R U L E S

OF

IMPERIAL GROUP MEDICAL SCHEME

ADMINISTERED BY:

METROPOLITAN HEALTH CORPORATE (PTY) LTD
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IMPERIAL GROUP MEDICAL SCHEME

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NAME, LEGAL PERSONA AND REGISTERED OFFICE

PART I

1. NAME

The name of the Scheme shall be the IMPERIAL GROUP MEDICAL SCHEME hereinafter referred to as the "Scheme". The abbreviated name shall be IMPERIALMED.

2. LEGAL PERSONA

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

3. REGISTERED OFFICE

The registered office of the Scheme shall be situated at 11 Park Lane, Entrance 15 Junction Avenue, Parktown, 2193, Gauteng, but the Board shall have the right to transfer such office to any other situation in the Republic of South Africa, should circumstances so dictate.

DEFINITIONS

PART II

4. DEFINITIONS

In these Rules, words and expressions defined in the Medical Schemes Act,(Act No. 131 of 1998), bear the meanings thus assigned to them and, unless inconsistent with the context;

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

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

(c) the following expressions shall have the following meanings:

"ACT", the Medical Schemes Act (Act No 131of 1998) and the regulations promulgated there under as amended from time to time.

"ACTUARY", shall mean an Actuary as defined in the Act.

"ADULT DEPENDANT", a dependant other than a child dependant.

"ANNUAL LIMIT", the maximum amount to which benefits to a member and his registered dependants shall be paid by the Scheme in terms of these Rules, which amount shall be calculated annually to coincide with the financial year of the Scheme.

"AUDITOR", an auditor registered in terms of the Public Accountants and Auditors Act, 1991 (Act No 80 of 1991).

"BENEFICIARY", a member or a person admitted as a dependant of a member.

"BOARD", the Board of Trustees.

"CHILD", a member's dependent child including a step-child, legally adopted child or a child placed in the care and custody of the member or spouse or partner by virtue of a Court Order (including grandchildren).

"CHILD DEPENDANT", a child under the age of 21 years including a full-time student up to the age of 25 years, and a financially dependent part-time student up to the age of 25 years, and excluding the members' spouse or partner who is under the age of 21.

"CONTRIBUTION", in relation to a member, the core contribution, exclusive of interest, payable by or in respect of a member plus any voluntary additional contribution.

"CONDITION-SPECIFIC WAITING PERIOD", a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made.

"CONTINUATION MEMBER", a member who retains membership of the Scheme or a dependant who becomes a member in terms of Rule 6.3.

"CREDITABLE COVERAGE", any period during which a late joiner was –

(a) a member or a dependant of a medical scheme, but excluding any period of coverage as a child dependant, under the age of 21 years;
(b) 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;
(c) a uniformed employee of the South African National Defence Force; or
(d) a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years

"DATE OF SERVICE":

(a) in the event of a consultation, visit or treatment, the date on which such consultation, visit or treatment took place;

(b) in the event of an operation, procedure or confinement, the date on which such operation, procedure or confinement occurred;

(c) in the event of hospitalisation, the date of discharge from a hospital or nursing home or date of cessation of membership, whichever date occurs first;

(d) in the event of any other service, the date on which such service was rendered.

"DEPENDANT":

(a) The member's spouse or partner who is not a member or registered dependant of a member of a medical scheme;

(b) the child of a member who is not a member or registered dependant of a member of a medical scheme;

(c) any other member 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 a medical scheme;

(d) any minor brother or sister of a child dependant, which child dependant has been orphaned and as a consequence thereof is registered as a member in terms of Rule 6.3.2 provided such minor brother or sister is registered as a dependant at the time of the child dependant is registered as a member;

(e) the Principal Officer may, at his sole discretion, upon application admit any other person as dependant.

“DEPENDANT – DISABLED”, a disabled dependant of any age who is financially dependent on the principal member will pay a child rate contribution.

"DESIGNATED SERVICE PROVIDER", a healthcare provider or group of providers selected by the Scheme as preferred provider/s to provide to the beneficiaries, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.

"*DOMICILIUM CITANDI ET EXECUTANDI*", shall mean the member’s chosen physical address at which notices as well as legal process, or any action arising there from, may be validly delivered and served.

"EMPLOYEE", shall mean:

(a) A person in the employment of Imperial Holdings Limited and its associated and subsidiary companies and who are eligible for membership in terms of their employment contracts; and

(b) A person in the employment of a former subsidiary or associated company (“entity”) of Imperial Holdings Limited on the express conditions that:

(i) such employees and the management of such entity have elected to remain on the Scheme; and

(ii) the Trustees of the Scheme have given approval that these employees may remain on the Scheme; and

(iii) such entities remain in the same trade, occupation or industry as what they were operating in whilst the entities were part of the Imperial Holding Limited group.

"EMPLOYER", shall mean Imperial Holdings Limited, its associated and subsidiary companies and former subsidiaries or associated companies of Imperial Holdings provided that such former subsidiaries or associated companies remain in the same trade or industry as they have been whilst part of the Imperial Holdings Limited group.

"FINANCIAL YEAR", a calendar year commencing on 1 January and ending 31 December.

"GENERAL WAITING PERIOD", a period during which a beneficiary is not entitled to claim any benefits.

“GENERIC REFERENCE PRICING”, is equal to the Metropolitan Health Risk Management (Previously known as Qualsa) maximum price.

"INCOME", for the purposes of the contribution schedule, income shall refer to:

(a) In the case of an employee, pensionable salary.

(b) In the case of a continuation member, total income from any source.

“LATE JOINER”, an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 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 3 consecutive months since April 2001.

"LIABLE FOR FAMILY CARE AND SUPPORT", a liability for financial support enforceable by a court of law.

“LIFE CHANGING EVENT”, shall mean *inter alia* divorce, marriage, retrenchment, spouse or partner’s change of employment or death.

"MANAGED HEALTH CARE PROGRAMME" shall mean a health care delivery arrangement designed to monitor and to reduce the unnecessary utilisation of services, to contain costs and to measure performance while providing accessible, quality and effective health care including the most effective and efficient utilisation of benefits available to each beneficiary and as referred to in Annexure B, Schedule of Benefits.

"MEDICINE PRICE" shall mean the single exit price published in terms of the Medicines and Related Substances Act No. 101 of 1965 plus the dispensing fee authorised by the Board in respect of such medicine.

"MEDICAL SCHEME RATE", the rate at which health services are reimbursed by the Scheme, which shall be determined by the Scheme from time to time.

"MEDICAL PRACTITIONER", a general practitioner or a specialist.

"MEMBER", any person who is enrolled as a member of the Scheme in terms of these Rules.

"MEMBER FAMILY", the member and all his registered dependants.

"MINIMUM BENEFITS", any service falling within the prescribed minimum benefits obtained by a member from a public hospital and which service is not different from the service available to a public hospital patient.

"MONTH", the period from the first day of a month to the last day of such month, both days inclusive.

"OTHER IMMEDIATE FAMILY", shall mean a member's parent (including an adoptive parent), brother and sister.

"PARTNER", a person with whom the member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, for a period of at least one year irrespective of the gender of either party.

"PRESCRIBED", shall mean prescribed by regulation.

"RULES", these Rules of the Scheme including the annexures and any other provisions relating to the benefits granted or the contributions payable.

"SERVICE" shall mean any relevant health service.

"SPOUSE", the spouse of a member to whom the member is married in terms of any law or custom.

OBJECTS

PART 111

5. OBJECTS

The objects of the Scheme are to establish and maintain a Fund by contributions, donations or otherwise and thereby to undertake liability and to make provision for:

5.1 The granting of assistance to members in defraying expenditure incurred by them and their dependants in connection with health care treatment as provided for and in accordance with the Rules of the Scheme;

5.2 The rendering of a service, contemplated in these Rules, to members and their dependants either by the Scheme itself or by any supplier, or group of suppliers of a service in association with or in terms of an agreement with the Scheme; and

5.3 The obtaining by members thereof and by dependants of such members of any service.

MEMBERSHIP

PART IV

6. MEMBERSHIP

6.1 Benefit Plan

6.1.1 members' will be allowed to move from one benefit plan to another benefit plan at the beginning of each benefit year, i.e. on 1 January each year**.**

6.2 Employees

6.2.1 Subject to the further provisions in these Rules, membership of the Scheme is restricted to employees.

6.2.2 Subject to Rules 6.2.3 and 6.4 any employee who enters the service of the Employer and for whom membership is a condition of employment, shall become a member as from the date of becoming an employee.

6.2.3 An employee shall be entitled to choose between becoming a member of the Scheme (refer 6.2.2 above) or of joining his spouse's or partner's Medical Scheme as a dependant. All employees who choose to become a dependant on their spouse's or partner's Medical Scheme must produce evidence of such registration as dependant. In the event of the employee ceasing to be a dependant in terms of the provisions of his spouse's or partner's Medical Scheme, he shall apply to be admitted or readmitted as a member of the Scheme.

6.3 Continuation Members

6.3.1 Retirees

6.3.1.1 A member shall retain membership of the Scheme in the event of his retirement from the service of the employer or retirement due to reorganisation or whose

employment is terminated by the employer on account of age, ill-health or other disability:

The Scheme shall inform the member of his right to continue his membership and of the contribution due 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.

6.3.2 Dependants of Deceased Members

6.3.2.1 The dependants of a deceased member, who are registered with the Scheme as his dependants at the time of such member's death, shall be entitled to membership of the Scheme;

The Scheme shall inform the dependant of his right to continued membership and of the contributions due in respect thereof. Provided such dependant informs the Board in writing within three months of receiving the notification of eligibility of his intention to become a member, he shall be admitted as a member of the Scheme.

6.4 Seconded Employees

Notwithstanding anything to the contrary contained in these Rules a member and his dependants shall not forfeit any benefits or interest in the Scheme on the ground of the member having been seconded for service, in or outside the borders of the Republic of South Africa, by an Employer, but shall continue to be a member of or retain the right to participate in the Scheme.

6.5 Terms and Conditions Applicable to Membership

6.5.1 A minor may become a member with the assistance of his parent or guardian.

6.5.2 No person shall be a member or a dependant of a member of more than one medical scheme or a dependant:

6.5.2.1 of more than one member of a particular medical scheme; or

6.5.2.2 of members of different medical schemes; or

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

6.5.3 At the date of employment an employee wishing to join the Scheme shall complete and submit to the Scheme the application forms required by the Scheme.

Provided further that such person shall on application for membership, submit evidence in respect of himself and his dependants of age, income, state of health and any prior membership or admission as dependant of any other medical scheme to the satisfaction of the Board.

Provided further that the Board may in any particular case require a medical examination at the expense of the Scheme in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period ending on the date on which an application for membership was made.

6.5.4 Every member shall, within 3 months of the admission date, in respect of himself or his dependants furnish such information as the Board may require.

