

WITBANK COALFIELDS MEDICAL SCHEME

RULES - 2023

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REGISTERED BY THE COUNCIL FOR MEDICAL SCHEMES ON 7 JUNE 2023

WITBANK COALFIELDS MEDICAL AID SCHEME

RULES

1. NAME

The name of the Scheme is "WITBANK COALFIELDS MEDICAL AID SCHEME" hereinafter referred to as "the Scheme". The abbreviated name is "WCMAS".

2. LEGAL PERSONA

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

3. REGISTERED OFFICE

The registered office of the Scheme is located at corner of OR Tambo Road and Susanna Street, Emalahleni (previously Witbank), but the Board may transfer such office to any other location within the Republic of South Africa should circumstances so dictate.

4. DEFINITIONS

In these rules, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context.

- (a) a word or expression in the masculine gender includes the feminine;
- (b) a word in the singular number includes the plural, and *vice versa*;
- (c) and the following expressions have the following meanings:

4.1 "Act",

the Medical Schemes Act (Act No 131 of 1998), and the regulations framed thereunder;

4.2 “Admission date”,

4.2.1 In respect of an employer, the date on which the contract between the Scheme and the employer becomes operative.

4.2.2 In respect of a member, the date on which he becomes entitled to membership.

4.2.3 In respect of a dependant of a member, the date upon which such dependant is registered as a dependant in terms of these Rules.

4.3 "Annual limit",

the maximum benefits to which a member and his or her registered dependants are entitled in terms of these Rules, which shall be calculated annually according to the date of service to coincide with the financial year of the Scheme and will be applied pro-rata from the date of membership.

4.4 "Approval",

prior written approval.

4.5 “Associate Unit”

In the case where an employer or organisation does not have a written contract with the scheme such employer or organisation shall be an associate unit.

4.6 "Auditor",

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

4.7 “Beneficiary”

a member or a person admitted as a dependant of a member.

4.8 “BHF”,

the Board of Healthcare Funders of Southern Africa.

4.9 "Board",

the Board of Trustees constituted to manage the Scheme in terms of the Act and these Rules.

4.10 “Capitation fee”

is a negotiated monthly fee payable to Preferred Provider medical or dental practitioners or any other registered supplier of a medical or supplementary health service **including hospital services**, for a defined medical or supplementary health service rendered to the Scheme’s members and their dependants.

4.11 "Child

a member’s natural child, or a stepchild or legally adopted child or a child who has been placed in the custody of the member or his or her spouse or partner by an order of a competent Court, who is under the age of 21 and a child of a member who has attained the age of 21 years but is not yet 26 years of age, who is a student at a tertiary -, training - or education institution constituted in terms of the South African Qualifications Authority Act.

4.12 “Comprehensive Option”

the option described in Annexures “A” and “B”.

4.13 “Condition specific waiting period”

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

4.14 "Continuation member",

a member who retains his or her membership of the Scheme in terms of rule 6.2 or a dependant who becomes a member of the Scheme in terms of rule 6.3.

4.15 “Contracted fee”,

the fee determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services.

4.16 “Contracted Service Supplier”

a healthcare provider or group of providers selected by the Scheme as preferred provider/s to provide to the members, diagnoses, treatment and care in respect of one or more defined diagnosis and treatment pairings which may include prescribed minimum benefits conditions.

4.17 “Contribution”,

in relation to a member, the amount, exclusive of interest, paid by or in respect of the member and his or her registered dependants if any, as membership fees and shall include contributions to personal medical savings accounts.

4.18 “Cost”,

in relation to a benefit, the net amount payable in respect of a relevant health service.

4.19 “Creditable coverage”,

any period during which a late joiner was:-

4.19.1 a member or a dependant of a medical scheme;

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

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

4.19.4 a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years.

4.20 “Council”,

the Council for Medical Schemes as contemplated in the Act.

4.21 "Date of service"

- (a) in the event of a consultation, visit or treatment, the date on which each consultation, visit or treatment took place, whether for the same illness or not;
- (b) in the event of an operation, procedure or confinement, the date on which such operation, procedure or confinement occurred;
- (c) in the event of hospitalisation, the date of each discharge from a hospital or nursing home, or date of cessation of membership, whichever date occurs first;
- (d) in the event of any other service or requirement, the date on which such service was rendered or requirement obtained.

4.22 "Dependant"

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

4.22.2 a member's dependent child who is not a member or a registered dependant of a member of a medical scheme;

4.22.3 such other person or persons who are recognised by the Board as dependants for purposes of these Rules.

4.23 "Dependent",

in relation to a child, a child under the age of 21 or a child who, due to a mental or physical disability, remains dependent upon the member after the age of 21;

4.24 "Designated service provider",

a healthcare provider or group of providers selected by the scheme and approved by the Board of Trustees as preferred provider/s to provide to the beneficiaries, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions or any other relevant health service covered by the Scheme.

- 4.25 “Domicilium citandi et executandi”**,
the member’s chosen physical address at which notices in terms of rules 11 and 13.2.2 as well as legal process, or any action arising therefrom, may be validly delivered and served.
- 4.26 “Emergency medical condition”**,
the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in serious jeopardy.
- 4.27 “Employee”**,
a person, excluding an independent contractor, who is employed by an employer and includes members admitted in terms of rule 6.2 or rule 6.3. In the case of associate units, owners, partners, directors or members of a close corporation, who are members of the scheme, shall be deemed to be employees for the purposes of rules 6, 7, 8, 9, 10, 11, 12, 13, 16 and 18.
- 4.28 “Employer”**,
a Unit, as defined in the Rules of the Scheme, who is a company or operation within the coal mining or associated industries, that has entered into an agreement with the Scheme to the effect that, that Unit’s employees as defined in the agreement are obliged to become members of the Scheme.
- 4.29 “General waiting period”**
a period in which a beneficiary is not entitled to claim any benefits.
- 4.30 “Income”**,
for the purposes of calculating contributions in respect of -
- 4.30.1** a member who is an employee of a Unit, his or her monthly basic rate of pay;
- 4.30.2** members who have become members through an associate unit who are owners, partners, directors or members of a close corporation shall be deemed to earn the highest salary according to the contribution table (as per the Rates of Contribution Annexures) unless satisfactory proof is submitted to the Board of Trustees of a lower income,

disregarding tax concessions which do not apply to salaried employees;

4.30.3 a continuation member, his or her taxable monthly income , and should the income/pension not be indicated, the contribution will be calculated on the highest income group applicable to continuation members;

4.31 "Late joiner",

an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 consecutive months since 1 April 2001.

4.32 "Medicine",

any medicine as defined in the Medicines and Related Substances Control Act (Act No 5 of 1965) and registered in terms of Section 16 of that Act, and any equivalent substitution;

4.33 "Member",

any person who is admitted as a member of the Scheme in terms of these rules;

4.34 "Member family",

the member and all his or her registered dependants;

4.35 "ICD10 Codes"

ICD-10 stands for International Classification of Diseases and Related Health Problems. It is a coding system developed by the World Health Organisation (WHO), that translates the written description of medical and health information into standard codes. These codes are used to inform medical schemes about what conditions their members were treated for so that claims can be settled correctly.

4.36 “Partner”,

a person with whom the member has a committed relationship based on objective criteria of mutual dependency irrespective of the gender of either party and shall include the spouse or spouses of a member to whom she or he is married in terms of custom or tradition. The member must produce satisfactory proof to the Board of the committed relationship or marriage and mutual dependency.

4.37 “Pre-existing sickness condition”,

a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made;

4.38 “Prescribed minimum benefits”,

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

4.38.1 the Diagnostic and Treatment Pairs listed in Annexure A of the regulations, subject to any limitations specified therein; and

4.38.2 any emergency medical condition.

4.39 “Prescribed minimum benefit condition”,

a condition contemplated in the Diagnostic and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

4.40 “Prescription”

all the medicine that a medical or dental practitioner or other person legally authorised to do so prescribes at one time for one person for the sickness condition under treatment;

4.41 “Registrar”

the Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of section 18 of the Act.

4.42 “Social pension”

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

4.43 "Spouse"

the person to whom the member is married in terms of any law or custom. A member's spouse may not be a registered member of another medical scheme and cannot include a divorced spouse or former partner of the member.

4.44 "Unit"

a company or operation within the coal mining or associated industries which has contracted in writing with the scheme that its employees as specified in the contract shall become members of the scheme, which contract has been approved and accepted by the Board of Trustees.

4.45 "Scheme Rates"

4.45.1 100% of the currently applied reference price for 2011 plus an inflationary increase of 6% for 2012; thereafter the Scheme Rate will be determined annually by the Board Of Trustees;

4.45.2 the negotiated rate for Designated or Preferred Service Providers;

4.45.3 the negotiated rate for hospitals;

4.45.4 the dispensing fee as agreed by the Board of Trustees from time to time for medicines dispenses;

4.46 "Single Exit Price" (SEP)

the price of medicine determined by the department of Health from time to time;

4.47 "Excess Tariff Cover" (ETC)

where appropriate, the Scheme may allow additional tariff cover to a maximum of 200% of the Scheme Rates (SR);

4.48 "Midmas Option"

the option described in Annexures "H" and "I"

4.49 "Ntsika Option"

the option described in Annexures "F" and "G"

5. OBJECTIVES

The objectives of the Scheme are to undertake liability, in respect of its members and their dependants, in return for a contribution or premium -

- (a) to make provision for the obtaining of any relevant health service;
- (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/or
- (c) to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with the Scheme.

6. MEMBERSHIP

6.1 Eligibility

Subject to Rule 8, membership of the Scheme is restricted to employees of units. In the case of associated units, no employees as defined shall be admitted as members as from 1 January 2009.

6.2 Continuation and Widow Members (CAWMS)

A member shall retain his or her membership of the Scheme with his or her registered dependants, if any, in the event of his or her retiring from the service of his or her employer or his or her employment being terminated by his or her employer on account of age, ill-health or other disability.

The Scheme shall inform the member of his or her right to continue his or her membership and of the contribution payable from the date of retirement or termination of his or her employment. Unless such member informs the Board in writing of his or her desire to terminate his or her membership, he shall continue to be a member.

6.3 Dependants of deceased members:

6.3.1 The dependants of a deceased member who are registered with the Scheme as his or her dependants at the time of such member's death, shall be entitled to membership of the Scheme without any new restrictions, limitations or waiting periods.

