FEDHEALTH MEDICAL SCHEME

ANNEXURE D

(To be read in conjunction with Annexure B, C and E)

(With effect from 1 January 2023)

(Unless otherwise stated below)

1. WAITING PERIODS

1.1 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:

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

1.1.2 a condition specific waiting period of up to 12 months.

1.2 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:

1.2.1 a condition specific waiting period of up to 12 months, except in respect of any treatment of diagnostic procedures covered within the Prescribed Minimum Benefits;

1.2.2 in respect of any person contemplated in this sub-paragraph, 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.

1.3 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.

1.4 No waiting period may be imposed on:

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:46:55(UTC+02:00)
Signed by: Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
2022/12/09
REGISTRAR OF MEDICAL SCHEMES

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

1.4.1.1 change of employment; or

1.4.1.2 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;

1.4.2 a beneficiary who changes from one benefit option to another with the Scheme unless that beneficiary is subject to a waiting period of the current benefit option in which case the remaining period may be applied:

1.4.3 a child dependant born during the period of membership.

2. PROPORTIONATE ADJUSTMENT OF BENEFITS

For a beneficiary admitted during the course of a financial year the maximum benefits available to such member shall be adjusted in proportion to the period of membership from the admission date to the end of the financial year.

3. TERRITORIAL APPLICATION

Subject to the provisions of the main rules, the benefits available in terms of these rules shall be provided only within the borders of the Republic of South Africa, provided the Board may, in its absolute discretion, pay for benefits in respect of health services obtained outside such borders.

The Scheme shall not be required to make special arrangements to obtain foreign services or medicines for special conditions and this includes harvesting and transportation of organs and tissue for transplant and any medicines or medical services of any kind available only outside the Republic of South Africa.

A member requiring assistance for himself or a beneficiary with regard to potential healthcare costs incurred while travelling in foreign countries, must make separate provision for such insurance.

REGISTERED BY ME ON
Mfana Maswanganyi 2022/12/09
20/12/2022 07:49:06(UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

Ambulance services and benefits shall apply in respect of services provided within the Republic of South Africa, Namibia, Botswana, Zimbabwe, Lesotho, Swaziland and Mozambique (below the 22nd degree parallel).

4. REQUIREMENTS OF MANAGED HEALTHCARE PROGRAMMES

4.1 In order to qualify for the funding of benefits a pre-authorisation reference number (PAR) is required before the rendering of services in respect of hospitalisation and specialised radiology. A pre-authorisation reference number is a number allocated by the Scheme's managed healthcare organisation.

4.2 When the Scheme's relevant managed healthcare organisation grants a pre-authorisation reference number, it may, if deemed appropriate, also authorise the proposed clinical procedure or treatment to be performed in a medical practitioner's consulting rooms, instead of in a hospital, in which case the same benefit will apply as if the clinical procedure or treatment had been performed in hospital.

4.3 Whenever the expression "subject to the relevant managed healthcare programme", is used, with regards to hospitalisation in a hospital or admission to a sub-acute, day clinic, unattached operating theatre, physical rehabilitation centres or hospice, it shall imply that approval which is granted for admission and care covers all recognised services associated with that admission, except for specialised radiology.

Services which are subject to the hospital benefit management programme but not associated with admission to a hospital, sub-acute facility, day clinic, unattached operating theatre, physical rehabilitation hospital, rehabilitation centres or hospice requires an application to be made for each and every eligible service as indicated in Annexure B.

A request for prior-authorisation shall be made, except in the case of an emergency, to the managed healthcare programme at least 48 hours before a beneficiary is admitted to hospital, sub-acute facility, day clinic, unattached operating theatre, physical rehabilitation hospital, rehabilitation centres or hospice before a beneficiary received a relevant health service at such institution.

4.4 The granting of a pre-authorisation reference number is confirmation that the proposed clinical procedure or treatment complies with the clinical and funding protocols and is not a guarantee that benefits will be paid.