6.5.5.1 No waiting periods shall be imposed on an employee in respect of whom application is made for membership within 30 days of -

6.5.5.1.1 the employee's transfer to an associate company/subsidiary of the Employer, where the transfer results in membership of the Scheme becoming a condition of employment for the employee; or

6.5.5.1.2 a specified period of secondment by the Employer; or

6.5.5.1.3 first becoming an employee where such person had a break in membership of a medical scheme of 90 days on the date of application for membership as a result of being resident or employed outside of the borders of the Republic of South Africa.

6.5.5.2 Should an employee submit a completed written application for membership within 30 days of first becoming an employee, the Board may after consideration of the information referred to in Rule 6.5.3 and Rule 6.5.4, apply the waiting periods as set out in this Rule. Such waiting period will be subject to Annexure C, Rule 3.4.

6.5.5.2.1 The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application, a condition-specific waiting period of up to 12 months.

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

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

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

6.5.5.3 For the purpose of Rule 6 and Annexure C, Rule 3, membership of a medical scheme shall include any period for which the applicant produces evidence that the applicant was:

6.5.5.3.1 a beneficiary of an entity doing the business of a medical scheme which was exempt from the provisions of the Act; or

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

6.5.5.3.3 a beneficiary of the Permanent Force Continuation Fund.

6.5.6 Should an employee apply for membership when first becoming an employee, he or she shall be registered as a member without imposition of any waiting periods or late joiner penalties.

6.5.7 Should an employee undergo a life changing event and apply to be admitted or re-admitted as a member of the Scheme within 30 days of the life changing event taking place, he or she shall be registered as a member without the imposition of any waiting periods.

6.5.8 Should an employee elect not to become a member of the Scheme when first becoming eligible for membership or a member terminate his membership of the Scheme with the view to becoming a dependant on his spouse's or partner's medical scheme, he may, on cessation of his registration as dependant on his spouse's or partner's medical scheme, apply to be admitted or re-admitted as a member of the Scheme. The Board may, apply the waiting periods as provided for in Annexure C.

6.5.9 Every member shall, on admission to membership, receive a summary of the Rules.

6.5.10 Payment of a contribution shall be deemed to constitute the members acceptance that he shall, on behalf of himself and his dependants, be bound by these Rules and by any amendment thereto.

6.5.11 No member shall 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 and any such cession or assignment will be of no force and effect and will not be recognised by the Scheme. The Scheme may withhold, suspend or discontinue the payment of the 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.

6.6 Membership Card and Certificate of Membership

6.6.1 Every member shall be issued with a membership card, containing the 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 shall be returned to the Scheme on cessation of membership, or when a new card is issued.

6.6.2 Utilisation of a membership card by any person other than the member or his registered dependants, with the knowledge or consent of the member or his dependants shall be considered to be a serious abuse of the benefits of the Scheme.

6.6.3 On termination of membership or on de-registration of a dependant, the Scheme shall within 30 days of the termination of membership or at any time at the request of any former member or dependant, provide the member or dependant or medical scheme to which such member or dependant applies

for membership, with a certificate stating the period of cover, type of cover and whether or not the person qualified for late joiner status.

6.7 Movement from another Scheme

If the members of a scheme who are members of that scheme by virtue of their employment by a particular employer terminate their membership of that scheme with the object of obtaining membership of the Scheme, the Scheme shall admit as a member, without a waiting period or imposition of new restrictions on account of the state of his health or the health of any of his dependants, any such member of such scheme who is a continuation member of such scheme by virtue of his or a deceased member's employment by such employer.

7. REGISTRATION OF DEPENDANTS

7.1 Registration of New Dependants

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

7.1.2 If a member applies for the registration of a new born or newly adopted child within 30 days of the date of birth or adoption of the child, such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption.

7.1.3 If a member who marries subsequent to joining the Scheme applies within 30 days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of marriage.

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, and if the member applies within 30 days of such event to the Scheme for the registration of such person as a dependant, such person shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month in which such person qualified as dependant and benefits will accrue as from the date on which such person first become eligible for registration as a dependant.

7.1.5 Should a member elect not to register his eligible dependants as provided for in the a-foregoing Rules, then upon future application for registration of such dependants the member will be required to provide evidence of health to the Board.

7.1.6 On registration as dependant other than as contemplated in rules 7.1.1 to 7.1.4, benefits in respect of such dependant shall be subject to the waiting periods as provided for in Annexure C.

If a member fails to apply for registration of a new born child within the 30-day period provided for in Rule 7.1.2, but applies for the registration of such child within six months from the birth of such child, the Scheme shall register such child from the first day of the month following the date of application and benefits will accrue from date of registration.

7.2 De-registration of Dependants

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

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

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

7.2.3.1 At the end of the month during which a child registered as a dependant reaches the age of 21 or any other age thereafter, unless the member provides satisfactory evidence that such child is still dependent on the member. Such proof is to be provided thirty days before the child's 21st birthday and every birthday thereafter.

7.2.3.2 At the beginning of a financial year if a dependant qualified as a dependant in terms of paragraph (c) of the definition of dependant unless the member provides satisfactory evidence that the requirements to qualify as a dependant still apply. Such proof is to be provided thirty days before the start of a new financial year.

8. CHANGE OF ADDRESS AND BANKING ACCOUNT DETAILS OF MEMBERS

A member shall notify the Scheme within thirty (30) days of any change of address including his ***domicilium citandi et executandi*** and change of banking account details. The Scheme shall have no responsibility or liability in respect of a member's rights which are prejudiced or forfeited as a result of failure to comply with the requirements of this Rule.

9. CESSATION AND SUSPENSION OF MEMBERSHIP

9.1 Resignation

Save as provided in Rule 6.2.3, a member who, in terms of his conditions of service as an employee, is required to be a member of the Scheme shall not be permitted to withdraw his membership while he remains an employee, except by prior approval by the Board.

9.2 Ceasing Employment

Subject to any provision to the contrary contained in the Rules, a member who ceases to be an employee shall, on the date of such termination, cease to be a member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto.

9.3 Voluntary Termination

Voluntary termination of active employees and pensioner/continuation members are subject to the following criteria:

- Join spouses medical aid (proof to be provided)
- Specific conditions approved by the Principal Officer of the Scheme
- 30 days notice required

9.4 On Death

9.5 Abuse

The Board may refuse benefits or terminate the membership of a member or registration of a dependant if the Board has evidence of abuse of the privileges offered by the Scheme, fraud, submission of false claims, misrepresentation or non-disclosure of material information. Should the Board have reason to suspect misrepresentation or non-disclosure of material information, a member or dependant shall at the request of the Board provide such evidence of health as the Board may require.

Should the member or dependant fail to supply such proof, the Board shall be entitled to terminate membership. If the membership was terminated due to non-disclosure, the member will be granted the opportunity to re-apply for membership and full underwriting will apply.

9.6 Non-Payment

9.6.1 Contributions

The Board shall have the right to terminate or suspend the membership of a member if contributions for such member are more than one month in arrears. Benefits shall only be payable in respect of services rendered up to the date for which contributions has been received in full.

9.6.2 Shortfalls (Member Share of Claims)

The Board shall have the right to terminate or suspend the membership of a member whose share of claims is more than one month in arrears.

9.7 On re-instatement of membership, the onus of proof of claims during the period of suspension of membership will remain with the member.

9.8 Nothing in these Rules shall be construed as altering in any way the employer's right to terminate the service of an employee who is a member of the Scheme or to terminate or in any way vary the conditions of any agreement between the employer and the employee in regard to conditions of service.

CONTRIBUTIONS

PART V

10. CONTRIBUTIONS

10.1 The monthly contributions due to the Scheme for a member (including continuation members) are as set out in Annexure A.

10.2 Contributions are calculated on the basis of :

10.2.1 The income of a member;

10.2.2 The number of dependants of the member;

10.3.1 Contributions of active employees shall be paid monthly in arrears and shall be paid to the Scheme by not later than the third business day of the month following the last business day of month in which it became due. If not paid within 30 days of the due date, the Scheme shall have the right to give the member notice at his ***domicilium citandi et executandi*** that if contributions or such other debts are not paid up to date within a further 90 days of such notice, membership will be cancelled. Such notice must be given by means of registered post. The member's postal or residential address on his application shall be deemed to be his ***domicilium citandi et executandi.***

10.3.2 Contributions of debit order Pensioner and Continuation members shall be paid monthly in advance and shall be paid to the Scheme by no later than the 1st day of the month in which it becomes due. If not paid by the due date, the Scheme shall have the right to suspend the member and give the member notice at his ***domicilium citandi et executande*****. I**f contributions or such debts are not paid up to date within a further 30 days of such notice, a 2nd notice will be issued and membership will be terminated after 14 days of the date of the 2nd notice. The member's postal or residential address on his application shall be deemed to be his ***domicilium citandi et executandi.***

10.4 All contributions in respect of new members shall be due from the first day of the month during which employment commences or date of admission, except when the date on which employment commences (with simultaneous admission) is the 15th or later of a month, in which case the contributions shall be due from the first day of the following month. Benefits shall commence (subject to the various provisions of Rule 6) from the date on which employment or membership commences, whichever is the later.

10.5 When a member's employment terminates on the 15th or later of a month, contribution for the full month shall be due. In cases where termination takes place up to and including the 14th of the month, no contribution is due for that month, provided that the employer advises the Scheme of the date of such termination immediately it takes place. Benefits shall cease on the date of termination of employment.

10.6 Other than as provided for in these Rules, no refund of any portion of a contribution shall be due to any member where such member's membership or that of any of his dependants has terminated.

10.7 Payment of Shortfalls, a member shall be liable to pay any shortfall becoming due by him to the Scheme immediately on receipt of a notice from the Scheme setting out the amount due.

Payment shall be made to such place and in such manner as the Scheme shall, from time to time, determine.

10.8 Late Joiner Penalties – Contribution Penalties will be applied with effect from 1 January 2012 in respect of adult dependants over the age of 35 years, according to the age bands below:

- Age over 35 years: 1 – 4 years @ 0.05 x relevant contribution
- Age over 35 years: 5 – 14 years @ 0.25 x relevant contribution
- Age over 35 years: 15 – 24 years @ 0.50 x relevant contribution
- Age over 35 years: 25 + years @ 0.75 x relevant contribution

Any years of creditable coverage which can be demonstrated by the applicant for his or her adult dependant shall be subtracted from his or her current age in determining the application penalty.

The contribution penalty will not be a fixed amount and will increase with the annual contribution increase of 1 July every year.

The following formula shall be applied to calculate the applicable penalty band to be applied to a late joiner:

A = B minus (35 + C) where:

"A" means the number of years referred to in the first column of the table above, for purposes of determining the appropriate penalty band;
"B" means the age of the late joiner at the time of his/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.

11. LIABILITY OF EMPLOYER AND MEMBER

11.1 The liability of an Employer shall be the total of unpaid contributions together with any other amounts he is obliged to pay to the Scheme in terms of any agreement between the Employer and the Scheme.

