medhealth

medical scheme for you with you

# BENEFIT

## STRUCTURE

**FOR 2024**

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# TABLE OF CONTENT


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# INTRODUCTION

**1.1 The purpose of the Scheme is to:**

a. *Undertake liability, in respect of its members and their dependants, in return for a Premium;*

b. *Make provision for the accessing of any relevant health service provided for under the Scheme;*

c. *Grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service.*

Should any of the Members or their Dependants as defined in the Scheme Rules, require medical and/or surgical treatment or assistance as a result of sickness contracted during the period of membership, MedHealth, hereinafter referred to as "the Company" shall , subject to the required medical treatment falling within the benefits provided under a chosen Scheme Plan, and subject to the Premium having been paid by the Member in the manner provided by and subject to the Terms, Conditions and Limitations of the Contract, provide for the costs incurred.

# *PRODUCT* *OFFERING*

Welcome to MedHealth, a Malawian owned corporation that strives to serve its members wholly without any bias or prejudice Where members are welcomed and made to feel at home.

At MedHealth we know how important it is for you to have quality service assured and peace of mind, that is why our arms are always wide open to assist you with your health and wellbeing.

With us you are not just a statistic but a member of a warm and loving family.

Medical Scheme for You with You

*Moving From Success to Significane*

# MEDHEALTH SCHEME BENEFITS

*1ST JAN, 2024*
*TO 31ST DECEMBER, 2024*

## CARE
IN PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| 001 | Overall Annual Limit | 5,700,000 |
| IP01 | Hospitalisation (General medical and surgical wards including Ward and Theatre medicines) | Subject to overall OA Limit |
| IP02 | HDU and ICU | 10 Days Per Annum Subject to overall OA Limit |
| IP03 | Specialists and General Practitioners | Subject to overall OA Limit |
| IP04 | Theatre Costs | Subject to overall OA Limit |
| IP05 | Blood Transfusion | Subject to overall OA Limit |
| IP06 | Major Disease Benefit (MDB) | 1,250,000 |
| IP07 | Oncology Subject to MDB per beneficiary p.a. | |
| IP08 | Organ Transplants *D Subject to MDB per beneficiary p.a. | |
| IP09 | Chronic Benefit *R | 300,000 |
| | Pandemic Benefit (COVID-19 etc) *P - 20% co-payment | 300,000 |
| IP11 | Physiotherapy *R per beneficiary p.a. | 5 Sessions Per Hospitalizations Subject to overall OA Limit |
| IP12 | Medicines to take home (TTO) | Subject to overall OA Limit |
| IP13 | Radiology and Pathology | 70,000 per Hospitalization |
| IP14 | Specialised Radiology | 1 at 100%; 1 Additional MRI/CT Scan 30% co-payment |
| IP15 | Maxillofacial Surgery | 250,000 |
| IP16 | Maternity (Delivery including postpartum & Neonatal Care) | 456,000 |
| IP17 | Internal and external prosthesis | 241,500 |
| IP18 | Medical Appliances | 50,000 |
| IP19 | Psychiatric hospitalisations | 10 DAYS P.A |
| IP20 | Sub-Acute Care | 10 DAYS P.A |
| IP21 | Ambulance Services | 150,000 per event |
| IP22 | Emergency Air/Cross-Border Evacuation & Foreign Referal | Not covered |
| IP23 | Repatriation of Mortal Remains | Not covered |
| IP24 | Emergency Foreign cover | Not covered |

## CARE
OUT PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| OP01 | Consultations Limit | 84,000 |
| OP02 | Specialists Consultations on Referral | Subject to Consultation Limit |
| OP03 | Antenatal and Postnatal Benefit *E | Covered |
| OP04 | Antenatal and Postnatal Consultations | 8 Visits |
| OP05 | Ultrasounds | 2 Scans |
| OP06 | Pathology | Hepatitis B, Blood Group and RH, Blood Sugar, 2 Full Blood Count; VDRL; 4 Urinalysis; HIV-Ag Test |
| OP07 | Procedures | 85,500 |
| OP08 | Pathology and Radiology | |
| OP09 | (Subject to Procedures Limit) | |
| OP10 | HIV/AIDS Benefit *E Anti-Retroviral Therapy and Pathology Tests | Covered accordingly to Malawi HIV Policy |
| OP11 | Basic Dentistry | 60,500 |
| OP12 | Specialised Dentistry and Orthodontics *P | Not Covered |
| OP13 | Auxiliary Services *R | Not Covered |
| OP14 | Physiotherapy *R | Not Covered |
| OP15 | Acute Medicines | 68,400 |
| OP16 | Optometry (Lens and Frame)- Every 2 years | 80,000 |
| OP17 | Eye Test for Optometry Subject to Optometry Limit | 1 Eye Test Every 24 months |
| OP18 | Funeral Expense Benefit | 400,000 |
| | | |

**KEY**

- ***E** Enrolment Required
- ***P** Pre-Authorization Required
- ***R** Referral by GPor Specialist Required
- ***D** Donor not Covered

## CAREPLUS
IN PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| 001 | Overall Annual Limit | 8,250,000 |
| IP01 | Hospitalisation (General medical and surgical wards including Ward and Theatre medicines) | Subject to overall OA Limit |
| IP02 | HDU and ICU | 10 Days Per Annum Subject to overall OA Limit |
| IP03 | Specialists and General Practitioners | Subject to overall OA Limit |
| IP04 | Theatre Costs | Subject to overall OA Limit |
| IP05 | Blood Transfusion | Subject to overall OA Limit |
| IP06 | Major Disease Benefit (MDB) | 4,600,000 |
| IP07 | Oncology Subject to MDB per beneficiary p.a. | |
| IP08 | Organ Transplants *D Subject to MDB per beneficiary p.a. | |
| IP09 | Chronic Benefit *R | 1,700,000 |
| | Pandemic Benefit (COVID-19 etc) *P - 20% co-payment | 2,500,000 |
| IP11 | Physiotherapy *R per beneficiary p.a. | 5 Sessions Per Hospitalizations Subject to overall OA Limit |
| IP12 | Medicines to take home (TTO) | Subject to overall OA Limit |
| IP13 | Radiology and Pathology | 120,000 per admission |
| IP14 | Specialised Radiology | 1 at 100% ; 2 Additional MRI/CT Scan 30% co-pay |
| IP15 | Maxillofacial Surgery | 1,245,000 |
| IP16 | Maternity (Delivery including postpartum & Neonatal Care) | 3,000,000 |
| IP17 | Internal and external prosthesis | 300,000 |
| IP18 | Medical Appliances | 66,000 |
| IP19 | Psychiatric hospitalisations | 10 DAYS P.A |
| IP20 | Sub-Acute Care | 10 DAYS P.A |
| IP21 | Ambulance Services | 300,000 per event |
| IP22 | Emergency Air/Cross-Border Evacuation & Foreign Referal | Not covered |
| IP23 | Repatriation of Mortal Remains | Not covered |
| IP24 | Emergency Foreign cover | Not covered |