4.5 Payment of benefits for a clinical procedure or treatment in respect of which a pre-authorisation reference number is granted, is subject to:

4.5.1 the rules of the Scheme;

4.5.2 qualification for and availability of benefits;

4.5.3 submission of such information as is reasonably required by the relevant managed healthcare programme;

4.5.4 the clinical procedure or treatment does not exceed the authorisation;

4.5.5 approval by the relevant managed healthcare programme for any extension of an authorisation, failing which only the authorised portion of the clinical procedure or treatment will qualify for benefits;

4.5.6 with the exception of an emergency medical condition, if application for a pre-authorisation reference is not made or is refused for a clinical procedure or treatment, no benefits are payable;

4.5.7 in an emergency, a pre-authorisation reference must be applied for within 2 business days after a clinical procedure was performed or treatment commenced;

4.5.8 the member or his beneficiary is responsible for ensuring that an appropriate authorisation and pre-authorisation reference number is obtained;

4.5.9 where a beneficiary's entitlement to benefits is subject to such managed healthcare programme as may be stipulated in paragraph 6, the beneficiary shall be obliged to furnish any information required by the Scheme to perform its duties. Specifically the Scheme may require details of diagnosis, clinical investigations, procedures and treatment by the attending medical practitioner of the beneficiary prior to admission of the beneficiary to hospital;

4.5.10 the Scheme or its managed healthcare organisation reserves the right to inquiry and/ or intervention in the treatment of all members and their beneficiaries admitted into an intensive care unit where the treatment or care exceeds a reasonable time for any specific condition as identified by the Scheme. In addition, all treatment in an intensive care unit in excess of 4 days is subject to specific inquiry and/ or intervention;

4.5.11 in terms of specific re-imbursement contracts with private hospitals certain benefits for specific in-hospital services, drugs or devices might not be covered under special circumstances. These benefits for in-hospital services are divided into different categories, which will be reviewed quarterly and supplied to all hospitals;

4.5.12 if the health problems of beneficiaries are of such a nature that they qualify for admittance to any of the Schemes Active Disease Risk Management Programmes further benefits insofar as they are related to the specific complaint will be settled in accordance with the benefits for said programme, up to the available limit in the benefit schedule or only pay benefits for a lower level of service, subject to Prescribed Minimum Benefits;

4.6 A member or beneficiary is responsible for insuring that the Scheme or the relevant managed healthcare programme is notified if the said member or beneficiary is enrolled in a clinical trial.

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:49:24 (UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

5. FUNDING GUIDELINES AND PROTOCOLS

If the Scheme or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of other clinical guidelines, subject to Regulations 15(H) and 15(I).

A Protocol is a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways. Protocols are developed on the basis of evidence-based medicine taking into account considerations of cost-effectiveness and affordability and may be updated from time to time, with reasonable notice, to reflect new indications, price changes, emerging scientific data and/ or appeals from stakeholders.

Specific protocols, where relevant, are available to a member or healthcare provider and members of the public upon request, when the request is to provide clarity regarding a specific issue affecting a member or beneficiary undergoing treatment related to such protocols.
Where a protocol has proven to be ineffective, has caused or would cause harm to a member or beneficiary, appropriate exceptions shall be made without penalty to that member or beneficiary.

6. SCHEDULE OF MANAGED HEALTHCARE PROGRAMMES

6.1 HIV Infection Management (Aid for AIDS) Programme

A programme adopted by the Scheme incorporating such clinical protocols as defined in the relevant annexures to the contract between the Scheme and its managed healthcare organisation which is contracted to perform disease management in order to contain costs at an appropriate level of care and for the ongoing review and monitoring of patients living with HIV infection and AIDS.

6.2 Ambulance Services

A programme adopted by the Scheme to provide ambulance services to beneficiaries as set out in the contract between the Scheme and its service provider.

6.3 Dental Management Programme

A programme adopted by the Scheme for the management of dental benefits as set out in the contract between the Scheme and its managed healthcare organisation.

6.4 Chronic Medicine Management Programme

A programme adopted by the Scheme for the prior authorisation and management of medicine claims against the chronic disease medicine benefit in respect of diseases that qualify for reimbursement.

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:42:01 (+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

6.4.1 The chronic medicine management programme includes three chronic medicine formularies which includes the rules defined by the chronic medicine management programme against which applications for chronic medicines are adjudicated by applying the principles of clinical appropriateness, cost-effectiveness and affordability. Applicable formularies differ per option.

