SUREMED HEALTH

RULES

2022

1. NAME

The name of the scheme is Suremed Health, hereinafter referred to as the "Scheme".

2. LEGAL PERSONA

The Scheme is a body corporate capable of suing and of being sued in its own name 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 Act and these rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 7 Lutman Street, Richmond Hill, Port Elizabeth, 6001, but the Board may transfer such office to any other location in the Republic of South Africa.

[Amended w.e.f. 1 September 2007]

4. DEFINITIONS

In these rules, a word or expression defined in the Medical Schemes Act, 1998, (Act No 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context,

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

(ii) a word in the singular number includes the plural, and *vice versa;*

(iii) the following expressions have the following meanings:

4.1 "Act", shall mean the Medical Schemes Act (Act No 131 of 1998), and the regulations promulgated thereunder.

4.2 "adult dependant", shall mean a dependant other than a child dependant;

4.3 "approval", shall mean prior written approval of the Board or its authorized representative;

4.4 "auditor", shall mean an auditor registered in terms of the Public Accountants' and Auditors' Act, 1991, (Act No. 80 of 1991);

4.5 "authorisation", shall mean the authorisation by or on behalf of the Scheme for a case to be managed under the relevant managed health care programme and for which application has been made by or on behalf of a beneficiary prior to admission to a hospital or day clinic or for such other specific services and or procedures as may be determined by the Scheme from time to time and such authorisation shall be deemed to authorise all procedures and services as may be necessary during the stipulated period.

4.6 "beneficiary", shall mean a member or the dependant of a member.

4.7 "Board", shall mean the Board of Trustees constituted to manage the Scheme in terms of the Act and these rules.

4.8 "chemotherapy", shall mean medication used in the cure and containment of a malignant neoplastic condition and includes cytostatics and hormone inhibitors;

4.9 "child", shall mean a member's natural child, stepchild or legally-adopted child or child in the process of being adopted or in the process of being placed in foster care, under the age of 21 (twenty-one) years who is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child irrespective of age who, due to a mental or physical disability, is dependent upon the member.

4.10 "condition specific waiting period", shall mean 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.

4.11 "continuation member", shall mean:

4.11.1 a member who retains membership in terms of these rules in the event of his retiring from the service of his employer; or his employment being terminated by his employer, or

4.11.2 a dependant of a deceased member who obtains membership in terms of these rules.

4.12 "contribution", shall mean 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 and shall include contributions to medical savings accounts.

4.13 "cost", shall mean in relation to a benefit, the net or final amount payable in respect of a relevant health service.

4.14 "Council", shall mean the Medical Schemes Council formed in terms of the Act.

4.15 "creditable coverage", shall mean any period during which a late joiner was

4.15.1 a member or a dependant of a medical scheme;

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

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

4.15.4 A member or a dependant of Permanent Force Continuation Fund,

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

4.16 "day", shall mean calendar day and "weekday" shall mean any day not being a Saturday Sunday or public holiday;

4.17 "dependant", shall mean

4.17.1 a member's spouse or partner, irrespective of sex, who is not a member or a registered dependant of a member of another medical scheme registered under the Act;

4.17.2 a member's child who is not a member, or a registered dependant of a member, of another medical scheme registered under the Act;

4.17.3 other members of the member's immediate family, in respect of whom the member is liable for family care and support, and who is not a member or registered dependant of a member of another medical scheme registered under the Act.

4.18 "designated service provider", shall mean a health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions;

4.19 "domicilium citandi et executandi", shall mean the member's chosen physical address at which notices in terms of rules 11 and 13 as well as legal process, or any action arising therefrom, may be validly delivered and served;

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

4.21 "employee", shall mean a person in the permanent employment of an employer.

4.22 "employer", shall mean a participating employer who has contracted with the Scheme for purposes of admission of its employees as members of the Scheme.

4.23 "income", *see Annexure A;*

4.24 "late joiner", shall mean an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001;

4.25 "liable for family care and support", shall mean a liability for financial support enforceable by a court of law;

4.26 "managed health care programme", shall mean a programme adopted by the Scheme incorporating such clinical protocols as defined in relevant annexures to the contract between the Scheme and the institution or managed healthcare organization contracted to perform the management of a relevant health service in order to contain costs or for the ongoing review and monitoring of patients as set out in paragraph 6 of Annexure D;

4.27 "medicine designated price", shall mean the maximum reimbursable price for a medicine or group of medicines according to the medicine price list;

"medicine price list", shall mean a list prepared by the relevant managed health care programme containing the maximum reimbursable price of specified medicines.

4.28 "member", shall mean any person who is admitted as a member of the Scheme in terms of these rules.

4.29 "member family", shall mean the member and all his registered dependants.

4.30 "minimum benefits", shall mean any service falling within the prescribed minimum benefits in respect of relevant health services as prescribed by the Minister in terms of section 67(1)(g) of the Act obtained by a member from a public hospital and which service is not different from the service available to a public hospital patient; and any emergency medical condition.

4.31 "negotiated fee", shall mean a charge agreed to between the Scheme and dispensers and preferred providers in respect of the dispensing of registered medicines;

4.32 "other immediate family", shall mean a member's parent(s) (including an adoptive parent) and siblings.

4.33 "partner", shall mean 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 sex of either party.

4.34 "person", shall mean a citizen or permanent resident of the Republic of South Africa or a foreign national who, in the sole discretion of the Board, is accepted as being eligible to become a member or a dependant beneficiary.
[Added w.e.f. 1 September 2007]

4.35 "pre-existing sickness condition", shall mean 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 "prescribed minimum benefit condition", shall mean a condition contemplated in the Diagnosis and Treatment pairs listed in Annexure A or any emergency medical condition.

4.37 "prosthesis", shall mean a fabricated or artificial substitute or support for a diseased or missing part of the body, which is surgically implanted with the intention to restore functionality, and shall include all components such as pins, rods, screws, plates, nails, fixation material, or similar items, forming an integral and necessary part of the device so implanted, and shall be charged (where applicable) as a single unit.

4.38 "Registrar", shall mean the Registrar or Deputy Registrar(s) of Medical Schemes appointed in terms of section 18 of the Act.

4.39 "regulations", shall mean the regulations promulgated by the Minister of Health in terms of the Act.

4.40 "social pension", shall mean the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (Act No. 59 of 1992).

4.41 "spouse", shall mean the person to whom the member is married in terms of any law, custom or religious rites.

4.42 "Suremed Scheme Tariff", shall mean the tariff payable for health services as determined by the Board of Trustees**. [Added with effect from 1 January 2011]**

5. OBJECTS

The objects of the Scheme are:

5.1 to undertake liabilities in respect of its members and their dependants, in return for a contribution or premium;

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

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

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

6. 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.

6.3 Dependants of deceased members

6.3.1 The dependant(s) 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 registered under the Act.

6.3.4 Where a child dependant has been orphaned the child shall be deemed to be the member, and if there is more than one orphan, the eldest child shall be deemed to be the member, and any younger sibling(s), the child dependant(s).

6.4 Interchangeability and waiting periods

See Annexure D.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 CONDITIONS APPLICABLE TO MEMBERSHIP

7.1.1 A member may apply for the registration of his dependants at the time that he joins the Scheme in terms of rule 8.

7.1.2 A member may apply to register a newborn or newly adopted child within 30 (thirty) days of the date of birth or adoption of the child and such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall 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 A member who marries subsequent to joining the Scheme may apply within 30 (thirty) days of the date of such marriage to register his spouse as a dependant and his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall 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, provided that no such spouse shall 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 within 30 (thirty) days of such event for the registration of such person as a dependant, whereupon the provisions of these rules shall apply *mutatis mutandis.*

7.1.5 The Scheme shall under no circumstances be obliged to register as a member or as a dependant of a member any person whose membership or registration as dependant was terminated by the Scheme or any other scheme on any of the grounds provided for in these rules or in section 29(2) of the Act.

7.1.6 On registration as dependant, benefits in respect of such dependant shall be available, subject to the provisions of Annexure D.

7.1.7 The registered dependant(s) of a member shall participate in the same benefit option as the member.

7.2 De-registration of Dependant(s)

7.2.1 A member shall inform the Scheme within 30 (thirty) 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.

7.2.3 For purposes of these rules a child dependant shall be deemed to have ceased to be a child dependant:

[Amended w.e.f. 1 January 2008]

7.2.3.1 at the end of the month during which a child registered as a dependant reaches the age of 21 (twenty-one) years, unless the member provides satisfactory evidence that such child is not yet 25 (twenty five) years of age and is a full-time registered student at a registered tertiary education institution. Such proof is to be provided 30 (thirty) days before the child's 21st (twenty-first) birthday and every birthday thereafter until the child's 24th (twenty fourth) birthday.

[Amended w.e.f. 1 January 2008]

7.2.3.2 at the beginning of a benefit year if a registered dependant qualified as a dependant in terms of rule 4.17.3 unless the member provides satisfactory evidence that the requirements to qualify as a dependant still apply. Such proof is to be provided annually thirty days before the start of the new benefit year.

[Amended w.e.f. 1 January 2008]

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 the Scheme or a dependant of a member of the Scheme or claim benefits from the Scheme, if he is a member, or a dependant of a member of another medical scheme registered under the Act, or claims or accepts benefits in respect of himself or any of his dependants from another medical scheme registered under the Act.

8.3 Members shall,

8.3.1 prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in respect of the member and any dependant(s) of the member, of:

8.3.1.1 identity

8.3.1.2 **[Deleted w.e.f. 1 September 2007]**

8.3.1.3 **[Deleted w.e.f. 1 September 2007]**

8.3.1.4 age,

8.3.1.5 income,

8.3.1.6 state of health and of any medical advice, diagnosis, care or treatment recommended or obtained within a period of 12 (twelve) months immediately prior to the date on which application to the Scheme was made,

8.3.1.7 proof of any prior membership of any other medical scheme registered under the Act, and

8.3.2 annually, on or before 31st March of every year, and whenever there is any change in the income of the member or the spouse or partner of a member, submit to the Scheme satisfactory evidence of:

8.3.2.1 income of the member,

8.3.1.2 income of the spouse or partner of the member registered as a dependant of the member.

8.4 The Scheme may at any time after registration of a member require the member to again provide satisfactory evidence of the information specified in rule 8.3 within 14 (fourteen) days of being requested so to do. Should a member fail to comply with such a request within the specified period, or should the information provided differ from the information provided with the member's application to join the Scheme, same shall be regarded as constituting one or all of the contraventions stipulated in rule 12.5 and the Scheme shall forthwith be entitled to invoke the provisions of rule 12.5 unless the member can provide a reasonable explanation.

8.5 Every member will, on admission to membership and thereafter annually on or before 30th November of each year, receive a precis of these rules which shall include contributions, benefits, limitations in respect of all benefits options of the Scheme and details of the member's rights and obligations. Members and their dependant(s), 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.

8.6 The Scheme shall give members at least 30 (thirty) days notice of any changes to their contributions, benefits, limitations and the member's rights and obligations.

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

9. TRANSFER OF CONTINUATION MEMBERS ASSOCIATED WITH EMPLOYER GROUPS TRANSFERRING FROM ANOTHER MEDICAL SCHEME

If the members of another medical scheme registered under the Act 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 the Scheme and are accepted as members of the Scheme in terms of these rules, the Board will admit as a member, without a waiting period or the imposition of new restrictions on account of the state of his health or the health of any of his dependants, any member of such first-mentioned scheme who is a continuation member by virtue of his past employment by the particular employer and register as dependant, any person who has been a registered dependant of such a member.

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 dependant(s), with the knowledge or consent of the member or his dependant(s), is not permitted and shall be construed as an abuse of the privileges of membership of the Scheme in terms of rule 12.5.

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

11. CHANGE OF ADDRESS OF MEMBER

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

12. TERMINATION OF MEMBERSHIP

12.1 Resignation (employer groups)

12.1.1 A participating employer may terminate his participation with the Scheme on giving 3 (three) months written notice whereupon the membership of all employees and continuation members who have joined the scheme by virtue of their association with such employer shall cease.

12.1.2 A member, who joined the scheme as a result of his status as an employee of an employer may not terminate his membership while he remains an employee without the prior written consent of both his employer and the Scheme.

12.1.3 A member who resigns or is dismissed from the service of the participating employer shall be eligible on the date of such termination to maintain individual membership if he so chooses without the imposition of any new restriction that did not exist at the time of his dismissal or resignation.

12.1.4 The Board may at its sole discretion agree to reduce the period of notice required.

12.2 Termination of membership (Individual members)

12.2.1 A member, who is not an employee of an employer may terminate his membership of the Scheme on giving 3 (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 registered under the Act is compulsory as a result of a condition of employment.

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 shall be terminated as provided in these rules.

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

The Board shall immediately exclude from benefits and terminate the membership of a member or dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme as a result of such member refusing or failing to comply in full with rules 8.3 and 8.4, presenting false information, presenting false claims or

making a material misrepresentation or non-disclosure of factual information whether upon application to join the Scheme or at any time after being registered as a member. In such event such member shall be required by the Board and obliged 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.

12.6 The *audi alteram partem* rule

In order to comply with the *audi alteram partem* rule a member who is aggrieved by a decision of the Board pursuant to rules 12.4 and/or 12.5 shall have the right to refer his grievance to the disputes committee as provided for in rule 29.2.2.

13. CONTRIBUTIONS

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

13.2 Contributions from an Employer and private members who joined the scheme before 31 December 2018 shall be due in monthly arrears and all other contributions for new members who do not belong to an Employer group joining on or after 1 January 2019 shall be due monthly in advance and payable to the Scheme in terms of the provisions of Annexure A. Where contributions or any other debt owing to the Scheme, have not been paid within 3 days of the due date, the Scheme shall have the right:**[Amended with effect 1 January 2019]**

13.2.1 to suspend all benefit payments which have accrued to such member during the period of default; and

13.2.2 to give the member written notice at his *domicilium citandi et executandi* that if contributions or such other debts are not paid up to date within 14 days of such notice, membership may be cancelled. A notice sent by prepaid registered post to the member at his *domicilium citandi et executandi* indicating the outstanding amount shall be deemed to have been received by the member on the 7th day after the date of posting. In the event that the member fails to nominate a *domicilium citandi et executandi,* the member's postal or residential address on his application form shall be deemed to be his *domicilium citandi et executandi.*

13.3 In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with rule 13.2.2 above, 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 times remain the property of the member and any balance remaining upon termination shall be retained by the Scheme for up to five months and used to pay any claims received after termination of membership in respect of services rendered to the member or his dependants prior to termination. Subject to the provisions of Annexure A(2) – Appendix 1 any balance then remaining after five months shall be refunded to the member.

[Amended w.e.f. 1 September 2007]

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 sum of his unpaid contributions and any amounts incorrectly disbursed by the Scheme on his behalf or on behalf of his dependants and any interest and expenses due in terms of rule 13.3, which have not been paid or repaid to the Scheme.

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.

15. CLAIMS PROCEDURE

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 in the regulations.

15.1 If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme shall, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars:

15.1.1 the name and the membership number of the member;

15.1.2 the name of the supplier of service;

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

15.1.4 the total amount charged for the service concerned; and

15.1.5 the amount of the benefit awarded for such service.

15.2 In order to qualify for benefits, any claim other than electronically submitted claims must be signed and certified by the member as correct and must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

15.3 Where a member has paid an account, he shall, in support of his claim, submit a receipt.

15.4 Accounts for treatment of:

15.4.1 willfully self-inflicted injuries, or

15.4.2 injuries resulting from motor vehicle accidents, or

15.4.3 injuries incurred by a member in the course of his employment

must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained in order to enable the Scheme to determine whether the claim is excluded from benefits or may be recoverable from a third party insurer.

On receipt of payment in respect of medical expenses, the member will reimburse the Scheme any money paid out in respect of this benefit by the Scheme.

15.5 Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the relevant health care provider within 30 (thirty) days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and provider the opportunity to resubmit such corrected account or statement within sixty days following the date from which it was returned for correction.

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. Should there at any time be more than one benefit option available, a member must, on admission, elect to participate in any one of the available options detailed at the time in Annexure B.

16.2 In the event of a member joining or leaving the Scheme during a financial year, he shall only be entitled to a pro-rata proportion of each annual benefit limit scheduled in Annexure B which shall be calculated by dividing the number of completed months of membership during the year by 12 (twelve), and multiplying the result by each annual benefit limit scheduled in Annexure B.

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

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

16.3.2 Application to change from one benefit option to another must be in writing and lodged with the principal officer by not later than the later of:

16.3.2.1 31st December immediately preceding the 1st January of the year in which it is intended that the change shall take place, or

16.3.2.2 30 (thirty) days after the member has been sent notification of any intended changes in benefits or contributions for the next year.

16.4 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 (thirty) days of receipt of the claim pertaining to such benefit.

16.5 Any benefit option offered in Annexure B covers in full the cost of the minimum benefits rendered by a State hospital. In those instances where the State hospital service is not reasonably available, the Scheme remains liable for 100% of the cost in relation to those PMB's in whichever facility the beneficiary is compelled to seek treatment (in accordance with the Scheme's managed care protocols). **[Amended with effect from 1 January 2012]**

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

17. PAYMENT OF ACCOUNTS

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

17.2 Any discount whether on an individual basis or bulk discount received in respect of a relevant health service shall be for the benefit of the member in determining the net amount payable for the service and appropriate deduction from the applicable benefit limit, or medical savings account, as the case may be.

17.4 The Scheme may, whether by agreement or not, pay the benefit to which the member is entitled, directly to the supplier (or group of suppliers) who rendered the service.

17.5 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 account or benefit overpayment is recoverable by the Scheme from the member.

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

17.7 Payments for PMB conditions will be funded at 100% of the cost with the applicable co-payments and limits if the services are voluntary obtained from a non-designated service provider subject to the Scheme's managed care protocols. **[Amended with effect from 1 January 2012]**.

18. GOVERNANCE

18.1 Board of trustees

18.1.1 The affairs of the Scheme must be managed according to these Rules and the Act and regulations by a Board of trustees consisting of at least 3 (three) and no more than 6 (six) persons who are fit and proper to be trustees.

18.1.2 The following persons are not eligible to serve as members of the Board and any nomination of such a person shall be void:

18.1.2.1 a person under the age of 21 (twenty-one) years;

18.1.2.2 a director, employee, officer, consultant, contractor, partner, representative or agent of the administrator of the Scheme or of any controlling or subsidiary company of the administrator;

18.1.2.3 a person, including a legal person, associated with the administrator of the Scheme or of any controlling or subsidiary company of the administrator;

18.1.2.4 the principal officer of the Scheme;

18.1.2.5 a director, employee, partner, representative or agent of any actuary, consultant, broker or intermediary of the Scheme or of any controlling or subsidiary company of any actuary, consultant, broker or intermediary of the Scheme;

18.1.2.6 a person, including a legal person, associated with any actuary, consultant, broker or intermediary of the Scheme or of any controlling or subsidiary company of any actuary, consultant, broker or intermediary of the Scheme;

18.1.2.7 the auditor of the Scheme;

18.1.2.8 A broker.

18.1.3 Nomination, election and removal of trustees shall take place according to the procedures set out in these Rules.

18.1.4 Persons referred to in rules 18.1.2.5 or 18.1.2.6 may be co-opted to assist the Board in terms of rules 18.7.6 or a committee of the Board in terms of rule 20.3.