## CAREPLUS
OUT PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| OP01 | Consultations Limit | 176,000 |
| OP02 | Specialists Consultations on Referral | Subject to Consultation Limit |
| OP03 | Antenatal and Postnatal Benefit *E | Covered |
| OP04 | Antenatal and Postnatal Consultations | 8 Visits |
| OP05 | Ultrasounds | 2 Scans |
| OP06 | Pathology | Hepatitis B, Blood Group and RH, Blood Sugar, 2 Full Blood Count; VDRL; 4 Urinalysis; HIV-Ag Test |
| OP07 | Procedures | 180,000 |
| OP08 | Pathology and Radiology | |
| OP09 | (Subject to Procedures Limit) | |
| OP10 | HIV/AIDS Benefit *E Anti-Retroviral Therapy and Pathology Tests | Covered accordingly to Malawi HIV Policy |
| OP11 | Basic Dentistry | 150,000 |
| OP12 | Specialised Dentistry and Orthodontics *P | 287,000 |
| OP13 | Auxiliary Services *R | 200,000 |
| OP14 | Physiotherapy *R | Subject to Auxiliary limit |
| OP15 | Acute Medicines | 140,000 |
| OP16 | Optometry (Lens and Frame)- Every 2 years | 120,000 |
| OP17 | Eye Test for Optometry Subject to Optometry Limit | 1 Eye Test Every 24 months |
| OP18 | Funeral Expense Benefit | 600,000 |

**KEY**

- ***E** Enrolment Required
- ***P** Pre-Authorization Required
- ***R** Referral by GPor Specialist Required
- ***D** Donor not Covered

## MEDISAVE
IN PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| 001 | Overall Annual Limit | 20,100,000 |
| IP01 | Hospitalisation (General medical and surgical wards including Ward and Theatre medicines) | Subject to overall OA Limit |
| IP02 | HDU and ICU | 15 Days Per Annum Subject to overall OA Limit |
| IP03 | Specialists and General Practitioners | Subject to overall OA Limit |
| IP04 | Theatre Costs | Subject to overall OA Limit |
| IP05 | Blood Transfusion | Subject to overall OA Limit |
| IP06 | Major Disease Benefit (MDB) | 8,200,000 |
| IP07 | Oncology Subject to MDB per beneficiary p.a. | |
| IP08 | Organ Transplants *D Subject to MDB per beneficiary p.a. | |
| IP09 | Chronic Benefit *R | 3,000,000 |
| | Pandemic Benefit (COVID-19 etc) *P - 20% co-payment | 3,500,000 |
| IP11 | Physiotherapy *R per beneficiary p.a. | 7 Sessions Per Hospitalizations Subject to overall OA Limit |
| IP12 | Medicines to take home (TTO) | Subject to overall OA Limit |
| IP13 | Radiology and Pathology | 150,000 per Hospitalization |
| IP14 | Specialised Radiology | 1 at 100% ; 2 Additional MRI/CT Scan 20% co-payment |
| IP15 | Maxillofacial Surgery | 2,200,000 |
| IP16 | Maternity (Delivery including postpartum & Neonatal Care) | 4,500,000 |
| IP17 | Internal and external prosthesis | 800,000 |
| IP18 | Medical Appliances | 120,000 |
| IP19 | Psychiatric hospitalisations | 10 DAYS P.A |
| IP20 | Sub-Acute Care | 10 DAYS P.A |
| IP21 | Ambulance Services | 500,000 per event |
| IP22 | Emergency Air/Cross-Border Evacuation & Foreign Referal | Subject to overall MDB |
| IP23 | Repatriation of Mortal Remains | Not covered |
| IP24 | Emergency Foreign cover | 200,000.00 |

# MEDISAVE
OUT PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| OP01 | Consultations Limit | 226,000 |
| OP02 | Specialists Consultations on Referral | Subject to Consultation Limit |
| OP03 | Antenatal and Postnatal Benefit *E | Covered |
| OP04 | Antenatal and Postnatal Consultations | 8 Visits |
| OP05 | Ultrasounds | 2 Scans |
| OP06 | Pathology | Hepatitis B, Blood Group and RH, Blood Sugar, 2 Full Blood Count; VDRL; 4 Urinalysis; HIV-Ag Test |
| OP07 | Procedures | 285,000 |
| OP08<br>OP09 | Pathology and Radiology<br>(Subject to Procedures Limit) | |
| OP10 | HIV/AIDS Benefit *E Anti-Retroviral Therapy and Pathology Tests | Covered according to Malawi HIV Policy |
| OP11 | Basic Dentistry | 230,000 |
| OP12 | Specialised Dentistry and Orthodontics *P | 300,000 |
| OP13 | Auxiliary Services *R | 300,000 |
| OP14 | Physiotherapy *R | Subject to Auxiliary limit |
| OP15 | Acute Medicines | 216,000 |
| OP16 | Optometry (Lens and Frame)- Every 2 years | 150,000 |
| OP17 | Eye Test for Optometry Subject to Optometry Limit | 1 Eye Test Every 24 months |
| OP18 | Funeral Expense Benefit | 800,000 |

**KEY**

- ***E** Enrolment Required
- ***P** Pre-Authorization Required
- ***R** Referral by GPor Specialist Required
- ***D** Donor not Covered

# MEDICARE
IN PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| 001 | Overall Annual Limit | 40,000,000 |
| IP01 | Hospitalisation (General medical and surgical wards including Ward and Theatre medicines) | Subject to overall OA Limit |
| IP02 | HDU and ICU | 15 Days Per Annum Subject to overall OA Limit |
| IP03 | Specialists and General Practitioners | Subject to overall OA Limit |
| IP04 | Theatre Costs | Subject to overall OA Limit |
| IP05 | Blood Transfusion | Subject to overall OA Limit |
| IP06 | Major Disease Benefit (MDB) | 12,500,000 |
| IP07 | Oncology Subject to MDB per beneficiary p.a. | |
| IP08 | Organ Transplants *D Subject to MDB per beneficiary p.a. | |
| IP09 | Chronic Benefit *R | 4,150,000 |
| | Pandemic Benefit (COVID-19 etc) *P - 20% co-payment | 5,000,000 |
| IP11 | Physiotherapy *R per beneficiary p.a. | 10 Sessions Per Hospitalizations Subject to overall OA Limit |
| IP12 | Medicines to take home (TTO) | Subject to overall OA Limit |
| IP13 | Radiology and Pathology | 170,000 per Hospitalization |
| IP14 | Specialised Radiology | 1 at 100% ; 2 Additional MRI/CT Scan 20% co-pay |
| IP15 | Maxillofacial Surgery | 2,550,000 |
| IP16 | Maternity (Delivery including postpartum & Neonatal Care) | 7,150,000 |
| IP17 | Internal and external prosthesis | 1,570,000 |
| IP18 | Medical Appliances | 250,000 |
| IP19 | Psychiatric hospitalisations | 15 DAYS P.A |
| IP20 | Sub-Acute Care | 15 DAYS P.A |
| IP21 | Ambulance Services | 650,000 Per Event |
| IP22 | Emergency Air/Cross-Border Evacuation & Foreign Referal | Subject to overall MDB |
| IP23 | Repatriation of Mortal Remains | 2,500,000 |
| IP24 | Emergency Foreign cover | 300,000 |

# MEDICARE
OUT PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| OP01 | Consultations Limit | 350,000 |
| OP02 | Specialists Consultations on Referral | Subject to Consultation Limit |
| OP03 | Antenatal and Postnatal Benefit *E | Covered |
| OP04 | Antenatal and Postnatal Consultations | 8 Visits |
| OP05 | Ultrasounds | 2 Scans |
| OP06 | Pathology | Hepatitis B, Blood Group and RH, Blood Sugar, 2 Full Blood Count; VDRL; 4 Urinalysis; HIV-Ag Test |
| OP07 | Procedures | 370,000 |
| OP08<br>OP09 | Pathology and Radiology (Subject to Procedures Limit) | |
| OP10 | HIV/AIDS Benefit *E Anti-Retroviral Therapy and Pathology Tests | Covered according to Malawi HIV Policy |
| OP11 | Basic Dentistry | 270,000 |
| OP12 | Specialised Dentistry and Orthodontics *P | 400,000 |
| OP13 | Auxiliary Services *R | 350,000 |
| OP14 | Physiotherapy *R | Subject to Auxiliary limit |
| OP15 | Acute Medicines | 250,000 |
| OP16 | Optometry (Lens and Frame)- Every 2 years | 200,000 |
| OP17 | Eye Test for Optometry Subject to Optometry Limit | 1 Eye Test Every 24 months |
| OP18 | Funeral Expense Benefit | 1,000,000 |