6.4.2 Chronic medicine is medicine that meets all of the following requirements:

6.4.2.1 it is prescribed by a medical practitioner for an uninterrupted period of at least three months;

6.4.2.2 for a condition appearing on the list referred to in paragraph 6.4.3;

6.4.2.3 it has been applied for in the manner, and at the frequency, prescribed by the Scheme; and

6.4.2.4 it has been registered for the indication.

6.4.3 The following chronic diseases, in addition to the chronic diseases referred to in paragraph 7.11.2 and relevant Prescribed Minimum Benefits conditions qualify in terms of the Schemes Chronic Medicine Management Programme:

Prescribed Minimum Benefits are available to all members on all options as part of their chronic medicine entitlement.

1. Addison's Disease
2. Asthma
3. Bipolar Mood Disorder
4. Bronchiectasis
5. Cardiac Failure
6. Cardiomyopathy
7. COPD/Emphysema/ Chronic Bronchitis
8. Chronic Renal Disease
9. Coronary Artery Disease
10. Crohn's Disease
11. Diabetes Insipidus
12. Diabetes Mellitus type 1 & 2
13. Dysrhythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. Hyperlipidaemia
18. Hypertension
19. Hypothyroidism

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:42:32 (+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

20. Multiple Sclerosis
21. Parkinson's Disease
22. Rheumatoid Arthritis
23. Schizophrenia
24. Systemic Lupus Erythematosus
25. Ulcerative Colitis

6.5 Hospital Management Programme

A programme adopted by the Scheme for the ongoing monitoring, by the Scheme or its managed healthcare organisation, of the treatment of a sickness condition of a beneficiary for a stipulated period. The monitoring shall include a sickness condition which might occur whilst the beneficiary is in a private hospital, sub-acute facility, unattached operating theatre or day clinic, physical rehabilitation hospital, rehabilitation centre or hospice a sickness condition for which the beneficiary was admitted in the first instance and which may extend beyond the period of hospitalisation.

The hospital management programme includes the case management programme which is a programme whereby clinically indicated, appropriate and cost-effective healthcare, as an alternative to hospitalisation, or otherwise, is offered to beneficiaries with specific healthcare needs, on condition that the Scheme or the Scheme's managed healthcare organisation directs a beneficiary's participation in the programme or approves an application by a beneficiary for participation in the programme.

The hospital management programme includes surgical formularies which contain the rules adopted by the Scheme for the management of claims in respect of items used during hospitalisation, by applying principles of clinical appropriateness, cost-effectiveness and affordability from the perspective of the Scheme.

6.6 Optometry Management Programme

The programme adopted by the Scheme for the management of optometry benefits by the Scheme or its managed healthcare organisation.

6.7 Routine Medicine Management Programme

The programme adopted by the Scheme for the management of claims by the Scheme or its managed healthcare organisation in respect of routine medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability.
The routine medicine management programme includes the routine medicine management programme formulary which contains the rules adopted by the Scheme for the management of claims in respect of routine medicine benefits, by applying the principles of clinical appropriateness, cost-effectiveness and affordability from the perspective of the Scheme.

The routine medicine management programme furthermore includes the Medicine Exclusion List. This list refers to the product exclusions collated by the contracted routine medicine benefit management programme, based on scientific evidence and independent expert opinion. Products may be listed for the following reasons:

6.7.1 place in therapy is not well-established;

6.7.2 benefit is not clinically significant;

6.7.3 non-drug therapy is the mainstay of therapy;

6.7.4 product is too expensive relative to its clinical value;

6.7.5 chronic medicines that only qualify for reimbursement if strict financial and clinical prior authorisation criteria are met;

6.7.6 newly registered product under review by a scientific committee;

6.7.7 cheaper alternative drugs are available;

6.7.8 product is misused and alternatives are available.