- 6.3.2** The Scheme shall inform the dependant of his or her right to membership and of the contributions payable in respect thereof. Unless such person informs the Board in writing of his or her intention not to become a member, he or she shall be admitted as a member of the Scheme.
- 6.3.3** Such a member's membership terminates if he or she becomes a member or a dependant of a member of another medical scheme.
- 6.3.4** Where a child dependant/s has been orphaned, the eldest child may be deemed to be the member, and any younger siblings, the child dependant/s.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of Dependants

- 7.1.1** A member may apply for the registration of his or her dependants at the time that he applies for membership in terms of Rule 8.
- 7.1.2** If a member applies to register a new born or newly adopted child within 30 days of the date of birth or adoption of the child, such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption. The Board may request such documentary evidence about the date of birth and parentage as it deems necessary.
- 7.1.3** If a member marries subsequent to joining the Scheme, applies within 30 days of the date of such marriage to register his or her spouse as a dependant, his or her spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the date of marriage and benefits will accrue as from the date of marriage.

7.1.4 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the member may apply to the Scheme for the registration of such person as a dependant, whereupon the provisions of Rule 8 shall apply *mutatis mutandis*.

7.1.5 students that are accepted as child dependants in terms of Rule 4.12 shall be recognised as dependants for periods of not more than twelve (12) months at a time;

7.1.6 in the event of a member applying to have his or her partner registered as a dependant in terms of Rule 4.38 such member must produce satisfactory proof to the Board of Trustees of the committed relationship and mutual dependency.

7.2 De-registration of Dependants

7.2.1 A member shall inform the Scheme within 30 days of the occurrence of any event, which results in any one of his or her dependants no longer satisfying the conditions in terms of which he may be a dependant, e.g. divorce, child dependant full time employed (this is not the complete list).

7.2.2 When a dependant ceases to be eligible to be a, 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.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 A minor may become a member with the consent of his or her parent or guardian.

8.2 No person may be a member of more than one medical scheme or a dependant:

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

8.2.2 of members of different medical schemes or claim or accept benefits in respect of himself or herself any of his or her dependants from any

medical scheme in relation to which he or she is not a member or a dependant of a member.

8.3 **No person may** claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member.

8.4 Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, 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. The Scheme may require an applicant to provide the Scheme with a medical report in respect of any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made. The costs of any medical tests or examinations required to provide such medical report will be paid for by the Scheme. The Scheme may however designate a provider to conduct such tests or examinations.

8.5 Waiting periods

8.5.1 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 –

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

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

8.5.2 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 –

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

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

8.5.3 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.

8.6 No waiting periods may be imposed on:

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

8.6.1.1 change of employment; or

8.6.1.2 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.

- 8.6.2** a beneficiary who changes from one benefit option to another within the scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;
- 8.6.3** a child dependant born during the period of membership;
- 8.7** The registered dependants of a member must participate in the same benefit option as the member.
- 8.8** Every member shall, on admission to membership, receive a detailed summary of these rules which shall include contributions, benefits, limitations, 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.
- 8.9** A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a member is entitled under these rules, or any right in respect of such benefit or payment of such benefit to such member, if a member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.
- 8.10** The Scheme shall in no circumstances be obliged to reinstate membership of a member whose membership has been terminated in terms of Rule 12.4 or 12.5.

9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

If the members of a medical scheme who are members of that scheme by virtue of their employment by a particular employer, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Board will admit as a member, without a waiting period, any member of such first-mentioned scheme who is a continuation member by virtue of his past employment by the particular

employer and admit any person who has been a registered dependant of such member, as a dependant.

10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

10.1 Every member shall be furnished with a membership card, containing such particulars as may be prescribed. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership.

10.2 The utilisation of a membership card by any person other than the member or his or her registered dependants, with the knowledge or consent of the member or his or her dependants, is not permitted and is construed as an abuse of the privileges of membership of the Scheme.

10.3 On termination of membership or on de-registration of a dependant, the Scheme must, upon request by the member, within 30 days, furnish such person with a certificate of membership and cover, containing such particulars as may be prescribed.

11. CHANGE OF ADDRESS OF MEMBER

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

12. TERMINATION OF MEMBERSHIP

12.1 Resignation

12.1.1 As the scheme is a restricted membership scheme, a member who resigns from the service of the employer shall, on the date of such termination, cease to be a member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto.

12.1.2 Concessionary rule in respect of restricted membership schemes:-

A member whose employment is terminated for reasons related to the operational requirements of the employer may, in the discretion of the Board, be allowed continued membership for a period of up to six months after termination of employment, provided that if such member should obtain alternative employment, his/her membership shall terminate with immediate effect.

12.2 Voluntary termination of membership

12.2.1 If a member wishes to terminate his or her membership of the Scheme in order to become a member of another Scheme where that member's spouse or partner is already a member, then the member of this Scheme must give written notice of not less than one (1) month to the Board of Trustees of the Scheme. All rights to benefits cease after the last day of membership of this Scheme.

12.2.2 Such notice period may be waived in substantial cases where membership, by the spouse or partner of another medical scheme is compulsory as a result of a condition of employment applicable to that member's spouse or partner or where there is an alternate group agreement.

12.2.3 Where an employer wishes to terminate his participation in the Scheme, he must provide six (6) month's written notice to that effect to the Board of Trustees of the Scheme, subject to the condition stipulated in Rule 12.2.4 below.

12.2.4 Termination in the case of an employer will mean termination after giving the required notice in terms of Rule 12.2.3 or any wilful action on the part of the employer and or its employees which will have the effect of a significant number of active members of that employer leaving the Scheme.

12.2.5 Such notice to terminate, as contemplated in Rule 12.2.3, will not be valid nor enforceable, unless the employer undertakes in writing to remove all its members from this Scheme, including all of its

continuation members as contemplated in Rule 6.2 and Rule 6.3 of the Rules of the Scheme.

12.2.6 Employers who terminate their participation in the Scheme whether voluntary or otherwise will not be entitled to any Scheme reserves upon withdrawal from the Scheme.

12.3 Death

Membership of a member terminates on his or her death.

12.4 Failure to pay amounts due to the Scheme

If a member fails to pay amounts due to the Scheme, his or her membership may be terminated as provided in these Rules.

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

The Board may exclude from benefits or terminate the membership of a member or dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual and relevant information. In such event he may be required by the Board to refund to the Scheme any sum which, but for his or her abuse of the benefits or privileges of the Scheme, would not have been disbursed on his or her behalf.

13. CONTRIBUTIONS

13.1 The total monthly contributions payable to the Scheme by or in respect of a member are set out in the Rate of Contribution Annexures. Due to the group nature of the scheme, employers advise the scheme of changes in income. However, it remains the responsibility of the member to notify the scheme of changes in income that may necessitate a change in contribution in terms of the Rate of Contribution Annexures hereto.

13.2 Contributions shall be due monthly and be payable not later than the 3rd day of each month. Where contributions or any other debt owing to the scheme,

have not been paid within thirty (30) days of the due date, the scheme shall have the right:-

13.2.1 to suspend all benefit payments in respect of claims which arose during the period of default;

13.2.2 to give the member written notice at his/her domicilium citandi et executandi that if contributions or such other debts are not paid within twenty-one (21) days of posting of such notice, membership may be cancelled.

A notice sent by prepaid registered post to the member at his/her domicilium citandi et executandi shall be deemed to have been received by the member on the 7th day after due date of posting. In the event that the member fails to nominate a domicilium citandi et executandi, the member's postal or residential address on his/her application form shall be deemed to be his/her domicilium citandi et executandi.

13.3 In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with rule 13.2.2, benefits shall be reinstated without any break in continuity subject to the right of the scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest on the arrear amount at the prime overdraft rate of the scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the member from the date of default and any such benefit paid will be recovered by the scheme.

14. LIABILITIES OF EMPLOYER AND MEMBER

14.1 The liability of the employer towards the Scheme is limited to any amounts payable in terms of any agreement between the employer and the Scheme.

14.2 The liability of a member is limited to the amount of his/her unpaid contributions together with any sum disbursed by the Scheme on his/her behalf or on behalf of his/her dependants which has not been repaid by him/her to the Scheme. Any amount owing by a member to the Scheme in respect of himself/herself or his/her dependants may be recouped out of his remuneration from the employer by arrangement with such member.

14.3 In the event of a member ceasing to be a member, any amount still owing by such member is a debt due to the Scheme and recoverable by it.

15. CLAIMS PROCEDURE

15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement which must contain the following:-

- (a) the surname and initials of the member;
- (b) the surname, first name and other initials, if any, of the patient;
- (c) the name of the scheme concerned;
- (d) the membership number of the member;
- (e) the practice code number, group practice number and individual provider
- (f) registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;
- (g) the relevant diagnostic and such other item code numbers that relates to such relevant health service;
- (h) the date on which each relevant health service was rendered;
- (i) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of, the medicine;
- (j) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;
- (k) ICD.10 and Nappi Codes
- (l) where mention is made in such account or statement of the use of a theatre:-
 - (i) the name and relevant practice number and provider number contemplated in sub-paragraph (e) of the medical practitioner or dentist who performed that operation;
 - (ii) the name or names and the relevant practice number and provider number contemplated in sub-paragraph (e) of every

- medical practitioner or dentist who assisted in the performance of that operation; and
 - (iii) all procedures carried out together with the relevant item code number contemplated in subparagraph (f); and
- (m) in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating:-
- (i) the expected total amount in respect of the treatment;
 - (ii) the expected duration of the treatment;
 - (iii) the initial amount payable; and the monthly amount payable.

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

- (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.

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

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

15.4 Accounts for treatment of injuries or expenses recoverable from third parties, must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained. If requested by the Board, a member shall cede the claim in respect of medical expenses

he/she may have against a third party to the scheme, if he does not prosecute his or her claim against the third party concerned.

- 15.5** Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member or the health care provider, whichever is applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member or provider the opportunity to return such corrected claim to the Scheme within sixty (60) days of the notice.

16. BENEFITS

- 16.1** Members are entitled to benefits during a financial year, as per Annexure B (Comprehensive Option), Annexure G (Ntsika Option) and Annexure I (Midmas Option) depending on the option exercised by the member and such benefits extend through the member to his or her registered dependants.

- 16.2** Members joining the Scheme must, on admission, elect to participate in any one of the available options.