18.2 Member elected trustees

18.2.1 At least half of the total number of trustees must be members elected by members to serve terms of office of 3 (three) years each (member elected trustees) provided that if the number of member elected trustees shall fall below the number of employer nominated trustees as a result of resignations or disqualification or as a result of a poll in terms of rule 28.8.2, the remaining members of the Board shall validly continue to hold office until such time as an election is held to successfully replace the resigned or disqualified member elected trustees.

18.2.2 Retiring members of the Board are eligible for re-election.

18.2.3 Nominations to fill vacancies for member elected trustees must be submitted to the Scheme:

18.2.3.1 No later than 7 days prior to the date of the meeting in respect of elections to be held at the next annual general meeting, or

18.2.3.2 by the due date specified in the notice of a special general meeting called in terms of rule 28.8.2.3.1 or rule 28.8.2.3.3.

18.2.4 A nomination for a candidate to be an member elected trustee must contain the following:

18.2.4.1 The name, membership number and signature of the member making the nomination indicating that he is so doing;

18.2.4.2 The name, membership number and signature of the member seconding the nomination indicating that he is so doing;

18.2.4.3 The name, membership number and signature of the member being nominated as candidate for election, indicating that he is not ineligible to serve nor disqualified from serving as a trustee and that he is willing to stand for election.

18.2.5 If any of the members signing the aforementioned nomination, be he proposer, seconder or candidate, is more than one month in arrears with contributions at the date that the nomination form is lodged with the Scheme, such nomination shall be void.

18.2.6 Except as provided for in rules 18.4.1.1 and 28.8.2.3 the election for member elected trustees must be carried out by the members present and entitled to vote at the annual general meeting of members of the Scheme.

18.2.7 Trustees elected by members shall serve as such until the third annual general meeting succeeding their election.

18.3 Employer nominated trustees

18.3.1 The balance of trustees shall be nominated by employers to serve terms of office of 3 (three) years each (employer nominated trustees).

18.3.2 Retiring employer nominated trustees are eligible for re-nomination.

18.3.3 Employer nominated trustees need not be members of the Scheme nor employees of the employer making the nomination, provided that, where the nominee is neither an employee of the nominating employer nor a member of the Scheme, such nomination shall be subject to the approval and acceptance of the Board .

18.3.4 Candidates for the position of employer nominated trustees shall be nominated by employers either verbally or in writing provided that an employer whose employee members are more than one month in arrears with contributions shall not be entitled to make such a nomination. An employer shall not be entitled to nominate more than one trustee at one time nor shall an employer be entitled to nominate a new trustee while one of its previous nominees is serving on the Board.

18.3.5 Any candidate nominated by an employer shall, be immediately deemed to be elected and shall immediately serve as a member of the Board, provided that he is not ineligible to serve as a trustee in terms of rule 18.1.2 nor disqualified from serving in terms of rule 18.6.4 and provided further that the total number of employer nominated trustees shall not exceed the number of member elected trustees.

18.3.6 In the event that a nomination is received, which, if accepted, would result in the number of employer nominated trustees exceeding the number of member elected trustees, such nomination shall be deferred until a vacancy arises amongst employer nominated trustees.

18.3.7 In the event that the number of employer nominated trustees exceeds the maximum number of employer nominated vacancies, then the Scheme shall conduct a postal poll amongst employers to determine which of the nomination(s) shall be successful.

18.3.8 In conducting the poll the Scheme shall post to each employer by ordinary mail:

18.3.8.1 the names of the candidates together with an abridged curriculum vitae for each candidate;

18.3.8.2 the number of vacancies;

18.3.8.3 a poll form setting out the procedure to be adopted for voting and the deadlines and procedures to be followed for submission of the completed poll form to the Scheme;

18.3.8.4 if the employer is ineligible to vote in terms of rule 18.3.11, a note specifying that this is so.

18.3.9 The poll forms shall be posted to employers at least 14 (fourteen) days before the deadline specified for submission of completed poll forms.

18.3.10 Each employer shall have a number of votes per vacancy equal to the number of his employees who are registered as members of the Scheme on the first day of the calendar month immediately preceding the deadline for submission of completed poll forms.

18.3.11 Any employer whose employee members are more than one month in arrears with contributions at the date of the deadline for submission of completed poll forms shall be ineligible to vote in the poll.

18.3.12 Neither a delay or *bona fide* error in the (de)registration of employees' membership nor non-receipt of the poll form by an employer shall invalidate the poll.

18.4 Void in the Board

18.4.1 In the event that there should be no Trustees at all ("void in the Board"), or in the circumstances postulated in rule 28.8.2.3, the principal officer shall immediately:

18.4.1.1 convene a special general meeting to be held within 60 (sixty) days to conduct an election and shall in the notice thereof specify a deadline for submission of nominations for candidates to be elected as member elected trustees, and

18.4.1.2 circulate a notice to employers calling for nominations for candidates to become employer nominated trustees and any persons nominated pursuant to this circular shall serve as an interim Board until the conclusion of an election held pursuant to rule 18.4.1.1 above.

18.5 Casual vacancies in the Board

18.5.1 The Board may fill by co-option and appointment any casual vacancy (whether in respect of member elected trustees or in respect of employer nominated trustees) which occurs during its term of office.

18.5.2 In the case of the appointment of a replacement for a member elected trustee, the replacement must be a member of the Scheme and must retire at the first ensuing annual general meeting, but shall be eligible for nomination as a candidate for re-election.

18.5.3 In the case of the appointment of a replacement for an employer nominated trustee, the replacement trustee shall serve for the unexpired period of office of the vacating member of the Board.

18.6 Termination of office

18.6.1 A member of the Board may resign at any time by giving written notice to the Board.

18.6.2 All member elected trustees cease to hold office if so decided by a poll of members pursuant to the provisions of rule 28.8.2.

18.6.3 All employer nominated trustees cease to hold office if so decided by a poll of employers pursuant to the provisions of rule 28.8.2.

18.6.4 A member of the Board ceases to hold office and any nominee shall be disqualified from serving on the Board if —

18.6.4.1 he is or becomes mentally incompetent or incapable of managing his affairs;

18.6.4.2 he is not permanently resident in the Republic of South Africa;

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

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

18.6.4.5 he has been or is removed by the court from any office of trust on account of misconduct;

18.6.4.6 he has been or is disqualified under any law from carrying on his profession;

18.6.4.7 subsequent to his becoming a trustee, his status changes to that of a person ineligible to serve as a member of the board in terms of rules 18.1.2.2 to 18.1.2.7;

18.6.4.8 he is an employer nominated trustee and the participating employer who nominated him requests his withdrawal, or being an member elected trustee, he ceases to be a member of the Scheme;

18.6.4.9 he absents himself from three consecutive meetings of the Board without the permission of the chairperson of the Board;

18.6.4.10 he is removed from office by Council in terms of section 46 of the Act.

18.7 Functioning of the Board

18.7.1 Half of the members of the Board physically/and or virtually present, plus one is a quorum at meetings of the Board and shall not include suspended Board members. **[Amended with effect from 1 January 2021]**

18.7.2 The Board must elect from its number a chairperson and vice-chairperson.

18.7.3 In the absence of the chairperson and vice-chairperson at any meeting of the Board, the Board members present must elect one of their number to preside over the meeting.

18.7.4 Matters 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.

18.7.5 The Board must meet at such intervals as are necessary for it to fulfill its duties in terms of these rules. These meetings can take place physically or virtually. **[Amended with effect from 1 January 2021]**

18.7.6 The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.

18.7.7 The chairperson may convene a special meeting of the board should the necessity arise. Any 2 (two) 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.

18.7.8 The Board may discuss and resolve matters by telephone or electronic conferencing means and may adopt resolutions on that basis provided that all members of the Board are consulted and agree to such a resolution.

18.7.9 Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as trustees. Remuneration will only be paid in respect of the Board members holding office and attendance at Board meetings. No remuneration will be payable to Board members in respect of consulting work done, or the attendance of seminars or conferences. **[Amended with effect from 1 January 2015]**

18.7.10 The Independent Remuneration Committee shall recommend on any remuneration to be paid to members of the Board and the Principal Officer. Any remuneration paid to any member of the Board shall be approved, in advance by members at the Annual General Meeting of the Scheme. Remuneration paid to the Board members shall be disclosed in the annual financial statements to be laid before each annual general meeting. **[Amended with effect from 1 January 2015]**

19. DUTIES OF BOARD OF TRUSTEES

19.1 The Board is responsible for the proper and sound management of the Scheme in terms of these rules and the Act and regulations.

19.2 The Board must act with due care, diligence, skill, and in good faith and must take all reasonable steps to ensure that the interests of members and dependants in terms of these rules and the Act and regulations are protected at all times.

19.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board and shall act with impartiality in respect of all members and dependants.

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

19.5 The Board shall appoint a principal officer who is fit and proper to hold such office and shall within 30 (thirty) days of such appointment give notice thereof in writing to the Registrar. The Board may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the principal officer and of any person employed by the Scheme. The principal officer shall be responsible for managing the day to day affairs of the Scheme. **[Amended with effect from 1 January 2015]**

19.6 Subject to the provisions of Item 6 of Schedule 2 to the Act, the provisions of rules 18.1.2, 18.6.4 and 19.19 apply *mutatis mutandis* to the principal officer.

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

19.8 The Board must ensure that proper minutes, accounts, entries, registers, books and records of all operations of the Scheme are kept and that proper minutes are kept of all resolutions passed by the Board.

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

19.10 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.

19.11 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.

19.12 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance in such amount as the Board may determine, subject to the provisions of the Act and regulations.

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

19.14 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.

19.15 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any member's or dependant's state of health.

19.16 The Board must approve all disbursements.

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

19.18 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.

19.19 A member of the Board or of its staff or any person attending meetings of the Board shall not disclose any information relating to the affairs of the Board except for the purposes of the performance of his duties or the exercise of his powers in terms of these rules or the Act or regulations or any other law or when required to do so under any law before a court of law.

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

19.21 The Board must disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme as prescribed.

19.22 It is incumbent upon the Board to at all times remain independent and objective of the day to day management of the Scheme with this function being delegated to the principal officer and staff of the Administrator. **[Added with effect from 1 January 2015]**

20. POWERS OF BOARD

The Board at its sole discretion has the power, without the approval of members:

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 contracts binding the Scheme and to ensure and secure the due fulfillment of the Scheme's obligations under such contracts;

20.3 to appoint committee(s) consisting of such Board members and other experts as it may deem appropriate;

20.4 to enter into agreements with service providers;

20.5 to appoint accountants, consultants, legal and medical experts on such terms and conditions as it may determine;

20.6 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;

20.7 to appoint an actuary to the Scheme on such terms and conditions as it may determine;

20.8 to appoint, compensate and contract with any accredited broker for the introduction or admission of a member to the Scheme; and for ongoing broker services subject to the provisions of the Act and the Regulations thereto provided that a broker contract with an accredited broker will not be unreasonably withheld.

20.9 to contract with and compensate any accredited managed health care organisations subject to the provisions of the Act;

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

20.11 to let or hire movable or immovable property;

20.12 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 monies upon security and to realise, re-invest or otherwise deal with such monies and investments;

20.13 subject to prior approval of the Council or subject to such directives as the council may issue, 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;

20.14 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;

20.15 to donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or some of the members or dependants;

20.16 to grant repayable loans to members or to make *ex gratia* payments on behalf of members in order to assist such members to meet commitments in regard to any matter specified in Rule 5;

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

20.18 to reinsure obligations in terms of the benefits provided for in these rules provided that Sections 20 (2) to 20(7) of the Act are fully complied with;

20.19 to authorise the principal officer and/or such members of the Board as it may determine from time to time, 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;

20.20 to contribute to any association that is instituted for the furtherance, encouragement and co-ordination of medical schemes registered under the Act;

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

21. DUTIES OF PRINCIPAL OFFICER AND STAFF

21.1 The staff of the Scheme must ensure the confidentiality of all information regarding its members.

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

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

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

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

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

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

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

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

21.4 The principal officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Board and the Scheme and any other duly appointed committee where his attendance may be required and shall ensure proper recording of the proceedings of all meetings.

21.5 The principal officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

21.6 The principal officer shall keep full and proper records of all monies received and expenses incurred by the Scheme and of all assets, liabilities and financial transactions of the Scheme.

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

21.8 The following persons are not eligible to be a principal 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 The provisions of rules 18.6.4.1 to 18.6.4.6 apply *mutatis mutandis* to the principal officer.

22. INDEMNIFICATION & 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.

23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the 1st January to the 31st December of each year.

24. BANK ACCOUNT

The Scheme must establish and maintain a bank account under its direct control with a registered commercial bank. All monies received must be deposited directly to the credit of such account. 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 & AUDIT COMMITTEE

25.1 An auditor (who must be approved by the Registrar 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 No person shall be appointed as auditor who is:

25.2.1 a member of the Board;

25.2.2 otherwise engaged as 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 its administrator;

25.2.4 not engaged in private practice as an auditor;

25.2.5 disqualified from acting as an auditor in terms of section 275 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 (thirty) days appoint another auditor to fill the vacancy for the unexpired period which appointment must be approved by the Registrar in terms of section 36 (2) of the Act;

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 (thirty) 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 the annual general meeting.

25.7 The auditor must, in the performance of his duties, comply with section 36 of the Act.

25.8 The Board must appoint an audit committee in the prescribed manner.

26. GENERAL MEETINGS OF MEMBERS

26.1 Annual general meeting

The annual general meeting of members must be held not later than 30th June of each year to:

26.1.1 elect member elected Trustees;

26.1.2 receive the report of the Board and the annual financial statements of the Scheme as approved by the Board;

26.1.3 receive the report of the auditor of the Scheme;

26.1.4 reappoint or appoint the auditor of the Scheme;

26.1.5 consider any motions duly proposed.

26.2 Special general meeting

26.2.1 The Board may call a special general meeting of members if it deems it necessary or if required to do so in terms of these rules.

26.2.2 The Board shall call a special general meeting within 60 days for the purpose of an election if the number of member elected trustees falls below half of the total number of trustees.

26.2.3 The principal officer shall call a special general meeting of members in the circumstances set out in rule 18.4.1.

26.2.4 On the requisition of at least 15 (fifteen) 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.

26.2.4.1 The requisition must be deposited at the registered office of the Scheme and must state the objects of the meeting and proposed motions in terms of rule 28.8.1.2. Each of the requisitioning members shall include his name and membership number and signature.

26.2.4.2 The name of any member whose contributions are more than one month in arrears at the date the requisition is lodged shall be struck from the requisition and motion and if this should result in fewer than 15 (fifteen) requisitionists remaining then the meeting shall not be called.

27. RIGHTS TO ATTEND, SPEAK AND VOTE

27.1 Every member who is present at a general meeting of members of the Scheme and whose contributions are not more than one month in arrears, has the right to speak and vote or may, subject to this rule, appoint another member of the Scheme whose contributions are not more than one month in arrears, 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.

27.3 The proxy shall be lodged with the Scheme at least 7 (seven) weekdays before the relevant meeting.

27.4 A member whose contributions are more than one month in arrears has the right to receive notice of and to attend a general meeting of members of the Scheme but shall not be entitled to speak nor vote nor act as proxy for any other member nor shall he be entitled to appoint a proxy to attend or vote on his behalf.

27.5 A member whose benefits or membership have been suspended shall not be entitled to receive notice of nor to attend a general meeting of members of the Scheme.

28. CONDUCT OF MEETINGS

28.1 Calling of meetings

28.1.1 A meeting of members of the Scheme may only be called:

28.1.1.1 by the Board or

28.1.1.2 by the principal officer in the circumstances set out in these rules.

28.1.2 Any meeting of members called or convened by any other person shall be void.

28.2 Notice of meetings

28.2.1 Any notices of meetings of members shall be in writing and shall contain at least the following information:

28.2.1.1 the date, time and place of the proposed meeting;

28.2.1.2 the agenda for the meeting;

28.2.1.3 minutes of the previous meeting of members of the Scheme;

28.2.1.4 the form of proxy prescribed by the Board;

28.2.1.5 in the case of the annual general meeting:

28.2.1.5.1 A comprehensive summary of the annual financial statements, together with notification of availability of the full documentation as specified in this rule. The annual financial statements shall consist of a balance sheet dealing with the state of affairs of the Scheme, an income statement, a cash flow statement, management accounts in respect of every benefit option offered by the Scheme indicating the financial performance thereof and the number of members enrolled per option, and the report by the auditor of the Scheme.
[Amended w.e.f. 1 September 2007]

28.2.1.5.2 a report of the Board which shall *inter alia* deal with every matter which is material for the appreciation by members of the state of affairs and the business of the Scheme and the results thereof, and relevant information indicating whether or not the resources of the Scheme have been applied economically, efficiently and effectively;

28.2.1.5.3 The full and complete financial statements specified in rule 28.2.1.5.1 shall be available for inspection at the Schemes' offices at least 21 days before the date of the meeting and shall be sent to any member requesting a copy thereof. The financial statements and report specified in rules 28.2.1.5.1 and 28.2.1.5.2 shall be laid before the meeting.

28.2.2 Any motions proposed for the meeting may but are not required to be included with the notice of the meeting provided that the issue raised by the motion appears with sufficient particularity on the agenda.

28.2.3 In the event of a *bona fide* error resulting in the omission from the notice of any information other than the agenda, date, time and place of the proposed meeting, the Board may distribute the information at the meeting, provided that the chairperson shall, if so requested by any member present, allow the attending members reasonable time to peruse and study the information prior to any discussion in respect thereof. Within 14 (fourteen) days after the meeting a copy of the information distributed at the meeting shall be sent by post to all members of the Scheme.

28.2.4 A notice of a meeting of members may be given:

28.2.4.1 by the Board, or

28.2.4.2 by the principal officer if authorised so to do by the Board or if there is a void in the Board, or

28.2.4.3 by the administrator of the Scheme acting on the instructions of the Board or the principal officer,

28.2.5 The notice shall not be required to specify that the Board or principal officer has authorised the notice.

28.2.6 Notice to a member shall be deemed to have been validly given if:

28.2.6.1 such notice is posted to the member's address in the Republic of South Africa as recorded in the records of the Scheme, or

28.2.6.2 in the absence of such a residential address being recorded in the records of the Scheme, such notice is posted to the member *care of* his Employer, or

28.2.6.3 such notice is electronically submitted to the members at the email address used for daily communication, or (Amended as from 1 May 2013)

28.2.6.4 Such notice is prominently displayed on the notice board of the employer (Amended as from 01 May 2013)

28.2.6.5 the member attends the meeting despite not having received notice thereof.

28.2.7 Notice of a meeting shall be posted to members at least 14 (fourteen) days before the date of a special general meeting and at least 21 (twenty-one) days before the date of an annual general meeting.

28.2.8 Periods of notice shall be computed by including the day of posting of the notice of the meeting but excluding the day of the meeting.

28.2.9 The non-receipt of a notice by a member does not invalidate the proceedings at a meeting.

28.3 Attendance at meetings

The following persons shall be permitted to attend and participate in meetings of the Scheme:

28.3.1 subject to the provisions of rule 27.5, all members of the Scheme, and

28.3.2 the curator or guardian of a member, and

28.3.3 the proxy of a member, and

28.3.4 members of the Board, and

28.3.5 the principal officer and the person appointed by the principal officer in terms of rule to take minutes of the meeting, and

28.3.6 at the request of the Board, the administrator, knowledgeable persons and experts co-opted or appointed by the Board in terms of the rules, and

28.3.7 in the case of the annual general meeting, the auditors of the Scheme;

provided that only members of the Scheme and/or their proxies shall be entitled to vote.