6.8 Active Disease Risk Management:

The active disease management programme has a holistic approach, focusing on the patients and using all the relevant hospital admission information relating to the disease to determine whether a beneficiary is eligible for admission to a disease management programme. The programme involves patient counselling and intervention, behaviour modification, the application of clinical and therapeutic guidelines and protocols and case management. It's a coordinated system of health care interventions aimed at beneficiaries with chronic diseases with the emphasis being placed on the prevention of exacerbation and or complications utilising evidence based protocols and formularies. Essential components include the risk stratification of the beneficiary population so that interventions can be targeted; coordination of care, services and interventions; education and coaching with a focus on behaviour modification and self-management; and the ongoing monitoring of outcomes (quality, clinical and financial). The service may extend (but is not limited) to beneficiaries who fall within the following groups, and this is also option dependant:

- High risk beneficiaries as identified through data analytics
- Emerging risk beneficiaries as identified through data analytics
- Beneficiaries with mental illness
- Diabetics

REGISTERED BY ME ON
Mfana Maswanganyi
2022/12/09
20/12/2022 07:49:56(UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

- Beneficiaries with chronic back and neck pain
- Weight Management
- Smoking Cessation

6.9 Oncology Management Programme

A programme adopted by the Scheme for the management of Oncology Benefits as set out in the contract between the Scheme and its managed care organization.

6.10 Co-ordination of Care Management Programme

A programme adopted by the Scheme, for all beneficiaries of the Scheme, for the co-ordination of care whereby specialist referrals will need to be obtained through a Family Practitioner, prior to consultation with a specialist. Failure to obtain a referral prior to consultation with a specialist, may result in a co-payment of 40% being imposed.

7. PRESCRIBED MINIMUM BENEFITS

7.1 Members and their registered dependants shall be entitled to Prescribed Minimum Benefits for relevant health services, and each case shall be assessed individually with reference to Regulation 8 and Annexure A to the Regulations published in terms of the Act and in accordance with the Scheme's healthcare programmes and protocols.

7.2 Prescribed Minimum Benefits are not subject to annual benefit limits. Once these limits are exceeded, further treatment for Prescribed Minimum Benefits conditions is afforded strictly in accordance with the minimum prescribed by law.

7.3 For all Prescribed Minimum Benefits conditions, the benefits are only available (except in an emergency), at 100% of cost in State (public hospitals or clinics) or other designated service provider ("DSP") facilities and/or medicine in accordance with a drug formulary issued by the relevant Managed Healthcare Programme.

7.4 The Scheme designates the following service provider(s) for the delivery of Prescribed Minimum Benefits to its beneficiaries:

7.4.1 any group of service providers appointed by the Scheme as a designated service provider for the provision of service delivery for the Prescribed Minimum Benefits;

7.4.2 Specialist Network appointed by the Scheme as the designated service provider for the provision of service delivery for Prescribed Minimum Benefits;

REGISTERED BY ME ON
Mfana Maswanganyi
2022/12/09
20/12/2022 07:56:06(UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

7.4.3 GP Network appointed by the Scheme as the designated service provider for the provision of service delivery for Prescribed Minimum Benefits;

7.4.4 Hospital Network appointed by the Scheme as the designated service provider for the provision of service delivery for Prescribed Minimum Benefits.

7.4.5 Day Surgery Network appointed by the Scheme as the designated service provider for the provision of service delivery for the Prescribed Minimum Benefits.

7.4.6 Substance Abuse Network appointed by the Scheme as the designated service provider for the provision of service delivery for the Prescribed Minimum Benefits

7.4.7 preferred providers for chronic medicine:

7.4.7.1 Medi-Rite, Dis-chem, Clicks and the following courier pharmacies: Medi-rite Courier, Pharmacy Direct, Click Direct Medicine and Dis-chem Direct subject to Scheme's medicine formulary at 100% of the cost.

7.4.8 The above service providers shall for the purposes of this paragraph be referred to as "designated service providers". "Designated service provider" means a healthcare provider or group of providers selected by the Scheme as the contracted provider or providers to provide to its members the respective services as set out above.

7.4.9 Designated service providers for renal dialysis for the provision of service delivery for Prescribed Minimum Benefits;

7.5 Prescribed Minimum Benefits obtained from designated service provider:

100% of cost in respect of diagnosis, treatment and care of Prescribed Minimum Benefit conditions if those services are obtained from a designated service provider. Co-payments in respect of the costs of Prescribed Minimum Benefits may not be paid out of medical savings accounts.