- 16.3** Eligible members are entitled to change from one to another option subject to the following conditions:-

16.3.1 The change may be made only with effect from 1 January of any financial year. The Board may, in its absolute discretion, permit a member to change from one to another benefit option on any other date provided that the member may change to another option in the case of midyear contribution increases or benefit changes.

16.3.2 Application to change from one benefit option to another must be in writing and lodged with the scheme within the period notified by the scheme provided that the member has had at least 30 days prior notification of any intended changes in benefits or contributions for the next year.

- 16.4** The scheme shall, where an account has been rendered, pay any benefit due to a member, either to that member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.
- 16.5** All benefit options cover the cost of services rendered in respect of the prescribed minimum benefits, in accordance with Appendix 1.
- 16.6** Statutory prescribed minimum benefits will be paid in full subject to therapeutic algorithms, protocols, formularies and DSP's.
- 16.7** Unless otherwise provided for or decided by the Board, expenses incurred in connection with any of the following will not be paid by the scheme:-
- 16.7.1** All costs for operations, medicines, treatment and procedures for cosmetic purposes.
- 16.7.2** Holidays for recuperative purposes.
- 16.7.3** Purchase of the following:-
- Medicines not registered with the Medicines Control Council
 - Toiletries and beauty preparations
 - Slimming products
 - Homemade remedies
 - Alternative medicines
- 16.7.4** All costs that are more than the annual benefit to which a beneficiary is entitled in terms of the rules of the scheme.
- 16.7.5** Charges for appointments which a beneficiary fails to keep.
- 16.7.6** Costs for services rendered by:-
- persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
 - any institution, nursing home or similar institution not registered in terms of any law except a state or provincial hospital.
- 16.8** Beneficiaries admitted during the course of a financial 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 membership calculated from the date of admission to the end of the particular financial year.

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

17. PAYMENT OF ACCOUNTS

17.1 Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit.

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

17.3 The Scheme may, whether by agreement or not with any supplier or group of suppliers of a service, pay the benefit to which the member is entitled, directly to the supplier who rendered the service.

17.4 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.

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

17.6 Notwithstanding the provisions of this rule, should the claims of a supplier of service warrant further investigation by the Scheme for whatever reason including due to the high volume of claims submitted by that supplier to the Scheme, the perceived inappropriateness of tariffs charged and/or codes used by that supplier on accounts to the Scheme for services rendered to beneficiaries, or if fraudulent behaviour/conduct by and/or over-servicing of a beneficiary by a supplier of services is suspected, the Scheme shall, pending the further investigation of the accounts and/or behaviour/conduct of that

supplier of service, pay the benefit to which the member is entitled in terms of these Rules directly to the member.

17.7 Notwithstanding the provisions of this rule, should any fraudulent behaviour/conduct, billing practices outside of the Scheme's norm for a specific discipline or provider group or over-servicing of a beneficiary by a supplier of services be detected or established by the Scheme, the Scheme shall pay any benefit to which the member is entitled in terms of these Rules in respect of services rendered to a beneficiary by that supplier of service directly to the member.

18. GOVERNANCE

18.1 The affairs of the Scheme must be managed according to these Rules by a Board consisting of at least **ten** persons who are fit and proper to be trustees;

18.2 Fifty percent of trustees must be elected by members from amongst members to serve terms of office of two years each. (hereinafter referred to as "elected representatives"); At least two alternates may be elected at the annual general meeting;

18.3 Fifty percent of trustees shall be nominated by employers; appointed representation will be allocated pro-rata according to the number of employees who are members of the Scheme;

18.4 Term of office

18.4.1 An appointed representative shall hold office for two years or until their nomination is withdrawn by the employer. The appointed representative may be re-appointed a maximum of two further terms.

18.4.2 An elected representative shall hold office for two years and may be re-elected a maximum of two further terms

18.5 The Board may allow, by invitation, Trade Union and employee association representatives to attend Board meetings as observers only. Such observers shall not have a vote.

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

- 18.6.1** a person under the age of 21 years;
 - 18.6.2** an employee, director, officer, consultant, or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;
 - 18.6.3** the principal officer of the Scheme;
 - 18.6.4** the auditor of the Scheme;
 - 18.6.5** a broker.
- 18.7** Retiring members of the Board are eligible for re-election.
- 18.8** Nominations to fill vacancies, signed by the candidate signifying his or her consent to stand for election, must be submitted to the Scheme seven (7) days before each Annual General Meeting and the election must be carried out by the members present in person or by proxy at the annual general meeting of the scheme.
- 18.8** The Board may fill by appointment by the remaining members of the Board, any casual vacancy which occurs during its term of office. A person so appointed must retire at the first ensuing annual general meeting and that meeting must fill the vacancy for the unexpired period of office of the vacating member of the Board;
- 18.9** The Board may co-opt knowledgeable persons to assist it in its deliberations provided that such persons shall not have a vote.
- 18.10** Half of the active voting members of the Board plus one voting member is a quorum at meetings of the Board.
- 18.11** The Board must, at its first meeting after each annual general meeting and thereafter as the need arises, elect from amongst its members a chairperson and vice-chairperson of the Scheme for a term of two years. A Chairperson and Vice-chairperson may be re-elected for a maximum of two consecutive terms. The Chairperson and Vice-chairperson shall cease to hold office if they are not members of the Board

- 18.12** In the absence of the chairperson and vice-chairperson, the Board members present must elect one of their numbers to preside at that meeting.
- 18.13** Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson shall have a casting vote in addition to his or her deliberative vote.
- 18.14** A member of the Board may resign at any time by giving written notice to the Board.
- 18.15** A member of the Board ceases to hold office if such Board member–
- 18.15.1** becomes mentally ill or incapable of managing his or her affairs;
 - 18.15.2** is declared insolvent or has surrendered his or her estate for the benefit of his or her creditors;
 - 18.15.3** is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;
 - 18.15.4** is removed by the court from any office of trust on account of misconduct;
 - 18.15.5** is disqualified under any law from carrying on his or her profession;
 - 18.15.6** in the case of an appointee, has not been re-appointed by a participating employer and in the case of an elected member, has not been re-elected;
 - 18.15.7** absents himself from three consecutive meetings of the Board without the permission of the Chairperson; or
 - 18.15.8** is removed from office by the Council in terms of Section 46 of the Act.
 - 18.15.9** the provisions of Rules 18.15.1 to 18.15.5 apply *mutatis mutandis* to the principal officer.
- 18.16** The Board must meet at least once every month or at such intervals as it may deem necessary.

- 18.17** The chairperson may convene a special meeting should the necessity arise. Any four members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.
- 18.18** The Board may, subject to participation by sufficient members to form a quorum, discuss and resolve matters by telephone or electronic conferencing means and may adopt resolutions on that basis.
- 18.19** Members of the Board, are remunerated, as determined by the remuneration committee and approved by the AGM as follows:-
- a) a fixed fee for attendance of meetings;
 - b) training course fees; and
 - c) reimbursement of reasonable travel expenses incurred.
- 18.20** A member of the Board who acts in a manner which is seriously prejudicial to the interests of beneficiaries of the medical scheme may be removed by the Board, provided that:-
- 18.20.1** before a decision is taken to remove the member of the Board, the Board shall furnish that member with full details of the evidence which the Board has at its disposal regarding the conduct complained of, and allow such member a period of not less than 30 days in which to respond to the allegations.
 - 18.20.2** the resolution to remove that member is taken by at least two thirds of the members of the Board.
 - 18.20.2** the member shall have recourse to disputes procedures of the scheme or complaints and appeal procedures provided for in the Act.
- 18.21** To ensure continuity the Board, at its first meeting after the annual general meeting held in 2000 must decide which two employee representatives will serve for a term of only one year i.e. till the annual general meeting which is to be held in 2001. The Board may decide on the criteria to be used to decide which two employee representatives will serve only one year.

19. DUTIES OF BOARD OF TRUSTEES

- 19.1** The Board is responsible for the proper and sound management and strategic oversight of the Scheme, in terms of these rules. The execution of the day-to-day affairs is delegated to a Principal Officer
- 19.2** The Board must act with due care, diligence, skill and in good faith.
- 19.3** Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.
- 19.4** The Board must apply sound business principles and ensure the financial soundness of the Scheme.
- 19.5** The Board shall appoint a principal officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the principal officer and of any person employed by the Scheme.
- 19.6** The chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.
- 19.7** The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme. The Board must ensure that proper control systems are employed by and on behalf of the scheme.
- 19.8** The Board must ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the Rules.
- 19.9** The Board must take all reasonable steps to ensure that contributions are paid timeously to the scheme in accordance with the Act and the Rules.
- 19.10** The Board must take out and maintain professional indemnity insurance and fidelity guarantee insurance from and up to such amount as the scheme's auditor, with the concurrence of the Registrar, may determine.

- 19.11** The Board must obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.
- 19.12** The Board must ensure that the Rules and the operation and administration of the scheme comply with the provisions of the Act and all other applicable laws.
- 19.13** The Board must take all reasonable steps to protect the confidentiality of medical records concerning any member or dependant's state of health.
- 19.14** The Board must approve all disbursements.
- 19.15** The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme.
- 19.16** The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.
- 19.17** The Board shall disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme.

20. POWERS OF BOARD

The Board has the power —

- 20.1** to cause the termination of the services of any employee of the Scheme;
- 20.2** to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations under such appointments;
- 20.3** to appoint a committee consisting of such Board members and other experts as it may deem appropriate.

- 20.4** to appoint a duly accredited administrator or medical scheme on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the regulations.
- 20.5** to appoint, contract with and compensate any accredited broker for the introduction or admission of a member to the scheme and for ongoing broker services subject to the provisions of the Act and Regulations thereto provided that a broker contract with an accredited broker will not be unreasonable withheld.
- 20.6** to appoint, contract with and compensate any accredited managed health care organisation, designated service provider or contracted service provider in the prescribed manner.
- 20.7** to contract with managed health care organisations, designated service provider or contracted service provider subject to the provisions of the Act and its regulations;
- 20.8** to purchase movable and immovable property for the use of the Scheme or otherwise, and to rent or sell it, or any of it;
- 20.9** to let or hire movable or immovable property;
- 20.10** to sell movable and immovable property of the scheme subject to sound business practice and fair value principles,
- 20.11** to provide administration services to other medical schemes;
- 20.12** in respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such moneys upon security and to realise, re-invest or otherwise deal with such monies and investments;
- 20.13** with the prior approval of the Council to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

- 20.14** subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any person or organisation, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the members of the Scheme;
- 20.15** to make donations to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the beneficiaries;
- 20.16** to grant repayable loans to members or to make *ex gratia* payments to or on behalf of members in order to assist such members to meet commitments in regard to any matter specified in Rule 5;
- 20.17** to contribute to any fund conducted for the benefit of employees of the Scheme;
- 20.18** to reinsure obligations in terms of the benefits provided for in these rules in the prescribed manner;
- 20.19** to authorise the principal officer and /or such members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;
- 20.20** to contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes;
- 20.21** in general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.