28.4 Attendance register

28.4.1 The Board may require all persons attending a meeting of members of the Scheme to sign the attendance register;

28.4.2 The Board shall keep a record of all proxies lodged with the Scheme in respect of the meeting.

28.5 Quorums and inadequate facilities

28.5.1 At the annual general meeting of members of the Scheme, a number of members of the Scheme present in person as well as members attending virtually, should comprise of at least twice the number of Board members present plus one member, 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 2 (two) or more members then present shall constitute a quorum. **[Amended with effect from 1 January 2021]**

28.5.2 At a special general meeting of members of the Scheme, a number of members of the Scheme present in person as well as members attending virtually, should comprise of at least twice the number of Board members present plus one member, shall constitute a quorum. If a quorum is not present at a special general meeting after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting shall be cancelled. **[Amended with effect from 1 January 2021]**

28.5.3 Both members present in person or attending virtually shall be counted in determining whether or not a quorum is present - members represented by proxy shall not be included in such a count; **[Amended with effect from 1 January 2021]**

28.5.4 Once a meeting has commenced with a valid quorum the departure or walking-out of members shall not invalidate the quorum nor subsequent proceedings and the meeting shall be deemed to have a quorum for so long as at least 2 (two) members remain present.

28.5.5 In the event that there is inadequate seating for all attendees at a meeting of members the chairperson may make whatever *ad hoc* arrangements he deems necessary to accommodate the attendees and proceed with the meeting with reasonable expedition and may delay the start of the meeting for up to 30 (thirty) minutes so to do. Such *ad hoc* arrangements may include the request that some or all attendees be requested to sit on tables or stairs or to stand.

28.5.6 If, notwithstanding such endeavours, it remains impossible to accommodate all attendees, the chairperson may delay the start of the meeting for up to a further 30 (thirty) minutes in order to arrange better facilities which shall be within 2 (two) kilometers of the original venue. The chairperson shall then allow attendees a final 30 (thirty) minutes to make their way to the new venue.

28.5.7 If the chairperson is unable to make satisfactory arrangements within the time allowed, the meeting shall be postponed to the same time originally scheduled for 7 (seven) days hence, provided that if this should not fall on a weekday, the meeting shall be held on the next succeeding weekday, and:

28.5.7.1 attendees at the original venue shall be required to provide a contact telegraphic address, or a facsimile telephone number or an e-mail address where they may be given notice of the new venue;

28.5.7.2 the Board shall arrange a suitable venue for the postponed meeting;

28.5.7.3 the Board shall dispatch details of the new venue to the addresses provided by the attendees at least 48 (forty eight) hours prior to the scheduled time that the postponed meeting is due to start.

28.6 Determination of chairperson of meetings

28.6.1 The chairperson to preside over the meeting shall, in order of precedence, be:

28.6.1.1 the chairperson of the Board or, in his absence, the vice-chairperson of the Board;

28.6.1.2 if neither the chairperson nor the vice-chairperson of the Board is present the trustee nominated by the members of the Board that are present;

28.6.1.3 if only one trustee is present, that trustee;

28.6.1.4 if no trustees are present the principal officer;

28.6.1.5 if neither the principal officer nor any trustee is present then the person elected by the members present;

28.6.2 If any person entitled to preside declines to do so then the above sequence shall be continued or repeated to determine the chairperson to preside.

28.6.3 If the chairperson recuses himself from the chair during the meeting then the above sequence shall be repeated to determine the chairperson to preside during the period of such recluse.

28.6.4 A member shall not be entitled to object to the appointment of the chairperson correctly nominated to preside according to the above procedure, but may call for the chairperson to recluse himself from the chair during the time that a question to be put to the meeting involves the chairman in a conflict of interest, provided that the decision whether or not to recluse shall be the chairperson's alone and shall not be subject to a vote of members.

28.6.4.1 Any member aggrieved by the chairperson's refusal to recluse himself shall be obliged to refer his grievance to the disputes committee of the Scheme prior to being entitled to take any other action.

28.7 Duties and powers of the chairperson

28.7.1 Immediately upon taking the chair the chairperson shall determine that the procedure set out in rule 28.6 has been correctly followed.

28.7.2 If the procedure has not been correctly followed the chairperson shall step down in favour of the correct nominee.

28.7.3 The chairperson shall then determine whether there is a quorum – in the absence of a quorum, he shall:

28.7.3.1 In the case of an annual general meeting, consult the members of the Board present and postpone the meeting to a later date and time as provided for in rule 28.5.1;

28.7.3.2 In the case of all other meetings of members, declare the meeting null and void.

28.7.4 If there is a quorum, the chairperson shall declare the meeting duly constituted and shall proceed to conduct the meeting.

28.7.5 The chairperson shall then read any rulings on motions duly delivered to the Scheme that are void or *ultra vires* the Rules and that have been excluded from the agenda.

28.7.5.1 Any member aggrieved by such a ruling shall be entitled to obtain a written copy of such rulings, but shall be obliged to refer his grievance to the disputes committee of the Scheme prior to being entitled to take any other action.

28.7.6 The chairperson in his sole and absolute discretion may vary the order in which items on the agenda are placed before the meeting but shall ensure that all items on the agenda are dealt with.

28.7.7 The chairperson shall determine the order and precedence of speakers and may restrict any member to speaking only once on any question before the meeting.

28.7.8 The chairperson shall apply his mind to points of order and procedure raised by members and shall give rulings on same. In so doing, the chairman may, but shall not be obliged to, call for assistance and advice from knowledgeable persons present at the meeting.

28.7.9 The chairperson may prohibit a member from repeatedly raising the same points of order or procedure, provided that the chairman shall warn the member at least 3 (three) times that he may take such action if the member persists. A member so prohibited shall not thereafter be permitted to speak except on the substance of any questions before the meeting.

28.7.10 The chairperson may remove or cause the removal of any disorderly person from the meeting, provided that the chairman has warned the member at least (3) three times that he may take such action if the member persists and that the chairperson has requested the person to leave voluntarily. The chairperson may adjourn the meeting for the reasonable time needed in order to effect such removal.

28.7.11 The chairperson may limit speakers to a reasonable period of time to address any question before the meeting and may stipulate the maximum time any speaker shall be allowed. Where in the opinion of the chairman, a person is exceeding or appears to be destined to exceed the allowed time, the chairman may give 2 (two) minutes notice of his intention to end the speaker's turn and after the elapse of 2 (two) minutes, order the speaker to stop.

28.7.12 The chairperson may adjourn the meeting;

28.7.12.1 to tally the results of a ballot or poll, or

28.7.12.2 where there is a serious disruption or prevailing disorder.

28.7.13 The chairperson shall postpone the meeting where required to do so in terms of rules 28.5.1 and 28.5.7 and may delay the start of the meeting in terms of rule 28.5.5 and 28.5.6.

28.7.14 The chairperson shall dissolve the meeting once all items on the agenda have been dealt with.

28.8 Motions

28.8.1 A member may propose motions to be placed before the annual general meeting by lodging the motion in writing at the registered office of the Scheme on or before the 31st March. The member shall include his name, membership number and signature with the motion.

28.8.1.1 A motion lodged by a member whose contributions are more than one month in arrears at the date the motion is lodged shall be void and shall not be placed on the agenda.

28.8.1.2 Where members requisition a special general meeting in terms of rule 26.2.4 they shall simultaneously with the requisition for such a meeting lodge at the registered office of the Scheme their proposed motion(s) to be placed before the special general meeting. At least 15 (fifteen) of the requisitioning members shall include their names, membership numbers and signatures with the motion.

28.8.2 A no-confidence motion or any motion proposing the removal of the member elected trustees and/or the employer nominated trustees shall take the form of a motion to call for a poll of all members and/or all employers, as the case may be:

28.8.2.1 if such a motion is passed by a majority in a poll of members in general meeting, then the Board shall within 21 (twenty one) days initiate a poll of all registered members and/or all employers as the case may be and complete the poll within 42 (forty two) days;

28.8.2.2 in such a poll,

28.8.2.2.1 members may vote for or against the removal of all of the member elected trustees and each member shall have one vote, and

28.8.2.2.2 employers may vote for or against the removal of all of the employer nominated trustees and each employer shall have a number of votes equal to the number of his employees who are registered as members of the Scheme on the first day of the calendar month preceding the date on which polling closes;

28.8.2.3 in the poll,

28.8.2.3.1 if more than 50 (fifty) per cent of the members return duly completed poll forms voting in favour of the removal of the member elected trustees, then all the member elected trustees shall immediately cease to hold office and the principal officer shall immediately call a special general meeting as contemplated in rule 18.4.1.1;

28.8.2.3.2 if employers return duly completed poll forms voting in favour of the removal of the employer nominated trustees in numbers exceeding 50 (fifty) per cent of the number of members eligible to vote, then all of the employer nominated trustees shall immediately cease to hold office and the principal officer shall immediately call for new employer nominations in the manner set out in rule 18.4.1.2.

28.8.2.3.3 if more than 50 (fifty) per cent of the members return duly completed poll forms voting in favour of the removal of the member elected trustees, and employers return duly completed poll

forms voting in favour of the removal of the employer nominated trustees in numbers exceeding 50 (fifty) per cent of the number of members eligible to vote, then all of the trustees shall immediately cease to hold office and the principal officer shall immediately proceed as contemplated in the whole of rule 18.4.

28.8.3 A member shall not be permitted to submit to the Scheme any substantive motion seeking to interfere with or usurp the functions, duties or powers of the Board. Any such motion shall be ruled by the chairperson to be *ultra vires* these rules; it shall not be included on the Agenda of any meeting of members nor may it be proposed from the floor at any meeting of members of the Scheme.

28.8.4 At any meeting of members of the Scheme, any member may propose any of the following motions:

28.8.4.1 a motion to amend the motion before the meeting, which if adopted shall cause the main motion to lapse, provided that such a motion may not substantially change the substance of the main motion;

28.8.4.2 a motion to refer (to a committee or smaller group of persons);

28.8.4.3 a motion to limit debate, provided that such a motion shall require a 2/3rds (two thirds) majority in order to be adopted;

28.8.4.4 a motion to close debate, provided that the chairperson shall not permit such a motion to be put before the meeting unless, in his opinion, the views of members have been sufficiently heard;

28.8.4.5 a motion to proceed to the next business which, if adopted, shall cause the main motion to lapse;

28.8.4.6 a motion that the question lie on the table which, if adopted, shall require the meeting to proceed to the next item on the agenda but shall not prevent the meeting from reverting to the motion later in the meeting;

28.8.4.7 a motion to adjourn provided that the chairperson may decline to place such a motion before the meeting.

28.8.5 A substantive question which has been placed before the meeting shall not be withdrawn prior to a vote without the consent of the proposer, or in the case of joint proposers, all of the proposers.

28.8.6 The following motions shall not be permitted to be proposed from the floor at a meeting of members of the Scheme:

28.8.6.1 a motion to amend or rescind a resolution already adopted at the same meeting;

28.8.6.2 a substantive motion not contained in the agenda.

28.9 Points of Order

28.9.1 At any meeting of members of the Scheme, any member may propose any of the following motions on points of order:

28.9.1.1 any point of order relating to the improper procedure or conduct of the meeting;

28.9.1.2 that there is no quorum;

28.9.1.3 that a motion or amendment is not within the scope of the meeting;

28.9.1.4 that there is no motion before the meeting;

28.9.1.5 that legal requirements or laws are being violated.

28.9.2 An appeal against a ruling by the chairperson shall not be permitted except on the grounds that he has not applied his mind to the ruling in which case the chairperson shall reconsider his ruling. The decision then given shall be final for the purposes of that meeting and until it is reversed as a result of an aggrieved member referring same to the disputes committee or thereafter to higher authority .

28.9.3 Any member aggrieved by such a final ruling shall be entitled to refer his grievance to the disputes committee of the Scheme.

28.10 Voting

28.10.1 Except in the case of a motion proposing a poll for the removal of the Board, voting on all questions before meetings of members of the Scheme shall be by a show of hands. Voting at a meeting on a question calling for a poll of all members and/or employers for the removal of trustees shall be by a poll.

28.10.1.1 On a show of hands every member present shall have one vote and the chairperson shall (subject to rule 28.3) have a casting vote in addition to his deliberative vote.

28.10.1.2 Once voting has been completed, the chairperson shall declare the result of voting.

28.10.1.3 Any member may immediately challenge the result and call for either a ballot or poll, in which case the voting shall be by ballot or poll, as the case may be, provided that a call for a poll shall take precedence over a call for a ballot.

28.10.1.4 A member shall not be permitted to call for a poll after a ballot has commenced or has been completed.

28.10.2 On a ballot each member present shall be required to complete an anonymous ballot form indicating how he votes and shall hand it to the chairperson.

28.10.3 On a poll each member present shall be required to complete a poll form indicating:

28.10.3.1 his name,

28.10.3.2 how he votes,

28.10.3.3 number of proxies held,

28.10.3.4 how he votes his proxies (which must be in accordance with any instructions included on the proxy form lodged with the Scheme prior to the meeting),

and shall sign the poll form and hand it to the chairperson.

28.10.4 Once the completed ballot or poll forms are received by the chairperson he may adjourn the meeting for the reasonable time required to tally the result.

28.10.5 Upon resumption of the meeting the chairperson shall declare the result which shall be final.

28.10.6 All resolutions of members shall be adopted by a simple majority except where otherwise stipulated in these rules.

28.10.7 In the event of an equality of votes the chairperson shall first declare that this is so and then subject to rule 28.3 use his casting vote to determine the result.

28.11 Minutes

28.11.1 The principal officer shall appoint a person to take minutes at every meeting of members the Scheme.

28.11.2 The minutes may be as comprehensive as specified by the Board, but shall contain at least a record of all resolutions passed at a meeting.

28.11.3 Minutes of a meeting shall be distributed with the notice of the next directly ensuing meeting of members of the Scheme.

28.11.4 At the next meeting any member who attended the previous meeting and who requires amendments in respect of the correctness of the minutes as a true reflection of the previous meeting may propose a motion from the floor with the proposed corrections, which, if adopted, shall be incorporated in the minutes. The minutes shall then be confirmed and signed by the chairperson.

28.11.5 The Board at its sole discretion may arrange for proceedings at meetings of members to be recorded by electronic means but shall not be obliged to do so irrespective of whether or not same is demanded by a member.

28.11.6 Any member wishing to make electronic recordings of meetings of members may do so provided that:

28.11.6.1 he obtains the written consent of the Board at least 7 (seven) days prior to the meeting, which consent shall not be unreasonably withheld;

28.11.6.2 he shall at his own expense make the necessary arrangements at the venue of the meeting for the provision and set-up of any power, tables, cabling or other special equipment or requirements;

28.11.6.3 the set-up of such power, tables, cabling or other special equipment or requirements is completed at least 30 (thirty) minutes prior to the time scheduled for the meeting;

28.11.6.4 the chairperson of the meeting shall not be required to delay or disrupt the meeting in any way as a result of such arrangements;

28.11.6.5 in the event of the recording process causing any disruption whatsoever at the meeting the chairperson may order that such recording cease immediately.

29. COMPLAINTS AND DISPUTES

29.1 COMPLAINTS

29.1.1 The Scheme or its administrators shall provide a dedicated telephone number, which may be used by members for lodging telephonic complaints.

29.1.2 Members may lodge their complaints, in writing, to the Scheme.

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

29.2 DISPUTES

29.2.1 A disputes committee of three knowledgeable persons, who shall not be members of the Board, employees or officers of the Scheme or the administrator, must be appointed by the Board annually. At least 1 (one) of such members shall be a legal practitioner.

29.2.2 Any dispute, which may arise between a member, prospective member or a former member and the Scheme, the Board, any member of the Board or an officer of the Scheme, may be submitted in writing by the aggrieved member and submitted by hand or sent by registered post, addressed to the "Disputes committee, Suremed Health" at the registered address of the Scheme and shall be referred by the principal officer to the disputes committee for adjudication. Such notice of dispute shall contain a comprehensive and detailed exposition of the complaint. The aggrieved member shall be bound to the contents of his notice of dispute and shall not be allowed to add new facts thereto after same has been submitted.

[Amended w.e.f. 1 January 2008]

29.2.2.1 If the matter is urgent and would otherwise give rise to an immediate legal application, the member shall contact the principal officer or any member of the Board and arrange for his written dispute to be submitted by hand or by facsimile or by electronic mail ("e-mail") and shall specify in his complaint that he is prepared to waive written notice and that he agrees to 7 (seven) days notice of a hearing as provided for in rule 29.2.5. The recipient shall then cause the written dispute to be delivered to the principal officer by the most expeditious means available. The principal officer shall immediately advise the member in writing that he has received the dispute. The member shall ensure that he receives such confirmation as proof of receipt by the Scheme.

29.2.3 On receipt of a dispute in terms of this rule the principal officer must convene a meeting of the disputes committee to hear and adjudicate the dispute and shall determine the date, time, and venue of such hearing.

29.2.3.1 The principal officer shall give not less than 21 (twenty-one) days notice in writing to the complainant, the party complained against and all the members of the disputes committee,

stating the date, time, and venue of the hearing and particulars of the dispute. Such notice shall include the full notice of dispute submitted by the aggrieved member to enable the other parties to prepare for the hearing.

29.2.4 Within 14 (fourteen) days of receipt of such notice of dispute the party complained against shall deliver to the principal officer a comprehensive reply to all points of dispute raised by the aggrieved member and the principal officer shall ensure that the aggrieved member and each member of the disputes committee receive a copy thereof within 24 (twenty four) hours of the receipt of such reply.

29.2.5 If the matter is urgent as set out in rule 29.2.2.1, the principal officer shall convene the hearing within 7 (seven) days of receipt of the dispute and the party complained against shall deliver the reply set out in rule 29.2.4 above to the hearing.

29.2.6 The disputes committee shall determine the procedure to be followed at the hearing.

29.2.7 All parties to any dispute shall have the right to be heard at the hearing, either in person or through or with the assistance of a legal representative.

29.2.8 The disputes committee shall make a decision as soon as possible and in any event within 7 (seven) days of the hearing and shall advise all parties to the dispute in writing of their decision and their reasons.

29.2.9 An aggrieved party has the right in terms of section 48 of the Act to appeal to Council against the decision of the Scheme in respect of a complaint to the Scheme or against a 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 or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.

29.2.10 The operation of any decision which is the subject of an appeal under rule 29.2.9 shall be suspended pending the decision of the Council on such appeal.

30. TERMINATION OR DISSOLUTION

30.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution in terms of section 64 of the Act.

30.2 Members in a poll of members at a general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by a poll as set out below whether the Scheme must be liquidated. The Scheme must be liquidated in terms of section 64 of the Act if the majority of members so decide.

30.3 Pursuant to a decision by members taken in terms of rule 30.2 the principal officer must 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 a voluntary dissolution, together with a poll paper.

30.4 Every member must be requested to return his poll paper duly completed before a set date. If at least 50 (fifty) per cent of the members return their poll papers duly completed in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint a competent person as liquidator which appointment is to be approved by the Registrar.

30.5 The liquidator must proceed with the liquidation and comply with the Act and, more specifically, section 64 thereof.

30.6 Any surplus remaining in the estate of the Scheme, after the payment of the costs of the dissolution and all creditors of the Scheme, shall be distributed to members as at the day of the dissolution, pro-rata to each member's monthly contribution to the Scheme at the date the dissolution commenced.

31. AMALGAMATION AND TRANSFER OF BUSINESS

31.1 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 from any person or any other medical scheme registered under the Act, subject to approval by members through a poll as set out in rule 31.3.