**KEY**

- ***E** Enrolment Required
- ***P** Pre-Authorization Required
- ***R** Referral by GPor Specialist Required
- ***D** Donor not Covered

# MEDIPLUS

IN PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| 001 | Overall Annual Limit | 65,000,000 |
| IP01 | Hospitalisation (General medical and surgical wards including Ward and Theatre medicines) | Subject to overall OA Limit |
| IP02 | HDU and ICU | 15 Days Per Annum Subject to overall OA Limit |
| IP03 | Specialists and General Practitioners | Subject to overall OA Limit |
| IP04 | Theatre Costs | Subject to overall OA Limit |
| IP05 | Blood Transfusion | Subject to overall OA Limit |
| IP06 | Major Disease Benefit (MDB) | 14,000,000 |
| IP07 | Oncology Subject to MDB per beneficiary p.a. | |
| IP08 | Organ Transplants *D Subject to MDB per beneficiary p.a. | |
| IP09 | Chronic Benefit *R | 5,000,000 |
| | Pandemic Benefit (COVID-19 etc) *P - 20% co-payment | 6,650,000 |
| IP11 | Physiotherapy *R per beneficiary p.a. | 10 Sessions Per Hospitalizations Subject to overall OA Limit |
| IP12 | Medicines to take home (TTO) | Subject to overall OA Limit |
| IP13 | Radiology and Pathology | 200,000 per Hospitalization |
| IP14 | Specialised Radiology | 2 at 100%; 2 Additional MRI/CT Scan 20% co-payments |
| IP15 | Maxillofacial Surgery | 3,000,000 |
| IP16 | Maternity (Delivery including postpartum & Neonatal Care) | 10,000,000 |
| IP17 | Internal and external prosthesis | 3,900,000 |
| IP18 | Medical Appliances | 350,000 |
| IP19 | Psychiatric hospitalisations | 15 DAYS P.A |
| IP20 | Sub-Acute Care | 15 DAYS P.A |
| IP21 | Ambulance Services | 750,000 |
| IP22 | Emergency Air/Cross-Border Evacuation & Foreign Referal | Subject to overall MDB |
| IP23 | Repatriation of Mortal Remains | 3,000,000 |
| IP24 | Emergency Foreign cover | 330,000 |

# MEDIPLUS

OUT PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| OP01 | Consultations Limit | 400,000 |
| OP02 | Specialists Consultations on Referral | Subject to Consultation Limit |
| OP03 | Antenatal and Postnatal Benefit *E | Covered |
| OP04 | Antenatal and Postnatal Consultations | 8 Visits |
| OP05 | Ultrasounds | 2 Scans |
| OP06 | Pathology | Hepatitis B, Blood Group and RH, Blood Sugar, 2 Full Blood Count; VDRL; 4 Urinalysis; HIV-Ag Test |
| OP07 | Procedures | 600,000 |
| OP08<br>OP09 | Pathology and Radiology (Subject to Procedures Limit) | |
| OP10 | HIV/AIDS Benefit *E Anti-Retroviral Therapy and Pathology Tests | Covered according to Malawi HIV Policy |
| OP11 | Basic Dentistry | 500,000 |
| OP12 | Specialised Dentistry and Orthodontics *P | 500,000 |
| OP13 | Auxiliary Services *R | 500,000 |
| OP14 | Physiotherapy *R | Subject to Auxiliary limit |
| OP15 | Acute Medicines | 300,000 |
| OP16 | Optometry (Lens and Frame)- Every 2 years | 250,000 |
| OP17 | Eye Test for Optometry Subject to Optometry Limit | 1 Eye Test Every 24 months |
| OP18 | Funeral Expense Benefit | 1,500,000 |

## KEY

***E** Enrolment Required

***P** Pre-Authorization Required

***R** Referral by GPor Specialist Required

***D** Donor not Covered

## PREMIUMCARE
IN PETIENT SERVICE

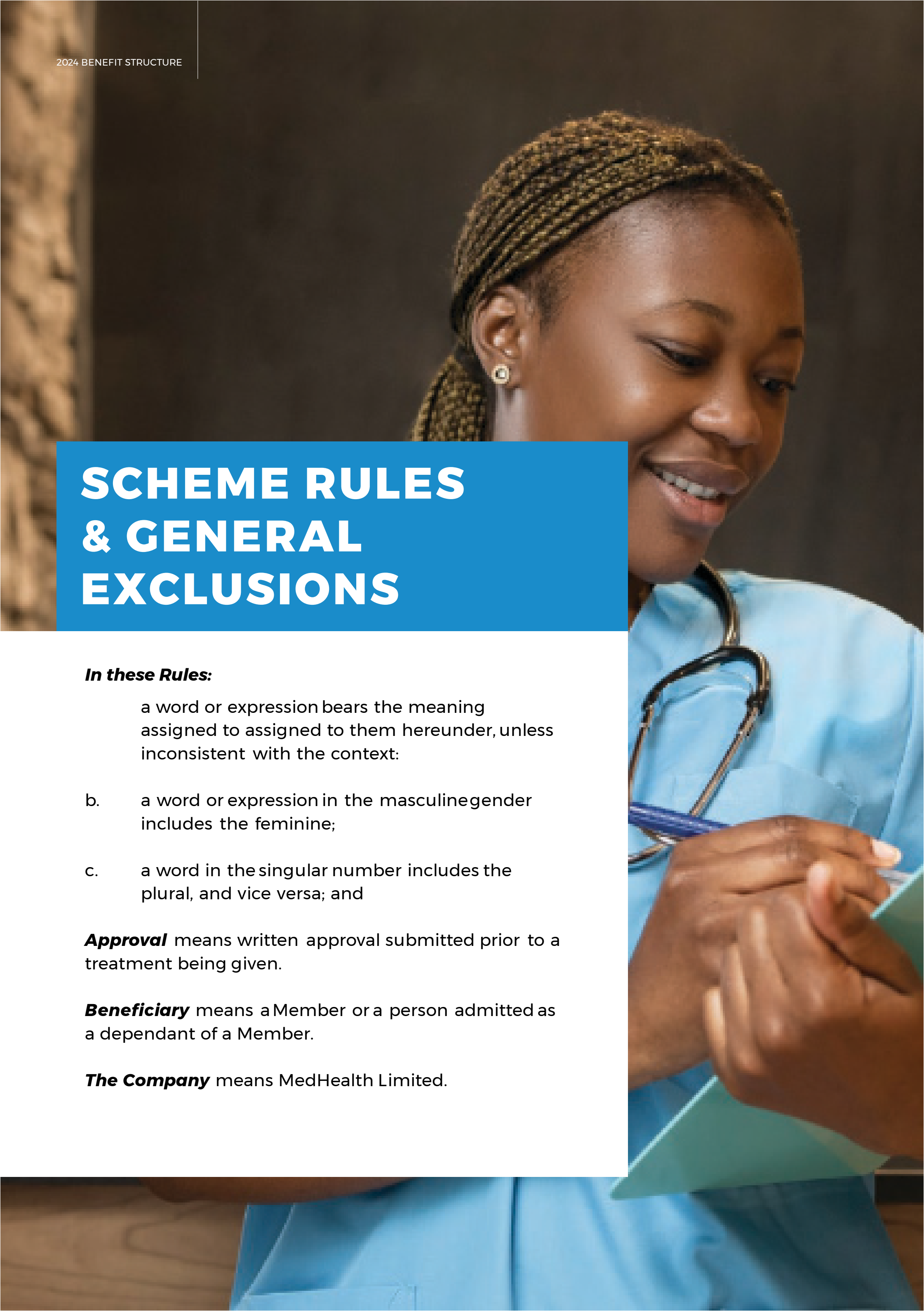
| CODE | Services | Coverage |
|---|---|---|
| 001 | Overall Annual Limit | 200,000,000 |
| IP01 | Hospitalisation (General medical and surgical wards including Ward and Theatre medicines) | Subject to overall OA Limit |
| IP02 | HDU and ICU | 15 Days Per Annum Subject to overall OA Limit |
| IP03 | Specialists and General Practitioners | Subject to overall OA Limit |
| IP04 | Theatre Costs | Subject to overall OA Limit |
| IP05 | Blood Transfusion | Subject to overall OA Limit |
| IP06 | Major Disease Benefit (MDB) | 21,350,000 |
| IP07 | Oncology Subject to MDB per beneficiary p.a. | |
| IP08 | Organ Transplants *D Subject to MDB per beneficiary p.a. | |
| IP09 | Chronic Benefit *R | 9,500,000 |
| | Pandemic Benefit (COVID-19 etc) *P - 20% co-payment | 7,000,000 |
| IP11 | Physiotherapy *R per beneficiary p.a. | 12 Sessions Per Hospitalizations Subject to overall OA Limit |
| IP12 | Medicines to take home (TTO) | Subject to overall OA Limit |
| IP13 | Radiology and Pathology | 300,000 per Hospitalization |
| IP14 | Specialised Radiology | 2 at 100%; 2 Additional MRI/CT Scan 20% co-pay |
| IP15 | Maxillofacial Surgery | 6,500,000 |
| IP16 | Maternity (Delivery including postpartum & Neonatal Care) | 15,000,000 |
| IP17 | Internal and external prosthesis | 5,200,000 |
| IP18 | Medical Appliances | 500,000 |
| IP19 | Psychiatric hospitalisations | 15 DAYS P.A |
| IP20 | Sub-Acute Care | 15 DAYS P.A |
| IP21 | Ambulance Services | 1,000,000 |
| IP22 | Emergency Air/Cross-Border Evacuation & Foreign Referal | Subject to overall MDB |
| IP23 | Repatriation of Mortal Remains | 5,000,000 |
| IP24 | Emergency Foreign cover | 300,000 |