21. DUTIES OF PRINCIPAL OFFICER AND STAFF

- 21.1** The staff of the scheme must ensure the confidentiality of all information regarding its members.

- 21.2** The principal officer is the executive officer of the scheme and as such shall ensure that:
- 21.2.1** He acts in the best interests of the members of the scheme at all times;
 - 21.2.2** the decisions and instructions of the Board are executed without unnecessary delay;
 - 21.2.3** where necessary, there is proper and appropriate communication between the Scheme and those parties, affected by the decisions and instructions of the Board;
 - 21.2.4** he or she keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;
 - 21.2.5** he or she keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of section 57(6) of the Act;
 - 21.2.6** he or she does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he or she at all times observes the authority of the Board in its governance of the scheme.
- 21.3** The principal officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.
- 21.4** The principal officer shall ensure the carrying out of all of his or her duties as are necessary for the proper execution of the business of the Scheme. He or she shall attend all meetings of the Board, and any other duly appointed committee where his or her attendance may be required, and ensure proper recording of the proceedings of all meetings.
- 21.5** The principal officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

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

21.7 Should the Scheme be administered in terms of an agreement between the Board and an administrator, the duties of the Principal Officer shall be as laid down in the Act.

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

21.9 The Principal Officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

21.10 The following persons are not eligible to be a principal officer unless otherwise approved by the Registrar of Medical Schemes:-

21.10.1 an employee, director, officer, consultant or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;

21.10.2 a broker.

21.11 The provisions of rules 18.15.1 to 18.15.5 apply mutatis mutandis to the principal officer.

22. INDEMNIFICATION AND FIDELITY GUARANTEE

22.1 The Board and any officer of the Scheme must be indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim in connection with the Scheme, not arising from their negligence, dishonesty or fraud.

22.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers (including members of the Board) having the receipt or charge of moneys or securities belonging to the Scheme.

23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the first day of January to the 31st day of December of that year.

24. BANKING ACCOUNT

The Scheme must maintain a banking account with a registered commercial bank. All moneys received must be deposited to the credit of such account and all payments must be made either by electronic transfer, tape exchange or by cheque under the joint signature of not less than two persons duly authorised by the Board.

25. AUDITOR AND AUDIT COMMITTEE

25.1 An auditor (who must be approved by the Registrar in terms of section 36 of the Act) must be appointed by resolution at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.

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

25.2.1 a member of the Board;

25.2.2 an employee, officer or contractor of the Scheme;

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

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

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

25.3 Whenever for any reason an auditor vacates his or her office prior to the expiration of the period for which he has been appointed, the Board must within 30 days appoint another auditor to fill the vacancy for the unexpired period.

25.4 If the members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this rule, the Board must within 30 days make such appointment, and if it fails to do so, the Registrar may at any time do so.

- 25.5** The auditor of the Scheme at all times has a right of access to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from the Board and the other officers of the Scheme such information and explanations as he deems necessary for the performance of his or her duties.
- 25.6** The auditor must report to the members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in general meeting.
- 25.7** The Board must appoint an audit committee of at least five members. The majority of the members of the committee, including the chairperson and vice-chairperson, shall not be members of the Board of Trustees. 50% of members will constitute a quorum of which 50% must be non-Board of Trustee members. The duties and functions of the audit committee shall be as detailed in section 37(12) of the Act.

26. GENERAL MEETINGS

26.1 Annual general meeting

- 26.1.1** The annual general meeting of members must be held not later than 30th June of each year.
- 26.1.2** The notice convening the annual general meeting, containing the agenda, all the information pertaining to the proposed trustees' remuneration for the ensuing year (*only required if the scheme remunerates trustees*) and financial information, must be furnished to members and the Registrar at least 21 days before the date of the meeting. The non-receipt of such notice by a member and/or the Registrar does not invalidate the proceedings at such meeting provided that the notice procedure followed by the Board was reasonable.
- 26.1.3** The financial information mentioned in 26.1.2 above consists of:
- 26.1.3.1** Summarised set of Annual Financial Statements,
- 26.1.4** At least 30 members of the Scheme present in person or via the Scheme designated virtual meeting platform, shall constitute a quorum. If a quorum is not present after the lapse of 30 minutes

from the time fixed for the commencement of the meeting, the meeting must be postponed to a date determined by the Board, with notice of such postponed meeting being reissued in terms of rule 26.1.2, and members then present constitute a quorum.

26.1.5 The financial statements and reports specified in rule 26.1.2 must be laid before the meeting.

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

26.2 Special general meeting

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

26.2.2 On the requisition of at least 25 members of the Scheme, the Board must cause a special general meeting to be called within 30 days of the deposit of the requisition. The requisition must state the objectives of the meeting and must be signed by all the requisitionists and deposited at the registered office of the Scheme. Only those matters forming the objectives of the meeting may be discussed.

26.2.3 The requisition must be accompanied by an explanatory memorandum, which clearly explains why the proposed meeting should be held and the resolution to be taken. The proposed wording of the resolution to be passed at this meeting shall also be submitted.

26.2.4 The Principal Officer may convene the Special General Meeting as contemplated in Rule 26.2.5, or reject the convening of such a meeting in the event that the requisition and its supporting documentation does not comply with these Rules, or if the Principal Officer is of the view that the resolution to be taken at such a Special General Meeting is in contravention of Rule 26.2.7. Where the Principal Officer fails to convene the Special General Meeting requested, he shall give reasons therefore within twenty (20) days of the signed requisition being deposited. The members who feel

aggrieved with the Principal Officer's decision shall be entitled to refer a dispute to the dispute committee in terms of these Rules or to the Council in terms of the Act.

26.2.5 The notice convening the special general meeting, containing the agenda, the meeting rules and conditions and the consequences of failing to meet any meeting rules or conditions which will be applicable to the Special General Meeting as described in Rule 27.5 must be furnished to members at least 14 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such a meeting provided that the notice procedure followed by the Board was reasonable.

26.2.6 At least 50 members present in person or via the Scheme's designated virtual meeting platform, shall constitute a quorum. If a quorum is not present at a special general meeting after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.

26.2.7 No motion shall be passed by the meeting that is inconsistent or in contravention with objectives of the Scheme, the Act or these Rules.

26.3 Board of Trustee Meetings

The Board of Trustees will meet at least once every month.

26.3.1 Notice of Board of Trustee meetings, where important resolutions or Rule changes will be dealt with, must be sent to members of the Board at least seven (7) calendar days before the meeting.

26.3.2 Fifty (50) percent of the members of the Board plus one (1) will form a quorum at meetings of the Board.

26.3.3 Matters serving before the Board must be decided by a majority vote of members present at a Board meeting and in the event of an equality of votes, the Chairperson shall have a casting vote in addition to his or her deliberative vote.

27. VOTING AT MEETINGS

- 27.1** Every member who is present at a general meeting of the Scheme and whose contributions are not in arrears, has the right to vote, or may, subject to this rule, appoint another member of the Scheme as proxy to attend, speak and vote in his or her stead.
- 27.2** The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the member and the person appointed as the proxy. Only proxies received by the Scheme no later than 48 (forty eight) hours prior to the date of the general meeting will be recognised. A member shall not have more than 20 proxy votes.
- 27.3** All proxies held by any member of the Scheme must be declared before the commencement of the meeting.
- 27.4** The chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson, if he is a member, has a casting vote in addition to his or her deliberative vote.
- 27.5** The Board shall be entitled to lay down meeting rules and conditions to be satisfied by members attending a general meeting and the consequences which will attach in the event that the meeting rules or conditions are not inconsistent with the Act and the Rules. The meeting rules and conditions and the consequences of failing to meet any meeting rules or conditions, which will be applicable to any general meeting, must accompany the notice which convenes the meeting.

28. COMPLAINTS AND DISPUTES

- 28.1** Members may lodge their complaints, in writing, to the scheme. The scheme or its administrator shall also provide a dedicated toll free telephone number to be used for dealing with telephonic enquiries and complaints.
- 28.2** All complaints received in writing must be responded to by the Scheme in writing within 30 days of receipt thereof.
- 28.3** A disputes committee of three persons, who may not be members of the Board, employees of the administrator of the Scheme or officers of the Scheme, must be appointed by the Board annually to serve a term of office of one year. At least one of such persons shall be a person with legal expertise.

- 28.4** Any dispute, which may arise between a member, prospective member, former member or a person claiming by virtue of such member and the Scheme or an officer of the Scheme, shall be referred by the principal officer to the disputes committee for adjudication.
- 28.5** On receipt of a request in terms of this rule, the principal officer must convene a meeting of the disputes committee by giving not less than 21 days notice in writing to the complainant and all the members of the disputes committee, stating the date, time, and venue of the meeting and particulars of the dispute.
- 28.6** The disputes committee may determine the procedure to be followed.
- 28.7** The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.
- 28.8** An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to the Council and shall be furnished with the Registrar not later than three months after the date on which the decision concerned was made or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.
- 28.9** A member may appeal to the Council against a decision of a review panel established in terms of Chapter 5 of the regulations to the Act.
- 28.10** The operation of any decision which is the subject of an appeal under rule 28.8 shall be suspended pending the decision of the Council on such appeal.

29. TERMINATION OR DISSOLUTION

- 29.1** The Scheme may be dissolved by order of a competent court or by voluntary dissolution. **29.2** Members in general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by ballot whether the Scheme must be liquidated. Unless the majority of members decide that the Scheme must continue, the Scheme must be liquidated in terms of section 64 of the Act.

29.3 Pursuant to a decision by members taken in terms of rule 29.2 the principal officer must, in consultation with the Registrar, furnish to every member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

29.4 Every member must be requested to return his or her ballot paper duly completed before a set date. If at least 50 percent of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person, in which event the Board must arrange for members to decide by ballot whether the proposed amalgamation or transfer should be proceeded with or not.

30.2 If at least 50 percent of the members return their ballot papers duly completed and if the majority thereof is in favour of the amalgamation or transfer then, subject to section 63 of the Act, the amalgamation or transfer may be concluded.