11.2 The liability of a member shall include the amount of his unpaid contributions, if any, together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants which has not been repaid by him to the Scheme.

CLAIMS

PART VI

12. CLAIMS PROCEDURE

12.1 Every claim submitted to the Scheme in respect of the rendering of a health care service as contemplated in these Rules, shall be accompanied by an account or statement which shall comply with the provisions of the Act.

12.2 If an account, statement or claim is correct or where a corrected amount, 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:-

12.2.1 The name and the membership number of the member;
12.2.2 The name of the supplier of service;
12.2.3 The final date of service rendered by the supplier of service on the account or statement which is covered by the payment; and
12.2.4 The total amount charged for the service concerned; and
12.2.5 The amount of the benefit awarded for such service.

12.3 In order to qualify for benefits, any claim by a member shall be submitted to the Scheme not later than the last day of the fourth month following the date on which the service was rendered.

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

12.5 Accounts for treatment of injuries which may be recoverable from third parties, shall be supported by a statement, setting out particulars of the circumstances in which the injury was sustained.

12.6 Notwithstanding the provisions of this Rule, where the Scheme is of the opinion that a claim is incorrect or unacceptable for payment, the

Scheme shall notify the member and healthcare provider accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why the claim is incorrect or unacceptable. The member and healthcare provider shall return a corrected claim in the manner provided for in Rule 12.1 within sixty days following the date from which the claim was returned for correction.

12.7 Should the Scheme fail to notify the member and the healthcare provider or fail to provide an opportunity for correction and resubmission in terms of Rule 12.6 it shall, in the event of a dispute, be the Scheme's responsibility to demonstrate that such account, statement, or claim is erroneous or unacceptable for payment.

13. PAYMENT OF ACCOUNTS

13.1 The Scheme shall pay any benefit due to a member within 30 days of receipt of the claim pertaining to such benefit. The Scheme may, by mutual agreement with any supplier or group of suppliers of a service, pay the account or the benefit to which the member is entitled in respect of a service rendered, direct to such supplier.

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

MANAGEMENT

PART VII

14. MANAGEMENT

14.1 Subject to the provisions of Rules 19, 20, 21 and 22, the affairs of the Scheme shall be managed by a Board consisting of six members who are fit and proper to be trustees of whom three shall be appointed by the Employer and three elected by the members of the Scheme at an Annual General Meeting. All Trustees shall serve a term of 3 years and may be re-appointed (Employer Appointed Trustees) or re-elected (Member Elected Trustees) after each three year term.

14.2 In an election year, new candidates for election as Member Elected Trustees shall be nominated in writing by a proposer, a seconder and the nominee, all of whom shall be members of the Scheme. Nomination forms must be submitted to the office of the Principal Officer no later than 7 days prior to the Annual General Meeting. The election of Trustees, for new candidates and for those Trustees that stand to be re-elected, shall be determined by majority vote for all members voting by ballot under arrangements made by the Board.

14.3 Trustee appointments by the Employer shall be at the Employer's discretion.

14.4 The Board may nominate and appoint such knowledgeable persons, as Professional Trustees, for the purpose and period it deems fit to assist with the prudent management of the Scheme, provided that such persons shall not have a vote.

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

14.5.1. A person under the age of 21 years;

14.5.2. 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;

14.5.3. a broker;

14.5.4 a person who is not a member of the Scheme

14.5.5. the Principal Officer of the Scheme; and

14.5.6. the auditor of the Scheme.

14.6 Subject to rule 15.1, the Board shall have the power to fill any casual vacancy which may occur. The continuing members may act notwithstanding a casual vacancy in the body.

14.7 The Board members may meet together for the despatch of business, adjourn and otherwise regulate their meetings as they see fit.

Provided that a resolution in writing signed by all the Board members who form a quorum in terms of Rule 15.4 shall be as effective for all purposes as if it had been passed at a meeting of the Board Members duly convened, held and constituted. Any such resolution may consist of several copies of the resolution, each of which may be signed by one or more trustees (or their alternates, if applicable) and shall be deemed to have been passed on the date on which it was signed by the last trustee who signed it unless a statement to the contrary is made in the resolution. Any resolution passed in terms of this Rule shall be noted at the first meeting of the Board held after the passing of such resolution.

14.8 Half of the members of the Board plus one shall constitute a quorum for a meeting of the Board.

14.9 The Board shall appoint a Chairman from among its numbers.

14.10 In the absence of the Chairman the Board members present shall elect one of their members to preside.

14.11 Matters before the Board shall be decided by a majority vote and in the event of an equality of votes, the Chairman, in the chair for that meeting, shall have a casting vote in addition to his deliberative vote.

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

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

14.13.1 He becomes mentally ill or incapable of managing his affairs; or

14.13.2 He is declared insolvent or has surrendered his estate for the benefit of his creditors; or

14.13.3 He is convicted, whether in the Republic of South Africa or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury; or

14.13.4 He is removed by a Court from any office of trust on account of misconduct; or

14.13.5 His appointment is terminated by the Employer; or

14.13.6 His membership of the Scheme is terminated; or

14.13.7 He is removed from office by the Council in terms of section 46 of the Act.

14.14 Members of the Board shall be remunerated as determined from time to time at the annual general meeting and may in addition be reimbursed for travelling and other expenses properly and

necessarily incurred by them in and about the business of the Scheme.

15. DUTIES OF SCHEME'S OFFICERS

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

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

15.3 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.

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

15.5 The Board shall appoint a principal officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the principal officer and of any person employed by the Scheme.

The following persons are not eligible to be a principal officer:

15.6.1 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; and

15.6.2 a broker.

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

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

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

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

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

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

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

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

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

15.15 Subject to rule 17.16, the Board must approve all disbursements.

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

15.17 The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines

pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.

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

16. POWERS OF THE BOARD

The Board has the power —

16.1 to cause the termination of the services of any employee of the Scheme;

16.2 to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations under such appointments;

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

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

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

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

16.7 to let or hire movable or immovable property;

16.8 in respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise

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

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

16.10 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;

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

16.12 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;

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

16.14 to reinsure obligations in terms of the benefits provided for in these rules. The Board shall ensure that proper records are maintained of premiums, commissions, fees and benefits due under such arrangements;

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

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

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

17. DUTIES OF PRINCIPAL OFFICER AND STAFF

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

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

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

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

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

17.2.4 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;

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

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

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

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

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

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

18. INDEMNIFICATION

The Committee, the Board of Trustees, the Administrator, any Officer of the Scheme and any person employed by or on behalf of the Scheme shall be indemnified by the Scheme against all proceedings, damages, claims, costs and expenses incurred by reason of any claim in connection with the Scheme, not arising from negligence, dishonesty or fraud.

19. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme shall run from the first day of January to the end of December of each year.

20. BANKING ACCOUNT

The Scheme shall maintain a banking account with a registered commercial bank. All monies received shall be deposited to the credit of such account and all payments shall be made either by electronic transfer or by cheque under the joint signature of not less than two persons nominated by the Board.

21. AUTHORITY FOR PAYMENTS

Subject to Rule 21.4, all disbursements shall be approved by the Board:

Provided that such authority may be delegated to the Principal Officer, the Administrator or such other person as the Board may approve.

AUDITOR

PART VIII

22. AUDITOR

Subject to the provisions of section 36 of the Act, the following shall apply:

22.1 An auditor shall be appointed by the Board at each Annual General Meeting to hold office from the conclusion of that meeting to the conclusion of the next Annual General Meeting.

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

22.1.2 a member of the Board;

22.1.3 an employee, officer or contractor of the Scheme;

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

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

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

22.2 At any General Meeting a retiring auditor, however appointed, shall be deemed to be re-appointed at the Annual General Meeting following his appointment or re-appointment until the conclusion of the next Annual General Meeting without any resolution being passed to that end, unless :

22.2.1 He is not qualified for re-appointment; or

22.2.2 A resolution is passed at the first-mentioned meeting appointing somebody else in his place or providing expressly that he is not being re-appointed; or

222.3 He has given the Scheme notice in writing of his unwillingness to be re-appointed.

22.3 The Board may at any general meeting remove from office any auditor appointed or re-appointed under this Rule and appoint another auditor in his place.

22.4 Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board shall within thirty days appoint another auditor to fill the vacancy.

22.5 The auditor of the Scheme shall be entitled to attend any general meeting of the Scheme and to receive all notices of and other communications relating to any general meeting which any member of the Scheme is entitled to receive and to make at such meetings any statement in relation to any return, account or balance sheet examined by him or report made by him.

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

22.7 The auditor shall make a report to the members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in general meeting.

22.8 The Board shall appoint an audit committee of five members of whom two shall be members of the Board.

GENERAL MEETINGS

PART IX

23. GENERAL MEETINGS

23.1 Annual General Meeting

23.1.1 The annual general meeting of members shall be held before the 31st of July each year.

23.1.2 Members and continuation members shall be furnished with a notice convening the annual general meeting containing the agenda, the Board Report and a summary of the financial statements and other documents provided for in section 37 of the Act at least 14 days before the meeting. The non-receipt of such notice by any member shall not invalidate the proceedings at such a meeting.

23.1.3 10 members of the Scheme present in person shall form a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed until the same day of the next week and the members then present shall form a quorum.

Provided that, if the same day of the next week is a public holiday, the meeting will be postponed till the first working day following the public holiday.

23.1.4 The financial statements and reports specified in section 37 of the Act shall be laid before the meeting.

23.1.5 Notice of motions to be placed before the annual general meeting must reach the Principal Officer not later than 7 days prior to the date of the meeting.

23.1.6 In order to enable members' resident in different parts of South Africa to attend and participate in the Annual

General Meeting the Board may, in consultation with the Advisory Committee, direct that the Annual General Meeting take place in any appropriate form or fashion. Provided that no such arrangements shall be prejudicial to the rights of the members. For the sake of clarity it is recorded that such arrangements may take the form of a series of Regional meetings at which the quorum shall be no less than 10 members.

23.2 Special General Meeting

23.2.1 A special general meeting of members may be called by the Board, if it is deemed necessary.

23.2.2 At the request of at least 12 members of the Scheme, the Board shall cause a special general meeting to be called within 21 days. The request shall state the objects of the meeting and shall be signed by all 12 or more of the members and be delivered to the Principal Officer at the registered office of the Scheme.

23.2.3 The notice convening the special general meeting containing the agenda shall be displayed prominently at the employers' places of business and dispatched to continuation members at least 14 days before the date of the meeting. The non-receipt of such notice by any member shall not invalidate the proceedings at such a meeting.

23.2.4 12 members present in person shall form a quorum. If a quorum is not present at a special general meeting called by the Board after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed till the same day and time of the next week and the members then present shall form a quorum:

Provided that, if the same day of the next week is a public holiday, the meeting will be postponed till the first working day following the public holiday.

Provided further than if a quorum is not present at a special general meeting convened at the request of members after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.