## PREMIUMCARE
OUT PETIENT SERVICE

| CODE | Services | Coverage |
|---|---|---|
| OP01 | Consultations Limit | 500,000 |
| OP02 | Specialists Consultations on Referral | Subject to Consultation Limit |
| OP03 | Antenatal and Postnatal Benefit *E | Covered |
| OP04 | Antenatal and Postnatal Consultations | 8 Visits |
| OP05 | Ultrasounds | 2 Scans |
| OP06 | Pathology | Hepatitis B, Blood Group and RH, Blood Sugar, 2 Full Blood Count; VDRL; 4 Urinalysis; HIV-Ag Test |
| OP07 | | |
| OP08 | Procedures | 700,000 |
| OP09 | Pathology and Radiology (Subject to Procedures Limit) | |
| OP10 | HIV/AIDS Benefit *E Anti-Retroviral Therapy and Pathology Tests | Covered according to Malawi HIV Policy |
| OP11 | Basic Dentistry | 500,000 |
| OP12 | Specialised Dentistry and Orthodontics *P | 500,000 |
| OP13 | Auxiliary Services *R | 500,000 |
| OP14 | Physiotherapy *R | Subject to Auxiliary limit |
| OP15 | Acute Medicines | 400,000 |
| OP16 | Optometry (Lens and Frame)- Every 2 years | 350,000 |
| OP17 | Eye Test for Optometry Subject to Optometry Limit | 1 Eye Test Every 24 months |
| OP18 | Funeral Expense Benefit | 2,000,000 |

**KEY**

- ***E** Enrolment Required
- ***P** Pre-Authorization Required
- ***R** Referral by GPor Specialist Required
- ***D** Donor not Covered



# SCHEME RULES & GENERAL EXCLUSIONS

***In these Rules:***

a word or expression bears the meaning assigned to assigned to them hereunder, unless inconsistent with the context:

b. a word or expression in the masculine gender includes the feminine;

c. a word in the singular number includes the plural, and vice versa; and

***Approval*** means written approval submitted prior to a treatment being given.

***Beneficiary*** means a Member or a person admitted as a dependant of a Member.

***The Company*** means MedHealth Limited.

# CHILD DEPENDANT

Means a Member's natural child who has not reached the age of twenty-one (21), is single, and is not self-supporting. A child dependant may include a stepchild or legally adopted child or a child in the process of being legally adopted or a child in the process of being placed in foster care, or a child for whom the Member has a duty of support or a child who has been placed in the custody of the Member or his/her spouse or partner.

a.

A disabled child who has reached twenty one (21st) years of age but has not reached the age of 24 years, who due to mental or physical disability is not self-supporting, may on submission of the relevant supporting medical evidence for such condition, be granted Child Dependant status.

b.

A child who has reached twenty one (21st) years of age but has not reached the age of twenty five years of age, who is single, is not a Member on another Medical Scheme, and who is a full time student at a registered school, College or University as confirmed by certificate from the institution at the beginning of each year provided that such Membership is subject to annual review by the company, shall be granted child dependant status.

***Benefit***
*limit Means the maximum amount that can be claimed over the benefit year from the Scheme pertaining to a specific benefit category available on an option.*

***Benefit year***
*Means 12 months, 1 January to 31 December, of each year.*

***Proration***
*Means the monthly apportioning of benefitlimitsaccordingtoBeneficiary benefit year exposure to a particular option.*

***Condition specific waiting period***
*Means 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.*

***Continuation Member***
*Means a Member who retains his Membership of the Scheme in terms of rules 7 and 8 or a dependant who becomes a Member of the Scheme.*

***Premium***
*Means, in relation to a Member, the amount, exclusive of interest, paid by or in respect of the Member and his registered dependants, if any, as Premium and might include contributions to personal medical savings accounts depending on the option selected.*

***Dependant***
*Means a registered dependant described here below of such Member enrolled under the contact and who is entitled to the cover of the selected option:*

a.

A Spouse, with whom the Member is married in terms of any law or custom; or partner, based on objective criteria of mutual dependency who is not a Member or Dependant of any other registered Medical Scheme.

b.

A Special Dependant refers to parents or parents-in-law, grandchildren, nephews and nieces, brothers and sisters, third generation dependants or children placed with a legal guardian other than a foster child, domestic employees and their children.

c.

A child who has reached the twenty-one (21) years of age but has not reached the age of twenty five years, who is unmarried, not self-supporting, is not a Member on another Medical Scheme and who has proved to be a full time student at a registered school, College or University, may be granted Special Dependant status.

***Designated service provider***
*Means a healthcare provider or group of providers selected by the Health Plan as preferred provider/s to providediagnosis, treatmentand care to the Members.*

***Domicilium citandi et executandi***
*Means 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.*

***Emergency medical condition***
*Means the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.*

***Employee***
*Means a person in the employment of a company located within Malawi and resident or ordinary domiciled in Malawi and not exceeding the age of 60 years on joining.*

***Employer***
*Means any company or business, which has contracted with the Company for the purpose of admission of its employees as Members of the chosen Health Plans.*

***General waiting period***
*Means a period during which a beneficiary is not entitled to claim for any benefits.*

***Member***
*Means any person who is admitted as a Member of the Scheme in terms of these rules.*

***Underwriting***
*Means the waiting period, general or condition specific, premium loadings, and/or exclusions that the Company may impose on a Member or group joining one of the options.*

# MEMBERSHIP CARD

Every Beneficiary shall be furnished with a Membership Card, containing such particulars as may be prescribed.