30.3 The Registrar may, on good cause shown, ratify a lower percentage.

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any beneficiary must on request and on payment of a fee of R10 be supplied by the Scheme with a copy of the following documents:

31.1.1 The rules of the Scheme;

31.1.2 the latest audited annual financial statements, returns, Trustees reports and auditors report of the Scheme; and

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

31.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in rule 31.1 and to make extracts therefrom.

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

32. AMENDMENT OF RULES

32.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

No alteration, rescission or addition which affects the objectives of the scheme or which increases the rates of contribution or decreases the extent of benefits of the scheme or of any particular benefit option by more than twenty five percent during any financial year, is valid unless it has been approved by a majority of members present in a general meeting or a special meeting or by ballot.

32.2 Members must be furnished with a copy of such amendment within 14 days after registration thereof. Should a member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.

32.3 Notwithstanding the provisions of rule 32.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.

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

**ANNEXURE A: RATES OF CONTRIBUTIONS AND PREMIUM PENALTIES –
COMPREHENSIVE OPTION**

1. RATES OF CONTRIBUTION W.E.F. 1 JANUARY 2023

The monthly contributions payable by members or their Units shall be based upon the member's monthly income, as defined in Rule 4.32, and will be as follows:-

Table	Income Group	Principal Member	Adult Dependant	Child Dependant
A	0 – 2000	R2,428	R2,428	R644
B	2001 – 3000	R2,780	R2,780	R644
C	3001 – 4000	R3,455	R3,455	R644
D	4001 – 5000	R3,455	R3,455	R644
E	5001 – 6000	R3,782	R3,782	R644
F	6001 – 7000	R3,782	R3,782	R644
G	7001 – 8000	R3,782	R3,782	R644
H	8001 – 9000	R3,931	R3,931	R644
I	9001 – 10000	R3,931	R3,931	R644
J	10001 +	R4,315	R4,315	R644

2. PREMIUM PENALTIES FOR PERSONS JOINING LATE IN LIFE

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

<u>Penalty Bands</u>	<u>Maximum Penalty</u>
1 – 4 years	0.05 x contribution
5 – 14 years	0.25 x contribution
15 – 24 years	0.5 x contribution
25 + years	0.75 x contribution

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

A = B minus (35 + C) where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of application

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

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

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

3. MEDICAL SAVINGS ACCOUNT (MSA) – COMPREHENSIVE OPTION

3.1. On admission to the Scheme, members will participate in a Medical Savings Account (MSA) held by the Scheme. Contributions payable in respect of the MSA component shall be credited and benefits in respect thereof, shall be debited to the account.

3.2. The amount allocated to the MSA by the scheme for the benefit of the member is 25% of the total gross contributions in respect of the member during the financial year concerned. Savings will be available upfront at the discretion of the Board of Trustees and interest is applied to positive savings account balances.

3.3. Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to claim for all health care services indicated under MSA in Annexure B, at 100% of the cost and the following conditions will apply:-

3.3.1. Sub limits will not be applied to MSA benefits while sufficient funds are available in the MSA.

3.3.2. Annual thresholds will apply in respect of MSA benefits. The annual threshold limit is equal to the annual MSA contributions plus a self-funded amount equal to 50% of the annual MSA contribution.

3.3.3. MSA benefits will be paid at cost up to the maximum amount allowed in the MSA, where after the member must self-fund related expenses up to the pre-determined threshold.

3.3.4. Self-funded claims will be processed when a member submits the claim together with proof of payment to update the threshold.

3.3.5. Medical expenses accumulated towards the annual threshold will be calculated at Scheme Rates (SR).

3.3.6. Once the medical expenses reach the threshold, the scheme will again commence payment of the MSA related benefits at the applicable benefit

percentages at Scheme Rates (SR) and subject to the annual or bi-annual sub limits.

- 3.4. Funds allocated to the members MSA shall be available for the exclusive benefit of the member and his/her dependants. Any credit balance in the MSA at the end of a financial year accumulates for the benefit of the member.
- 3.5. Upon the death of the member, the balance due to the member will be transferred to his/her dependants who continue membership of the scheme or paid into his/her estate in the absence of such dependants.
- 3.6. On transfer to another benefit option of the scheme, which does not provide for such an account, any balance standing to the credit of the member in the MSA will be refunded to the member, not later than 4 months after such transfer and subject to applicable taxation laws.
- 3.7. Should a member terminate membership of the scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme or option which does not provide for a MSA, the balance due to the member must be refunded to the member not later than 4 months after termination of membership, and subject to applicable taxation laws.
- 3.8. Should a member transfer to another benefit option or be admitted to membership of another medical scheme, which provides for a similar account, the balance due to the member must be transferred to such benefit option or scheme not later than 4 months after transfer to benefit option or termination of membership, as the case may be.
- 3.9. The funds in the member's MSA may not be used to pay for the costs of a prescribed minimum benefit or to offset contributions.
- 3.10. On termination of membership, funds in the member's MSA may be used to offset any debt owed by the member including outstanding contributions.
- 3.11. Unclaimed MSA balances above R100, where a member cannot be traced within three years of the member leaving the Scheme and after all reasonable attempts at tracing the members have been pursued, will be written back as Scheme Funds.

ANNEXURE B: BENEFITS - COMPREHENSIVE OPTION - 2023

SERVICE	% BENEFIT (SR) (SCHEME RATE)	SUB LIMITS APPLICABLE TO NON-PMB's
A. STATUTORY PRESCRIBED MINIMUM BENEFITS	100% (Cost)	Services rendered by Hospitals and Designated Service Providers. No limit.
B. GENERAL PRACTITIONER SERVICES	(SR)	
1. Consultative	100%	MSA Member 15 visits after threshold M + 1 21 visits after threshold M + 2 26 visits after threshold M + 3 30 visits after threshold M 4 + 34 visits after threshold (Limits applicable only after threshold has been reached)
2. Hospital Visits	100%	-
3. Non-Surgical Treatments	100%	-
4. Surgical Procedures	100%	-
5. Anaesthetics	100%	-
6. Confinements	100%	-
7. Maternity Benefits	100%	Maximum of 12 pre-natal visits payable from Risk Pool at Scheme Rate thereafter out of MSA. Antenatal vitamins limited to R340 per month from MSA. 1 post-natal visit payable from Risk Pool at Scheme Rate thereafter out of MSA. Ante-natal pathology for risk screening (Qualitative bHCG, Blood glucose, HIV status, Syphilis, German measles, Hepatitis B, Anaemia, Blood group, Blood cross-matching)
8. Pre-screening: oncology, diabetes, cholesterol, hypertension conditions	100%	1 visit per beneficiary per annum from risk pool subject to protocols

SERVICE	% BENEFIT (SR) (SCHEME RATE)	SUB LIMITS APPLICABLE TO NON-PMB's
<p>C. SPECIALIST SERVICES</p> <p>1. Consultative</p> <p>2. Hospital Visits</p> <p>3. Non-Surgical Treatments</p> <p>4. Surgical Procedures</p> <p>5. Pre-op Assessment</p> <p>6. Anaesthetics</p> <p>7. Confinements</p> <p>8. Maternity Benefits</p> <p>9. Paediatric Visits</p>	<p>(SR)</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>(Including Psychiatry consultations)</p> <p>MSA</p> <p>Member 10 visits after threshold M + 12 visits after threshold (Limits applicable only after threshold has been reached)</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>Maximum 12 visits payable from Risk Pool at Scheme Rate thereafter out of MSA. Antenatal vitamins limited to R340 per month from MSA. 1 post-natal visit payable from Risk Pool at Scheme Rate thereafter out of MSA. Selected pre-natal pathology payable at Scheme Rate thereafter out of Pathology benefit.</p> <p>Limited to age 16 years</p>
<p>D. PRESCRIBED MEDICINE</p> <p>1. Chronic Medication (Non-PMB Non-PPO) Chronic Medication (Non-PMB – PPO)</p> <p>2. Acute Medication</p>	<p>SINGLE EXIT PRICE (SEP)</p> <p>85%</p> <p>95%</p> <p>100%</p>	<p>Prescribed, administered and/or dispensed by a practitioner legally entitled to do so. Subject to managed care protocols and processes, the Scheme's medicine benefit management programme, formulary and DSP's.</p> <p>MMA and Reference Pricing</p> <p>MSA/MMA and Reference Pricing Member R7,380 after threshold M + 1 R10,190 after threshold M + 2 R14,650 after threshold M + 3 R15,540 after threshold M 4 + R16,560 after threshold (Limits applicable only after threshold has been reached)</p>

SERVICE	% BENEFIT (SR) (SCHEME RATE)	SUB LIMITS APPLICABLE TO NON-PMB's
<p>E. DENTAL SERVICES (Including Orthodontic treatment)</p> <p>1. Consultative</p> <p>2. Surgical Procedures (in rooms)</p> <p>3. Orthodontics</p> <p>4. Non-Surgical Procedures</p> <p>5. Dental Technician's Fees</p> <p>6. Dentures</p> <p>7. Preventative dentistry</p> <p>8. Surgical procedures in hospital (e.g. removal of impacted teeth, implants, periodontics, etc.)</p>	<p>(SR)</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>All dental procedures in hospital to be pre-authorized.</p> <p>MSA</p> <p>MSA</p> <p>MSA (Initial fee of R6,590 per treatment plan from risk pool)</p> <p>MSA</p> <p>MSA</p> <p>MSA</p> <p>Member R7,380 after threshold M + 1 R10,190 after threshold M + 2 R14,650 after threshold M + 3 R15,540 after threshold M 4 + R16,560 after threshold (Limits applicable only after threshold has been reached)</p> <p>R770 per beneficiary per year (selected preventative dentistry) will be allowed from the Risk Pool.</p> <p>Risk Pool subject to pre-authorization.</p>
<p>F. HOSPITALS F1 PRIVATE Admittances to be pre-authorized 72 hours prior to admission (Intervention by Case Managers)</p> <p>1. Ward Fees / Intensive Care / High Care / Step-down</p> <p>2. Theatre Fees</p> <p>3. Drugs Material and Equipment</p> <p>4. Out-Patient Fees</p> <p>5. Fixed Fee Procedures</p> <p>6. Per Diem/Global Fees</p> <p>7. Cochlear implants</p> <p>8. Other internal Protheseses/appliances</p> <p>9. T.T.O.'s</p>	<p>(SR)</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for co-payment(s).</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>Limited to R158,550 per beneficiary per year and subject to clinical protocols.</p> <p>Limited to R84,560 per beneficiary per year.</p> <p>Limited to one month's supply</p>