23.3 Voting at General Meetings

23.3.1 Every member who is present at a general meeting of the Scheme and whose contributions are not in arrear shall have the right to vote at the meeting or, subject to the provisions of Rule 23.3.2, appoint another person who is a member of the Scheme as a proxy to attend, speak and to vote in his stead.

23.3.2 The instrument appointing the proxy shall be in writing, in a form determined by the Board and shall be signed by the member and the other person who is appointed as proxy. The proxy form shall be deposited not later than 2 days before the time for holding the meeting at the registered office of the Scheme or at such other place or places as the Board shall decide and of which notice has been given in the notice of the meeting.

23.3.3 Failure to comply with the provisions of Rule 23.3.2 shall render any proxy invalid.

23.3.4 The Chairman's decision as to whether or not any proxy is valid shall be final and binding.

23.3.5 The Chairman shall determine whether voting shall be by ballot or by a show of hands. In the event of the votes being equal, the Chairman shall, if he is a member of the Scheme, have a casting in addition to a deliberative vote.

MISCELLANEOUS

PART X

24. SETTLEMENT OF DISPUTES

24.1 A disputes committee consisting of three persons, who shall not be Officers of the Scheme or employees of the administrator, shall be appointed by the Board as and when requested by a member, prospective member, former member, or person claiming by virtue of such member, in order that a dispute may be decided. Any dispute which may arise between a member, prospective member, former member or a person claiming by virtue of such member, and the Scheme or an officer of the Scheme shall be referred by the Principal Officer to the disputes committee for review.

24.2 On receipt of a request in terms of this Rule, the Principal Officer shall convene a meeting of the disputes committee by giving not less than 14 days notice in writing to the complainant, members of the Board and all members of the disputes committee, stating the date, place and hour of the meeting and particulars of the dispute.

24.3 The disputes committee shall determine the procedure to be followed.

24.4 The parties to any dispute shall have the right to be heard before such committee either in person or through a representative. The decision of the disputes committee shall be binding subject to appeal to the Council for Medical Schemes. Such appeal shall be in the form of an affidavit directed to the Council for Medical Schemes to reach the Registrar by not later than 3 months after the date on which the decision concerned was made.

24.5 Members may lodge complaints in writing to the Scheme. The Scheme shall also provide a dedicated telephone number which may be used for dealing with telephonic complaints. All written

complaints will be responded to in writing within 30 days of receipt thereof.

25. DISSOLUTION

25.1 The Imperial Holdings Limited may, on three months written notice to the Board, reduce, suspend or terminate his contributions to the Scheme. The Board shall thereupon arrange for members to decide by ballot whether the Scheme shall continue business without the employer's contributions or with his reduced contributions, or whether the Scheme shall be liquidated. Unless a majority of members decide that the Scheme shall continue, the Scheme shall be liquidated as provided for in the Act.

25.2 A two-thirds majority at a general meeting may decide that the Scheme shall be dissolved in which event the Board shall arrange for members to decide by ballot whether the Scheme shall be liquidated. Unless the majority of members decide that the Scheme shall continue, the Scheme shall be liquidated in terms of Section 64 of the Act.

25.3 The Principal Officer shall despatch to every member by registered post a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper:

Provided that the memorandum and ballot paper shall before despatch be forwarded to the Registrar for comment. Every member shall be requested to return his ballot paper duly completed before a set date. If at least 50 per cent of the member return their ballot papers duly completed and if the majority thereof are in favour of the dissolution of the Scheme, the Board shall take a formal decision that the Scheme shall be dissolved with effect from a set date from which date no further contributions shall be payable to the Scheme. If a decision to dissolve the Scheme has

been taken, the dissolution shall be affected in accordance with the memorandum and as provided for in the Act. In such event, the Board shall, with the approval of the Registrar, appoint a liquidator.

26. AMALGAMATION

The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with or transfer its assets and liabilities to or take transfer of assets and liabilities from any other medical scheme.

27. PERUSAL OF DOCUMENTS

27.1 A beneficiary may on payment of a fee of R10 obtain from the Scheme copies of the following documents:

27.1.1 The rules of the Scheme;

27.1.2 the latest annual financial statements of the Scheme;

27.1.3 the latest auditor's report of the Scheme;

27.1.4 the latest annual report of the Scheme; and

27.1.5 the management accounts in respect of the Scheme.

27.2 A beneficiary shall be entitled to inspect, free of charge, at the registered office of the Scheme, any of the documents as provided for in rule 36.1 and to make extracts there from.

28. WAIVER OF TIME LIMITS

With the exception of circumstances in which such a determination might be inequitable or inconsistent with these Rules or the Objects of the Scheme, the Board shall have the right to waive or relax or condone the non-compliance with any time period provided for in these Rules.

29. AMENDMENT OF RULES

29.1 Unless otherwise provided, the Board shall be entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

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

29.3 Members shall be given 30 days advance written notice of any change in contributions, benefits or any other condition affecting their membership.

29.4 Notwithstanding the provisions of Rule 38.1 above, the Board shall, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.

29.5 No alteration, rescission or addition which affects the objects of the Scheme shall be valid unless it has been approved by a majority of members present in general meeting or by ballot.

30. MANAGED HEALTH CARE PROGRAMMES

30.1 The Board has the right to introduce managed health care programmes from time to time. In terms of such programmes, certain of the medical conditions are managed by the Scheme's Managed Health Care Organisations.

30.2 If a member fails to register with such a programme or does not comply with the conditions of the programme, benefits shall be payable at scheme rate other than those benefits laid down in Annexure B to these rules in respect of the Prescribed minimum Benefits.

ANNEXURE A

CONTRIBUTIONS

1. CONTRIBUTIONS

Contributions shall be payable as per the Schedules below.

2. CONTRIBUTION TABLES

2.1 Imperialmed Health Plan

Imperialmed Health Plan contribution table with effect from 1 July 2015			
Income Category	**Principal Member**	**Adult Dependent**	**Per Child (Max 3)**
R0 - R2 790	1 682	1 344	303
R2 791 – R4 190	1 901	1 522	342
R4 191 – R5 580	2 111	1 689	380
R5 581 – R6 340	2 349	1 881	424
R6 341 – R7 610	2 372	1 900	427
R7 611 – R8 870	2 396	1 917	433
R8 871 – R10 140	2 417	1 936	437
R10 141 – R11 420	2 442	1 954	441
R11 421+	2 467	1 976	446

2.2 Imperialmed Budget Plan

Imperialmed Budget Plan contribution table with effect from 1 July 2015			
Income Category	**Member**	**Adult Dependant**	**Per Child (Max 3) ***
R0 – R10 140	1 284	1 029	274
R10 141 – R11 420	1 367	1 094	322
R11 421 – R12 690	1 483	1 185	378
R12 691 – R13 960	1 629	1 304	391
R13 961 +	2 252	1 801	406

3 **Late Joiner Penalties** – Contribution Penalties will be applied with effect from 1 January 2012 in respect of adult dependants over the age of 35 years or older, according to the age bands below:

- Age over 35 years: 1 – 4 years @ 0.05 x relevant contribution
- Age over 35 years: 5 – 14 years @ 0.25 x relevant contribution
- Age over 35 years: 15 – 24 years @ 0.50 x relevant contribution
- Age over 35 years: 25 + years @ 0.75 x relevant contribution

Any years of creditable coverage which can be demonstrated by the applicant for his or her adult dependant shall be subtracted from his or her current age in determining the application penalty.

The contribution penalty will not be a fixed amount will increase with the annual contribution increased of 1 July every year.

The following formula shall be applied to calculate the applicable penalty band to be applied to a late joiner:

A = B minus (35 + C) where:

"A" means the number of years referred to in the first column of the table above, for purposes of determining the appropriate penalty band;
"B" means the age of the late joiner at the time of his/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.

ANNEXURE B

SCHEDULE OF BENEFITS

Subject to the exclusions, limitations and waiting periods that may be imposed as provided for in Annexure C or elsewhere in these Rules, the following benefits shall be available to a member and his dependants.

1. HOSPITAL BENEFIT MANAGEMENT PROGRAM

1.1 All scheduled hospital admissions are subject to pre-certification three (3) working days prior to the admission. Certification for unscheduled admissions or emergencies must be obtained within 24 hours of admission or on the first working day following such admission. Certification will only be granted for medically necessary treatment and procedures.

1.2 If certification is not obtained, the member will be liable for a co-payment of R500 on the hospital account.

1.3 Subject to the initial period authorised on pre-certification, hospital stays shall be limited to the following periods:

1.3.1 Specialised Intensive Care 1 Day
1.3.2 Confinements (Natural birth) 3 Days
1.3.3 Confinements (Caesarean Section) 4 Days

Provided that additional days may be allocated by the case manager. Benefits for intensive care units and high care wards are subject to a maximum period of seventy two (72) hours per case. Thereafter no further benefits shall be paid unless such stay is further certified with extended periods not exceeding seventy two (72) hours at a time.

1.4 Provided the initial hospitalisation was pre-certified, pathology, radiology and radiotherapy, provided out of hospital may at the discretion of the case manager be paid as part of the Major Medical Benefit. In all other instances post-hospitalisation care shall be paid as part of the day-to-day expenses.

1.5 Pre-certification will only be considered for conservative dentistry performed on persons who are 12 years or younger. All other dental related cases requiring surgery and that do not fall into the surgical class of tariffs, will have to be motivated by the attending dental practitioner. Such motivated cases would include those for simple extractions.

1.6 The sub-limits imposed in respect of ultrasound, MRI, CAT scans, prosthesis, appliances, nursing services sub-acute care ("Step Down Facility") will apply unless specifically waived by the case manager.

1.7 The Scheme will only cover the maximum rate payable for discharge prior to 12h00 on the date of discharge unless it receives a motivation by the responsible medical practitioner that it was medically necessary for the discharge to occur after 12h00. If a procedure is scheduled for after 12h00 on date of admission, the Scheme will only cover the rate payable for admission after 12h00 unless it receives a motivation by the medical practitioner that it was medically necessary for the admission to occur before 12h00.

1.8 Pre-certification will only be considered for otoplasty performed on beneficiaries who are under 12 years. No benefit is available for otoplasty for any beneficiary who is 12 years of older.

2. MATERNITY BENEFITS

Benefits are payable to a midwife only in the event of a general practitioner or gynaecologist not being involved. Midwife services only covered on the Imperialmed Health Plan.

3. DENTAL SERVICES

3.1 Benefits shall not be payable in respect of gold and other metal inlays in dentures.

3.2 When applying the sub-limits as provided for in the benefit schedule, services other than the administering of an anaesthetic by a medical

practitioner qualify for oral dental benefits if they are rendered for dental conditions.

4. MAXILLO-FACIAL AND ORAL SURGERY

No benefit will be paid in cases where the services are for cosmetic purposes only. The decision as to whether or not services were for cosmetic purposes shall be at the sole and absolute discretion of the Board.