The card shall be produced to the supplier of a service upon accessing of services.

The card shall remain the property of the Company and shall be returned to the Company on termination of Membership.

The utilisation of a Membership card by any person other than the Member or his registered dependants, with the knowledge or consent of the Member or his dependants, shall not be permitted and shall be construed as an abuse of the privileges of Membership of the Scheme.

Any insured person who has lost his Membership card shall on, request and on payment of a reasonable fee determined by the Company, be supplied with a replacement Membership card.

# RETIREES

A Member may retain his Membership of the Scheme with his registered dependants, if any, in the event of his retiring from the service of his employer or his employment being terminated by his employer on account of age

Provided that such Member shall request to retain their membership three (3) months before the employment termination date the Member shall pay premium in advance till the end of the year and in December for 12 months for the next year.

New applicants aged 60 years and over shall not be eligible for Membership, unless special approval has been granted by the Company. A request for such approval shall be supported by medical reports prepared by a medical practitioner nominated by the Company. After investigation of the doctor's report a general waiting period, a condition specific waiting period may be applied if the application is accepted.

The Company shall inform the Member of his right to continue his Membership and of the premium payable from the date of retirement or termination of his employment after which, such Member shall have to inform the Company in writing of his desire to continue his Membership, and the Company shall have to approve for him to continue to be a Member.

# WE FOCUSED ON CLIENT SATISFACTION

DEPENDA
OF DECEA
MEMBERS

- The employer or dependant of an Individual Member shall inform the Company of the death of a Member within thirty (30) days from the date of death of the Member.
- The Company shall inform the dependant of his right to Membership and of the contributions payable in respect thereof. Unless such person informs the Company in writing of his intention to become a Member, he shall not be admitted as a Member of the Scheme.
- The dependants of a deceased Member who are registered with the Scheme as his dependants at the time of such Member's death and wish to continue membership shall be entitled to Membership of the Scheme without any new restrictions, limitations or waiting periods.
- Such a Member's Membership shall terminate if the Member becomes a member or a dependant of a Member of another medical scheme.

# REGISTRATION & DEREGISTRATION OF DEPENDANTS

***Registration of Dependants***

A Member shall apply for the registration of his dependants on application for Membership.

A Member shall apply to register a new born or newly adopted child as a dependant within 30 days of the date of birth or adoption of the child and increased contributions shall be due from the first day of the month following the month of birth or adoption and benefits shall accrue from the date of birth or adoption.

Where a Member applies to register a new spouse, benefits shall accrue to the spouse from the first day of the month following the registration of the spouse with the Scheme and increased contributions shall be done as from the first day of the month following registration of the spouse with the sc

***De-registration of Dependants***

A Member shall inform the Company within 30 days of the occurrence of any event which disqualifies any one of his dependants from satisfying the conditions and terms of which he may be a dependant.

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.

# TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

- A minor may become a Member with the consent of his parent or guardian at the discretion of the Company. Such a member will be deemed a main member and contribute premiums as such.

- Maximum age limit for new applicants, individuals and/or corporate Members, is 59 years. If the Member is above this age limit, the Member shall be subject to underwriting and a medical report, at the expense of the applicant which shall be required before the applicant is accepted. Clause 4.2 of these rules shall apply to this provision.

- The Pregnancy Risk Cover (Maternity Benefit) shall be accessed once every twenty four (24) months regardless of the maximum benefit cover.

- No person may be

    a. of more than one Scheme; or

    b. a dependant of more than one member regardless of whether the members belong to different Schemes or not.

- Any Member who defrauds the Company shall be disqualified as a Member of the Scheme provided that the Company shall accord such a Member a right to be heard on the matter.

***Underwriting***

- Underwriting shall be a process where the Company determines the risk of the applicant and price the risk appropriately.
- Prospective Members shall, prior to admission, complete and submit the application forms required by the Company, together with satisfactory evidence in respect of himself and his dependants, of age, income, state of health and of any prior Membership or admission as dependant of any other medical scheme. All applications to be verified by the employer.
- The Company may require an applicant to provide the Company with a medical report in respect of any proposed beneficiary. Any report required by the Company for admission purposes shall be on the account of the applicant.
- Underwriting shall apply to individual Members and to groups with less than 30 main Members, or as otherwise specified by the Company's Underwriting policy. Waiting periods shall apply depending on the results of a Clinical and Risk analysis of a group or new business.

***Waiting periods***

- The Company may impose upon a group or person, in respect of whom an application is made for Membership or admission the following:
- An inpatient (general) waiting period of up to three (3) months; and/or
- A waiting period of 6 months for specialized dentistry;
- A condition specific waiting period for 12 to 24 months, at the discretion of the Company;
- A waiting period of 12 months for maternity related benefits shall be applied for Members that join the Scheme;
- A waiting period of up to 9 months for Optometry;
- A 12 months waiting period for elective foreign cover;
- A 12 months waiting period for emergency cross-border evacuation and/or foreign referral.

- No waiting periods may be imposed on:

    a. 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.

    b. Child dependant born during the period of Membership, provided registration takes place within 30 days of date of birth.

- The registered dependants of a Member shall participate in the same option as the Member unless member requests otherwise.

- Every Member may upon request, receive a copy of these rules, which shall include premiums, benefits, limits and exclusions, the Member's rights and obligations. Members and their dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.

- A Member may not or cede or assign any right to a benefit which he may have against the Company. The Company may withhold, suspend or discontinue the payment of a benefit to which a Member is entitled to 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 his rights and benefits to somebody else.

***Change of Address of Member***

- A Member shall notify the Company within 30 days of any change of address including his/her domicilium citandi et executandi. The Company shall not be held liable if a Member's rights are prejudiced or forfeited as a result of the Member's neglecting to comply with the requirements of this rule.

# TERMINATION OF MEMBERSHIP

***Termination***

- A participating employer may terminate membership of all his employees with the Scheme on giving three calendar months written notice.
- A Member who, in terms of his conditions of employment is required to be a Member of a Scheme, may not terminate his Membership while he remains an employee without the prior written consent of his employer.
- If Membership is terminated due to employment termination, the Employer shall be obliged to pay the Premium in respect of such Member and his dependants until the last day of the month during which employment was terminated.
- A Member may voluntarily terminate his/her Membership of the Scheme, where Membership is not a condition of employment, on giving one calendar month's written notice. All rights to benefits cease after the last day of Membership.

Upon termination of a Members' Membership, all the dependants of such a Member shall also automatically cease to be beneficiaries of the Scheme.

An ex-employee of an employer may request to convert his membership to Individual Member status. A request for such approval shall be subject to the terms and conditions of service applicable to Individual Members.

***Death***

- A person ceases to be a member of the Scheme on his/her death.
- In the event of the death of a Member, the Membership of the dependants, if any, shall be allowed to continue as stipulated in rule 5 above.
- Dependant of a deceased are subject to a premium waiver of six months or year-end depending on which comes first.
- Dependants subject to a premium waiver will not have access to Organ Transplant, Emergency Air/Cross-border Evacuation and Foreign Referral, and Elective Foreign Visits.
- Abuse of privileges, False claims, Misrepresentation and Nondisclosure of Factual information
- The Company may exclude benefits or terminate the Membership of a Member or dependant whom the Company finds guilty of abusing the benefits and privileges of the Scheme through presentation of false claims or making a material misrepresentation or non-disclosure of factual information. In such event, the Member may be required by the Company to refund to the Scheme any sum which, for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf

# PREMIUMS

Premiums shall be reviewed annually, with effect from the 1st of January each year unless otherwise stipulated in the service level agreement contract with the Employer or individual Member.