SERVICE	% BENEFIT (SR) (SCHEME RATE)	SUB LIMITS APPLICABLE TO NON-PMB's
<p>F2 PROVINCIAL</p> <p>Admittances to be pre-authorized 72 hours prior to admission (Intervention by Case Managers)</p> <p>9. Ward Fees / Intensive Care / High Care / Step-down</p> <p>10. Theatre Fees</p> <p>11. Drugs, Material and Equipment</p> <p>12. Out-patient Fees</p> <p>13. Fixed Fee Procedures</p> <p>14. Per Diem/Global Fees</p> <p>15. Cochlear implants</p> <p>16. Other Internal Prosthesis/appliances</p> <p>17. T.T.O.'S</p>	<p>(SR)</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for co-payment(s).</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>Limited to R158,550 per beneficiary per year and subject to clinical protocols.</p> <p>Limited to R84,560 per beneficiary per year unless a PMB, which is paid at cost</p> <p>Limited to one month's supply</p>
<p>F3 DAY CLINICS</p> <p>Admittances to be pre-authorized 72 hours prior to admission (Intervention by Case Managers)</p> <p>17. Ward Fees</p> <p>18. Theatre Fees</p> <p>19. Drugs, Material and Equipment</p> <p>20. Fixed Fee Procedures</p> <p>21. Per Diem/Global Fees</p> <p>22. Cochlear implants</p> <p>23. Other Internal Prostheses/appliances</p> <p>23. T.T.O.'S</p>	<p>(SR)</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for co-payment(s).</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>Limited to R158,550 per beneficiary per year and subject to clinical protocols.</p> <p>Limited to R84,560 per beneficiary per year unless a PMB, which is paid at cost</p> <p>Limited to one month's supply</p>
<p>F4 PSYCHIATRIC INSTITUTIONS</p>	<p>(SR)</p> <p>100%</p>	<p>35 Days per beneficiary per annum</p> <p>Subject to pre-authorization and case management</p>
<p>G. RADIOLOGY</p> <p>1. X-Rays</p> <p>2. Scopes – Diagnostic</p> <p>3. Scans – MRI, CAT & PET</p> <p>4. Scans – Sonars (Ultra Sound)</p> <p>5. Scans – Sonars for Maternity limited to 3</p> <p>6. Radiographers – out of hospital</p>	<p>(SR)</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>-</p> <p>Pre-authorization Required</p> <p>Non-PMB's limited to R33,040 per beneficiary per year. Pre-authorization required</p> <p>Pre-authorization required</p> <p>Pre-authorization required (incl 4D)</p> <p>Limited to R1,320 per beneficiary per year.</p>

SERVICE	% BENEFIT (SR) SCHEME RATE	SUB LIMITS APPLICABLE TO NON-PMBS
H. PATHOLOGY	(SR) 100%	-
1. Allergy tests	100%	Limited to R4,550 per beneficiary per year.
I. ONCOLOGY:	(SR)	Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for co-payment(s).
1. Radio- and chemotherapy	100%	Subject to ICON benefit management programme (Intervention by Case Managers) on the CORE protocol.
2. Pre-screening: oncology	100%	1 visit per beneficiary per year from risk pool subject to protocols.
3. Oncology social workers	100%	Subject to protocols.
J. OTHER	(SR)	Nappi codes to apply on all appliances, aids and prostheses
1.1 Medical Appliances and Prostheses		
a) Internal Prostheses/Appliances	100%	Limited to R84,560 per case unless a PMB, which is payable at cost
b) Hearing Aids (appliances and repairs, excluding batteries)	100%	R24,310 per ear every three years. Repairs limited to R2,070 per beneficiary per year.
c) Wheelchairs	100%	R7,830 per beneficiary every two years.
d) Artificial eyes/limbs	100%	R52,850 per beneficiary every two years subject to clinical motivation.
e) Breast prostheses and bras	100%	R5,290 per beneficiary per year with a sublimit of R4,230 applicable to bras
f) Orthopaedic braces and other similar aids.	100%	R14,320 per beneficiary per year. Subject to being prescribed by medical practitioner
g) Insulin pumps	100%	R61,310 per beneficiary every five years subject to clinical protocols.
1.2 Other Medical/ Surgical Appliances/Aids	100%	MSA / R4,610 per beneficiary per year. (Limit applicable only after threshold has been reached) Subject to being prescribed by medical practitioner.
a) Oxygen and home ventilation	100%	Pre-authorization required, limited to rental of R1,200 per beneficiary per month
b) Hyperbaric Oxygen treatment	100%	Pre-authorization required
c) CPAP (including mask)	100%	Limited to R12,170 per beneficiary every 5 years.
d) Nebulizer	100%	Limited to R730 per family every 5 years if an applicable condition is registered, otherwise payable from MSA.
e) Blood pressure monitors	100%	Limited to R800 per family every 5 years if an applicable condition is registered, otherwise payable from MSA.
f) Glucose monitors	100%	Limited to R590 per family every 2 years if an applicable condition is registered, otherwise payable from MSA.

SERVICE	% BENEFIT (SR) SCHEME RATE	SUB LIMITS APPLICABLE TO NON-PMBS
2. Blood Transfusions	(SR) 100%	-
3. Psychiatry a) Consultation b) Therapy	(SR) 100% 100%	Recommended by medical practitioner MSA Member 10 visits after threshold M + 12 visits after threshold (Included in Specialist visit limits) (Limits applicable only after threshold has been reached) -
4. Psychology (Benefits will only be allowed if services cannot be obtained free of charge through the Employee Assistance Programme) a) Consultation b) Therapy	(SR) 100% 100%	Recommended by medical practitioner MSA MSA R4,270 per beneficiary per year after threshold (Limit applicable only after threshold has been reached)
5. Speech Therapy a) Consultation b) Therapy and Treatment	(SR) 100% 100%	Recommended by medical practitioner MSA MSA R4,270 per beneficiary per year after threshold. (Limit applicable only after threshold has been reached)
6. Audiology a) Consultation b) Assessment	(SR) 100% 100%	Recommended by medical practitioner MSA MSA R4,270 per beneficiary per year after threshold. (Limit applicable only after threshold has been reached)
7. Dietetics	(SR) 100%	Recommended by medical practitioner MSA R1,100 per beneficiary per year after threshold. (Limit applicable only after threshold has been reached)
8. Ambulance and Emergency evacuation	(SR) 100%	-

SERVICE	% BENEFIT (SR) SCHEME RATE	SUB LIMITS APPLICABLE TO NON-PMBS
9. Chiropodist/Podiatrists a) Consultation b) Treatment	(SR) 100% 100%	Recommended by medical practitioner MSA MSA R4,270 per beneficiary per year after threshold. (Limit applicable only after threshold has been reached)
10. Occupational Therapy a) Consultation b) Treatment and Therapy	(SR) 100% 100%	Recommended by medical practitioner MSA MSA R4,270 per beneficiary per year after threshold. (Limit applicable only after threshold has been reached)
11. Private Nursing 11.1 Frail Care 11.2 Hospice - Imminent death regardless of the diagnosis - Step down or rehabilitation cases	(SR) 100% 100% 100% of cost	Limited to a maximum of R980 per beneficiary per day further limited to 60 days per beneficiary per year with a combined limit not exceeding R58,710. (To be recommended by medical practitioner and must be pre-authorized.) Limited to R160 per beneficiary per day with a combined limit not exceeding R58,710 per beneficiary per year (To be recommended by medical practitioner and must be pre-authorized.) PMB cases unlimited. Non-PMB cases limited to R1,730 per beneficiary per day in hospital care and limited to R540 per beneficiary per day for home visits. (To be recommended by medical practitioner and must be pre-authorized.)
12. Optometric Services a) Eye Test b) Frame c) Lenses d) Contact Lenses	(SR) 100% 100% 100% 100%	MSA / Limited to one per beneficiary per year after threshold MSA / R1,290 after threshold MSA / R2,800 after threshold MSA / R2,800 after threshold (Limits applicable only after threshold has been reached)
13. Clinical Technologists	(SR) 100%	-

SERVICE	% BENEFIT (SR) SCHEME RATE	SUB LIMITS APPLICABLE TO NON-PMBS
14. Chiropractic Services a) Consultation b) Treatment	(SR) 100% 100%	MSA MSA R4,270 per beneficiary per year after threshold. Limit applicable only after threshold has been reached.
15. Homeopathic and Naturopathic Services a) Consultations & Medicine	(SR) 100%	First R1,540 per family payable from insured benefits . Thereafter benefits for medicine only will be payable from MSA and above threshold benefits. Limited to R8,870 per family after threshold has been reached.
16. Physiotherapy & Biokinetic Treatment a) In-hospital b) Out-of-hospital	(SR) 100% 100%	Recommended by medical practitioner - MSA Member – R4,270 after threshold M+ - R8,530 after threshold (Limits applicable only after threshold has been reached) Additional R3,310 payable from insured benefits may be allowed by the Board of Trustees in respect of post-operative physiotherapy if substantiated by attending medical practitioner and within 60 days of operation.
K. LIMITS ON SPECIFIC ILLNESS CONDITIONS:- 1. Excimer Laser Procedures 2. Narcotism, Alcoholism, Drug Addiction and Sexually Transmitted Diseases. 3. Organ Transplants (harvesting, transplant and anti-reject medicine) 4. Chronic Renal Dialysis 5. Acquired Immune Deficiency Syndrome (AIDS) 6. HIV/Aids Vitamins – script required	(SR) 100% 100% 100% 100% 100% 100%	R14,890 per beneficiary per eye in respect of all related costs. Must be pre-authorized, protocols apply 30 days per beneficiary per year. Subject to pre-authorization and case management. R114,630 per beneficiary per year. PMB cases unlimited R92,970 per beneficiary per year. PMB cases unlimited PMB cases unlimited Limited to a 30 day supply per beneficiary per month.