31.2 The principal officer must furnish to every member a memorandum containing the reasons for the proposed amalgamation or transfer of assets and liabilities, together with a poll paper.

31.3 Every member must be requested to return his poll paper duly completed before a set date. If at least 50 (fifty) per cent of the members return their poll papers duly completed and in favour of the amalgamation or transfer then the amalgamation or transfer may be concluded in terms of section 63 of the Act.

32. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

32.1 Any beneficiary has the right to obtain on request and must on payment of a fee of R100 (one hundred rand) per copy be supplied by the Scheme within 6 (six) weekdays with a copy of the following documents:

32.1.1 the rules of the Scheme;

32.1.2 the latest audited annual financial statements, statutory returns, chairman's report and auditors report of the Scheme.

32.1.3 The management accounts in respect of the scheme and all its benefit options.

32.2 A member is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 32.1 and to make extracts therefrom.

32.3 This rule shall not be construed to restrict a person's rights in terms of the Promotion of Access to Information Act, Act No. 2 of 2000.

33. AMENDMENT OF RULES

33.1 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 is valid unless it has been approved by a majority of members present in a general meeting of members or a special general meeting of members or by a poll or ballot of members.

33.2 Should a member's rights, obligations, contributions or benefits be amended he shall be given 30 (thirty) days advance notice of such change. Members must be notified of such amendments within 14 days after registration thereof.

33.3 Notwithstanding the provisions of rule 33.1 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.

33.4 No amendment to these rules shall be valid until it has been approved and registered by the Registrar in terms of the Act.

34. RIGHTS AND OBLIGATIONS OF MEMBERS

34.1 All members, dependants of members, officers of the Scheme and any person who claims any benefits under these rules or whose claim is derived from a person so claiming shall be bound by these rules and any amendment thereof.

34.2 No attempt by any member to do anything which is in contravention of these rules shall be of any force or effect.

34.3 Members have only such rights and obligations as are specifically provided for in these rules, the Act and regulations. No demand(s) by any member(s) which does not endeavour to enforce a right provided for herein shall have any force or effect.

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SUREMED HEALTH

CHALLENGER OPTION

ANNEXURE A(1)

(With effect from 1 January 2022)

1. Definition of income

”income”, shall mean, for the purpose of calculating contributions in respect of :

1.1 an employee, the employee’s gross monthly salary/pensionable earnings;

1.2 An individual member, his/her gross average monthly earnings from all sources;

1.3 a continuation member in terms of rule 6.2, his/her gross monthly earnings from all sources;

1.4 a member who registers a spouse or partner as a dependant in regard to clause 1.2 and 1.3 above, the higher of member or spouse's or partner's gross monthly earnings, from all sources will be used;

1.5 a member who fails to provide satisfactory and or updated proof of income to the Scheme, the highest income category applicable in terms of this Annexure will apply.

Gross monthly earnings shall be the average for the previous tax year increased by a percentage equal to the CPIX index published by the department of statistics of the Republic of South Africa in respect of the previous calendar year.

2. Basis of contribution payable

2.1 The total contribution payable shall be based on the income and the number of dependants of the member as set out in the table below. Contributions in respect of child dependants shall be limited to a maximum of three registered child dependants. No contributions shall be payable in respect of more than three registered child dependants.

MEMBER'S CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2022

Principal Member	**Adult Dependant* (See Note 1 below)**	**Child Dependant* (See Note 2 below)**
R	R	R
R5 360	R4 000	R1 060

*Note 1: Excluding full-time registered students up to age 25 at a registered tertiary education institution.

*Note 2: Including full-time registered students up to age 25 at a registered tertiary education institution.

3. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions.

The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

4. Premium penalties for persons joining late in life

4.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

4.2 The premium penalties referred to in paragraph 4.1 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	0.50 x contribution
25+ years	0.75 x contribution

4.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 4.2 the following formula shall be applied:

A = B minus (35+C)

where

"A" means the number of years referred to in the first column of the table in paragraph 4.2 for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

4.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

4.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

6. Waiting periods

See Annexure D.

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SUREMED HEALTH

CHALLENGER OPTION

ANNEXURE B(1)

BENEFITS

Effective 1 January 2022
(unless otherwise stated below)

A ENTITLEMENT TO BENEFITS

Beneficiaries are entitled to the prescribed minimum benefits and the annual benefits stipulated in paragraph C this Annexure.
Entitlement to benefits is subject to the main rules, Annexures C and D, and paragraphs B and C of this Annexure.

B OVERALL ANNUAL LIMIT AND CHARGING OF BENEFITS

B1 Charging of benefits: Benefits shall be charged to the major medical risk pool up to the limits set out in the column headed "MONETARY OR OTHER LIMITS." On depletion of those limits the member shall be liable for payment of the claim. Subject to PMB's.

SUREMED
CHALLENGER OPTION
ANNEXURE B(1)

		MONETARY OR OTHER LIMITS
C	**ANNUAL BENEFITS**	
C1.	**ALTERNATIVE HEALTH CARE SERVICES**	
	Homeopathy	
	Consultations and medicines	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the national health reference price list (NHRPL) for services provided by practitioners registered in terms of the relevant South African law.	Combined limit with Paramedical Services
C2.	**AMBULANCE SERVICES**	
	100% of the cost if approved by the preferred provider.	Subject to overall annual limit if preferred provider is used or if preferred provider authorizes alternative provider

SUREMED
CHALLENGER OPTION
ANNEXURE B(1)

MONETARY OR OTHER LIMITS

C3. APPLIANCES (EXTERNAL ACCESSORIES)

C3.1 In hospital

Subject to the relevant managed health care programme and clinical protocols **[Amended with effect from 1 January 2013]**:

100% of the cost of general medical and surgical appliances. Subject to pre-authorisation **[Amended with effect from 1 January 2014]**	R9 300 per member family. **[Amended with effect from 1 January 2019]**
Hearing aid(s) once every 3 years, limited to R5 000 CPAP machine once every 3 years, limited to R5 000 Nebulisers / Humidifiers limited to R500 Glucometers once every 3 years, limited to R500 Back support limited to R2 500 Orthotics limited to R1 000 **[Amended with effect from 1 January 2013]**	

C3.2 Out of hospital

Subject to the relevant managed health care programme:

C3.2.1	100% of the cost of disposable materials used to treat diabetes.	Limited to and included in C3.1

Appliances (continued)		**MONETARY OR OTHER LIMITS**
C3.2.2	100% of the cost of oxygen, cylinders, concentrators, home ventilators and attachments including **[Amended with effect from 1 January 2013]** CPAP machines.	R6000 per member family **[Amended with effect from 1 January 2020]**
C3.2.3	100% of the cost of all other medical and surgical appliances.	Limited to and included in C3.1
C3.2.4	100% of the cost of hearing aids and wheelchairs.	Limited to and included in C3.1
C4.	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	
C4.1	100% of the cost of blood and blood products.	
C4.2	Subject to the relevant managed health care programme: 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	

C5.	**CONSULTATIONS AND VISITS**	**MONETARY OR OTHER LIMITS**
	This paragraph expressly excludes consultations and visits to dental practitioners and therapists (see paragraph C6), in-hospital psychiatrists and psychologists (see paragraph C12), oncologists (see paragraph C14), social workers (see paragraph C17), physiotherapists (see paragraph C19), and services provided in respect of ante-natal visits and post-natal visits (see paragraph C10), organ and tissue transplants (see paragraph C16) and renal dialysis (see paragraph C23).	
C5.1	**In hospital**	
	Subject to the relevant managed health care programme: 150% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for consultations and visits by medical specialists and general practitioners.	

Consultations and visits (continued)	**MONETARY OR OTHER LIMITS**
C5.2 Out of hospital	
C5.2.1 General practitioners	
100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for consultations and visits by general practitioners in the supplier's rooms or patient's home or primary health care facility.	R5 150 per beneficiary and R14 000 per member family **[Amended with effect from 1 January 2019]**
C5.2.2 Medical specialists	
100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for consultations and visits by medical specialists in the supplier's rooms or patient's home or primary health care facility.	Limited to and included in C5.2.1

MONETARY
OR OTHER
LIMITS

C6. DENTISTRY

Subject to the relevant managed health care programme:

C6.1 Basic

C6.1.1 Dental practitioners

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for basic dentistry.

C6.1.2 Dental therapists

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for basic dentistry performed by dental therapists.

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Dentistry (continued)		**MONETARY OR OTHER LIMITS**
C6.2	**Advanced** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for inlays, crowns, bridges, mounted study models, plastic or metal base partial dentures, the treatment by periodontists (excluding oral medical and periodontal plastic procedures), maxilla-facial surgery and prosthodontists and the dental technicians' fees for all such dentistry **[Amended with effect from 1 January 2013]**.	R6 960 per beneficiary to a maximum of R15 852 per member family. **[Amended with effect from 1 January 2020)**
C6.3	**Osseo-integrated implants and orthognathic surgery (functional correction of malocclusions)** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for all services rendered including the cost of special investigations, hospitalization, all general and specialist dental practitioners and their respective assistants and anaesthetist as well as the cost of materials, including all implant components, plates, screws and bone and bone equivalents.	

Dentistry (continued)	MONETARY OR OTHER LIMITS
This benefit includes all stages of treatment required to achieve the end result of placing an implant-supported tooth or supported teeth into spaces left by previous removal of natural teeth. This includes the surgical augmentation of jawbone and surgical placement and exposure of implants.	Limited to and included in C6.2
C6.4 Oral surgery	
100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff. Benefit for general anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of 12 years and impacted 3rd molars. Benefit limit includes all hospital and doctor cost. **[Amended with effect from 1 January 2013].**	R13 820 PMF **[Amended with effect from 1 January 2020]**
C6.5 Maxillo-facial surgery	
See paragraph C6.2 **[Amended with effect from 1 January 2013]**	See paragraph C24.3
C6.6 Orthodontic treatment	
Subject to pre-authorisation: 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	Limited to and included in C6.2

C7. HOSPITALISATION

This paragraph expressly excludes the benefit for hospitalization arising out of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), maternity (see paragraph C10.1) mental health (see paragraph C12.1), organ and tissue transplants (see paragraph C16) and refractive surgery (see paragraph C24.2).

Authorisation shall be obtained from the organisation that provides the Schemes Hospital Benefit Management programme before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency and PMB's) failing which a levy of R1000 per admission shall apply.

In the event of an emergency the organisation that provides the Schemes Hospital Benefit Management programme must be notified of such emergency within one working day after admission failing which a R1000 levy shall apply.

[Amended w.e.f. 1 January 2008]

C7.1 Private hospitals: Providers other than preferred providers

C7.1.1 Accommodation

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or NHRPL for accommodation in a general ward, high care ward and intensive care unit.

C7.1.2 Operating theatre

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or NHRPL for theatre fees.

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.1.3	**Medicine, material and hospital apparatus** 100% of the cost of disinfectants, medicine, injection material, anaesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.1.4	**Medicine on discharge (TTO's)** Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event. **[Amended w.e.f. 1 January 2008]**	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.1.5	**Casualty / emergency room visits**	
C7.1.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event. **[Amended w.e.f. 1 January 2008]**	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.1.5.2	Consultations and visits charged by a general practitioner or medical specialist	Limited to and included in C5.2
C7.1.5.3	Facility / ambulatory hospital fee: No benefit.	R500 per member family per case. **[Amended w.e.f. 1 January 2016]**

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Hospitalisation (continued)	**MONETARY OR OTHER LIMITS**
C7.2 Private hospitals: preferred providers	
C7.2.1 Accommodation	
100% of the negotiated fee	
C.7.2.2 Operating theatre	
100% of the negotiated fee for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	
C7.2.3 Medicine, material and hospital apparatus	
100% of the negotiated fee for disinfectants, medicine, injection material, anaesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.2.4 Medicine on discharge (TTO's)	
Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.2.5	**Casualty / emergency room visits**	
C7.2.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.2.5.2	Consultations and visits charged by a general practitioner or medical specialist	Limited to and included in C5.2
C7.2.5.3	Facility / ambulatory hospital fee.	R500 per member family per case. **[Amended w.e.f. 1 January 2016]**
C7.3	**Public hospitals**	
C7.3.1	**Accommodation**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL	
C7.3.2	**Operating theatre**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.3.3	**Medicine, material and hospital apparatus** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for disinfectants, medicine, injection material, anaesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.3.4	**Medicine on discharge (TTO's)** Medicines given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.3.5	**Casualty / emergency room visits**	
C7.3.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.3.5.2	Consultations and visits charged by a general practitioner or medical specialist	Limited to and included in C5.2
C7.3.5.3	Facility / ambulatory hospital fee	R500 per member family per case. **[Amended w.e.f. 1 January 2016]**

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.4	**Secondary facilities**	
C7.4.1	**Sub-acute facilities, hospice and rehabilitation facilities**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for all services rendered by sub-acute facilities, hospice and rehabilitation facilities. Excluding all services for the rehabilitation for substance abuse.	R20 000 PMF **[Amended with effect from 1 January 2014]**
C7.4.2	**Nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services.	Subject to limit C7.4.1 **[Amended with effect from 1 January 2013]**
C7.5	Compassionate Care Benefit. Limited to R20 000PMF unless a Prescribed Minimum Benefit (PMB). Subject to authorization. **[Amended with effect from 1 January 2018]**	Limited to R20 000PMF **[Added with effect from 1 January 2014]**

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		MONETARY OR OTHER LIMITS
C8.	**IMMUNE DEFICIENCY RELATED TO HIV INFECTION**	
	Subject to the relevant managed health care programme:	
C8.1	**Anti-retroviral medicines**	
	100% of the base price as determined from time to time in terms of the relevant managed health care programme, plus a fixed dispensing fee per line item or per prescription where applicable, less the negotiated discount.	Subject to Overall Annual Limit and PMB's
C8.2	**Related medicines**	
	In respect of legally prescribed medicines and injection materials: 100% of the reference price or negotiated price.	Subject to Overall Annual Limit and PMB's
C8.3	Benefits for all other services shall be subject to the benefits applicable in paragraphs C1 to C24.	Limits as per paragraphs C1 to C23

		MONETARY OR OTHER LIMITS
C9.	**INFERTILITY**	
	Subject to the relevant managed health care programme:	
	No benefit in the private sector.	Subject to PMB's
C10.	**MATERNITY**	
	Subject to the relevant managed health care programme:	
C10.1	**Confinement In hospital**	
C10.1.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for accommodation, theatre fees, labour ward fees, drugs, dressings, materials and equipment. Caesarean section must be provided as being clinically necessary to qualify for full payment. Non-clinically necessary caesarean sections would result in the confinement benefit being limited to the amount available for vaginal deliveries in accordance with the scheme approved tariff.	
C10.1.2	In respect of legally prescribed medicines and administration devices: 100% of the reference price or negotiated price. Medicines given to a patient to take home shall be limited to a maximum of R500 per beneficiary per event.	

Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.1.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for the delivery by a midwife, general practitioner or medical specialist, including the attendant anaesthetist and paediatrician.	
C10.2	**Confinement out of hospital**	
C10.2.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for the delivery by a general practitioner, medical specialist or midwife.	
C10.2.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for services at a registered birthing unit.	

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Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.3	**Related services**	
C10.3.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for pregnancy related tests and two 2D pregnancy scans during a normal pregnancy by a general practitioner, medical specialist or midwife.	
C10.3.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for registered medicines, dressings and materials supplied by a midwife.	Limited to and included in C11.1.1
C10.3.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for nine ante-natal consultations with a general practitioner, medical specialist or midwife.	
C10.3.4	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for post-natal care by a general practitioner, medical specialist or midwife up to and including the one post-natal consultation for normal confinements.	

Maternity (continued)		MONETARY OR OTHER LIMITS
C10.3.5	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for one amniocentesis by a general practitioner or medical specialist.	
C10.3.6	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for ante-natal classes.	Limited to R500 per member family
C10.3.7	100% of the lower of the reference price or the negotiated price in respect of the costs of immunisation for the child.	
C10.3.8	The benefits in respect of C10.3 are subject to registration and compliance with the relevant maternity programme within the prescribed time limit.	
C10.3.9	Maternity benefit paid at 100% of scheme tariff limited to 2 2D scans, 2 gynae/GP visits, one Paediatrician visit and Antenatal Vitamins: R65 per month for 9months payable from Acute Benefit. Subject to registration on the maternity programme. **[Added with effect from 1 January 2020]**	

C10.4	**Termination of pregnancy**	
	100% of the negotiated fee or, 100% of cost for accommodation, theatre fees, labour ward fees, drugs, dressings, medicines and materials in a private or State hospital and for drugs, dressings, medicines and materials used.	Subject to PMB's
		MONETARY OR OTHER LIMITS
C11.	**MEDICINES AND INJECTION MATERIAL**	
	This paragraph expressly excludes medicines in respect of alternative health care services, (see paragraph C1), in-hospital medicines (see paragraph C7.1.4), anti-retroviral drugs (see paragraphs C8.1 and C8.2), oncology (see paragraph C14.2) and organ and tissue transplants (see paragraph C16.3).	
C11.1	**Routine medication**	
	Subject to the relevant managed health care programme:	

		SUREMED CHALLENGER OPTION ANNEXURE B(1)
C11.1.1	In respect of legally prescribed routine medication, excluding homeopathic medicines 100% of the lower of the reference price or the negotiated price. This paragraph excludes prescriptions supplied for use in a hospital but includes a maximum of R500 per beneficiary per event for in-patients on discharge from hospital.	R6 600per beneficiary and R21 100 per member family. A 20% levy per beneficiary is imposed once the benefit utilisation of R3 700 per beneficiary is reached. **[Amended with effect from 1 January 2020]**
Medicines and injection materials (continued)		**MONETARY OR OTHER LIMITS**
C11.1.2	**Pharmacy advised therapy** In respect of Schedules 0, 1 and 2 medicines advised and dispensed by a pharmacist: 100% of the lower of the reference price or negotiated price.	Limited to 1 script per member family per month to a max of a R170 per script with an annual sub-limit of a R1 630 included in C11.1.1 **[Amended with effect from 1 January 2020]**

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C11.2	**Extended medication**	
	Subject to the relevant managed health care programme:	
C11.2 1	In respect of legally prescribed extended medication for the conditions referred to in paragraph 7.9.2 of Annexure D and the following conditions: Ankylosing spondylitis, Scleroderma, Dermatomyositis, Huntington's disease, Major depression, Myasthenia gravis Narcolepsy, Obsessive compulsive disorder, Organ transplantation, Paget's disease, Psoriasis, Osteoporosis & Severe Osteopenia with risk factors and Psychoses; 100% of the cost.	
C12.	**MENTAL HEALTH**	**MONETARY OR OTHER LIMITS**
C12.1	**In hospital**	
C12.1.1	Subject to authorisation from the relevant managed health care programme.	R 19 200 per member family. Inclusive of all costs (Hospital and attending providers) **[Amended with effect from 1 January 2019].**

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C12.1.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for accommodation in a general ward.	
C12.1.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for electro-convulsive treatment fees.	Limited to and included in C12.1.1
C12.1.4	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for materials and hospital equipment.	Limited to and included in C12.1.1
C12.1.5	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for consultations and visits.	Limited to and included in C12.1.1

Mental health (continued)		**MONETARY OR OTHER LIMITS**
C12.1. 6	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for procedures prescribed by general practitioners, psychiatrists or psychologists.	Limited to and included in C12.1.1

		SUREMED CHALLENGER OPTION ANNEXURE B(1)
C12.1.7	In respect of legally prescribed medicines and injection material: 100% of the lower of the reference price or negotiated price.	Limited to and included in C12.1.1
C12.1.8	**Medicines given to a patient to take home (TTO's)**	
	Subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).