5. MISCELLANEOUS CONDITIONS

5.1 Unless otherwise indicated, benefits shall be paid at cost or the applicable tariff, whichever is the lesser.

5.2 All benefits and sub-limits are subject to the Major Medical Expenses Limit.

5.3 Unless otherwise indicated, all limits refer to the limit available per member family.

5.4 Any benefits obtained by a member under the minimum benefits shall be off-set against any other applicable benefit limit available in terms of these.

6. PRESCRIBED MINIMUM BENEFITS

6.1 Any service falling within the prescribed minimum benefits rendered by the Scheme's Designated Service Providers' ("DSP") will be covered in full. The Scheme has appointed the following DSP's:

6.1.1 National Chronic Solutions (Pty) Ltd (NCS) are appointed as the DSP for medicines for chronic conditions as set out under the Prescribed Minimum Benefits for both the Imperialmed Health Plan and the Imperialmed Budget Plan.

6.1.2 Metropolitan Health Risk Management (MHRM) GP Network with referral to the Imperialmed Specialist Network is appointed

as the DSP for the diagnosis, treatment and care of prescribed minimum benefit conditions for the Imperialmed Budget Plan.

6.1.3 Imperialmed Specialist Network is appointed as the DSP for the specialist diagnosis, treatment and care of prescribed minimum benefit conditions for the Imperialmed Health Plan.

6.2 Any services falling within the prescribed minimum benefits which are voluntary obtained by a beneficiary from a service provider other than the DSP will be covered as follows:

6.2.1 If voluntarily, knowingly, a beneficiary declines a formulary drug that is clinically appropriate and effective and opts to use another drug for the treatment of the prescribed minimum benefit condition, the beneficiary shall be liable for a co-payment of 25% of the cost of the medicine.

6.2.2 If voluntarily, knowingly, a beneficiary opt to obtain chronic medication for the treatment of the prescribed minimum benefit condition from a non-DSP, the beneficiary shall be liable for a co-payment of 25% of the cost of the medicine.

6.2.3 The Scheme shall pay 100% of Scheme Tariff in respect of any services which are voluntarily obtained by a beneficiary from a service provider, other than the DSP, for a prescribed minimum benefit condition, other than medicine for a prescribed minimum benefit chronic condition.

6.3 Any services falling within the prescribed minimum benefits which are involuntarily obtained by a beneficiary from a service provider other than the DSP will be covered in full.

6.3.1 For purposes of 6.3 above, a beneficiary will be deemed to have involuntary obtained a service from a provider other than a designated service provider, if –

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

b) Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at a location which reasonably preclude the beneficiary from obtaining such treatment from a designated service provider; or

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

6.3.2 Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a member prior to obtaining a service from a designated service provider or from a non-designated service provider.

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

1. IMPERIALMED HEALTH PLAN

This is a traditional benefit plan providing unlimited private hospital cover at 100% of Scheme Rate and routine (Non-PMB) benefits at 85% of Scheme Rate up to generous annual limits.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
1	**Hospitalisation – Private & Provincial**	100% of MSR	MME Subject to pre authorisation
a)	A deductable of **R550** applies if the following procedures are done in hospital: o Scopes • Arthroscopies • Gastro-Intestinal endoscopies ▪ Gastroscopies ▪ Colonoscopies ▪ Sigmoidoscopies o Urological scopes & Cycstoscopies o Gynaecological scopes o Minor dermatological procedures o Dental procedure	No deductable if done in doctor's room and paid at 100% MSR if in doctor's rooms No deductable if done in doctor's room and paid at 85% MSR as per Day to Day benefit	

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
1	**Hospital – Private & Provincial - continue**		
b)	**Circumcision**	100% of MSR	R2 000 per beneficiary per annum from MME, subject to motivation and pre-authorisation
c)	Accommodation in general ward, recovery room, intensive care unit or high care ward	100% of MSR	MME
d)	Theatre fees	100% of MSR	MME
e)	Medicines used in hospital/theatre	100% of Medicine Price	MME
2	**General Practitioner (GP) and Specialists - In hospital**	100% of MSR	MME
a)	Visits & consultations	100% of MSR	MME
b)	Surgical procedures & anaesthetics	100% of MSR	MME
3	**Diagnostic Services**		
a)	Radiology (X-rays), & Pathology (in hospital)	100% of MSR	MME
b)	MRI, CAT and Radio-isotope scans (in and out of hospital)	100% of MSR	**R14 600** per beneficiary per annum
c)	Ultrasound scans (in and out of hospital)	100% of MSR	**R4 350** per beneficiary per annum

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
3 **d)**	**Diagnostic services continue** PET Scans (in and out of hospital)	100% of MSR	**R22 540** per beneficiary per annum
e)	Sleep Studies Diagnostic Polysomnograms In and out of hospital	100% of MSR	MME
4	**TTO** Medicines dispensed on discharge will be covered under the Major Medical Expenses benefit	100% of Medicine Price	MME subject to R370 per beneficiary per admission
5 **a)**	**Out-patient services** – Private hospital.	Consultation paid at 85% from the GP/Specialist Benefit. Procedure and related materials paid 100% from Major Medical Expenses	MME
b)	**Out-patient services** – Provisional	Consultation paid 100% from the GP/Specialist Benefit Procedure and related materials pays 100% from Major Medical Expenses	MME
6	**Blood Transfusion**	100% of Cost	MME

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
7	**Nursing Services, Sub-acute Care and Hospice Services including medicines, dressing, ointment, etc**	100% of MSR or cost, whichever is the lesser.	MME Subject to pre-authorisation
8	**Ambulance Services**	100% of Cost	**R7 400** per beneficiary per annum. Subject to approval by preferred provider and Scheme. Emergency air ambulance, not subject to the above limit.
9	**Internal Prostheses -** including all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices.	100% of Cost Sub-limits subject to PMB's	**All Internal Prostheses are per beneficiary per annum.** **Cardiac stents** (including carrier) subject to a limit of R**22 000** per stent.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
9	**Internal Prostheses (continued)** Patients may pre-certify 10 (ten) working days prior to admission for a joint replacement or spinal fusion operation. The internal prostheses limit may at the discretion of the Care Manager be paid as part of the MME.		**Cardiac stent** – drug eluting subject to a limit of **R19 000** per stent and a total of three stents. **Cardiac pacemakers** subject to a limit of **R52 500.** **Cardiac valves** subject to a limit of **R31 000** per valve, limited to two valves. **Cardiac pacemaker with Defibrillator** subject to a limit of **R90 000.** **Hernia Mesh** – subject to a limit of **R5 000.**

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
9	**Internal Prostheses (continued)**		**Hernia Mesh - Umbilical** repair subject to a limit of **R10 500.** **EVAR (Endo Vascular Repair)/ Anaconda** subject to a limit of **R60 000.** **Total hip replacement** subject to a limit of **R40 150** per hip, including cement and antibiotic. **Total knee replacement** subject to a limit of **R41 470** per knee, including cement and antibiotic.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
9	**Internal Prostheses (continued)**		**Total shoulder replacement** subject to a limit of **R37 400** per shoulder, including cement and antibiotic. **Spinal instrumentation** subject to a limit of **R28 700. Other approved spinal implantable devices** and intervertebral discs limited to **R37 200. Bone lengthening devices** limited to **R33 400. Neuro-stimulation/ abalation devices** for Parkinsons limited to **R33 900.**

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
9	**Internal Prostheses (continued)**		**Vagal stimulator** for intractable epilepsy limited to **R28 600.** **Aortic stents** subject to a limit of **R89 800** per stent (Including the delivery system), limited to one stent. **Carotid stents** limited to **R14 950.** **Detachable platinum coils** limited to **R37 200.** **Embolic protection devices** limited to **R37 100.** **Peripheral arterial stent grafts** limited to **R30 750.**

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
9	**Internal Prostheses (Continued)**		**Intraocular Lens** limited to **R4 000** per lens. **Any other prosthesis** will be subject to a limit of **R40 150**
10	**Renal Dialysis** (inclusive of all related costs) Benefit is subject to the submission of a treatment plan by the treating specialist to the Care Manager and approval of the treatment plan prior to the commencement of treatment.	Subject to 100% of the negotiated rate	MME
11 **a)**	**Organ Transplants** **Hospital accommodation, surgically related services & procedures.**	PMB's covered in full at 100% of negotiated rate.	MME Subject to pre-authorisation

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
11	**Organ Transplants - continue**		
b)	**Donor** Including organ search, harvest and transportation, the benefit shall cover the cost of the donor if the recipient is an Imperialmed member.	100% of Cost	Subject to pre-authorisation Limited to **R18 550** for a cadaver or limited to **R89 000** for live donors per beneficiary per annum
c)	**Anti-rejection drugs**	100% of Medicine Price to be obtained from a pharmacy DSP.	MME Subject to pre-authorisation.
12	**HIV & AIDS**		**MME**
a)	All consultations, pathology and medicine related to diagnoses & treatment of the disease.	Normal percentage benefits for applicable services payable. 100% cost unlimited.	Subject to pre-authorisation and clinical guidelines and protocols. HIV resistance tests provided only if registered and

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
12	**HIV & AIDS (Continued)**		
a)		Medicine subject to Generic Reference Price and to be obtained from the Scheme's DSP. 25% co-payment shall apply if obtained from a Non-DSP.	pre-authorised on the relevant HIV disease management programme. Polymerase chain reaction funded from MME for babies 18 months and younger where the diagnosis refers to HIV testing
b)	HPV Vaccines Only for HIV positive females registered on the YourLife Programme	100% of Cost	Gardasil injection or Cervarix injection