SERVICE	% BENEFIT (SR) SCHEME RATE	SUB LIMITS APPLICABLE TO NON-PMBS
WELLNESS BENEFIT	(SR)	
1. Flu vaccines	100%	Payable at 100% SEP plus a dispensing fee
2. 360° Wellness check	100%	Limited to R230 per beneficiary per year
3. Childhood vaccinations	100%	Ages 0 – 1 limited to R4,900 pb Ages 1 – 2 limited to R490 pb Ages 3 - 5 limited to R190 pb Age 6 - 12 limited to R190 pb
4. DBC Program	100%	Subject to protocols and preauthorisation.
L. EX-GRATIA PAYMENTS	-	In special circumstances where financial hardship is evident, the BOT may consider ex-gratia payments.
M. THRESHOLD	-	Annual thresholds will apply in respect of MSA benefits. The annual thresholds limit is equal to the annual MSA contribution plus a self funded amount equal to 50% of the annual MSA contribution.

Legend:-

BOT	=	Board of Trustees
SEP	=	Single Exit Price
MSA	=	Medical Savings Account
DSP	=	Designated Service Provider
SR	=	Scheme Rate
% Benefit	=	Cost
Member	=	Single Member
p.b.	=	per beneficiary
M +	=	Member with Dependants
PMB	=	Prescribed Minimum Benefits
PPO	=	Preferred Pharmacy Network Provider
MMAP	=	Maximum Medical Aid Price

ANNEXURE C: EXCLUSIONS AND LIMITATIONS

E.1 **EXCLUSIONS**

The Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the Scheme has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act:-

E.1.1 All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party is liable. The member is entitled to such benefits as would have applied under normal conditions provided that on receipt of payment in respect of medical expenses, the member will reimburse the Scheme any money paid out in respect of this benefit by the Scheme.

E.1.2 All costs in respect of injuries arising from professional sport, speed contests and speed trials subject to PMB.

E.1.3 All costs for operations, medicines, treatment and procedures for cosmetic purposes unless medically necessary.

E.1.4 Holidays for recuperative purposes.

E.1.5 Purchase of:-

E.1.5.1 Patent medicines and proprietary preparations;

E.1.5.2 Applicators, toiletries and beauty preparations;

E.1.5.3 Bandages, cotton wool and other consumable items;

E.1.5.4 Patented foods, including baby foods;

E.1.5.5 Tonics, slimming preparations and drugs as advertised to the public;

E.1.5.6 Household and biochemical remedies;

E.1.5.7 Exclusion of costs for: obesity; wilfully self-inflicted injuries; infertility; artificial insemination; purchase of medicines not included in a prescription; all costs for use of gold in dentures or as an alternative to non-precious metals in crowns; inlays and bridges subject to prescribed minimum benefits.

- E.1.6 All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules of the Scheme.
- E.1.7 Charges for appointments which a member or dependant of a member fails to keep.
- E.1.8 Costs for services rendered by:-
- E.1.8.1 persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
 - E1.8.2 any institution, nursing home or similar institution except a state – or provincial hospital not registered in terms of any law.

E.2 **LIMITATION OF BENEFITS**

- E.2.1 The maximum benefits to which a member and his or her dependants are entitled in any financial year are limited as set out in Annexure B (Comprehensive Option), Annexure G (Ntsika Option) and Annexure I (Midmas Option).
- E.2.2 Members admitted during the course of a financial year are entitled to the benefits set out in the Benefit Option Annexures, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year. Annual maximum benefits shall be calculated as to the date of service.
- E.2.3 Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof.
- E.2.4 Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for the difference between the Scheme Rate and fee charged by a DSP.

ANNEXURE D: UNITS

List of Units on WCMAS.

- 1 Thungela Shared Services
- 2 Thungela Goedehoop Colliery
- 3 Thungela Coalbrook Colliery
- 4 Thungela Greenside Colliery
- 5 Thungela Isibonelo Colliery
- 6 Thungela Khwezela Colliery
- 7 Thungela SA Coal Estates
- 8 Thungela Coal Mines Benefit
- 9 Glencore Operations iMpunzi
- 10 Glencore Operations Arthur Taylor Colliery
- 11 Glencore Operations Goedgevonden Colliery
- 12 Glencore Operations Group Services
- 13 Glencore Operations Phoenix Colliery
- 14 Glencore Operations South Witbank Coal Mines
- 15 Glencore Operations Tavistock Colliery
- 16 Glencore Operations Tavistock Central Colliery
- 17 Glencore Operations Tweefontein Colliery
- 18 Glencore Operations Spitzkop Colliery
- 19 Izimbiwa Coal Springlake Colliery
- 20 Izimbiwa Coal Wonderfontein Colliery
- 21 Izimbiwa Coal Graspan Colliery
- 22 Izimbiwa Coal Central
- 23 Koornfontein Colliery
- 24 WCMAS Staff members
- 25 Witbank Chamber of Commerce ° (Only existing businesses registered with Witbank Chamber of Commerce & whose employees are currently members of WCMAS, will be allowed to continue their membership of the Scheme).
- 26 Mafube Colliery (Joint venture Anglo Coal and Exxaro)
- 27 Thungela Inyosi Coal (Joint venture) - Zibulo Colliery
- 28 One Vision Investments - Msobo Coal
- 29 Buffalo Coal Dundee (Pty) Ltd
- 30 Mantella Trading 310 (Pty) Ltd
- 31 Seriti Coal Kriel Colliery
- 32 Seriti Coal New Denmark Colliery
- 33 Seriti Coal New Vaal Colliery
- 34 Seriti Coal Shared Services

ANNEXURE E: PRESCRIBED MINIMUM BENEFITS (PMB'S)

1. DEFINITIONS

“Prescribed minimum benefits”

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

- (a) the Diagnosis and Treatment Pairs listed in Annexure A of the regulations, subject to any limitations specified therein; and
- (b) any emergency medical condition.

“Prescribed minimum benefit condition”

a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

2. PRESCRIBED MINIMUM BENEFITS

Notwithstanding anything to the contrary contained in these rules, the scheme shall pay 100% of the costs for services rendered in respect of the prescribed minimum benefits (PMB's) on any benefit option, which includes the diagnosis, medical management and medication of prescribed minimum benefits subject to therapeutic algorithms, protocols, formularies and DSP's unless the reimbursement of PMB's is restricted by legislation, in which event the Scheme shall only be obliged to pay for services in respect of PMB's in accordance with such legislation.

3. DIAGNOSTIC TESTS FOR AN UNCONFIRMED PMB DIAGNOSIS

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

DIAGNOSIS	
Addison's disease	Asthma
Bipolar mood disorder	Bronchiectasis
Cardiac failure	Cardiomyopathy disease
Chronic renal disease	Coronary artery disease
Chronic obstructive pulmonary disorder	Crohn's disease
Diabetes insipidus	Diabetes mellitus type 1 & 2
Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
Hyperlipidaemia	Hypertension
Hypothyroidism	Multiple sclerosis
Parkinson's disease	Rheumatoid arthritis
Schizophrenia	Systemic lupus erythematosus
Ulcerative colitis	HIV/Aids and related conditions

ANNEXURE F: RATES OF CONTRIBUTIONS AND PREMIUM PENALTIES - NTSIKA

1. RATES OF CONTRIBUTION W.E.F. 1 JANUARY 2023

The monthly contributions payable by members or their Units shall be based upon the member's monthly income, as defined in Rule 4.32, and will be as follows:-

Table	Income Group	Principal Member	Adult Dependant	Child Dependant
A	0 – 10,000	R1,046	R1,046	R441
B	10,001 – 15,000	R1,096	R1,096	R496
C	15,001 +	R1,652	R1,652	R716

2. PREMIUM PENALTIES FOR PERSONS JOINING LATE IN LIFE

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

<u>Penalty Bands</u>	<u>Maximum Penalty</u>
1 – 4 years	0.05 x contribution
5 – 14 years	0.25 x contribution
15 – 24 years	0.5 x contribution
25 + years	0.75 x contribution

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

A = B minus (35 + C) where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of application

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

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

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

ANNEXURE G: BENEFITS - NTSIKA OPTION – 2023

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
A - STATUTORY PRESCRIBED MINIMUM BENEFITS	<p>Services rendered by Hospitals and Designated Service Providers</p> <p>100% of cost no limit</p>
B - GENERAL PRACTITIONER SERVICES	
1. Consultative	<p>Unlimited visits at the beneficiary's nominated network GP. A beneficiary may nominate up to two network GPs at a time. Paid at 100% of the DSP Network agreed rate unless PMB which is paid at cost within a DSP GP Network only. Motivation may be required after the sixth visit in a benefit year.</p>
2. Hospital visits	<p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p>
3. Acute medication	<p>All acute medication will be provided as part of the acute consultation (when dispensed by a dispensing practitioner) or by an accredited designated service provider/pharmacy if prescribed by a non-dispensing practitioner. The cost is included in the DSP Network agreed GP consultation tariff and is subject to a formulary.</p>
4. General practitioners out-of-area/network	<p>Limited to 2 visits per beneficiary per year limited to a maximum of R1,340 per event (including medicine, pathology and radiology) excluding the facility fees</p>
5. Emergency room/casualty	<p>Medical conditions: First paid as an out of area GP visit thereafter limited to: - Member- R1,290 - M+ R2,560</p> <p>Injuries and trauma (not resulting in hospitalisation): - Unlimited for life threatening injuries and paid from risk benefit</p> <p>Emergency transportation and stabilisation: - Unlimited and paid from risk benefit</p>
C. SPECIALIST SERVICES	
1. Consultative	<p>Paid at 100% of Scheme rate limited to maximum of 2 visits per beneficiary with maximum of 3 visits per family. Subject to referral by DSP network GP and pre-authorisation of each specialist visit. Limited to: - Member R1,860 - M+ R4,060</p>
2. Hospital Visits	<p>Paid at 100% of the Scheme rate and subject to the overall hospital limit unless PMB which is paid at cost</p>
3. Paediatric Visits	<p>Limited to age 16 years</p>
D. MEDICATION	
1. CDL chronic conditions	<p>27 CDL conditions – unlimited if prescribed by DSP network provider and dispensed within network pharmacy or dispensing DSP doctor. Subject to formulary and formulary reference pricing. Non-formulary medicines must pre-authorised and is subject to a 30% co-payment.</p>
2. Non-CDL chronic conditions	<p>A 30% co-payment will be applicable to voluntary use of a specialist without referral by a DSP Network GP</p>