Mental health (continued)		**MONETARY OR OTHER LIMITS**
C12.2	**Out of hospital**	
C12.2.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]**for consultations and visits.	Limited to and included in C5.2.1

C12.2.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for consultations by general practitioners, psychiatrists or psychologists at the supplier's rooms or in any facility or at any place other than a registered hospital.	Limited to and included in C5.2.1 or C17.1 **[Amended with effect from 1 January 2013]**
C12.2.3	In respect of legally prescribed medicines and injection materials: 100% of the lower of the reference price or negotiated price.	Limited to and included in C11.1.1
C12.3	**Rehabilitation for substance abuse**	
	100% of the lower of cost or the negotiated fee	R2 000 per member family for all services, subject to prior approval.

MONETARY OR OTHER LIMITS

C13. NON-SURGICAL PROCEDURES AND TESTS

This paragraph expressly excludes psychiatry and psychology (see paragraphs C12.1.5 and C12.2.2), radiology (see paragraph C21) and optometric examinations by registered optometrists or supplementary optical practitioners (see paragraph C15.4).

C13.1 In hospital

Subject to the relevant managed health care programme:

C13.1.1 General practitioner and clinical technologist

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a general practitioner or clinical technologist.

C13.1.2 Medical specialist

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a medical specialist.

Non-surgical procedures and tests (continued)		**MONETARY OR OTHER LIMITS**
C13.2	**Out of hospital (including treatment in practitioners' rooms)**	
C13.2.1	**General practitioner and clinical technologist** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a general practitioner or clinical technologist.	
C13.2.2	**Medical specialist** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a medical specialist.	
C14.	**ONCOLOGY** Subject to the relevant managed health care programme and PMB's	PMB's Unlimited through Preferred Provider
C14.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for oncologist consultations, visits, treatment and materials for radiotherapy and chemotherapy during the active treatment period.	Limited to R300 000 per member family. **[Amended with effect from 1 January 2018]**

		SUREMED CHALLENGER OPTION ANNEXURE B(1)
C14.2	In respect of legally prescribed medicine and injection material used in chemotherapy: 100% of the reference price or negotiated price.	Limited to and included in C14.1
C14.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for all services performed by a pathologist and radiologist during the active treatment period. Any radiology and pathology must be pre-authorised for benefits.	Limited to and included in C14.1
C15.	**OPTOMETRY** Subject to the relevant managed health care programme. Benefit for spectacles or contact lenses. **[Amended with effect from 1 January 2013]**	
C15.1	**Frames** 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2014]**	R1 150 per beneficiary. Included in C15.2.1. **[Amended with effect from 1 January 2018]**
C15.2	**Spectacle lenses** 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	
C15.2.1	**Single vision, bifocal and multifocal lenses and Readers**	

Optometry (continued)	MONETARY OR OTHER LIMITS
100% of the lower of the cost or Suremed Scheme tariff limited to clear, single vision, bifocal or multifocals or one pair of Readers in place of single vision reading lenses. **[Amended with effect from 1 January 2014]**	R2 100 per beneficiary and R5 880 per member family. Limited to either C15.2 or C15.3. **[Amended with effect from 1 January 2018]**
C15.2.2 Lens additions	
100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	Limited to and included in C15.2.1
C15.2.3 Sunglasses and repairs to frames	
No benefit.	No benefit
C15.3 Contact lenses	
100% of the lower of the cost or Suremed Scheme tariff for contact lenses, when prescribed by a registered optometrist, ophthalmologist or supplementary optical practitioner.	Limited to and included in C15.2.1 and to either C15.2 or C15.3.
C15.4 Optometric examinations	
100% of the lower cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	One examination per beneficiary per annum

C16. ORGAN AND TISSUE TRANSPLANTS

Subject to the relevant managed health care programme, pre-authorisation and PMB's:

C16.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for harvesting of the organ and transplantation thereof. The benefit does not include the cost incurred by the donor of the organ where the donor is registered on another medical scheme. **[Amended with effect from 1 January 2013]**	R170 000 per member family. **[Amended with effect from 1 January 2017]**
C16.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for stem cell harvesting and transplantation limited to allogenic and autologous drafts derived from the South African Bone Marrow Registry. **[Amended with effect from 1 January 2013]**	Limited to and included in C16.1
C16.3	In respect of legally prescribed post-operative anti-rejection medicines: 100% of the lower of the reference price or the negotiated price.	Limited to and included in C16.1

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ANNEXURE B(1)
MONETARY OR OTHER LIMITS

C17. PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)

C17.1 General services

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for services in respect of:	R2 250 per beneficiary and R5 700 per member family collectively for all services. **[Amended with effect from 1 January 2019]**

Audiology
Dietetics
Genetic counseling
Hearing aid acoustics
Homeopathy
Occupational therapy,
Orthoptics
Podiatry
Speech therapy
Social workers
Clinical and counseling psychology **[Amended with effect from 1 January 2013]**

C18. PATHOLOGY AND MEDICAL TECHNOLOGY

C18.1 In hospital

Subject to the relevant managed health care programme:

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for all tests performed by a pathologist or medical technologist. **[Amended with effect from 1 January 2013]**

C18.2 Out of hospital

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for all tests performed by a pathologist or medical technologist.

SUREMED CHALLENGER OPTION ANNEXURE B(1)

		MONETARY OR OTHER LIMITS
C19.	**PHYSICAL THERAPY**	
C19.1	**In hospital**	
	Subject to the relevant managed health care programme:	R6 000per beneficiary. **[Added with effect from 1 January 2021]**
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for physiotherapy, occupational therapy and biokinetics. **[Amended with effect from 1 January 2016].**	
C19.2	**Out of hospital**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for physiotherapy, chiropractics (including x-rays) and biokinetics.	Limited to and included in C17.1 **[Amended with effect from 1 January 2013]**

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		MONETARY OR OTHER LIMITS
C20.	**PREVENTATIVE CARE AND WELLNESS** Subject to pre-authorisation,100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for the following : mammograms, PAP smears, prostate examinations and tonometry as per standard.	R1 500 per beneficiary to a maximum of R3 000 per member family. **[Amended with effect from 1 January 2020]**
C21.	**PROSTHESES AND DEVICES – INTERNAL** This paragraph expressly excludes internal prosthesis (osseo-integrated implants) for the purpose of replacing a missing tooth or teeth. Subject to the relevant managed health care programme and PMB's : 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for internal prostheses. **[Amended with effect from 1 January 2013]**	R40 000 per beneficiary **[Amended with effect from 1 January 2019]**
	Spinal fusion, limited to 2 levels per year to a maximum of R23 000, Inta Occular lens limited to R2 500 and Mesh limited to R7 000. **[Amended with effect from 1 January 2013]**	

		MONETARY OR OTHER LIMITS
C22	**RADIOLOGY AND RADIOGRAPHY** Subject to the relevant managed health care programme and PMB's:	
22.1	**General radiology**	
C22.1.1	**In hospital**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for diagnostic radiology, tests and ultrasounds.	
C22.1.2	**Out of hospital**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for diagnostic radiology, tests and ultrasounds.	
C22.2	**Specialised radiology**	
C22.2.1	**In hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation additional to any pre-authorisation already obtained for hospitalization.	R18 700 per member family In and Out of hospital **[Amended with effect from 1 January 2019]**

		MONETARY OR OTHER LIMITS
C22.2.2	**Out of hospital** 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation failing which a 20% co-payment shall apply.	
C23.	**RENAL DIALYSIS (CHRONIC)** Subject to the relevant managed health care programme and PMB's: 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Scheme Rates for consultations, visits, all services, materials and medicines associated with the cost of renal dialysis.	Unlimited per member family. **[Amended with effect from 1 January 2020]**
C24.	**SURGICAL PROCEDURES** This paragraph expressly excludes services provided in respect of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), oral surgery (see paragraph C6.4), maternity (see paragraph C10) and organ and tissue transplants (see paragraph C16). Subject to the relevant managed health care programme:	

Surgical procedures (continued)	MONETARY OR OTHER LIMITS
C24.1 General 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for surgical procedures performed by a general practitioner, medical specialist and clinical technologist.	
C24.2 Refractive surgery No benefit.	No benefit
C24.3 Maxillo-facial surgery 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for maxillo-facial surgery.	Limited to and included in C6.2 **[Amended with effect from 1 January 2013]**

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SUREMED HEALTH

NAVIGATOR OPTION

ANNEXURE A(2)

(With effect from 1 January 2022)

1. Basis of contribution payable

1.1 The total contribution payable shall be based on the number of dependants of the member as set out in table 1 below including the additional contribution to the savings account the member makes in terms of paragraph 1.2 and table 2 below.

Contributions for child dependants as defined in the rules are only payable up to a maximum of 3 child dependants. All dependants thereafter are free.

1.2 Every member shall pay an additional contribution, based on the number of dependants of the member, in terms of table 2 below and that amount shall be credited to the member's personal medical savings account and shall be dealt with as set out in Annexure E.

SUREMED NAVIGATOR ANNEXURE A(2)

TABLE 1

MEMBER'S BASIC CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2022

Principal member	Adult dependant* See Note 1 below	Child dependant* See Note 2 below and paragraph 1.1 above
R	R	R
R2 880	R2 270	R850

***Note 1: "Adult dependant" means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: "Child dependant" means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

TABLE 2

MEMBER'S ADDITIONAL CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2022

Principal member	Adult dependant* See Note 1 below	Child dependant* See Note 2 below and paragraph 1.1 above
R	R	R
R450	R350	R145

***Note 1: "Adult dependant" means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: "Child dependant" means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

TABLE 3

MEMBER'S TOTAL CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2022

Principal member	Adult dependant* See Note 1 below	Child dependant* See Note 2 below and paragraph 1.1 above
R	R	R
R3 330	R2 620	R995

***Note 1: "Adult dependant" means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: "Child dependant" means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

2. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions. The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

3. Premium penalties for persons joining late in life

3.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

3.2 The premium penalties referred to in paragraph 3.1 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	0.50 x contribution
25+ years	0.75 x contribution

3.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 3.2 the following formula shall be applied:

A = B minus (35+C)

where

"A" means the number of years referred to in the first column of the table in paragraph 3.2 for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

3.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

3.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

4. Waiting periods

See Annexure D.

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SUREMED HEALTH

NAVIGATOR OPTION

ANNEXURE B(2)

BENEFITS

Effective 1 January 2022
(unless otherwise stated below)

A ENTITLEMENT TO BENEFITS

Beneficiaries are entitled to the prescribed minimum benefits and the annual benefits stipulated in paragraph C this Annexure.

Entitlement to benefits is subject to the main rules, Annexures C and D, and paragraphs B and C of this Annexure.

B ANNUAL LIMITS AND CHARGING OF BENEFITS. Subject to PMB's.

B1 There is an overall annual limit of R11 240 per beneficiary **[Amended with effect from 1 January 2022]**, to a maximum of R22 050 per member family **[Amended with effect from 1 January 2022]** in respect of benefits referred to in C1 (auxiliary) C3.1 (external appliances), C5.2 (out-of-hospital general practitioner and specialist consultations and visits), C6 (dentistry), C7.1.4 (non-preferred private hospital TTO medicines), C7.1.5 (non preferred private hospitals casualty/emergency room visits), C7.2.4(preferred private hospital TTO medicines), C7.2.5 (preferred private hospitals casualty/emergency room visits), C7.3.4 (public hospital TTO medicines), C7.3.5.1 (casualty / emergency room visits), C11.1 (routine medication), C12.1.8 (mental health TTO medicines), C12.2 (mental health out-of-hospital), C12.3 (rehabilitation for substance abuse), C13.2 (out-of-hospital non-surgical procedures and tests), C15 (Optometry), C18.2 (out-of-hospital pathology), C19.2 (out-of-hospital physical therapy), C20 (preventative care and wellness), C22.1.2 (out-of-hospital general radiology). All inner limits referred to in the columns in paragraph C below are included in and accumulate to this overall annual limit. Where no inner limit is stated, the benefit shall be subject to this overall annual limit.

B2 Charging of benefits: Benefits reflected in paragraph B1 of this Annexure shall be charged in terms of paragraph 2.3.1 of Annexure E. All benefits shall be subject to "MONETARY OR OTHER LIMITS" where applicable, irrespective of whether benefits payable from MSA or major medical risk pool **[Amended with effect from 1 January 2013]**

C ANNUAL BENEFITS

C1. ALTERNATIVE HEALTH CARE SERVICES

Auxiliary [Amended with effect from 1 January 2013]

Consultations and medicines

100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for practices registered in terms of the relevant South African law.

C2. AMBULANCE SERVICES

100% of the cost if approved by the preferred provider.

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ANNEXURE B(2)

MONETARY OR
OTHER LIMITS

C3. APPLIANCES (EXTERNAL ACCESSORIES)

C3.1 In and out of hospital

Subject to the relevant managed health care program and clinical protocol: **[Amended with effect from 1 January 2013]**

100% of the cost of general medical and surgical appliances including wheel chairs and hearing aids.	R2 500 per member family. **[Amended with effect from 1 January 2019]**

Hearing aid(s) 3 per cycle, limited to R5 000
CPAP machine 3 per cycle, limited to R5 000
Nebulisers / Humidifiers limited to R500
Glucometers 3 per cycle, limited to R500
Back support limited to R2 500
Orthotics limited to R1 000
[Amended with effect from 1 January 2013]

C4. BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS

C4.1 100% of the cost of blood and blood products.

C4.2 Subject to the relevant managed health care programme and PMB's :

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for blood equivalents.

C5. CONSULTATIONS AND VISITS

MONETARY OR OTHER LIMITS

This paragraph expressly excludes consultations and visits to dental practitioners and therapists (see paragraph C6), in-hospital psychiatrists and psychologists (see paragraph C12), oncologists (see paragraph C14), social workers (see paragraph C17), physiotherapists (see paragraph C19), and services provided in respect of ante-natal visits and post-natal visits (see paragraph C10), organ and tissue transplants (see paragraph C16) and renal dialysis (see paragraph C23).

C5.1 In hospital

Subject to the relevant managed health care programme: 125% **[Amended with effect from 1 January 2015]** of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for consultations and visits by medical specialists and general practitioners.

Consultations and visits (continued)

MONETARY OR OTHER LIMITS

C5.2 Out of hospital

C5.2.1 General practitioners

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for consultations and visits by general practitioners in the supplier's rooms or patient's home or primary health care facility.

C5.2.2 Medical specialists

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for consultations and visits by medical specialists in the supplier's rooms or patient's home or primary health care facility.

**MONETARY
OR OTHER
LIMITS**

C6. DENTISTRY

Subject to the relevant managed health care programme:

C6.1 Basic

C6.1.1 Dental practitioners

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff for basic dentistry **[Amended with effect from 1 January 2013]**

C6.1.2 Dental therapists

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for basic dentistry performed by dental therapists.

Dentistry (continued)	**MONETARY OR OTHER LIMITS**
C6.2 Advanced 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff for inlays, crowns, bridges, mounted study models, plastic or **[Amended with effect from 1 January 2013]** metal base dentures every three year **[Amended with effect from 1 January 2013]**, the treatment by periodontists (excluding oral medical and periodontal plastic procedures) and prosthodontists and the dental technicians' fees for all such dentistry.	R4 800 per beneficiary **[Amended with effect from 1 January 2020]**
C6.3 Osseo-integrated implants and orthognathic surgery (functional correction of malocclusions) 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff for all services rendered including the cost of special investigations, all general and specialist dental practitioners and their respective assistants and anesthetists as well as the cost of materials, including all implant components, plates, screws and bone and bone equivalents.	

Dentistry (continued)		**MONETARY OR OTHER LIMITS**
	This benefit includes all stages of treatment required to achieve the end result of placing an implant-supported tooth or supported teeth into spaces left by previous removal of natural teeth. This includes the surgical augmentation of jawbone and surgical placement and exposure of implants.	Limited to and included in C6.2
C6.4	**Oral surgery**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff. Benefit for general anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of 12 years and impacted 3rd molars. Benefit limit includes all hospital and doctor cost. **[Amended with effect from 1 January 2013]**	R10 700 PMF **[Amended with effect from 1 January 2020]**
C6.5	**Maxillo-facial surgery**	
	See paragraph C24.3	See paragraph C24.3
C6.6	**Orthodontic treatment**	
	Subject to pre-authorisation:	
	100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	Limited to and included in C6.2

MONETARY OR OTHER LIMITS

C7. HOSPITALISATION

This paragraph expressly excludes the benefit for hospitalisation arising out of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), maternity (see paragraph C10.1) mental health (see paragraph C12.1), organ and tissue transplants (see paragraph C16) and refractive surgery (see paragraph C24.2).

Authorisation shall be obtained from the organisation that provides the Schemes Hospital Benefit Management programme before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a levy of R1000 per admission shall apply. Except PMB's.
In the event of an emergency the organisation that provides the Schemes Hospital Benefit Management programme must be notified of such emergency within one working day after admission failing which a R1000 levy shall apply.

C7.1 Private hospitals: Providers other than preferred providers

C7.1.1 Accommodation

100% of the lower of the cost, NHRPL or negotiated fee for accommodation in a general ward, high care ward and intensive care unit.

C7.1.2 Operating theatre

100% of the lower of the cost or NHRPL for theatre fees.

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.1.3	**Medicine, material and hospital apparatus**	
	100% of the cost of disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.1.4	**Medicine on discharge (TTO's)**	
	Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.1.5	**Casualty / emergency room visits**	
C7.1.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.1.5.2	Consultations and visits charged by a general practitioner or medical specialist.	
C7.1.5.3	Facility / ambulatory hospital fee: no benefit.	No benefit

Hospitalisation (continued)	MONETARY OR OTHER LIMITS
C7.2 Private hospitals: preferred providers	
C7.2.1 Accommodation	
100% of the negotiated fee	
C.7.2.2 Operating theatre	
100% of the negotiated fee for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	
C7.2.3 Medicine, material and hospital apparatus	
100% of the negotiated fee for disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.2.4 Medicine on discharge (TTO's)	
Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.2.5	**Casualty / emergency room visits**	
C7.2.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.2.5.2	Consultations and visits charged by a general practitioner or medical specialist	
C7.2.5.3	Facility / ambulatory hospital fee: no benefit	No benefit
C7.3	**Public hospitals**	
C7.3.1	**Accommodation** 100% of the lower of the cost or NHRPL	
C7.3.2	**Operating theatre** 100% of the lower of the cost or NHRPL for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.3.3	**Medicine, material and hospital apparatus** 100% of the lower of the cost or the NHRPL for disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.3.4	**Medicine on discharge (TTO's)** Medicines given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event. **[Amended w.e.f. 1 January 2008]**	R500 per beneficiary per event.
C7.3.5	**Casualty / emergency room visits**	
C7.3.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.3.5.2	Consultations and visits charged by a general practitioner or medical specialist.	
C7.3.5.3	Facility / ambulatory hospital fee: no benefit.	No benefit

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Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.4	**Secondary facilities**	
C7.4.1	**Sub-acute facilities, hospice and rehabilitation facilities**	
	100% of the lower of the cost, Scheme rate or negotiated fee for all services rendered by sub-acute facilities, hospice and rehabilitation facilities unless a Prescribed Minimum Benefit (PMB). Excluding all services for the rehabilitation for substance abuse, see **C12.3. [Amended with effect from 1 January 2018]**	R20 000 PMF
C7.4.2	**Nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services**	
	100% of the lower of the cost, Suremed Scheme tariff **[Amended with effect from 1 January 2013]** or negotiated fee for nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services.	Included and limited to C7.4.1
7.5	Terminal Care Benefit. Limited to palliative care only unless a Prescribed Minimum Benefit (PBM).	Limited to R20 000PMF. Subject to authorization. **[Added with effect from 1 January 2014]**

SUREMED NAVIGATOR OPTION ANNEXURE B(2)

		MONETARY OR OTHER LIMITS
C8.	**IMMUNE DEFICIENCY RELATED TO HIV INFECTION**	
	Subject to the relevant managed health care programme and PMB's:	
C8.1	**Anti-retroviral medicines**	
	100% of the base price as determined from time to time in terms of the relevant managed health care programme, plus a fixed dispensing fee per line item or per prescription where applicable, less the negotiated discount.	
C8.2	**Related medicines**	
	In respect of legally prescribed medicines and injection materials:	
	100% of the lower of the reference price or negotiated price.	
C8.3	Benefits for all other services shall be subject to the benefits applicable in paragraphs C1 to C23.	Limits as per paragraphs C1 to C23

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MONETARY OR
OTHER LIMITS

C9. INFERTILITY

Subject to the relevant managed health care programme:

[Amended with effect from 1 January 2018] Subject to PMB's

C10. MATERNITY

Subject to the relevant managed health care programme:

C10.1 Confinement In hospital

C10.1.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for accommodation, theatre fees, labour ward fees, drugs, dressings, materials and equipment. Caesarean section must be provided as being clinically necessary to qualify for full payment. Non-clinically necessary caesarean sections would result in the confinement benefit being limited to the amount available for vaginal deliveries in accordance with the schemes tariff. **[Amended with effect from 1 January 2018]**

C10.1.2 In respect of legally prescribed medicines and administration devices:

100% of the lower of the reference price or negotiated price.