7.6 Prescribed Minimum Benefits voluntarily obtained from other providers:

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition during the applicable waiting period or when benefits are exceeded from a provider other than a designated service provider, the member shall be required to pay the following co-payments of the cost for such service:

7.6.1 a co-payment to the value of the difference between the scheme rate and the cost for such service, in respect of paragraphs 7.4.1 to 7.4.5 and 7.4.7 to 7.4.9;

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:20:12 (UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
2022/12/09
REGISTRAR OF MEDICAL SCHEMES

7.6.2 a co-payment of R8 000 in respect of paragraph 7.4.4;

7.6.4 a co-payment of R2 200 in respect of paragraph 7.4.5.

7.6.5 a co-payment will apply for no referral as indicated in Annexure B per option

Refer paragraphs 7.4.1 to 7.4.9 above.

7.7 Prescribed Minimum Benefits involuntarily obtained from other providers

7.7.1 If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefits condition from a provider other than a designated service provider, the Scheme shall pay 100% of the cost in relation to those Prescribed Minimum Benefits.

7.7.2 For the purposes of paragraph 7.7.1, a beneficiary shall be deemed to have involuntarily obtained a service from a provider other than a designated service provider if –

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

7.7.2.2 immediate medical or surgical treatment for a Prescribed Minimum Benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

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

7.7.3 Except in case of an emergency medical condition, prior authorisation shall be obtained by a member with the intention of involuntarily obtaining a service from a provider other than a designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 7.7.2 are applicable.

7.8 Medicine

7.8.1 Where a Prescribed Minimum Benefit includes medicine, the Scheme shall pay 100% of the cost of that medicine if that medicine is:

7.8.1.1 it is included on the applicable formulary in use by the Scheme; or

7.8.1.2 its cost is below the reimbursement limit set with regards to the Maximum Generic Price or Medicine Price List; or

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:24:12 (+02:00)
Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
2022/12/09
REGISTRAR OF MEDICAL SCHEMES

7.8.1.3 the formulary does not include a drug that is clinically appropriate and effective for the treatment of that Prescribed Minimum Benefit condition.

7.8.2 Where a Prescribed Minimum Benefit includes medicine, a co-payment of 40% of the cost will apply, except if:

7.8.2.1 included on the applicable formulary in use by the Scheme; or

7.8.2.2 Below the reimbursement limit set with regards to the Maximum Generic Price or Medicine Price List; or

7.8.2.3 the formulary does not include a drug that is clinically appropriate and effective for the treatment of that Prescribed Minimum Benefit condition.

7.9 Prescribed Minimum Benefits obtained from a public hospital

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

7.10 Diagnostic tests for an unconfirmed Prescribed Minimum Benefit diagnosis

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.

7.11 Chronic Disease List:

7.11.1 The Scheme covers Prescribed Minimum Benefits at cost which includes the diagnosis, medical management and medicine to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions and other relevant chronic Prescribed Minimum Benefits conditions.

7.12 Contracted and/ or Preferred Provider Services

7.12.1 Ambulance Service i.e. Europe Assist;

7.12.2 ICON (The Independent Clinical Oncology Network) for all options;

7.12.3 Pharmacy Direct, Dischem, Medi-Rite, Medi-Rite Courier, Clicks, Clicks Direct Medicine and Dis-chem Direct

7.12.4 Fedhealth Specialist Partners for all options;

REGISTERED BY ME ON
Mfana Maswanganyi
20/12/2022 07:50:31(UTC+02:00)
Signed by Mfana Maswanganyi
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
2022/12/09
REGISTRAR OF MEDICAL SCHEMES

7.12.5 Fedhealth GP Partners for all options;

7.12.6 Fedhealth Hospital Networks;

7.12.6.1 Fedhealth Psychiatric Hospital Networks

7.12.6.2 Renal Dialysis Hospital Network

7.12.6.3 Day Surgery Network.

7.12.7 Ampath, Lancet, Pathcare and Vermaak for Pathology services.

7.12.8 Preferred supplier agreements for appliances and prosthesis (internal)

7.12.9 Scriptpharm Network as the oncology medicine manager across all options

7.12.10 Alignd Managed Care Organisation for the Provision of palliative care services on all options.

7.12.11 Global Case Management Solutions for all options

oooOOOOOOooooo

REGISTERED BY ME ON

Mfana Maswanganyi
20/12/2022 07:30:39(UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM

2022/12/09

REGISTRAR OF MEDICAL SCHEMES