- Premiums shall be due monthly in advance and only by special arrangement in arrears, and be payable by not later than the 1st day of each month. Where premiums or any other debt owing to the scheme, have not been paid within seven (7) days of the due date, the Company shall have the right to:

- suspend all benefit payments in respect of claims which arose during the period of default; or after three months of default to cancel the membership through a written notice given to the employer at his/her domicilium citandi et executandi;

- In the event that payments are brought up to date and provided Membership has not been cancelled in accordance with agreement benefits shall be reinstated without any break in continuity subject to the right of the Company to levy a reasonable fee to cover any expenses associated with the default and to recover interest on the arrear amount at the prime overdraft rate of the Company's bankers. If such payments are not brought up to date, no benefits shall be due to the Member from the date of cancellation and any such benefit paid may be recovered by the Company.

- Unless specifically provided for in the rules in respect of savings accounts, no refund of any assets of the Company or any portion of a contribution shall be paid to any person where such Member's Membership or cover in respect of any dependant terminates during the course of a month.

***Liabilities of Employer and Member***

- The liability of the Employer towards the Company is limited to any amounts payable in terms of any agreement between the employer and the Company.

- The liability of a Member to the Company is limited to the amount of his unpaid premiums together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants in excess of benefits due.

- In the event of a person ceasing to be a Member, any amount still owing by such Member is a debt due to the Company and recoverable by it.

***Claims Procedure***

- Every claim submitted to the Company in respect of the rendering of a relevant health service as contemplated in these Rules, shall be accompanied by an account or statement as prescribed.

- If an account, statement or claim is correct or where a corrected account, statementorclaimisreceived,asthecasemaybe,theCompanyshalldispatch to the Member a statement containing at least the following particulars:

  a. the name and the Membership number of the Member;
  b. the name of the supplier of service;
  c. the final date of service rendered by the supplier of service on the account or statement which is covered by the payment;
  d. the total amount charged for the service concerned; and
  e. the amount of the benefit awarded for such service.

- In order to qualify for benefits, any claim shall, unless otherwise arranged, be submitted to the Company not later than the last day of the third month following the date of service.

- Where a Member has paid an account, he shall, in support of his claim, submit a receipt together with medical notes for the services accessed.

- Where the Company is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Company shall notify the Member and the relevant service provider within 30 days after receipt thereof and state the reasons for such an opinion. The Company shall afford such Member and service provider the opportunity to resubmit such corrected claim to the company within 30 days following the date from which it was returned for correction.

- In the event that Clause 11.5 has not being met by a member or service provider, the claim made for payment will become a stale claim and the Company will not be responsible for payment.

- Accounts for treatment of injuries or expenses recoverable from third parties mustbesupportedbyastatement,settingoutparticularsofthecircumstances

- The Company shall, where an account has been rendered, pay any benefit due to a Member, either to that Member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit, subject to section 11.5.

***Benefits***

- Members shall be entitled to benefits, as per Annexure B appended to these Rules, and such benefits extend through the Member to his registered dependants.

- A Member shall, on admission, elect to participate in any one of the available options.
- A Member shall be entitled to change from one to another option subject to the following conditions:
- The change may be made only with effect from 1 January of any year or unless otherwise stated in the contract with the Employer;
- should the Company make midyear contribution increases or benefit changes, then a Member shall have an opportunity to change to another option within a prescribed window; and
- Application to change from one benefit option to another shall be in writing and lodged with the Scheme by not later than 30 November prior to the year in which it is intended that the change shall take place.

***Proration of benefits***

- Beneficiaries admitted during the course of a benefit year are entitled to the benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of the Membership calculated from the date of admission to the end of the particular benefit year.
- Benefits shall only be prorated in the following situations:
- A new employer joining the scheme other than on the benefit year start date;
- A new beneficiary joining the scheme during the benefit year; or,
- An existing Member changing benefit options, during any particular benefit year.
- An existing member leaving the scheme during the benefit year.

***Payment of Accounts***

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

- The Scheme may, whether by agreement or not, pay the benefit to which the Member is entitled, directly to the supplier who rendered the service.

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

- Notwithstanding the provisions of this rule, the Scheme shall have the right to pay any benefit directly to the Member concerned.

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

***Managed care***

***Pre-authorisation***

- Benefits shall be granted if an authorisation number has been issued by the Company or its proxy, previously or, in an emergency, on the first working day after admission.

- If a beneficiary receives treatment without an authorisation number having been obtained (whether because prior application was not made or because a prior application was refused), no benefits shall be granted.

- If an authorisation number has been obtained and the authorisation is exceeded, only the benefits of the authorised treatment shall be granted and the Member shall be liable for payment of the excess to the provider of service.

- The Scheme reserves the right to evaluate or have evaluated any claim for benefits for health services to determine the clinical applicability, cost effectiveness and quality of the services.

- The scheme reserves the right to visit service providers in order to assess services being rendered to a Member.

- In the case of a prolonged indisposition of a beneficiary, the Scheme may require such beneficiary to consult a particular specialist nominated by the Scheme after consulting the treating doctor, and if the advice of the specialist is not followed, the Scheme may decide not to grant any further benefits for the indisposition in question.

- The benefits on accounts properly lodged in terms of clause 12 of these Rules shall be granted, and the Member shall be liable for the difference between the benefits granted and the amount of the full account. Agreed tariff means the tariff as negotiated with the specific providers, or whichever is the lesser.

- A beneficiary shall only be entitled to benefits on a managed healthcare program offered by the Scheme such as the respective Disease Management programs, according to internal protocols, on condition that the beneficiary has registered for the respective program and has furnished the specific ICD-10 code in respect of the condition/s and any information required by the Scheme to perform its duties.

***Overall Annual Limit***

- The total benefits in a financial year for the Member with his dependants shall be limited to limits per beneficiary per annum, as indicated in the Benefit Guide.

- Consultations, visits, and treatments (General Practitioners, Dentists and Specialists)

- The Scheme pays 100% of the preferred provider tariff consultations, diagnostic examinations, visits, and treatments by general practitioners and specialists. Provided that the benefit for consultations shall be limited as set out in the Benefit Guide.

- Anytreatmenttoberenderedoutsideof Malawishallrequirepreauthorisation and subject to the terms and conditions set by the Company.

***Consultations, visits, and treatments (General Practitioners, Dentists and Specialists)***

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- Provided that the benefit for consultations shall be limited as set out in the Benefit Guide.
- AnytreatmenttoberenderedoutsideofMalawishallrequirepreauthorisation and subject to the terms and conditions set by the Company.

***Hospitalisation***

- Subject to the provisions of Clause 15, no benefits shall be granted for hospitalisation if an authorising number is not obtained before, or in the event of an emergency, on the business day following admission. The obtaining of a retrospective authorising number (within seven days of the admission date) shall be subject to a levy admission.
- All sub-limits shall be quoted in monetary value, include both the cost of the hospital and that of the service provider(s).
- The Benefit Guide shall specify if in-patient treatment is available at private hospitals, mission hospitals or government facilities.
- Admission in a Specialised Care Unit (High Care, Intensive Care and/or Neonatal ICU) shall be subject to overall annual limit. Limit of 10 days for specialised care per admission applies.
- Chronic Dialysis shall be subject to the limit as stipulated in the Benefit Guide per beneficiary per financial year.
- Psychiatric hospitalization shall be limited to ten to fifteen days acute care per beneficiary per financial year or as per treatment protocol subject to the limit as stipulated in Benefit Guide.
- Internal medical and surgical Prosthesis (including appliances) placed in the bodyasasupportingmechanismduringanoperationand/orwhichforfunctional medical reasons are implanted as a prosthesis to replace parts of the body are pre-authorised and shall be paid at cost with a maximum as per the limits set out in Benefit Guide (Annexure B) per prosthesis per beneficiary per annum.