Medicines given to a patient to take home shall be limited to a maximum of R500 per beneficiary per event.

Maternity (continued)		MONETARY OR OTHER LIMITS
C10.1.3	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for the delivery by a midwife, general practitioner or medical specialist, including the attendant anaesthetist and paediatrician. **[Amended with effect from 1 January 2018]**	
C10.2	**Confinement out of hospital**	
C10.2.1	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for the delivery by a general practitioner, medical specialist or midwife. **[Amended with effect from 1 January 2018]**	
C10.2.2	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for services at a registered birthing unit. **[Amended with effect from 1 January 2018]**	
C10.3.	Maternity benefit paid at 100% of scheme tariff limited to 2 2D scans, 2 gynae/GP visits, one Paediatrician visit and Antenatal vitmains: R65 per month for 9 months payable from acute benefit. Subject to registration on the maternity programme. **[Added with effect from 1 January 2020]**	

Maternity (continued)

MONETARY OR OTHER LIMITS

C10.3 Related services

C10.3.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for pregnancy related tests and two 2D pregnancy scans during a normal pregnancy by a general practitioner, medical specialist or midwife.

C10.3.2 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for registered medicines, dressings and materials supplied by a midwife.

C10.3.3 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for nine ante-natal consultations with a general practitioner, medical specialist or midwife.

C10.3.4 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the scheme tariff for post-natal care by a general practitioner, medical specialist or midwife up to and including the one post-natal consultation for normal confinements.

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Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.3.5	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for one amniocentesis by a general practitioner or medical specialist.	
C10.3.6	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for ante-natal classes.	Limited to R370 per member family included in C10.
C10.3.7	The benefits in respect of C10.3 are subject to registration and compliance with the relevant maternity programme within the prescribed time limit.	
C10.3.8	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the scheme in respect of the costs of hospitalisation for the child.	
C10.4	**Termination of pregnancy**	
	100% of the negotiated fee or 100% of cost for accommodation, theatre fees, labour ward fees, drugs, dressings, medicines and materials in a private or State hospital and for drugs, dressings, medicines and materials used.	Subject to PMB's

SUREMED NAVIGATOR OPTION ANNEXURE B(2) MONETARY OR OTHER LIMITS

C11. MEDICINES AND INJECTION MATERIAL

This paragraph expressly excludes medicines in respect of alternative health care services, (see paragraph C1), in-hospital medicines (see paragraph C7.1.4), anti-retroviral drugs (see paragraphs C8.1 and C8.2), oncology (see paragraph C14.2) and organ and tissue transplants (see paragraph C16.3) and

C11.1 Routine medication

Subject to the relevant managed health care programme:

C11.1.1	In respect of legally prescribed routine medication excluding homeopathic medicines: 100% of the lower of the reference price or the negotiated price. This paragraph excludes prescriptions supplied for use in a hospital but includes a maximum of R500 per beneficiary per event for in-patients on discharge from hospital.	R3 165 per beneficiary. For PAT see C11.1.2 **[Amended with effect from 1 January 2020]**

SUREMED NAVIGATOR OPTION ANNEXURE B(2)

Medicines and injection materials (continued)		**MONETARY OR OTHER LIMITS**
C11.1.2	**Pharmacy advised therapy**	
	In respect of Schedules 0, 1 and 2 medicines advised and dispensed by a pharmacist: 100% of the lower of the reference price or negotiated price.	Limited to 1 script per member family per month to a max of a R160 per script with an annual sub-limit of a R1 425, included in C11.1.1. **[Amended with effect from 1 January 2020]**
C11.2	**Extended medication**	
	Subject to the relevant managed health care programme:	
C11.2 1	In respect of legally prescribed extended medication: 100% of the formulary price.	

C12.	**MENTAL HEALTH**	**MONETARY OR OTHER LIMITS**
C12.1	**In hospital**	
C12.1.1	Subject to authorisation from the relevant managed health care programme. Subject to Prescribed Minimum Benefits (PMB's). **[Amended with effect from 1 January 2018]**	
C12.1.2	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for accommodation in a general ward.	R16 000 per member family **[Amended with effect from 1 January 2019]**
C12.1.3	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for electro-convulsive treatment fees.	Limited to and included in C12.1.1
C12.1.4	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for materials and hospital equipment.	Limited to and included in C12.1.1
C12.1.5	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for consultations and visits.	Limited to and included in C12.1.1

Mental health (continued)		MONETARY OR OTHER LIMITS
C12.1. 6	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for procedures prescribed by general practitioners, psychiatrists or psychologists.	Limited to and included in C12.1.1
C12.1.7	In respect of legally prescribed medicines and injection material: 100% of the lower of the reference price or negotiated price.	Limited to and included in C12.1.1
C12.1.8	**Medicines given to a patient to take home (TTO's)** Subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.

Mental health (continued)

MONETARY OR OTHER LIMITS

C12.2 Out of hospital

C12.2.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for consultations and visits.

C12.2.2 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for procedures by general practitioners, psychiatrists or psychologists at the supplier's rooms or in any facility or at any place other than a registered hospital.

C12.2.3 In respect of legally prescribed medicines and injection materials:

100% of the lower of the reference price or negotiated price.

C12.3 Rehabilitation for substance abuse

100% of the lower of cost or the negotiated fee
[Amended with effect from 1 January 2018]

C13. NON-SURGICAL PROCEDURES AND TESTS

This paragraph expressly excludes psychiatry and psychology (see paragraphs C12.1.5 and C12.2.2), radiology (see paragraph C21) and optometric examinations by registered optometrists or supplementary optical practitioners (see paragraph C15.4).

C13.1 In hospital

Subject to the relevant managed health care programme:

C13.1.1 General practitioner and clinical technologist

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a general practitioner or clinical technologist.

C13.1.2 Medical specialist

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a medical specialist.

Non-surgical procedures and tests (continued)		**MONETARY OR OTHER LIMITS**
C13.2	**Out of hospital (including treatment in practitioners' rooms)**	
C13.2.1	**General practitioner and clinical technologist**	
	100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a general practitioner or clinical technologist.	
C13.2.2	**Medical specialist**	
	100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a medical specialist.	
C14.	**ONCOLOGY**	PMB's Unlimited through Preferred Provider
	Subject to the relevant managed health care programme and PMB's	
14.1	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for oncologist consultations, visits, treatment and materials for radiotherapy and chemotherapy during the active treatment period.	Limited to R250 000 per family**[Amended with effect from 1 January 2018]**

SUREMED NAVIGATOR OPTION ANNEXURE B(2)

Oncology (continued)		**MONETARY OR OTHER LIMITS**
C14.2	In respect of legally prescribed medicine and injection material used in chemotherapy: 100% of the lower of the reference price or negotiated price.	Limited to and included in C14.1
C14.3	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for all services performed by a pathologist and radiologist during the active treatment period. Any radiology and pathology must be pre-authorised for benefits.	Limited to and included in C14.1
C15.	**OPTOMETRY** Subject to the relevant managed health care programme. Benefit for spectacles or contact lenses **[Amended with effect from 1 January 2013]**	R1 260 per beneficiary to a maximum of R3 165 per member family. **[Amended with effect from 1 January 2020]**
C15.1	**Frames** 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	Limited to and included in C15.
C15.2	**Spectacle lenses** 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	Limited to and included in C15.
C15.2.1	**Single vision, bifocal and multifocal lenses and Readers**	

Optometry (continued)		SUREMED NAVIGATOR OPTION ANNEXURE B(2) MONETARY OR OTHER LIMITS
	100% of the lower of the cost or Suremed Scheme tariff, limited to clear, single vision, bifocal or multi focals or one pair of Readers in place of single vision reading lenses. 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	Limited to and included in C15. Limited to either C15.2 or C15.3.
C15.2.2	**Lens additions**	
	100% of the lower of the cost or Suremed Scheme tariff 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**.	Limited to and included in C15.
C15.2.3	**Sunglasses and repairs to frames**	
	No benefit.	No benefit
C15.3	**Contact lenses**	
	100% of the lower of the cost or scheme tariff for contact lenses, when prescribed by a registered optometrist, ophthalmologist or supplementary optical practitioner.	Limited to and included in C15. and to either C15.2 or C15.3.
C15.4	**Optometric examinations**	
	100% of the lower cost or scheme tariff.	One examination per beneficiary per annum. Limited to and included in C15.

		MONETARY OR OTHER LIMITS
C16.	**ORGAN AND TISSUE TRANSPLANTS** Subject to the relevant managed health care programme, pre-authorisation and PMB's:	
C16.1	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for harvesting of the organ and transplantation thereof. **[Amended with effect from 1 January 2018]**	R150 000 per member family **[Amended with effect from 1 January 2019]**
C16.2	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for stem cell harvesting and transplantation limited to allogenic and autologous drafts derived from the South African Bone Marrow Registry. The benefit does not include the cost incurred by the donor of the organ.	Limited to and included in C16.1
C16.3	In respect of legally prescribed post-operative anti-rejection medicines: 100% of the reference price or the negotiated price.	Limited to and included in C16.1

SUREMED NAVIGATOR OPTION ANNEXURE B(2)

		MONETARY OR OTHER LIMITS
C17.	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)**	
	No benefit	No benefit
C18.	**PATHOLOGY AND MEDICAL TECHNOLOGY**	
C18.1	**In hospital**	
	Subject to the relevant managed health care programme: 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all tests performed by a pathologist or medical technologist.	
C18.2	**Out of hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all tests performed by a pathologist or medical technologist.	

SUREMED NAVIGATOR OPTION ANNEXURE B(2)

		MONETARY OR OTHER LIMITS
C19.	**PHYSICAL THERAPY**	
C19.1	**In hospital**	
	Subject to the relevant managed health care programme:	R5 650 per beneficiary unless PMB's apply **[Added with effect from 1 January 2020]**
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for physiotherapy and biokinetics.	
C19.2	**Out of hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for physiotherapy, chiropractics (including x-rays) and biokinetics.	
C20.	**PREVENTATIVE CARE AND WELLNESS**	
	Subject to pre-authorisation, 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for the following : mammograms, PAP smears, prostate examinations and tonometry as per standard.	R1 110 per beneficiary to a maximum of R2 100 per member family. **[Amended with effect from 1 January 2020]**

SUREMED NAVIGATOR OPTION ANNEXURE B(2)

		MONETARY OR OTHER LIMITS
C21.	**PROSTHESES AND DEVICES – INTERNAL**	
	This paragraph expressly excludes internal prosthesis (osseo-integrated implants) for the purpose of replacing a missing tooth or teeth.	
	Subject to the relevant managed health care programme:	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for internal prostheses.	R35 000 per beneficiary **[Amended with effect from 1 January 2019]**
	Spinal fusion, limited to 2 levels per year to a maximum of R25 000, Inta Occular lens limited to R2 500 and Mesh limited to R8 000. **[Amended with effect from 1 January 2019]**	
C22.	**RADIOLOGY AND RADIOGRAPHY**	
	Subject to the relevant managed health care programme and PMB's	
C22.1	**General radiology**	
C22.1.1	**In hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for diagnostic radiology, tests and ultrasounds.	

Radiology and radiography (continued)	MONETARY OR OTHER LIMITS
C22.1.2 Out of hospital 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for diagnostic radiology, tests and ultrasounds.	
C22.2 Specialised radiology	R16 900 per family In and out of hospital **[Amended with effect from 1 January 2020]**
C22.2.1 In hospital 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation additional to any pre-authorisation already obtained for hospitalisation.	
C22.2.2 Out of hospital 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation failing which a 20% co-payment shall apply.	

Radiology and radiography (continued)	**MONETARY OR OTHER LIMITS**
C23. RENAL DIALYSIS (CHRONIC)	
Subject to the relevant managed health care programme and PMB's :	
100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme Rates for consultations, visits, all services, materials and medicines associated with the cost of renal dialysis.	Unlimited per member family **[Amended with effect from 1 January 2020]**
C24. SURGICAL PROCEDURES	
This paragraph expressly excludes services provided in respect of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), oral surgery (see paragraph C6.4), maternity (see paragraph C10) and organ and tissue transplants (see paragraph C16).	
Subject to the relevant managed health care programme:	

Surgical procedures (continued)	MONETARY OR OTHER LIMITS
C24.1 General 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for surgical procedures performed by a general practitioner, medical specialist and clinical technologist.	
C24.2 Refractive surgery No benefit.	No benefit
C24.3 Maxillo-facial surgery 100% of the negotiated fee or in the absence of such fee, 100% of the lower of cost or NHRPL for maxillo-facial surgery.	
C25 Oxygen 100% of the cost of oxygen and cylinders.	R4000 per member family **[Amended with effect from 1 January 2020]**

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SUREMED HEALTH

SHUTTLE OPTION

ANNEXURE A(3)

(With effect from 1 January 2022)

1. Basis of contribution payable

1.1 The total contribution payable shall be based on the number of dependants of the member as set out in table 1 below including the additional contribution to the savings account the member makes in terms of paragraph 1.2 and table 2 below.

1.2 Every member shall pay an additional contribution, based on the number of dependants of the member, in terms of table 2 below and that amount shall be credited to the member's personal medical savings account and shall be dealt with as set out in Annexure E.

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SHUTTLE
ANNEXURE A(3)

MEMBER'S TOTAL CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2022

Income Category	Principal member	Adult dependant* See Note 1 below	Child dependant* See Note 2 below and paragraph 1.1 above
R	R	R	R
0-9000	R 990	R 990	R 515
9001-14000	R 1 200	R 1 200	R 624
14001-17000	R 1 700	R 1 700	R 884
17001+	R 1 950	R 1 950	R 1 015

***Note 1: "Adult dependant" means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: "Child dependant" means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

2. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions. The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

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ANNEXURE A(3)

3. Premium penalties for persons joining late in life

3.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

3.2 The premium penalties referred to in paragraph 3.1 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	0.50 x contribution
25+ years	0.75 x contribution

3.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 3.2 the following formula shall be applied:

A = B minus (35+C)

where

"A" means the number of years referred to in the first column of the table in paragraph 3.2 for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

3.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

3.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

4. Waiting periods

See Annexure D.

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ANNEXURE B3 – SHUTTLE OPTION

BENEFITS WITH EFFECT 1 January 2022

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100% of cost	No limit	-Services rendered by Public Hospitals or any Designated Service Provider. - Prime Cure Protocols Apply -All services to be delivered at designated service provider only, alternatively through referral by a Prime Cure DSP/DSPN to a Prime Cure approved non-DSP provider subject to preauthorization of all referrals through the Prime Cure Call Centre **[Amended with effect from 1 January 2020]**
B.	BENEFITS OTHER THAN PRESCRIBED MINIMUM BENEFITS		BENEFIT LIMITS AS DESCRIBED BELOW	

C.	HOSPITALISATION LIMIT 1. Private & public hospitals, registered unattached operating theatres and day clinics: 1.1 Accommodation in a general ward, high care ward and intensive care unit. 1.2 Theatre fees. 1.3 Medicines, materials and hospital equipment. 1.4 Visits by medical practitioners. 1.5 Confinement and midwives. 2. Secondary Facilities: 2.1 All services rendered by sub-acute facilities, hospice and rehabilitation facilities. 2.2 All services rendered by nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services. 3. Psychiatric hospitalisation. 4. Maxillo-facial 5. In hospital dental 6. Compassionate Care Benefit **[Amended with effect from 1 January 2018]**	Preferred Provider Network of public and private hospitals appointed or contracted by Kaelo Prime Cure100%	1. Unlimited 2. R11 000 per family and subject to In-hospital overall annual limit. 3. PMB's only. 4. Limited to R17 000 per family 5. Limited to trauma , < 7 years and impacted 3rd molars 6. No Benefit. **[Amended with effect from 1 January 2022]**	Pre-authorization required prior to admission for all non-emergency cases and within 24 hours of admission for all emergency cases, or the first working day after admission. Where no pre-authorization is obtained for elective admissions by the member (or the provider of services), the member will be liable for a co-payment of R5,000 (five thousand rand) per admission **[Amended with effect from 1 January 2020]** A co-pay of R2000 required if listed procedures are not done in a Day Clinic or Free Standing contracted theatres: Gastroscopes, Colonoscopies, Cystoscopies, Hysteroscopies, Arthroscopies, Sigmoidoscopies, Tonsils and adenoidectomies in children, Grommets, Wisdom teeth **[Amended with effect from 1 January 2020]** A co-pay of R2500 will apply for all laproscopic and arthroscopy surgery performed in hospital (57 & 58 Hospitals) In the event of an emergency, members have access to any private or public hospital for emergency medical care, Once stabilised, the member will be transferred to a DSP/DSPN hospital. **[Amended with effect from 1 January 2020]**