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
13	**Maternity Benefits**		
a)	**Labour and ward accommodation**		
	Normal delivery limited to 3 days.	100% of Cost	MME
	Elective Caesarean delivery limited to 4 days. Additional days are subject to submission of a motivation by the attending doctor and approved by the case manager	100% of Scheme rate	MME
b)	**Midwife** (for midwife delivery, confinement in a registered birthing unit or home delivery) - including birth attendant and birth bath. Midwife must be registered with BHF and Nursing Council. If a gynaecologist is not used, benefit covers pre- and post-confinement costs. **Benefits listed below are subject to enrolment on maternity programmes**	100% of MSR.	MME 4 post natal midwife consultations per event.
c)	**Antenatal classes** - only registered midwife	100% of MSR	**R1 000 per** beneficiary per annum.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
13	**(Maternity – continued)**		
d)	**Ultrasounds scans (pregnancy)**	100% of MSR	2 x two-dimensional scans per pregnancy.
e)	**Antenatal vitamins** during pregnancy	100% of Generic Reference Price	**R75** per month
f)	**Gynaecologist Consultations** during pregnancy – as per Care Plan	100% of MSR	MME
14	**Rehabilitation** The benefit covers beneficiaries who are acutely disabled as a result of strokes, spinal cord injuries or brain injuries. The condition must be non-progressive. All associated accounts will be paid subject to this limit.	100% of MSR	**R65 000** per beneficiary per annum Subject to pre-authorisation
15	**Psychiatric Institutions and Substance and Alcohol Abuse**	100% of MSR	Maximum of **21 days per beneficiary per annum** Subject to pre-authorisation
16	**Stoma Care Products**	100% of MSR	MME Subject to pre-authorisation.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
17	**Cochlear Implants** The Care Manager, the Scheme will allow for a first and second Cochlear Implant, even if this occurs in one year. For beneficiaries older than six years, subject to submission of motivation by the treating doctor and subject to approval by the Clinical Advisory Committee.	100% of Cost	**R250 000** per implant per beneficiary per annum. Subject to pre-authorisation .
18 **a)**	**Dentistry** **Dental Alveolar Surgery** Surgical procedures involving the teeth and supporting jawbone ridges, such as • Basic dental procedures in children under 8 years • Surgical dental procedures in exceptional clinical scenarios in children older than 8 years and adults: • surgical removal of multiply teeth /impacted teeth / roots	**Hospital and Anaesthetist fee** 100% of MSR of hospitalisation, operating theatre, sedationist and anaesthetist fee. **Dental Procedures** Note that the associated dental procedures remain to be funded at 85% of MSR from the respective Dental benefit categories as indicated under Day to Day benefits	MME Subject to pre-authorisation

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
18	**Dentistry (Continuted)** • apicectomies • tooth exposures • corticotomiesSurgical preparation of mouth for dentures, etc		
b)	**Orthodontic Related Surgery** Surgical procedures of the jaw/s, facial bones, mouth and its various internal and surrounding structures, where required as part of an orthodontic treatment plan in order to improve the orthodontic malocclusion and related functional discrepancies, and / or to complement the non-surgical portion of the orthodontic treatment plan.	**Hospital and Anaesthetist fee** 100% of MSR of hospitalisation, operating theatre and anaesthetist fee. **Surgical Fee** - 100% of MSR	MME R10 000 per beneficiary per annum, applies to surgeon's fee.
c)	**Maxillo facial surgery** • Oral/facial trauma, such as fractured jaw or facial bones requiring hospitalisation • Oral cancer and similar aggressive oral pathologies	100% of MSR Regarding the surgical procedures and related hospitalisation	MME Subject to pre-authorisation.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
18 c)	**Dentistry (Continued)** **Maxillo facial surgery (cont)** • Cleft lip/palate repair • Salivary gland pathology • Serious life threatening infection of dental origin • Internal Temperomandibular joint ("jaw-joint") pathology		
19	Excimer Laser, Radial Keratotomy, Holmium Procedures, LASIK, Phakic lenses and intra-stromal rings (surgically related services & procedures). Subject to SAOA guidelines.	Normal percentage benefits for applicable services payable.	**R5 300** per beneficiary per annum
20	**Breast Reduction, Mammaplasty & other cosmetic surgery if deemed medically essential** (prior approval by Medical Advisor)	Normal percentage benefits for applicable services payable.	Normal annual limits for applicable services payable.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
21	**Prosthetic Limbs and Eyes** The submission of a quote prior to purchase is required.	100% of Cost	**All Prosthetics are per beneficiary per annum** and subject to pre-authorisation **Prosthetic leg** subject to a limit of **R61 800** per leg. **Prosthetic arm** subject to a limit of **R61 800** per arm. **Prosthetic eye** subject to a limit of **R21 300** per eye. Above limits are available every 2 – 5 years as per clinical protocol.
22	**Infertility** Benefit limited to the treatment guidelines applied by the State hospitals.	100% of Cost	Prescribed Minimum Benefits only

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
23	**Oncology** Subject to an admission of a treatment plan and enrolment of the Oncology Programme.	100% of MSR - subject to PMBs	**R260 000** per beneficiary per annum, subject to pre-authorisation. Limited to
	Brachytherapy materials (including seeds and disposables) and equipment.	100% of MSR.	**R33 920** per beneficiary per annum and included in the Oncology Benefit Subject to pre-authorisation. Limit of
	Pathology, X-rays, MRI and CAT Scans, radio-isotope scans.	100% of MSR	**R21 000** per beneficiary per annum, not subject to the overall oncology limit.
	Oncology medicines	100% of generic reference pricing	Subject to above R260 000 overall limit

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
24	**Services Rendered Abroad by a foreign supplier** No benefit for beneficiaries travelling outside the borders of the Republic of South Africa for more than 90 (ninety) consecutive days.	Normal percentage benefits for applicable services payable. Provided that medicines will be limited to the Medicine Price in South Africa.	**R1 000 000** per beneficiary per annum.
25	**Home Oxygen, cylinders, concentrators and ventilation expenses** Provided the patient enrols on the Lifecare Programme, the benefit includes the cost of the appliance provided that the appliance is obtained from a preferred provider.	100% of cost	**R12 830** per beneficiary per annum subject to PMB's. Subject to pre-authorisation.
26	**External Medical Appliances** Permanent or temporary devices that are not surgically implanted and are seen to improve the function of a diseased organ, e.g. wheelchair, crutches, CPAP machine, Baumanometer and all orthopaedic braces. Incontinence Diapers which are required as part of a chronic condition are included.	100% of Cost	**R11 000** per beneficiary per annum Motivation and pre-authorisation required for devices and appliances above R1 000.

MAJOR MEDICAL EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
	No benefit shall be available for APS machines unless approved by the Scheme.		
27	**Hearing Aids** Subject to an audiology report and pre-certification.	100% of Cost	**R13 150** per beneficiary per ear, over a two year cycle.
28	**Prescribed Medicines** **Chronic medicine:** prescribed for a Prescribed Minimum Benefit and/or additional chronic conditions. Subject to the chronic medicine baskets with core formulary medicines only	100% of Generic reference price. To be obtained from the Scheme's DSP. A 25% co payment will apply if obtained from a non-DSP	**R20 500** per beneficiary per annum

DAY TO DAY EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
1	**General Practitioner (GP) and Specialists - Out of hospital**		
a)	**Visits, consultations and treatment by a GP or Specialist**	85% of MSR	Member family limit calculated as follows: **R2 350** per member **R1 760** per Adult dependant **R1 470** per child dependant (maximum of three children)
b)	**All procedures** (including those procedures listed in 1a of the Major Medical benefit), will be at paid from MME and not the Day To Day limits, when done in doctor's rooms, except for Dental Procedures as indicated in 1a. Of the MME benefits.	100% of MSR	MME
c)	**Circumcision** – done in the doctor's rooms	100% of MSR	MME **R1 000** per beneficiary per annum from MME

DAY TO DAY BENEFITS – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
d)	**GP and Specialists - Out of hospital - continue** **PMB Care Plan Services** Consultations as authorised on Care Plan	100% of Cost	MME Subject to pre-authorisation.
2 **a)**	**Diagnostic Services - Out of hospital** **Radiology (X-rays) & Pathology**	85% of MSR	Member family limit calculated as follows: **R3 030** per Member **R3 030** per Adult Dependant **R530** per child dependant (maximum of three children)
b)	**PMB Care Plan** Radiology and Pathology services as authorised on Care Plan.	100% of Cost	MME
3 **a)**	**Dentistry** **Preventative dentistry** • Scaling and /or polishing and Flouride treatment	100% of MSR	Two per beneficiary per annum.

DAY TO DAY BENEFITS – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
3	**Dentistry - continue**		
a)	**Preventative dentistry**		
	• Fissure sealing	100% of MSR	Once off for permanent molars in persons under 18 years
b)	**Basic dentistry** • Oral examination • Diagnostics (x-ray, etc) • Restorations (fillings) • Non-surgical extractions • Root canal treatment	85% of MSR	**R3 200** per beneficiary per annum
c)	**Advanced/specialised dentistry** • Inlays, onlays, veneers, crowns & bridges • Study models • Dentures • Dental implants, placement, exposure and related procedures such as jaw ridge, sinus lifts, augmentation, etc • Orthodontic retainers, space maintainers, biteplates • Periodontal (“gum”) treatment all bullets in this section	85% of MSR	Member family limit calculated as follows: **R4 570** per member **R2 210** per adult dependant **R960** per child dependant (Maximum of three children) Pre authorisation required

DAY TO DAY BENEFITS – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
d)	**Dental Implants** Includes the cost of the implants only. The anaesthetist's fees are covered as part of the Major Medical Expenses limit	100% of MSR	**R12 430** per beneficiary Pre-authorisation required.
e)	**Orthodontic treatments**	100% of MSR	**R6 400** per beneficiary per annum **Pre-authorisation required**
4	**Acute medicine**		
a)	Acute medicines and injection material	100% of Generic Reference Price after deduction of **R25** levy	Member family limit calculated as follows: **R5 190** – Member **R3 260** per Adult Dependant **R980** per child dependant (maximum of three children)

DAY TO DAY EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
4 **b)**	**Acute medicine - continue Pharmacist Advised Therapy (PAT)** is medicines supplied to a member by a registered pharmacist without a doctor's prescription. Subject to an over the counter formulary	100% of Generic Reference Price, up to a maximum of **R185** per script.	**R1 070** per family per annum. Subject to Acute Medication limit
5 **a)** **b)** **c)** **d)** **e)** **f)** **g)**	**Medical Auxiliaries - Out of hospital** Podiatry Orthoptic Treatment Audiometry/Audiology Occupational therapy Therapeutic Dietician Other Registered Medical Auxiliaries: remedial & speech therapy, clinical technology, chiropody, acupuncture, social work, biokinetic, kinesiology, ayurvedics and reflexology. Consultations, treatment and radiological examinations by Chiropractors, homeopaths, naturopaths, Osteopaths and herbalists.	85% of MSR	**R6 710** per family per annum for all services from 5a) to g).
6)	**Physiotherapy – Out of Hospital**	85% of MSR	**R4 240** per family per annum

DAY TO DAY EXPENSES – HEALTH PLAN			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
7	**Mental Health – Out of Hospital**	85% of MSR	**R4 260** per beneficiary per annum
8	**Optical Services**		
a)	Eye test	85% of MSR	1 (one) test per beneficiary per annum from MME.
b)	Spectacles, lenses, (replace, repair & adjust), contact lenses & fitting of contact lenses	85% of Cost	**R2 200** per beneficiary per annum
c)	Frames	85% of Cost	**R700** per beneficiary per per annum, included in the overall Optical limit above.
d)	Sunglasses	No benefit	No benefit

2. IMPERIALMED BUDGET PLAN

The Budget Plan provide low-cost cover for essential, basic healthcare benefits with unlimited in-hospital cover at 100% of Scheme Rate, no Non-PMB chronic benefits, a GP Network with specialist referrals and Day-to-Day benefits paid at 85% of Scheme Rates, with relatively low annual limits.