- Oncology/Cancer Treatment limited to the benefit limit set out in the Benefit Guide per beneficiary per annum.

- Sub-acute Care shall be limited to benefit limit set out in Benefit Guide per beneficiary per annum.

- Physiotherapy shall be limited to benefit limit set out in the Benefit Guide per beneficiary per annum.

- Radiology, Pathology, MRI/CT Scans shall be limited to the benefit limit set out in Benefit Guide per beneficiary per annum.

- Maternity and Neonatal ward fees shall be limited to the benefit limit set out in the Benefit Guide per beneficiary per annum.

***Ambulance services***

- Ambulance in country is limited to the benefit limit set out in the Benefit Guide per event per beneficiary. Air/Cross Border Evacuation shall be subject to the limit set out in the Benefit Guide, provided that the service shall be pre-authorised by the Company's duly appointed preferred providers for ambulance services as being medically necessary and that the preferred provider arrange the service. Should the preferred provider not be used there is no benefit entitlement payable by the Company. Provided that a local specialist from a service provider in Malawi has motivated for the evacuation as follows;

- There is no specialist within the country to provide the required treatment.

  There is no facility in the country to provide the required treatment.

***Supplementary services***

- The agreed tariffs for X-rays and other radiology and pathology services: Radiology, Pathology, MRI/CT Scans shall be limited to the benefit limit set out in Annexure B per beneficiary per annum provided that pre-authorisation is obtained for MRI's, CT's, radio isotope studies, and mammography.

- The costs of treatments and/or tests for the following services shall be jointly limited to the benefit limit set out in annexure B per beneficiary per financial year. If the services and treatment are ordered beforehand by a medical practitioner and are rendered by auxiliary health service personnel, 100% of the agreed tariff shall be payable by the Company:

- Chiropody
- Occupational therapy
- Orthotic services
- Audiometry and Speech therapy
- Hearing aid acoustics
- Dieticians
- Counselling
- Dental Services

- Conservative Dentistry, Oral Surgery, Specialised Dentistry and Services by Dental Technicians are limited to the benefit limit set out in the Benefit Guide per beneficiary per annum subject to the limits set out in the Benefit Guide, the exclusions listed in Annexure A as well as pre-authorisation processes listed in 14.1

***Frequency of Treatment***

- The frequency of replacement of plastic dentures, replacement of crowns, treatment of specific dental problems, oral examinations etcetera shall be as specified.

- Pre-authorisation For the following services, a treatment plan indicating the proposed treatment, tooth identification and costs shall be required by the Company before benefits are considered:

- All services categorised as "Advanced or Specialised Dentistry"

- Hospitalisation benefits for services described above

- Conscious Sedation benefits for services described above.

***Prescribed Medicine***

*Acute medicines*

- The benefits for medicine prescribed by a medical practitioner or dentist or a person authorised by law to do so shall be calculated at 100% of the Company's agreed price or cost whichever is the lesser after discount after discharge from the hospital, subject to a limit as set out in the Benefit Guide per beneficiary per annum

### *Chronic medicine*

- Members shall furnish the Company with an annual medical report with proven medical information substantiating the prescription. The granting of the benefits as Chronic Medicine shall vest in the Company or its proxy provided that the medicine be obtained from the Company's contracted network of suppliers and that such a benefit shall only apply from the date of approval with the maxima per financial year as set out in the Benefit Guide per beneficiary per annum.

- The Chronic Disease List (CDL) specifies medication and treatment for the 24 chronic conditions that are covered in this section :

  - Addison's disease
  - Asthma
  - Bronchiectasis
  - Cardiac failure
  - Cardiomyopathy
  - Chronic obstructive pulmonary disorder
  - Chronic renal disease
  - Coronary artery disease
  - Crohn's disease
  - Diabetes insipidus
  - Diabetes mellitus types 1 & 2
  - Dysarrhythmias
  - Epilepsy
  - Glaucoma
  - Haemophilia
  - Hyperlipidaemia
  - Hypertension
  - Hypothyroidism
  - Multiple sclerosis
  - Parkinson's disease
  - Rheumatoid arthritis
  - Schizophrenia
  - Systemic lupus erythematosus
  - Ulcerative colitis

### *Pathology and Radiology*

The Company shall pay 100% of the preferred provider tariff for all out of hospital Pathology and Radiology including MRI's, CT's and radio-isotope studies provided by the preferred provider subject to an annual limit per beneficiary as set out in the Benefit Guide.

***Spectacles***

The Company shall pay 100% of the negotiated tariff rates for consultations/ refraction tests and where the payment for white, mono/bi-/multi focal lenses, consultations/refraction tests and frames shall be subject to the limits specified in the Benefit Guide. The difference between the cost of frames and benefit due to the Member, if any, shall be paid by the Member to the provider of service directly.

***Contact lenses***

The benefit for contact lenses and spectacle lenses are subject to a joint limit, i.e. either contact lenses or spectacles shall be covered by the Company, but not both. In the event that a Member would want both spectacles and contact lenses, they shall have to seek approval from the Company subject to the following:

A Member's application shall be supportedbytherecommendationof an ophthalmic surgeon/optometrist stating full medical/clinical reasons why the Member should be making use of contact lenses together with spectacles(instead of only spectacles) and why it is essential, together with a lens prescription;

Benefits with regards to contact lenses are subject to the limits stipulated in the Benefit GuideAAAAaa;

No benefits shall be granted for contact lenses if a pair of spectacles has already been granted to the Member in the preceding period of 24 months unless prior approval has been obtained from the Company as specified in paragraph 20.2.1; and

No benefits shall be granted for contact lens preparations, cleaners, apparatus or coloured contact lense

ANNEXURE A

# GENERAL EXCLUSIONS

No benefits shall be paid by the Company in respect of the following:

1. Any claim in connection with any injury or disablement directly or indirectly caused by or contributed to by participation in:

    a. Riot, strike or civil commotion;
    b. Civil war, rebellion, revolution, insurrection or military or usurped power;
    c. Any declared or undeclared war or the like invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not); and
    d. Nuclear fission, ionizing radiation or contamination by radioactivity from nuclear fuel, weapons or waste.