				ICU and High Care limited to 10 days per admission, Prime Cure will cover the cost of a Private ward if required for medical reasons, pre authorisation required **[Amended with effect from 1 January 2020]** Elective Caesarean Section subject to case management and second opinion if required by Prime Cure **[Amended with effect from 1 January 2020]** No in-hospital benefits will be paid except in respect of dental procedures for children aged under 7 years. Impacted 3rd molars, and procedures related to trauma are covered. **[Amended with effect from 1 January 2020]** PMB's only and Subject to pre-authorisation at preferred provider network of private and public hospitals only **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
D.	OSSEO-INTEGRATED IMPLANTS (Dental implants)	0% **[Amended with effect from 1 January 2013]**	Not applicable **[Amended with effect from 1 January 2013]**	Not applicable **[Amended with effect from 1 January 2013]**
E.	SPECIALIST SERVICES: 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services, including material supplied for injections, pathology and radiology unless stated otherwise in this annexure.	100% Prime Cure agreed tariff **[Amended with effect from 1 January 2020]**	1. Unlimited. **[Amended with effect from 1 January 2020]** 2. 5 x Consultations per family per year, max 3 per beneficiary for non-CDL-PMB conditions 2. Limits for non-PMB visits: R7150 per family and R3 575 per beneficiary per annum. **[Amended with effect from 1 January 2022]**	- Subject to Prime Cure protocol. - In case of involuntary use of non-DSP specialist for PMB conditions and a 30% co-pay will apply if no pre-authorisation obtained in the case of non - emergencies. - Unlimited consultations for PMB conditions, managed according to Prime Cure Protocol. - 30% (thirty percent co-payment by member on the Prime Cure agreed rate if the members fail to obtain a pre-authorisation for a PMB condition. Pre-Authorisation required for each visit and any other referrals or procedures by provider or member - Prime Cure contracted General Practitioner has to refer a patient. - **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
F.	GENERAL PRACTITIONER and NURSING SERVICES 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services as per list of approved codes, including material supplied for injections, unless stated otherwise in this annexure.	100% of Prime Cure's Agreed Tariff. **[Amended with effect from 1 January 2020]**	1. Unlimited. **[Amended with effect from 1 January 2020]** 2. Unlimited through preferred provider **[Amended with effect from 1 January 2020]**	- Subject to Prime Cure protocol. - Members are required to complete the symptom checker on the member app prior to accessing benefit for non-emergency conditions - The member will then be provided an authorisation for a nurse visit, Over The Counter Pharmacy medication for non-emergencies or a GP consultation - Non PMB's -Failure to complete the symptom checker and obtain an authorisation to the appropriate level of care (Nurse, General Practitioner or Specialist) will result in the member being responsible for a 30% co-payment for the account and all associated accounts, for example, pathology, radiology, acute medication - PMB's -Failure to complete the symptom checker for non-emergencies and obtain an authorisation to the appropriate level of care (Nurse, General Practitioner or Specialist) will result in the member being responsible for a co-payment of 30% of the account and all associated accounts, for example, pathology, radiology, acute medication – except in the case of a medical emergency

				- All out-of-hospital General Practitioner consultations, including small in-rooms procedures at Prime Cure approved DSP Network providers, provided such consultations are medically indicated and subject to Prime Cure's pre-authorisation procedures. - Members will be required to nominate two (2) General Practitioner from the list of contracted Prime Cure providers - Failure to nominate a General Practitioner from the list of contracted Prime Cure providers, the administration system will nominate the General Practitioners on the member's behalf by allocating the first General Practitioner visited as the first nominated General Practitioner and the second General Practitioner visited as the second nominated General Practitioner. Should a member visit a non-nominated General Practitioner without a pre-authorisation or a non-contracted General Practitioner the claim will be rejected if a non-PMB and a 30% co-payment will be applied for consultations related to a PMB condition. Members may change their nominated General Practitioner on the member application

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
G.	CLINICAL TECHNOLOGISTS 1. For services provided in-hospital. 2. In all other cases other than in-hospital treatment.	1. 100% of Prime Cure AT 2. No Benefit **[Amended with effect from 1 January 2020]**	Subject to In-hospital overall annual limit **[Amended with effect from 1 January 2020]**	
H.	DENTAL SERVICES 1. Conservative dentistry including ordinary fillings, extractions, preventative treatment and fluoride application according to a list of approved codes. 2. Specialised dentistry 3. Dentistry emergency visits (out of preferred provider's contracted dental network) according to a list of approved codes **[Amended with effect from 1 January 2013]**	100% Prime Cure Tariffs	1. Unlimited when clinically appropriate, subject to Prime Cure protocols Fluoride treatment only covered for children under 12 years **[Amended with effect from 1 January 2020]** 2. No Benefit 3. Emergency pain and sepsis treatment and extractions only, one per beneficiary per year **[Amended with effect from 1 January 2020]**	- Limited to a Prime Cure list of approved dental codes and case management - One consultation for a full mouth examination per beneficiary per annum– subject to list of benefit codes - Preventative treatments – one treatment per beneficiary per annum - Fillings (White or Amalgam according to Prime Cure protocols). Pre-authorisation required for 4/more restorations or 5/more Composite fillings (only anterior covered). - Extractions (Only if clinically necessary). Pre-authorisation required for 5/more extractions **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	**PRESCRIBED MEDICATION AND INJECTION MATERIAL:** 1. Acute sickness conditions.	100% Prime Cure agreed tariff **[Amended with effect from 1 January 2020]**	1. Unlimited provided an authorisation is obtained for the referrer of the service. **[Amended with effect from 1 January 2020]**	1. Must be prescribed by the members nominated or allocated contracted General Practitioner 2. Medication not prescribed by a nominated or allocated General Practitioner if on formulary will incur a 30% co-payment. - Only medication on the Prime Cure acute medicine formulary will be covered. -The medication will be provided as part of the acute consultation (when dispensed by a nominated or allocated dispensing practitioner) or by an a contracted service provider/pharmacy if prescribed by a non-dispensing practitioner -Acute Medication prescribed by a Specialist out-of-hospital is covered 100% of agreed rate if the member was referred by a Prime Cure contracted General Practitioner and an authorisation was obtained for the Specialist visit (Non PMB'S). If no authorization obtained the member will be liable for a 30% co-payment. - Standard formulary medication is available without co-payment, subject to Drug Utilisation Review and Pharmacy Benefit Management 2. Unlimited Chronic Medication but according to a fixed Prime Cure medication formulary only. - Member must register on the program
	2. Chronic sickness conditions.		2. Subject to scheme list of chronic conditions including PMB's.	
	3. To-Take-out medicines (TTO)		3. Subject to a Prime Cure medicines formulary. Limited to 7 days post hospital supply. **[Amended with effect from 1 January 2020]**	

				- Nominated or allocated Contracted Prime Cure General Practitioner to complete the Prime Cure Chronic Application Form and submit to Prime Cure, in accordance with Prime Cure Protocol, as amended from time to time. - Only medication prescribed by a Prime Cure contracted General Practitioner will be covered. - Chronic Medication prescribed by a specialist out-of-hospital will only be covered if the member was referred by a Prime Cure Nominated or allocated contracted General Practitioner and the medication is within the Prime Cure formulary, and such medication is dispensed by a Prime Cure contracted pharmacy, once approved by Prime Cure. 3. Subject to a Prime Cure medicines formulary at a Prime Cure Medical Centre or at a DSP pharmacy or through a Prime Cure contracted dispensing practitioner, subject to all medication being prescribed by a Prime Cure general practitioner or other Prime Cure contracted service provider (DSP/DSPN) only

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
	4. Self -Medication Benefit	100% Prime Cure Agreed Tariff	R360 per beneficiary per annum, Maximum of R120 per event (a maximum of 3 events per beneficiary per annum) **[Amended with effect from 1 January 2022]**	- Limited to the fixed Prime Cure medicine formulary for OTC medicines only. Self-medication items for the treatment of day to day ailments. -Medication dispensed by Prime Cure contracted service provider only **[Amended with effect from 1 January 2020]**
J.	RADIOLOGY 1. Specialised Radiology MRI, CAT and/or GALLIUM SCANS and/or RADIOISOTOPES 2. Basic Radiology	1. Preferred Provider 100% Prime Cure Tariff 2 1. In hospital 100% Prime Cure Tariff 2 2. Out Of Hospital - 100% Prime Cure Agreed Tariff **[Amended with effect from 1 January 2020]**,	1. Specialised Radiology R20 000 per family per annum and R9 500 per beneficiary per annum combined limit for in- and out-of-hospital specialised radiology (including CT and MRI scans) Unless PMB 1.1 Subject to In-hospital annual limit 1.2 Unlimited Subject to Prime Protocols **[Amended with effect from 1 January 2022]** 2. Unlimited, subject to an authorisation being obtained for the referral. **[Amended with effect from 1 January 2020]**	- Subject to pre-authorisation and case management - Unless the CT and/or MRI scan forms part of a PMB diagnosis or care plan for a PMB condition according to Prime cure protocols, the benefit is paid at the lower of agreed DSP tariff or NHRPL fees. - Pre-Authorisation is required from Prime Cure Call Centre for certain Radiology tests by the attending doctor, as stipulated on the Prime Cure Radiology Request Form, which is available on request . - Advanced radiology (e.g. MRI, CAT scans, angiography, etc.) are subject to the in-hospital radiology limit for MRI and CT scans. - 3D scans are paid as for 2D scans Agreed Rate - PET Scans are not covered - **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
K.	PATHOLOGY and MEDICAL TECHNOLOGY 1. Pathology 2. Medical Technology	1. Prime Cure Preferred Provider - 100% **[Amended with effect from 1 January 2020]**, 2. No Benefit **[Amended with effect from 1 January 2020]**,	- Unlimited. **[Amended with effect from 1 January 2015]**,	- In-hospital pathology is subject to the approved list of tests. - No Benefit for out of hospital Medical Technology - Pre-authorisation is required from Prime Cure's call centre for certain pathology tests. - Pathology tests requested by Specialists are only covered if the member was referred by a Prime Cure contracted service provider and authorization was obtained for the specialist consultation - PMB rules apply **[Amended with effect from 1 January 2020]**
L.	CHEMOTHERAPY and RADIOTHERAPY	Preferred Provider - 100% **[Amended with effect from 1 January 2015]**,	PMB's only **[Amended with effect from 1 January 2020]**	Subject to pre-authorisation and registration on Disease Management programme / Case Management, formulary oncology drugs only, confirmation of PMB diagnosis. DSPN State facility only **[Amended with effect from 1 January 2020]**,

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
M.	RENAL DIALYSIS	100%	PMB's Only **[Amended as from 1 January 2020]**	DSPN State facility only Subject to confirmation of PMB diagnosis, members to register on the Disease Management programmes **[Amended as from 1 January 2020]**
N.	PHYSIOTHERAPY 1. In-hospital 2. Out-of-hospital	1. Preferred Provider - 100% 2.No Benefit **[Amended with effect from 1 January 2015]**	1. Subject to In-hospital overall annual limit . **[Amended with effect from 1 January 2020]** 2. No Benefit . **[Amended with effect from 1 January 2015]**	DSP only and Subject to confirmation of PMB diagnosis **[Amended as from 1 January 2020]**
O.	CLINICAL PSYCHOLOGY	100% of Agreed tariff **[Amended as from 1 January 2020]**	PMB's Only **[Amended with effect from 1 January 2020]**	Pre-Authorisation required and beneficiary must be referred by their contracted General Practitioner or a specialist where the specialist consultation has been authorised. **[Amended as from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
P.	BLOOD TRANSFUSIONS	Preferred Provider - 100% **[Amended with effect from 1 January 2015]**	Unlimited. **[Amended with effect from 1 January 2015]**	Prime Cure Preferred Provider and agreed rate **[Amended with effect from 1 January 2020]**
Q.	AMBULANCE SERVICES and EMERGENCY TRANSPORT SERVICES (Road and Air)	Preferred Provider - 100% **[Amended with effect from 1 January 2015]**	No limit	- Authorisation must be obtained from Prime Cure before use is made of an ambulance service, unless PMB's apply. **[Amended with effect from 1 January 2015]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
R.	AFTER HOURS EMERGENCY CARE: 1. General practitioner consultations and outside preferred provider network or contracted providers consulted after hours 2 Emergency out of preferred provider network visits	1. 100% of Agreed rate**[Amended with effect from 1 January 2015]** 2. 100% of Agreed rate**[[Amended with effect from 1 January 2015]**	1 Limited to 1(one) visit per beneficiary or 2 (two) per family. Limited to R1 100 per event including all services **[Amended as from 1 January 2022]** 2. Unlimited **[Amended with effect from 1 January 2015]**	1 Excluding facility fees. • Authorisation is required via the ***member application*** within 72 hours by member or provider. • At any registered emergency medical facility • Excludes services provided by practitioners who are not registered with Health Professional Council of South Africa (HPCSA)Member maybe required to pay and claim back 2 Unlimited without co-payment provided the episode meets the requirements of the *Prime Cure* definition on an ***emergency medical condition***[1] - means the sudden, and at the time unexpected, onset of a life-threatening health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. • At any registered emergency medical facility

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

				Authorisation is required via the ***member application*** within 72 hours by member or provider
S.	AUXILIARY SERVICES Speech, Occupational Therapy, Physiotherapy and Psychology	100%. Of agreed rate **[Amended with effect from 1 January 2013]**	Subject to Prime Cure Protocols PMB's only **[Amended with effect from 1 January 2020]**	Benefits are only covered provided: - Must form part of a PMB treatment protocol - Referred by a contracted Prime Cure designated service provider - Pre-authorisation is obtained from the Prime Cure Call Centre - In cases where patients self-refer to providers or fails to obtain an authorisation that provide Additional Benefit Option services, the eligible member will be held liable for 30 % of the account **[Amended with effect from 1 January 2020]**
T.	INTERNAL SURGICAL IMPLANTS	100% **[Added as from 1 January 2013]**	PMB rules apply R29 500 PB unless PMB's apply. **[Amended as from 1 January 2022]**	Subject to pre-authorisation, clinical protocols, special motivation, pre-authorisation and case management and to DOH national guidelines. **[Amended as from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
U.	OTHER MEDICAL AND SURGICAL APPLIANCES	100% of cost **[Amended with effect from 1 January 2020]**	R4 000 per family per annum PMB rules apply **[Amended with effect from 1 January 2022]**	- Combined in and out of hospital limit **Amended with effect from 1 January 2020]**

V.	OPTICAL 1. Eye examinations 2. Spectacles 3. Contact lenses 4. Frames **[Amended with effect from 1 January 2020]**	1. 100% Prime Cure Rates **[Amended with effect from 1 January 2020]**	1. One optometric examination per beneficiary per annum. 2. 1 Pair of spectacles per beneficiary per 24 month period 3. No benefits 4. 1 Frame for spectacles allowed per beneficiary every 24 months **[Amended with effect from 1 January 2020]**	-Includes a visual evaluation, tonometry screening and a diagnosis. -Includes standard CR39 lenses (High quality clear plastic lenses), Single Vision or Bi-focal lenses (Please refer to Qualifying norms) and Members are not entitled to any monetary value regarding the benefit. -Spectacles are granted if the following norms are met: 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 sphere and or 0,5 dioptre cylinder on distance vision and 1,25 dioptre sphere on near vision and For the granting of bi-focals, members have to comply with both the distance vision and near vision qualifying norms for both eyes. Prime Cure will however, in borderline cases, take the functionality of the bi-focals into account. -The choice of frame is specified to be from a quality range of Prime Cure approved range of frames, An excess is payable by the member for any frame not from the specified Prime Cure range and Members are not entitled to any monetary value regarding the frame. **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
W.	Pregnancy tests, post- and antenatal care, and preventative care.	!00% of Agreed rate at preferred provider. **[Amended with effect from 1 January 2020]**	Unlimited subject to Prime Cure protocols **[Amended with effect from 1 January 2019]**	- Foetal / Maternal ultrasound scans are limited to 2 (two) scans per pregnancy - Ante natal visited at allocate or nominated General Practitioner **[Amended with effect from 1 January 2020]**
X.	HIV/AIDS out-of-hospital benefit	100% of Agreed rate at contracted providers. **[Amended with effect from 1 January 2020]**	No limit	- Ongoing care plan and anti-retroviral treatment subject to registration on the Prime Cure HIV/AIDS programme and treatment according to an evidence based treatment protocol and medicine formulary - Each eligible member is encouraged to register on the Disease Management Program once diagnosed as HIV positive - Consent to record data on the Prime Cure Disease Management Information System - Voluntary counselling and testing - Antiretroviral therapy, prophylactic antibiotics & supplements according to Prime Cure protocol - Treatment support

				- Pathology and monitoring (incl. CD4, viral load, liver enzymes, cholesterol, glucose, urine tests) according to protocols - Treatment of opportunistic infections, according to Prime Cure formulary. -Available at selected service providers only (Members to contact Prime Cure Call Centre for details) **[Amended with effect from 1 January 2020]**
Y.	ORGAN TRANSPLANTS	100%	No limit - PMB rules apply.	-DSPN State facility only -Subject to confirmation of PMB diagnosis, pre-authorisation and registration on Disease Management programme / Case Management -Subject to DOH national guidelines **[Amended with effect from 1 January 2020]**

SUREMED HEALTH

EXPLORER OPTION

ANNEXURE A(4)

(With effect from 1 January 2022)

1. Definition of income

”income”, shall mean, for the purpose of calculating contributions in respect of :

1.1 an employee, the employee’s gross monthly salary/pensionable earnings

1.2 an individual member, his/her gross average monthly earnings from all sources;

1.3 a continuation member in terms of rule 6.2, his/her gross monthly earnings from all sources;

1.4 a member who registers a spouse or partner as a dependant in regard to clause 1.2 and 1.3 above, the higher of member or spouse's or partner's gross monthly earnings, from all sources will be used;

1.5 a member who fails to provide satisfactory and or updated proof of income to the Scheme, the highest income category applicable in terms of this Annexure will apply.

Gross monthly earnings shall be the average for the previous tax year increased by a percentage equal to the CPIX index published by the department of statistics of the Republic of South Africa in respect of the previous calendar year.

2. Basis of contribution payable

2.1 The total contribution payable shall be based on the income and the number of dependants of the member as set out in the table below.

MEMBER'S CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2022

Monthly income	**Principal Member**	**Adult Dependant* (See Note 1 below)**	**Child Dependant* (See Note 2 below)**
R	R	R	R
0 – 500	480	480	480
501 – 8 500	1 195	1 060	550
8 501 – 13 000	1 500	1 325	670
13 001 – 17 000	2 380	2 380	695
17 00 Plus	2 975	2 975	930

***Note 1: Excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: Including full-time registered students up to age 25 at a registered tertiary education institution.**

3. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions.

The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

4. Premium penalties for persons joining late in life

4.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

4.2 The premium penalties referred to in paragraph 4.1 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	0.50 x contribution
25+ years	0.75 x contribution

4.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 4.2 the following formula shall be applied:

A = B minus (35+C)

where

"A" means the number of years referred to in the first column of the table in paragraph 4.2 for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

4.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

4.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

6. Waiting periods

See Annexure D.