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
1	**Hospitalisation – Private and Provincial**	100% of MSR	MME Subject to pre-authorisation
a)	A deductable of **R550** applies if the following procedures are done in hospital: o Scopes ➢ Arthroscopies ➢ Gastro-Intestinal endoscopies ▪ Gastroscopies ▪ Colonoscopies ▪ Sigmoidoscopies o Urological scopes & Cystoscopies o Gynaecological scopes o Minor dermatological procedures	No deductable if done in doctor's room and paid at 100% of MSR if in doctor's	
	o Dental procedures	No deductable if done in doctor's room and paid at 85% of MSR as per Day-to-Day benefit	MME
b)	Accommodation in general ward, recovery room, intensive care unit or high care ward	100% of Scheme Rate	MME

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
1	**Hospitalisation - continue**		
c)	**Circumcision**	100% of MSR	**R2 000** per beneficiary per annum from MME, subject to motivation and pre-authorisation
d)	Theatre fees	100% of Scheme Rate	MME
e)	Medicines used in hospital/theatre	100% of Medicine Price	MME
2	**General practitioners and specialists (in hospital)**		
a)	Visits and consultations	100% of MSR	MME
b)	Surgical procedures and anaesthetics	100% of MSR	MME
3	**Diagnostic services**		
a**)**	Radiology (X-rays and pathology (In hospital)	100% of MSR	MME
b)	MRI, CAT and radio-isotope scans (in and out of hospital)	100% of MSR	One scan (MRI or CAT or Radio-isotope) per beneficiary per annum – pre-authorisation required
c)	Ultrasound scans (in and out of hospital)	100% of MSR	**R1 370** per beneficiary per annum
d)	PET scans	No Benefit	
e)	Sleep studies	No Benefit	

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
4	**To-take-out (TTO) medicine** Medicines dispensed on discharge from hospital will be covered under the Major Medical Expenses Benefit	100% of Generic Reference Price	MME Benefit, subject to **R370** per beneficiary per admission
5	**Out-patient services**		
a)	Private hospital	Consultation paid at 85% from the GP/Specialist Benefit. Procedure and related materials paid 100% from Major Medical Expenses	MME
b)	Provincial	Consultation paid 100% from the GP/Specialist Benefit Procedure and related materials pays 100% from Major Medical Expenses	MME
6	**Blood Transfusion**	100% of cost	MME, subject to PMB
7	**Nursing Services, Sub-acute Care and Hospice Services**	No benefit	

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
8	**Ambulance services** Pre-authorisation must be obtained from Europ Assistance	100% of cost	**R2 300** per beneficiary per annum subject to approval by preferred service provider and Scheme.
9	**Internal Prosthesis** Includes all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of internal prostheses and devices Patients may obtain pre-authorisation 10 (ten) working days prior to admission for a joint replacement or spinal operation	100% of cost	Limited to **R30 000** per family per annum for prosthesis
10	**Renal Dialysis** (Inclusive of all related costs) Benefit is subject to the submission of a treatment plan by the treating specialist to the case manager and approval of the treatment plan before treatment begins	Subject to 100% of the negotiated rate and PMB's	MME Subject to pre-authorisation
11 **a)**	**Organ Transplants** **Hospital accommodation and surgically-related services and procedures**	PMB's covered in full at 100% of negotiated rate	MME Subject to pre-authorisation

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
11	**Organ transplant - continue**		
b)	**Donor** Including organ search, harvesting and transportation, the benefit covers the cost of the donor if the recipient is an Imperialmed member	100% of cost	Subject to pre-authorisation. Limited to **R6 200** for a cadaver or limited to **R30 000** for live donors per beneficiary per annum
c)	**Anti-rejection drugs**	100% of Medicine Price to be obtained from a DSP pharmacy	MME Benefits Subject to pre-authorisation
12	**HIV and AIDS**		
a)	All consultations, pathology and medicine related to diagnoses & treatment of the disease	Normal percentage benefits for applicable services payable 100% of cost unlimited. Medicine subject to Generic Reference Price and to be obtained from the Scheme's DSP. 25% co-payment shall apply if obtained from a Non-DSP.	MME - Subject to pre-authorisation and clinical guidelines and Protocols. HIV resistance tests provided only if pre-authorised by a relevant Case Manager on the HIV YourLife programme

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
12	**HIV and AIDS - continue**		
a)			Polymerase chain reaction funded from Major Medical Expenses Benefit for babies 18 months and younger where the diagnosis relates to HIV testing
b)	HPV Vaccines Only for HIV positive females registered on the YourLife Programme	100% of Cost	Gardasil injection or Cervarix injection
13	**Maternity Benefit**		
a)	**Labour and ward accommodation** Normal delivery limited to 3 days	100% of cost	MME
	Elective Caesarean delivery limited to 4 days Additional days are subject to submission of a motivation by the attending doctor and approval by the case manager	100% of MSR	MME Subject to pre-authorisation

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
13	**Maternity Benefit - continue**		
b)	**Midwife** **Benefits listed below are subject to enrolment on Maternity Programme**	100% of MSR	As per the Maternity Care Plan
c)	**Antenatal classes**	100% of MSR	As per the Maternity Care Plan
d)	**Ultrasound scans (pregnancy)**	100% of MSR	As per the Maternity Care Plan
e)	**Antenatal vitamins**	100% of MSR	As per the Maternity Care Plan
f)	**Gynaecologist Consultations**	100% of MSR	As per the Maternity Care Plan
14	**Rehabilitation**	100% of cost – PMB only	Subject to Clinical Protocols
15	**Psychiatric institutions and substance and alcohol abuse**	100% of Scheme rate	Up to a maximum of **21 days** per beneficiaries per annum subject to pre-authorisation

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
16	**Stoma Care Products**	100% of Scheme Rate	MME Subject to pre-authorisation
17	**Cochlear Implant**	No Benefit	

18	**Dentistry Benefits**
	Dental Alveolar
	Surgery /Surgical procedures involving the teeth and supporting jawbone ridges, such as:
	• Basic dental procedures in children under 8 years
	• Surgical dental procedures in exceptional clinical (health) scenarios in children > 8 years and adults:
	  • surgical removal of multiple teeth/impacted teeth/roots
	  • apicetomies
	  • tooth exposures
	  • corticotomies
	  • surgical preparation of mouth for dentures, etc
		Hospital and Anaesthetist fee
		100% of Scheme rate for hospitalization, operating theatre, seditionist and anesthetists' fee
		
		Dental Procedures
		Note that the associated dental procedures remain to be funded at 85% of MSR from the respective benefit categories as indicated under Dental/Oral Benefits.
			MME
			Subject to Pre-Authorisation

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
18 b)	**Dentistry benefit - continue** **Maxillo facial surgery** • Oral/facial trauma, such as fractured jaw or facial bones requiring hospitalization • Oral cancer and similar aggressive oral pathologies • Cleft lip/palate repair • Salivary gland pathology • Serious life threatening infection of dental origin Internal Temperomandibular joint ("jawjoint") pathology	100% of Scheme rate Regarding the surgical procedures and related hospitalisation	MME Subject to pre-authorisation
19	**Excimer Laser, Radial Keratotomy, Holmium Procedures, LASIK, Phakic lenses and intra-stromal rings (surgically related services and procedures)**	No Benefit	
20	**Breast Reduction, Mammoplasty and other cosmetic surgery if deemed medically essential**	No Benefit	
21	**Prosthetic Limbs and Eyes** The submission of a quotation prior to purchase is required	100% of cost	Subject to the **R30 000** Internal Prosthesis Limit
22	**Infertility**	100% of cost – PMB Only	

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
23	**Oncology**		
	Subject to a treatment plan and enrolment on the Oncology Programme	100% of Scheme rate, subject to PMB's	**R86 700** per beneficiary per annum
	Brachytherapy materials (including seeds and disposables) and equipment	100% of MSR	Limited to **R11 300** per beneficiary per annum and included in the oncology benefit
	Pathology, X-rays, MRI and CAT Scans and radio-isotope scans	100% of MSR	Limited to **R7 000** per beneficiary per annum
	Oncology medicines	100% of generic reference pricing	Subject to above R86 700 overall limit
24	**Services Rendered Abroad by a foreign supplier**	No Benefit	
25	**Home Oxygen cylinders, concentrators and ventilation expenses**	100% of cost – PMB Only	
26	**External Medical Appliances**	100% of cost	**R3 000** per beneficiary per annum Motivation and pre-authorisation required for devices and appliances

MAJOR MEDICAL EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
26	**External Medical Appliances - continue**		above **R1 000**
27	**Hearing Aids**	No Benefit	
28	**Prescribed Medicines** **Chronic medicine:** Prescribed for PMB conditions only. Subject to the chronic medicine baskets with core formulary medicines only.	100% of generic reference price and to be obtained from the Scheme's DSP. A 25% co-payment will apply if obtained from a non-DSP	Unlimited – PMB's only

	DAY TO DAY BENEFITS – BUDGET PLAN		
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
1	**General Practitioner (GP) and Specialists – Out of hospital**		
a)	Visits, consultations and treatment by **GP or Specialist** Benefits applicable to the nomination of 2 GP's per dependant. 2 out of Network GP visits allowed	85% of Scheme Rate These benefits are covered within the MHRM GP Network and Specialists only on a referral by the GP	Member family limit calculated as follows: **R800** per member **R590** per adult dependant **R490** per child dependant (Maximum of three children) Subject to the above limits
b)	**All procedures** (including those procedures listed in 1a of the Major Medical benefit), will be paid from MME and not Day-to-Day limits, when done in the doctors' rooms, except for Dental Procedures as indicated in 1a of the MME benefits.	100% of MSR	MME
c)	**Circumcision** – done in the doctor's rooms	100% of MSR	**R1 000** per beneficiary per annum from MME

DAY TO DAY EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
1	**General Practitioner (GP) and Specialists – Out of hospital - continue**		
d)	**PMB Care Plan Services** Consultation as authorized on Care Plan	100% of Cost These benefits are covered within the MHRM network and Specialists only on a referral by the GP	MME Subject to pre-authorisation
2	**Diagnostic Services – Out of hospital**		
a)	**Radiology (X-rays) and Pathology**	85% of Scheme rate	**R1 010** per member **R1 010** per adult dependant **R180** per child dependant (Maximum of 3 children)
b)	**PMB care Plan Services** **Radiology (X-rays) and Pathology as authorized on Care Plan** Including Cardiac Ultrasound	100% of Cost	MME
3	**Dentistry**		
a)	**Preventative Dentistry**	No Benefit	