2. Any losses or damages arising directly or indirectly from any acts of terrorism;

3. A Member who receives reimbursement for medical expenses resulting from an accident shall indemnify the Company for the funds of the Company used for the payment for services arising from an accident provided that the Company may in its absolute discretion pay such a benefit as would be the benefit of the Health Plan calculated on the difference between the amount of the account and the amount, from any source whatsoever, which shall be finally paid to the said Member or dependant as reimbursement for medical expenses in respect of the accident or event. The Company shall consider benefits only after compensation for medical expenses from whatsoever source has been finally settled;

4. Travel expenses except if provided for in the benefit;
5. Surgical appliances, except as provided in surgical appliance benefit;
6. Any other aids, except as provided in aids benefit;
7. Reports, examinations and tests requested for emigration, immigration, visas, insurance policies, employment, admission to schools or universities, court medical reports, muscle-function tests, fitness examinations and test, adoption of children, and for retirement because of ill-health;
8. All costs including costs for operations, treatment and procedures for cosmetic reasons;
9. Accounts for services rendered by persons not registered with a recognised professional body constituted in terms of an Act of Parliament and any institution, nursing home or similar institution except a state or provincial hospital not registered in terms of any law;

10. accounts for appointments not kept by Members or their dependants.
11. accounts in respect of:

a. Conditions for which the costs are recoverable from another party;
b. A condition arising from wilfully self-inflicted injuries, suicide or attempt to commit suicide, whether or not the person was criminally accountable and whether or not the person is sane or insane;
c. Injuries arising from professional sport and power-driven vehicle sport, scuba diving, bungee or parachute jumps and any other forms of extreme sports;
d. Appliances and medication to prevent injuries during sport and recreational activities
e. Injuries arising from actions on account of a criminal transgression on which the Member or his dependants were found guilty;
f. Accommodation in an old-age home or institution providing general care and nursing services to persons, e.g. the infirm aged or chronically sick patients, or similar institutions;

g. Examinations, test and treatment of impotence and of infertility or artificial insemination of a person within or outside the human body. In the case of artificial insemination no benefit shall be granted in respect of the preparatory expenses, i.e. pre-insemination expenses or insemination outside the female body;
h. Cost in excess of the annual maximum benefits to which the Member is entitled under the Rules of the Company;
i. Accommodation in spa's, health resorts or places of rest;
j. The cost of holidays for recuperation purposes;
k. Complications resulting from the treatment of cosmetic procedures;
l. Benefits not mentioned in this Schedule or services not rendered in terms of accepted protocol or not aimed at the treatment of an actual or supposed condition or deficiency, disadvantaging or endangering essential body functions;
m. Mammary surgery except where this is related to carcinoma, tumours and abscesses, and breast reconstruction;
n. Refractive surgery;
o. Any cost charged by a provider of service for motivations or prior motivations;
p. Breathing exercises;
q. Obesity and overweight;
r. Applicators, toilet preparations, cosmetics;
s. After-hours consultation according to Member's choice;
t. Hyperbaric oxygen treatment;
u. Telephone consultations;
v. Services rendered by social Workers;

w. Costs for services rendered outside the borders of Malawi unless the option makes provision therefore and preauthorisation has been given to the Member as per section 16.2 and section 17.13;

x. Elective maxillo-facial and elective oral surgery;

y. Consultation, investigations, medications, and care for sexually transmitted diseases unless the member is registered under the Disease Management Programme for HIV/AIDS;

z. Acupuncture; aa. Biokinetics; bb. Services rendered by Chiropractors, osteopaths, naturopaths, homeopaths and herbalists, inclusive of all alternative medicine/ remedies and

cc. Voluntary termination of pregnancy.; dd. An epidemic or pandemic

12. No benefit shall be paid in respect of the following medicine even if it is prescribed by a medical practitioner, dentist or a legally authorized person:

12.1 Patent and household remedies;

12.2 Acne treatment;

12.3 Nutritional supplements (including patent and baby foods) and slimming products or dietary supplements;

12.4 Aphrodisiacs;

12.5 Sun-screening agents (medicated or otherwise);

12.6 All soaps and shampoos (medicated or otherwise);

12.7 Cosmetic substances;

12.8 Anti-habit substances e.g. alcohol abuse, narcotic abuse, including smoking cessation products;

12.9 Medicines used specifically to treat alcoholism;

12.10 Contraceptives and devices to prevent pregnancy;

12.11 Contraceptives or any treatment for menopause

12.12 Anabolic steroids;

12.13 Tonics, stimulants, biological substances, vitamins, minerals and vitamin/ mineral combinations unless proven medical indications can be submitted;

12.14 Take home and/or over the counter : alcohol, alcohol wipes, betadine andbetadinewipes or iodine, iodine wipes, cotton swabs, peroxide or phisohex, gloves, masks, and bandages

12.15 Syringes and needles except when used for the administering of insulin for diabetes on Disease Management Programme;

12.16 Vaccines (biological) oral and parenteral except for Anti-Rabies Vaccine, Tetanus; Cervical Cancer Vaccine (terms and conditions apply);

12.17 Malaria prophylactics and any other prophylaxis (terms and conditions apply);

12.18 Stimulant laxatives

13. The treatment of HIV, HIV opportunistic infections and AIDS including but not limited to doctor visits, pathology tests, anti-retroviral therapy if the Member does not register their condition;
14. Unless otherwise provided for or decided by the Company, expenses incurred in connection with any of the following shall not be paid by the Company:

a. a drug, a cream, gel or emollient or an injection or a surgical procedure that is used as an aesthetic and not for medicinal reasons/benefits;
b. medicines not registered with a recognized, professional body;
c. homemade remedies;
d. over the counter medicine;
e. toiletries and beauty preparations

15. Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances included but not limited to drugs and alcohol;
16. Any treatment or part of treatment that is not of a reasonable cost or not medically necessary; drugs or treatment which are not supported by a prescription;
17. Unless otherwise decided by the Company, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof. For chronic claims, a prescription limit of three (3) month's supply of chronic medicine if the Member is enrolled on the Disease Management Programme.

***Dental exclusions***

1. Hospitalisation for orthodontic related surgery.
2. Periodontal surgery.
3. Dental implants, including placement, costs of components, associated restorative or prosthodontics therapy and complications arising from implant therapy.
4. Metal bases to full dentures.
5. Metal inlays.
6. Cosmetic procedures such as bleaching, resin and porcelain inlays, laminate veneers.
7. Oral hygiene instructions and Caries susceptibility tests.
8. Orthodontic therapy on persons older than 18 years.
9. Electrognathographic recordings.
10. lingual orthodontics.
11. Orthodontic re-treatment.
12. Direct pulp capping.
13. Bone regeneration procedures for compensation of dento-alveolar bone loss, including sinus lift procedures.

14. Endodontic procedures on primary teeth.
15. Resin and pre-formed crowns.
16. Cost of Posts placed in teeth.
17. Cost of Mineral Trioxide.
18. Ozone therapy.
19. l aboratory fabricated crowns primary on teeth or third molars.
20. Polishing of restorations.
21. Orthognathic surgery, unless in the case of severe congenital deformities and after severe facial deformity caused by trauma. Benefits shall be determined by the Company.
22. Fissure sealants are not covered for persons above 16 years.
23. Dental Laboratory procedures relating to excluded procedures are not covered.
24. Removal of asymptomatic wisdom teeth.
25. Apisectomies.
26. If a procedure does not attract a benefit, then any associated treatment shall also not attract a benefit. E.g. If an asymptomatic wisdom tooth is removed, the hospitalisation shall also not attract a benefit.
27. Consultations by General Practitioners, other than Dentists, Dental Therapists and Dental Technicians
28. Temporary crowns.
29. Acrylic and Resin Crowns and Resin Pontics.
30. ligation of blood vessels to eliminate headache

medhealth
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***Medhealth is a Malawian owned Medical Scheme that strive to serve its members without any bias or prejudice***

**Moving from success to sign ificance**

## OUR SCHEMES

**CARE | CAREPLUS | MEDISAVE |**
**MEDICARE MEDIPLUS | PREMIUM CARE**

No Shortfalls | No waiting periods | Lower Premium | Wellness Program
Cashless foreigh referral | Emergency Evacuation | Funeral Benefits

# HEALTH TIPS FOR HEALTH BODY

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**LET CALMNESS PREVAIL. WE'RE HERE FOR YOU**

## OUR SCHEMES

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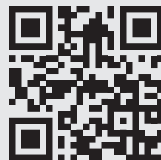

SCAN ME