shall not be liable for any expenditure for services obtained without the prior approval of the Scheme.

3.3.2 ENHANCED MATERNITY BENEFIT

Upon registration on the Maternity Program, a defined basket of both pre-and post-natal care will be available, which includes:

Health care services	Basis of cover: Subject to Prescribed Minimum Benefits	Limits
Out-of-hospital healthcare services related to pregnancy and delivery: - Antenatal classes and/or postnatal visits with a registered nurse - Antenatal consultations with a GP, gynaecologist or midwife - Prenatal screening or Non Invasive Prenatal Testing (NIPT) - Pregnancy scans - Paediatrician, ENT or GP consultations for infants - A defined basket of pregnancy blood tests - Postnatal consultation with a GP, gynaecologist or midwife - Dietician nutrition assessment - Postnatal mental health consultation with a GP, psychologist or counsellor - Lactation consultation with a registered nurse or lactation specialist - Cover for External Medical Items (EMI)/registered essential devices such as breast pumps or nebulisers - Private ward cover	Up to 100% of the Scheme rate Paid from Health Care cover: subject to any applicable limits Subject to pre-authorisation and/or registration and treatment meeting the Scheme's clinical entry criteria 3D and 4D scan will be paid up to the cost of a 2D scan Cover for infant consultations up to a maximum of 100% of the Scheme rate, for children under the age of 2 years Services in excess of the limit paid from MSA Limits apply for the duration of the pregnancy	Services: - Antenatal classes and/or postnatal visits: 5 consultations or classes per pregnancy and/or delivery - Antenatal consultations: 8 per pregnancy - Prenatal screening or Non Invasive Prenatal Testing (NIPT): 1 per pregnancy - Pregnancy scans: 2 per pregnancy - Consultations for infants: 2 per child - Blood tests: 1 routine basket of pregnancy tests per pregnancy - Postnatal consultations: 1 per delivery - Dietician nutrition assessment: 1 per delivery - Mental health consultations: 2 per delivery - Lactation consultation: 1 per delivery - R5 755 External Medical Items (EMI) benefit subject to a 25% co-payment - Private ward cover: 3 nights for a caesarean section birth and 2 nights for natural deliveries

3.3.3 WORLD HEALTH ORGANIZATION (WHO) GLOBAL OUTBREAK BENEFIT

Basket of care which includes in-hospital and out-of-hospital management and supportive treatment of global World Health Organization recognized disease outbreaks, subject to Prescribed Minimum Benefit guidelines or as otherwise legislated.	Up to 100% of the regulated price or a maximum of 100% of the Scheme rate for services within the basket of care. Subject to the Scheme's preferred provider, protocols and clinical entry criteria. Treatment for COVID-19 will be funded at 100% of cost at a designated service provider.

3.4. EMERGENCY SERVICES

3.4.1 In the event of a medical emergency, a member or his dependants are entitled to obtain the necessary services from any provider of their choice, subject to the Scheme being notified of any admission to hospital within one working day thereafter. This applies to the Major Medical Expenses and the Prescribed Minimum Benefits.

3.4.2 Following an emergency admission to hospital, the Scheme shall have the right to transfer the patient to another hospital or health care professional, with which it has concluded preferred provider arrangements, as soon as it is deemed practical and medically prudent, by the Scheme, to do so.

3.4.3 The cost of emergency services shall be paid from the appropriate benefit and be subject to the rules and limitations applicable to the respective benefits.

3.5. LIMITATIONS OF BENEFITS

3.5.1 Members admitted during the course of a financial year shall be entitled to the benefits as set out with the maximum benefit (annual limits) being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

3.5.2 In cases of illness of a protracted nature or proposed treatment with high associated costs, the Board shall have the right to insist upon the member or dependant consulting a medical practitioner nominated by the Board. In such

cases, if the medical practitioner's proposed treatment is not acted upon, the Board may disallow all further benefits for that particular illness.

3.5.3 The cost associated with optometric service (including the provision of glasses and contact lenses and refractory eye surgery) will not be paid from the Major Medical Expenses Benefit.

3.5.4 All questions regarding the medical necessity, nature and sufficiency of any relevant health service provided, or to be provided, in terms of the Rules shall, in its sole discretion and after consultation with the Scheme's medical adviser/s and other appropriate experts where deemed necessary, be decided by the Board.