DAY TO DAY EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
3	**Dentistry - continue**		
b)	**Basic dentistry** **»**» Oral examination **»**» Diagnostics (X-rays, etc.) **»**» Restorations (fillings) **»**» Extractions **»**» Root canal treatment	85% of the negotiated fee	**R2 130** per family per annum
c)	**Advanced/specialised dentistry**	No Benefit	
d)	**Dental Implants**	No Benefit	
e)	**Orthodontic treatment**	No Benefits	
4	**Prescribed Medicine**		
a)	**Acute Medication** Acute medicine (injection material included)	100% of generic reference price after deduction of a **R25** levy	**R1 730** per member **R1 090** per adult dependant **R330** per child dependant (Maximum of 3 children)
b)	**Pharmacist-advised Therapy (PAT)**	No Benefit	
5	**Medical Auxiliaries – Out of hospital** Includes only the following disciplines:	85% of MSR	**R1 600** per family per annum
a)	Clinical Psychology		
b)	Psychiatry		
c)	Physiotherapy		

DAY TO DAY EXPENSES – BUDGET PLAN			
	BENEFITS DESCRIPTION	**% BENEFIT PAYABLE**	**LIMITS APPLICABLE**
6	**Physiotherapy – Out of hospital**	85% of MSR	Included in Medical Auxiliaries
7	**Mental health – Out of hospital**	85% of MSR	Included in Medical Auxiliaries
8	**Optical Services**	85% of MSR	
a)	Eye Test		One test per beneficiary per annum
b)	**Optical Services** Spectacles (lenses, replacements, repairs and adjustments), contact lenses and fitting of contact lenses	85% of cost	**R1 000** per beneficiary per annum
c)	Frames	85% of cost	**R210** per beneficiary per annum, included in the overall Optical limit above.
d)	Sunglasses	No Benefit	

WELLNESS BENEFIT			
	BENEFIT DESCRIPTION	**% BENEFIT PAYABLE**	**ANNUAL LIMITS**
1a)	**Screening tests** – • Body Mass Index • Glucose • Blood Pressure • Cholestrol This benefit will be accessible via the Scheme's DSP for chronic medication	100% of negotiated rate at the Scheme's DSP	1 visit per beneficiary per annum
b)	**HIV test** This benefit will be accessible via the Scheme's DSP for chronic medication	100% of negotiated rate at the Scheme's DSP	1 test per beneficiary per annum
c)	**Childhood Vaccine Benefit** Only applicable on the Imperialmed Health Plan	100% of SEP	According to Scheme formulary from ages birth to 18 months Vaccines outside the formulary, will be paid from the Acute Medicine limit

NOTES:

- Unless otherwise indicated, benefit payable is the Medical Scheme Rate (MSR).
- Medical Scheme Rate (MSR) refers to the rate at which health services are reimbursed by the Scheme, which shall be determined by the Scheme from time to time.
- Medicine Price shall mean Single Exit Price (SEP) plus dispensing fee.

ANNEXURE C

EXCLUSIONS, LIMITATIONS AND WAITING PERIODS

1. EXCLUSIONS

Provided that no exclusions shall apply in respect of any service falling within the minimum benefits other than as provided for in Rule 3.1, expenses incurred in connection with any of the following will not be paid by the Scheme unless otherwise authorised by the Board:

1.1 Optometry

1.1.1 Tinted or coloured plano lenses and other cosmetic effect contact lenses (other than prosthetic lenses), and contact lens accessories and solutions.

1.1.2 Optical devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.

1.2 Breast reduction, except where associated with breast reconstruction following a diagnosis of cancer or the beneficiary is diagnosed with Gigantomastia of pregnancy accompanied by complications such as ulceration of breast tissue, massive infection, tissue necrosis with slough, significant haemorrhage or delivery is not imminent.

1.3 Treatment of surgery of scars, keloids and excision of a tattoo are deemed to be for cosmetic purposes except in cases of severe burn scars on the face and neck and functional impairment such as contractures. Where necessary the Board will refer cases to a panel of Medical Specialists for a final decision. The decision of the Board following advice from the Specialist panel will be final.

1.4 Any medical and/or surgical procedure related to the Gamate Intrafallopian Transfer, In-Vitro fertilization, Zygote Intrafallopian Transfer, Pronuclear Stage Tubal Transfer or any other transfer or egg or sperm collection will not be covered by the Scheme. Any other treatment or investigation not covered in respect of Code 902M (Diagnosis: Infertility) will not be covered by the Scheme.

1.5 Donor Cost – Organ harvesting and donor cost, in case where the donor recipient is not a member of Imperialmed.

1.6 Otoplasty for children 12 years of age or older.

1.7 Expenses incurred by a member or dependants of a member in the case of or arising out if wilful self-injury, professional sport, speed contests and speed trials except for Prescribed Minimum Benefits.

1.8 Laparoscopic surgery for the removal of an appendix except in the event of an emergency procedure.

1.9 Investigations, operations or treatments for cosmetic purposes, obesity, artificial insemination, impotence and erectile dysfunction or treatment of an experimental nature.

A medical or surgical procedure, treatment, cause of treatment, equipment, drug or medicine will be regarded as experimental:

(a) if it is not widely accepted and know to be safe, effective and appropriate for the treatment of illness or injury by a consensus of professional medical specialists which are recognised as such by the South African medical community;

(b) if it is under study, investigation, in a test period or part of or in a clinical research state;

(c) where no definite outcome results, following at least a five year trial period, are available; or

(d) if it is more expensive than that which is generally available and does not significantly change the outcome of the procedure, treatment or taking of medicine or drug; provided that should a member prefer to have the more expensive treatment, the Scheme shall pay the reasonable and customary fees associated with the treatment generally available.

1.10 Holidays for recuperative purposes.

1.11 Purchase of:

- patent medicine and proprietary preparations
- applicators, toiletries and beauty preparations
- bandages, cotton wool and similar aids
- patented foods, including baby foods
- contraceptives and apparatus to prevent pregnancy
- tonics, slimming preparations, drugs as advertised to the public and vitamins which are not approved by the Scheme
- household and biochemical remedies
- sunglasses
- exercise equipment
- any drug or medicine not registered by the Medicines Control Council or similar authority
- any medicines not registered for that specific condition.

1.12 All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules of the Scheme.

1.13 Examinations for insurance, employment, visas, pilot and driving licences or examinations for enrolment to University and College.

1.14 Any travelling or conveyance by whomsoever and of whatsoever nature except as by Ambulance or Ambulance Aircraft.

1.15 Dentistry

1.15.1 Labial frenectomy in respect of beneficiaries under the age of 12 years old.

1.15.2 Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable.

1.15.3 General anaesthetics, conscious sedation and hospitalisation for dental work, except in the case of patients under the age of 8 years or bony impactions of the third molars.

1.15.4 Periodontic plastic procedures for cosmetic reasons

1.15.5 Tooth bleaching, Linual (invisible) orthodontic braces, Gum guards for sports purposes.

1.16 The purchase of medicines prescribed by a person not legally entitled thereto.

1.17 Robotic assisted surgery

1.18 Costs of appointments cancelled or not kept by members.

1.19 Costs for services rendered by:

1.19.1 Persons not registered in terms of any law;

1.19.2 Any institution, except a state or provincial hospital, not registered in terms of any law.

1.20 Services which are regarded as not medically necessary. A treatment, procedure, supply, medicine, hospital or specialized centre stay (or part of a hospital or specialized centre stay) will be regarded as medically necessary if:

(a) it is appropriate and essential to the diagnosis and treatment of illness or injury of the member; and

(b) does not exceed, in scope, duration or intensity of the level of care which is needed to provide a safe, adequate and appropriate diagnosis or treatment; and

(c) it has been prescribed by a doctor; and

(d) it is consistent with the widely accepted professional standards of the medical practice in South Africa and in respect of overseas cover, the United States of America; and

(e) in the case of inpatient care, it cannot be provided safely on an outpatient basis.

The medical need shall be determined by the Scheme taking into account the above requirements. The fact that a Doctor has prescribed, recommended, approved or provided a treatment, service, supply or confinement shall not in itself be regarded as proof that a service is medically necessary. Where necessary the Board will refer cases to a panel of Medical Specialists for a final decision. The decision of the Board following advice from the Specialist panel will be final.

1.21 The following medicines, unless they form part of the public sector protocols and are authorised by the relevant managed healthcare programme:

1.21.1 Any specialised drugs that have not convincingly demonstrated a survival advantage of more than 3 (three) months in advanced or metastatic solid organ malignant tumours, for example Sorafenib for hepatocellular carcinoma, Bevacizumab for colorectal and metastatic breast cancer.

2. LIMITATION OF BENEFITS

Provided that no limitations shall apply in respect of any service falling within the minimum benefits other than as provided for in Rule 3.1, the following limitations shall apply:

2.1 The maximum benefits to which a member and his dependants shall be entitled in any financial year shall be limited as set out in Annexure "B".

2.2 Members admitted to the Imperialmed Health Plan during the course of a financial year shall be entitled to the benefits set out in Annexure B with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

2.3 The annual limits for members admitted to the Imperialmed Budget Plan will be pro-rated for members joining from 1 February to 31 July of each year, but those joining from 1 August to 31 December of a year will have access to the same benefit limits as those joining on 1 July of a year.

2.4 In cases where a specialist, except an eye specialist or gynaecologist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme, may, at the discretion of the

Board, be limited to the amount that would have been paid to a general practitioner for the same service.

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

2.6 In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending practitioner. In such case, if the specialist's proposed treatment is not acted upon, no further benefits will be allowed for that particular illness.

2.7 Subject to the general limitations on benefits determined by the Board from time to time, in the event that any other party may be liable for costs incurred for treatment of sickness conditions or injuries sustained by a beneficiary, the Scheme shall only be liable for such costs incurred by a beneficiary, to the extent that the beneficiary does not recover such costs from any other party.

In the event that the Scheme effects payment of any such costs incurred by the beneficiary prior to the beneficiary recovering all or a portion of such costs from another party, then the beneficiary shall:

2.7.1 be liable to repay to the Scheme all amounts or a portion thereof paid by the Scheme and recovered by or on behalf of the beneficiary from the party responsible to compensate such beneficiary, after deduction of any legal costs or deductions that may have been incurred in the recovery of such amount;

2.7.2 disclose to the Scheme, alternatively, instructs his legal representative to disclose to the Scheme, the full extent of

any compensation awarded in respect of past and future medical expenses;

2.7.3 sign all documentation as may be required by the Scheme to obtain copies of all such information not in the Scheme's possession, relating to the beneficiary's medical accounts and records from the relevant practitioners and/or medical institutions;

2.7.4 provide the Scheme with such assistance as the Scheme may reasonably require should the Scheme wish to recover any amounts paid on behalf of the member for which a third party may be liable

3. WAITING PERIODS

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

3.1.1 a general waiting period of up to three months; and

3.1.2 a condition-specific waiting period of up to 12 months.

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

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

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

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

3.4 No waiting periods may be imposed on:

3.4.1 a person in respect of whom application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of-

3.4.1.1. change of employment; or

3.4.1.2. an employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the scheme to which an application is made for such transfer to occur at the beginning of the financial year.

Where the former medical scheme had imposed a general or condition-specific waiting period in respect of persons referred to in this rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.

3.4.2 a beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied.

3.4.3 a child dependant born during the period of membership.