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ANNEXURE B4 – EXPLORER OPTION

BENEFITS WITH EFFECT 1 January 2022

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER ANNEXURE D	100% of cost	No limit	Services rendered by Public Hospitals or any Designated Service Provider.
B.	BENEFITS OTHER THAN PRESCRIBED MINIMUM BENEFITS		No overall annual limit	
C. MomTYB	HOSPITALISATION LIMIT 1. Private & public hospitals, registered unattached operating theatres and day clinics: 1.1 Accommodation in a general ward, high care ward and intensive care unit. 1.2 Theatre fees. 1.3 Medicines, materials and hospital equipment. 1.4 Visits by medical practitioners. 1.5 Confinement and midwives. 2. Secondary Facilities: 2.1 All services rendered by sub-acute facilities, hospice and rehabilitation facilities. 2.2 All services rendered by nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services. 3 Psychiatric hospitalisation.	Preferred Provider - 100% Non-Preferred Provider – 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	Unlimited **[Amended with effect from 1 January 2015]** 2. R12 500 PMF limit, unless PMB's apply. 3. PMB's at DSP only. **[Amended with effect from 1 January 2013]**	- Authorisation shall be obtained from the Scheme/Scheme's designated agent before a Beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R500 per admission shall apply. - In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. - The percentage benefit for Medicines shall be subject to a medication formulary and/or reference price list as defined by the Scheme's designated agent

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
				- In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the case or that the treatment could have been provided other than in-hospital, then, notwithstanding the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. - Accommodation in an intensive care or high care unit is subject to a maximum period 15 days; hereafter authorisation must be obtained for further accommodation. - Minor procedures and dressings which can be performed appropriately in a General Practitioner or specialist's surgery will not receive any hospitalisation benefit. - No in-hospital benefits will be paid in respect of dental procedures.
MomTYB	4. Compassionate Care Benefit **[Amended with effect from 1 January 2018]**		Limited to R20 000PMF unless a Prescribed Minimum Benefit (PMB) **[Added with effect from 1 January 2014]**	Subject to scheme protocol. Authorisation shall be obtained from the Scheme/Scheme's designated agent prior to the commencement of treatment, failing which no benefit will be paid. Limited to palliative care only. **[Added with effect from 1 January 2014]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
D.	OSSEO-INTEGRATED IMPLANTS (Dental implants)	0%	Not applicable	Not applicable
E. MomTYB	SPECIALIST SERVICES: 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital.	1. Preferred Provider - 100% Non-Preferred Provider -70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. R20 000 PMF, unless PMB's apply. **[Amended with effect from 1 January 2015]**	- To be referred through the primary care Preferred Provider and subject to scheme's protocol unless PMB's apply. - Authorisation shall be obtained from the Scheme or the Scheme's designated agent before specialist services are provided, failing which no benefit will be paid, except for PMB's. - In the event of an emergency the Scheme may provide authorisation retrospectively provided it is notified within one working day after the consultation and/or admission, failing which no benefit will be paid, unless PMB's apply. Penalties and levy may apply as indicated in paragraph C. **[Amended with effect from 1 January 2013]**
MomTYB	2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services, including material supplied for injections, unless stated otherwise in this annexure.	2. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	2.Limited to R3 400 PB per annum **[Amended with effect from 1 January 2019]**	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
F.	GENERAL PRACTITIONER and NURSING SERVICES			
MomTYB	1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital.	1. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. Included in hospitalisation limit, unless PMB's apply.	1. Subject to scheme protocol.
PrimeCure	2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services as per list of approved codes, including material supplied for injections, unless stated otherwise in this annexure.	2. Preferred Provider - 100% Non-Preferred Provider - 80%, unless PMB's apply. **[Amended with effect from 1 January 2021]**	2. 12 Consultations per beneficiary at preferred provider. **[Amended with effect from 1 January 2015]**	2. Authorisation after 12th visit for PMB's only. Subject to managed care protocol. **[Amended with effect from 1 January 2015]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
G.	CLINICAL TECHNOLOGISTS 1. For services provided in-hospital. 2. In all other cases other than in-hospital treatment.	Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. Included in hospitalisation limit, unless PMB's apply. 2. No limit.	Subject to preferred provider protocol.
H. Primecure	DENTAL SERVICES 1. Conservative dentistry including ordinary fillings, extractions, preventative treatment and fluoride application according to a list of approved codes.	1-2 **[Amended with effect from 1 January 2018]** Preferred Provider - 100% Non-Preferred Provider - 70%, 3. 0% 4. 100%	1. 1 Consultation PB, Unlimited extractions, 1 preventative treatment PB **[Amended with effect from 1 January 2013]** 2. R3 875 PMF – limited to one set PMF per 24 month cycle. **[Amended with effect from 1 January 2022]** 3. Not Applicable 4. Limited to 1 event PB (code 8201)	- General anaesthetic and hospitalisation for conservative dental work excluded. - Denture benefit applicable to members over the age of 21 only and subject to authorisation. Plastic dentures only. A co-payment of 20% for dentures. **[Amended with effect from 1 January 2015]** - The benefit in respect of the Dentistry emergency visits is restricted to emergency extractions and/or pain and sepsis treatment only. - Subject to preferred provider protocol.
Primecure	2. Dentures			
Primecure	3. Specialised dentistry 4. Dentistry emergency visits (out of preferred provider's contracted dental network) according to a list of approved codes			

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	**PRESCRIBED MEDICATION AND INJECTION MATERIAL:**			
Primecure	1. Acute sickness conditions.	1. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. No limit.	1.1 Medication to be prescribed by a person legally entitled to prescribe. 1.2 The percentage benefit for Medications shall be subject to the preferred provider's medication formulary and limited to prescriptions by the preferred provider's network of contracted General Practitioners and Dental Practitioners, unless PMB's apply. 2. The Chronic Sickness Condition benefit is subject to the preferred provider's protocols and formulary. 3. TTO's are subject to a prescribed formulary and/or reference price lists as defined by the Scheme's designated agent.
Primecure	2. Chronic sickness conditions.	2. Preferred Provider - 100% Non-Preferred Provider - 0%, except for PMB's	2. Subject to PMB's **[Amended with effect from 1 January 2013]**	
MomTYB	3. To-Take-out medicines (TTO)	3. Preferred Provider - 100% Non-PP - 0%, unless PMB's appl	3. R300 per beneficiary per event unless PMB's apply.	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
Primecure	4. Self -Medication Benefit	Preferred Provider -100% Non-Preferred Provider - 70%**[Amended with effect from 1 January 2018]**	R315 PB limited to a maximum of R100 per event , a max of R375 PMF **[Amended with effect from 1 January 2022]**	The Self Medication Benefit is subject to the preferred provider's self- medication formulary.
J. MomTYB	RADIOLOGY 1. Specialised Radiology MRI, CAT and/or GALLIUM SCANS and/or RADIOISOTOPES	1. Preferred Provider - 100% Non-Preferred Provider - 70%, except for PMB's **[Amended with effect from 1 January 2018]**	1. Radiology in-hospital and/or referred by a Specialist unless PMB's apply. Specialised Radiology (MRI/CAT and/or Gallium scans and/or Radio-isotopes) – 2 scans PMF. Services rendered in-hospital subject to hospitalisation limit. **[Amended with effect from 1 January 2013]** 2. Primary care Radiology – Unlimited	- MRI, CAT and/or GALLIUM Scans and/or RADIOISOTOPES must be authorised by the Scheme/Scheme's designated agent, except in emergencies, failing which a co-payment of R500 per scan shall apply. - In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the R500 co-payment shall apply. - Should pre-authorisation for MRI/CAT and GALLIUM scans and/or RADIOISOTOPES not be obtained and the scans would, under normal circumstances, not have been authorised, no benefit will be paid, unless PMB's apply. - Benefit in respect of basic radiology shall be limited to X-Rays prescribed by the preferred provider in accordance with their list of codes included in their radiology formulary. (Black and white X-Rays and soft tissue ultrasounds only). - Pre-authorisation is required from the preferred provider's call centre in respect of any basic radiology
(in hospital MOMTYB – out Prime Cure)	2. Basic Radiology	2. Preferred Provider - 100% Non-Preferred Provider - 70%, except for PMB's **[Amended with effect from 1 January 2018]**		

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
K. (in hospital MOMTYB – out PrimeCure)	PATHOLOGY and MEDICAL TECHNOLOGY 1. Pathology 2. Medical Technology	1. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. 2. Preferred Provider - 100% Non-Preferred Provider -70%, except for PMB's **[Amended with effect from 1 January 2018]**	- Services rendered in-hospital limited to R21 500 PMF, unless PMB's apply. **[Amended with effect from 1 January 2019]** - Primary care Pathology – Unlimited.	- In-hospital pathology is subject to the approved list of tests as determined between the Scheme and its preferred provider. - Out-of-hospital pathology is limited to tests prescribed by the preferred provider, unless PMB's apply. And subject to the preferred provider's list of approved tests. - Pre-authorisation is required from the preferred provider's call centre for certain pathology tests.
L. MomTYB	CHEMOTHERAPY and RADIOTHERAPY	Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. 100%**[Amended with effect from 1 January 2018]**	No Limit **[Amended with effect from 1 January 2013]**	PMB's at DSP only **[Amended with effect from 1 January 2013].** Authorisation shall be obtained from the Scheme/Scheme's designated agent prior to commencement of treatment, failing which no benefit will be paid, unless PMB's apply.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
M. MomTYB	RENAL DIALYSIS	100% **[Amended as from 1 January 2013]**	No limit **[Amended as from 1 January 2013]**	PMB's at DSP subject to regulation 8(3). **[Amended as from 1 January 2013]**
N. MomTYB	PHYSIOTHERAPY 1. In-hospital 2. Out-of-hospital	1. Preferred Provider - 100% Non-Preferred Provider - 70% **[Amended as from 1 January 2018]** 2. 0%	1. Limited to R3 550 PMF, unless PMB's apply. **[Amended as from 1 January 2019]** 2. Not Applicable	Pre- authorised subject to PMB's and scheme protocols. **[Amended as from 1 January 2013]**
O.	CLINICAL PSYCHOLOGY	0%	No limit subject to PMB's only.	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
P.	AUDIOMETRY	0%	Not Applicable	Not Applicable
Q. MomTYB	BLOOD TRANSFUSIONS	Preferred Provider - 100% Non-Preferred Provider - 70% **[Amended as from 1 January 2018]**	Included in hospitalisation limit, unless PMB's apply.	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
R. ER24	AMBULANCE SERVICES and EMERGENCY TRANSPORT SERVICES (Road and Air)	Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended as from 1 January 2018]**	No limit	- Authorisation must be obtained from the contracted preferred provider before use is made of an ambulance service, unless PMB's apply. - In the event of an emergency the contracted preferred provider shall be notified of such emergency within one working day after the transport is provided, failing which no benefit will be paid.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
S. PrimeCure	AFTER HOURS EMERGENCY CARE: 1. General practitioner consultations and outside preferred provider network 2 Emergency out of preferred provider network visits	1. 100% **[Amended with effect from 1 January 2015]** 2. 100%	1. R1100 per event **[Amended with effect from 1 January 2022]** including all services and medication limited to 1 visit PB and a maximum of 2 visits PMF, unless PMB's apply. 2. No limit (medical emergencies only)	- Limited to emergencies and after-hours services. - The unlimited emergency out of preferred provider network visits benefit is subject to the final diagnosis meeting the requirements of the preferred provider's definition of a medical emergency. - Member to settle account and submit to preferred provider for reimbursement - Subject to preferred provider protocols.
T. MOMTYB	AUXILIARY SERVICES Podiatrists, Speech Therapists and Occupational Therapists, Audiology, etc. 1.In-hospital 2. Out-of -hospital	1. 100% 2. 0%	1.PMB's only 2. Not applicable	Not Applicable
U. MomTYB	INTERNAL SURGICAL IMPLANTS	100% **[Added as from 1 January 2013]**	No limit. **[Added as from 1 January 2013]**	PMB's only. Authorisation must be obtained from the Scheme's designated agent Subject to scheme protocols.**[Added as from 1 January 2013]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
V. MomTYB	OTHER MEDICAL AND SURGICAL APPLIANCES 1. Back, leg, arm and neck supports 2. Crutches 3. Surgical Footwear (Excluding health footwear) 4. Respiratory Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient. 5. Medical apparatus continually essential for the medical treatment of the patient.	Preferred Provider – 100% Non-Preferred Provider – 70% unless PMB's apply. **[Amended with effect from 1 January 2018]**	R4 000 PMF, unless PMB's apply. **[Amended with effect from 1 January 2019]**	Subject to pre-authorisation by the Scheme and only allowed if forming part of in-hospital treatment unless PMB's apply.
W. Primecure	OPTICAL 1. Eye examinations 2. Spectacles	Preferred Provider - 100% Non-Preferred Provider - 70%**[Amended with effect from 1 January 2018]**	1. One optometry examination per beneficiary every year. 2. One pair spectacles PB every 2 years.	- This benefit shall be provided in accordance with the Preferred Providers' protocols. - The choice of frame is limited to the preferred provider's range of approved frames.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
X. MomTYB	Pregnancy tests, post- and antenatal care, minor trauma treatment. Maternity Benefit	Preferred Provider - 100% Non-Preferred Provider – 70% unless PMB's apply. **[Amended with effect from 1 January 2018]**	No limit except in respect of ultrasounds which are limited to 2 per pregnancy	Benefit includes sonars at Preferred Provider facilities subject to authorisation, failing which no benefit will be paid, unless PMB's apply. - Subject to registration on maternity programme. Limited to 2 visits (GP or Gynae and 2 2D scans,1 Paediatrician visit and Antenatal vitamins worth R65 per month for 9 months. **[Added with effect from 1 January 2020]**
Y. PrimeCure	HIV/AIDS out-of-hospital benefit	Preferred Provider – 100% Non-Preferred Provider –70% unless PMB's apply. . **[Amended with effect from 1 January 2018]**	No limit	- Benefit subject to compliance with the preferred providers disease management program, unless PMB's apply. - No benefit in respect of lost or destroyed medication.
Z. MomTYB	ORGAN TRANSPLANTS **[Added as from 1 January 2013]**	100% **[Added as from 1 January 2013]**	No limit **[Added as from 1 January 2013]**	PMB's at DSP subject to regulation 8(3). **[Added as from 1 January 2013]**

Reg. No.: 1464
7 Lutman Street, Richmond Hill, Port Elizabeth, 6001
P.O. Box 1672, Port Elizabeth, 6000
Hospital Authorisations: 0860080888
Customer Care: 0860080888
Email: info@suremedhealth.co.za
www.suremedhealth.co.za

Annexure C to Suremed Health Rules, Scheme Exclusions

Suremed Health does not provide for the following exclusions:

Please note that this list is not exhaustive and is subject to change, please contact the Scheme to confirm cover.

- All costs exceeding the annual or biennial maximums as set out in Annexure B in terms of the rules
- Medical, surgical and orthopaedic appliances, devices and products, including oxygen hire or purchase and attachments (unless specifically provided for in Annexure B)
- All costs for operations, medicines, treatments, and procedures for cosmetic purposes or for personal reasons
- Medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines (except for schedule 0, 1 and 2 medicines supplied by a registered pharmacist)
- Any health care service that is not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost
- Medicines not registered and approved by the South African Health Products Regulatory Authority (SAHPRA) for the clinical treatment of a condition.
- All costs for treatment if the efficacy and safety of such treatment cannot be scientifically proved
- MRI scans ordered by a general practitioner, except in emergencies
- Specialist (same specialty) referral for second opinions unless authorized by the Scheme
- Injuries sustained while voluntarily participating in a riot, civil commotion, war, invasion, act of foreign enemy, hostilities whether war is declared or not, and civil war: or injuries arising from professional sport, speed contests and speed trials, motor sports, paragliding, hang gliding, scuba diving, skydiving, mountaineering, motor cross, quad biking. Benefits limited to PMB's.
- Organ and tissue donations to any other person than to a member or dependant of a member.
- all costs incurred for treatment of any sickness condition sustained by a member or dependant of a member where such sickness condition is directly attributable to failure to carry out the instructions of a medical practitioner, unless if the sickness condition is a PMB, where upon relevant provisions will apply.

- Medical examinations for employers or employment and /or insurance/ and/or school readiness and/or legal purposes
- Non-disclosure of conditions
- Hire of medical, surgical and other appliances, unless PMB or authorized by Schemes' designated agent.
- The Scheme shall not be liable for the payment of any costs incurred by a member, which arose or may have arisen, as a result of the actions or omissions of another party including legal fees or deductions incurred by the member
- Accommodation in a private room of a hospital, unless clinically indicated and prescribed by medical practitioner and authorized by the Scheme
- All claims related to items noted in 3.10 of Annexure C of the Scheme rules
- Procedures listed on Suremeds procedure exclusion list, contact the Scheme to find out if your procedure is covered
- Accommodation and services provided in a geriatric hospital, old age home, frail care facility or the like (unless specifically provided for in Annexure B);
- Acupuncture (Only covered by approved providers)
- Medication listed on Suremed medication exclusion list, contact the Scheme to find out if your medication is covered
- Appointments which a beneficiary fails to keep
- Appliances, devices and procedures not scientifically proven or appropriate
- Dental procedures or devices which are not regarded by the relevant managed health care programme as clinically essential or clinically desirable
- Alternative providers not specifically listed for cover in the Suremed benefits and rules

Medication exclusions - Suremed health

Anabolic steroids
Anti-retroviral medication, except where authorised through the Scheme's Wellness Program
Appetite suppressants and medications registered for weight management
Bandages, dressings and other consumables - only allowed in hospital and on an out-patient basis, subject to authorisation as part of a wound management program
Chemotherapy, except where authorised through the Scheme's Oncology Program
Contact lens solutions

Cosmetic preparations
General soaps and shampoos
Growth Hormone
Homeopathic, herbal and complimentary medicine preparations
Immunostimulants except where authorised as part of approved treatment protocols
Immunosuppressants except where authorised as part of approved treatment protocols
Malaria prophylaxis
Medication relating to impotence, infertility (except PMB), libido or sexual dysfunction
Medicine and preparations used to assist in the cessation of smoking
Medicine classified as Biologicals except where authorised as part of approved treatment protocols
Medicine use to treat alopecia
Nutritional supplements, including baby food and special formula
Oral Rehydration solutions
Pre- and Probiotic medicines
Stimulant laxatives
Sunscreen and sun tanning agents
Topical Musculoskeletal medicines
Tuberculosis medication
Unmedicated throat lozenges (do not contain antiseptic or anaesthetic)
Unregistered medicines (not registered and approved by SAHPRA for treatment of a clinical condition) and off label usage of registered medicines
Vitamin and Mineral supplements

**this list is not exhaustive and was correct at time of publishing*

Suremed Health Scheme Rules - Annexure D

WAITING PERIODS

In terms of Section 29A of the Medical Schemes Act waiting periods can be classified as follows:

NUMBER OF DAYS SINCE TERMINATION OF MEMBERSHIP OF PREVIOUS MEDICAL AID AND APPLICATION			
90 DAYS OR MORE	**LESS THAN 90 DAYS**		
	Less than 2 Years Continuous Membership	**More than 2 Years Continuous Membership**	**Change of Scheme because:** - **change of employment, or** - **employer changes schemes at end of financial year upon giving reasonable notice.**
Section 29A (1) - 3 month general waiting period, and - 12 month condition-specific waiting periods. - PMB's not available	Section 29A (2) - No 3 month general waiting period. - 12 month condition-specific waiting periods except for treatment/diagnosis ito PMB, - any unexpired general or condition-specific waiting period from previous scheme. - PMB's are available	Section 29A (3) - 3 month general waiting period except for treatment/diagnosis ito PMB. - No 12 month condition specific waiting period - PMB's are available	Section 29A(6)(a) and (b) No waiting periods at all.

Condition Specific Waiting Periods
In terms of the Act a "condition specific waiting period" is defined as:
"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".

LATE JOINER PENALTIES

Premium penalties may be applied to a "late joiner" who is any person 35 years or older (but excludes someone with coverage on a medical scheme from a date prior to1 April 2001 and which coverage continued without a break in coverage for at least 3 consecutive months after 1 April 2001). This means that only cover from 2001 onwards is counted towards working out an LJP.
Penalties may be applied 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	0.50 x contribution
25 plus years	0.75 x contribution

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

A = B – (35 + C) where:
A = number of years to determine appropriate penalty band
B = age of the late joiner at time of application
C = number of years of creditable coverage which can be demonstrated.

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“Creditable coverage” is defined in detail in Regulation 11 and the rules. Basically it is the period that the Late Joiner was a member/dependant of a medical scheme, but excluding any period as a dependant under the age of 21 years.