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
<p>3. Acute medication</p> <p>4. Over the counter / pharmacy advised medication</p>	<p>All acute medication will be provided as part of the GP consultation (when dispensed by a dispensing practitioner) or by an accredited designated service provider/pharmacy if prescribed by a non-dispensing practitioner. The cost is included in the DSP Network agreed GP consultation tariff and is subject to a formulary.</p> <p>Paid at 100% SEP limited to R350 per beneficiary per annum.</p>
<p>E. HOSPITALS PRIVATE/PROVINCIAL HOSPITALS / DAY CLINICS</p> <p>A 72 hour leeway for all direct admissions and all booked cases (pre-admissions) need to apply 72 hours prior to admission</p> <p>1. Ward Fees-General/Intensive Care/High Care</p> <p>2. Theatre Fees</p> <p>3. Medicines</p> <p>4. Specialised radiology including MRI, CT scans</p> <p>5. Basic radiology (x-rays) including black and white x-rays and ultrasound</p> <p>6. Pathology</p> <p>7. Blood transfusion</p> <p>8. Physiotherapy in hospital (post-op treatment to be pre-authorised subject to protocols)</p> <p>9. Medicine on discharge - T.T.O.'s</p> <p>10. Psychiatric treatment in hospital</p> <p>11. Maternity</p> <p>12. Associated providers accounts</p> <p>13. In-Hospital procedure exclusions:</p> <ul style="list-style-type: none"> - Dental surgery - Back and neck surgery - Hip and knee replacement - Cochlear implants - Auditory brain implants and internal nerve stimulators - Nissen fundoplication (reflux surgery) - Treatment for obesity, skin disorders and functional nasal problems - Refractive eye surgery - Brachytherapy for prostate cancer - Fibroadenosis 	<p>Treatment subject to Scheme pre-authorisation, case management and Scheme protocols in a DSP network of Private and Public Hospitals. Some non-PMB related treatment is excluded as per Scheme Rules</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>Paid at 100% of Scheme rate unless PMB which is paid a cost. Subject to pre-authorisation and case management</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost. Subject to protocols and case management</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>Limited to 7 days' supply and R410 per discharge subject to MRP and formulary</p> <p>Limited to 21 days per family in hospital with psychiatric facility and mental health institution. Subject to DSP and protocols.</p> <p>Normal birth limited to 3 days, Caesarean section limited to 4 days' subject to Scheme protocols and authorisation. DSP Network only. A R6,000 co-payment applies to elective caesarean sections.</p> <p>Paid at 100% of the Scheme rate unless PMB which is paid at cost</p> <p>No Benefit unless a PMB</p>

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
<p>N. SPECIALISED RADIOLOGY</p> <p>1. MRI/CT/PET Scans</p>	<p>100% of Scheme rate limited R12,350 per beneficiary per year, unless PMB which is paid a cost. Subject to pre-authorisation and case management.</p>
<p>O. BASIC PATHOLOGY</p>	<p>100% of Scheme rate. Unlimited when clinically appropriate within the DSP Network and subject to referral by a DSP Network GP. Limited to a list of codes, subject to case management</p> <p>A 30% co-payment will be applicable if not referred by a Network provider or a Specialist following referral by a DSP network GP (except when involuntary). Authorisation required for specialised pathology.</p>
<p>P. OPTOMETRY</p>	<p>DSP Network only. 1 visit per beneficiary every second year. Subject to combined family limit per year of:</p> <ul style="list-style-type: none"> - M R2,860 - M+1 R2,860 - M+2 R3,850 <p>Single vision lenses and frames limited to R1,140 per beneficiary every second year subject to combined family limit</p> <p>Bi-focal lenses and frames limited to R1,680 per beneficiary every second year subject to combined family limit</p> <p>Frames limited to range within DSP Network subject to combined family limit</p> <p>No benefit for contact lenses.</p>
<p>Q. HIV/AIDS</p>	<p>Paid at 100% of cost subject to authorisation and protocols</p>
<p>R. AMBULANCE</p>	<p>Paid at 100% of Scheme rate</p>
<p>S. AUXILLARY SERVICES</p> <p>1. Speech therapy, Social workers, Chiropracist, Podiatrists, Occupational therapy, Homeopaths & Naturopaths, Dieticians, Chiropractors, Audiologists and Bio-kinetics</p> <p>2. Physiotherapy</p>	<p>No benefit unless PMB which is paid at 100% of cost</p> <p>One consultation per beneficiary per year payable at 100% Scheme Rate.</p>
<p>T. PSYCHOLOGY AND PSYCHIATRY</p> <p>1. Psychiatry</p> <p>2. Psychotherapy</p>	<p>One consultation at a psychiatrist per beneficiary per year payable at 100% Scheme Rate.</p> <p>Psychotherapy at a psychologist payable at 100% Scheme Rate limited to R3,500 per beneficiary per year.</p>
<p>U. WELLNESS BENEFITS</p> <p>1. 360° CHECK</p> <ul style="list-style-type: none"> - Blood pressure - Cholesterol - Glucose - BMI - Waist circumference - Exercise plan - Healthy meal plan 	<p>Paid from risk benefit at 100% Scheme Rate</p> <p>One consultation per beneficiary per year. Excludes procedures. Limited to tariff code 0190/1/2 and ICD10 Z00.0 or Z00.1. Cost limited to R230 per beneficiary per annum</p>

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
2. FLU VACCINE	1 dose per beneficiary per year
3. EMOTIONAL WELLNESS - Unlimited telephone consultations - 3 psychologist visits	Psychologist referral will be done by qualified professionals
4. ORAL CONTRACEPTIVES AND CONTRACEPTIVE INJECTIONS	Limited to R170 per beneficiary per month
5. PAP SMEAR	1 per adult female every three years.
6. MAMMOGRAM	1 per annum for females aged 45 to 1 every 2 years for females aged 55+
7. PROSTATE SPECIFIC ANTIGEN (PSA) TEST	1 every 2 years for males aged 45 to 75
8. CHILDHOOD VACCINATIONS	Paid at 100% SEP subject to the Department of Health's Expanded Program on Immunization (EPI) schedule.

LEGEND:

CDL	=	Chronic Disease List
PMB	=	Prescribed Minimum Benefits
TTO	=	To take out i.e. medicines taken out of hospital when discharged
DSP	=	Universal Provider Network (Designated Service Provider)

ANNEXURE H: RATES OF CONTRIBUTIONS AND PREMIUM PENALTIES – MIDMAS

1. RATES OF CONTRIBUTION W.E.F. 1 JANUARY 2023

The monthly contributions payable by members or their Units shall be as follows:-

Principal Member	Adult Dependant	Child Dependant
R2,724	R2,524	R626

2. PREMIUM PENALTIES FOR PERSONS JOINING LATE IN LIFE

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

<u>Penalty Bands</u>	<u>Maximum Penalty</u>
1 – 4 years	0.05 x contribution
5 – 14 years	0.25 x contribution
15 – 24 years	0.5 x contribution
25 + years	0.75 x contribution

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

A = B minus (35 + C) where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of application

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

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

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

3. MEDICAL SAVINGS ACCOUNT (MSA) – MIDMAS OPTION

- 3.1 On admission to the Scheme, members will participate in a Medical Savings Account (MSA) held by the Scheme. Contributions payable in respect of the MSA component shall be credited and benefits in respect thereof, shall be debited to the account.
- 3.2 The amount allocated to the MSA by the scheme for the benefit of the member is 22.5% of the total gross contributions in respect of the member during the financial year concerned. Savings will be available upfront at the discretion of the Board of Trustees and interest is applied to positive savings account balances.
- 3.3 Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to claim for all health care services indicated under MSA in Annexure I, at 100% of the cost.
- 3.4 Funds allocated to the members MSA shall be available for the exclusive benefit of the member and his/her dependants. Any credit balance in the MSA at the end of a financial year accumulates for the benefit of the member.
- 3.5 Upon the death of the member, the balance due to the member will be transferred to his/her dependants who continue membership of the scheme or paid into his/her estate in the absence of such dependants.
- 3.6 On transfer to another benefit option of the scheme, which does not provide for such an account, any balance standing to the credit of the member in the MSA will be refunded to the member, not later than 4 months after such transfer and subject to applicable taxation laws.
- 3.7 Should a member terminate membership of the scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme or option which does not provide for a MSA, the balance due to the member must be refunded to the member not later than 4 months after termination of membership, and subject to applicable taxation laws.
- 3.8 Should a member transfer to another benefit option or be admitted to membership of another medical scheme, which provides for a similar account,

the balance due to the member must be transferred to such benefit option or scheme not later than 4 months after transfer to benefit option or termination of membership, as the case may be.

- 3.9 The funds in the member's MSA may not be used to pay for the costs of a prescribed minimum benefit or to offset contributions.
- 3.10 On termination of membership, funds in the member's MSA may be used to offset any debt owed by the member including outstanding contributions.
- 3.11 Unclaimed MSA balances above R100, where a member cannot be traced within three years of the member leaving the Scheme and after all reasonable attempts at tracing the members have been pursued, will be written back as Scheme Funds.

ANNEXURE I: BENEFITS - MIDMAS – 2023

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
A - STATUTORY PRESCRIBED MINIMUM BENEFITS	Services rendered by Hospitals and Designated Service Providers 100% of cost no limit
B - GENERAL PRACTITIONER SERVICES 1. Consultative 2. Hospital Visits 3. General practitioners for CDL 4. Emergency Visits not resulting in hospitalisation	Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid at 100% of Scheme Rate except for PMB's which are paid at cost Paid at 100% of cost. Subject to Scheme protocol and DSP Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost Additional 4 GP visits per member and 6 GP visits per family once savings has been depleted at Scheme rate.
C - SPECIALIST SERVICES 1. Consultative 2. Hospital Visits 3. Specialists for CDL 4. Paediatric Visits	Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost. Paid at 100% of Scheme Rate except for PMB's which are paid at cost Paid at 100% of cost. Subject to Scheme protocol and DSP Limited to age 16 years
D - PRESCRIBED MEDICINE 1. Chronic Medication (non CDL, non ADL) (Reference pricing and MMAP will apply) 2. Chronic Medication (26 CDL conditions/PMB) (Reference pricing and MMAP will apply) 3. Chronic Medication (ADL conditions) (Reference pricing and MMAP will apply) 4. Acute and OTC Medication (Reference pricing and MMAP will apply)	Prescribed, administered and/or dispensed by a practitioner legally entitled to do so. Subject to managed care protocols and processes, the Scheme's medicine benefit management programme, formulary and DSP's Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost 100% of cost through DSP and Formulary. Authorisation required. 100% of cost through DSP and Formulary. Authorisation required. Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost
E - DENTAL SERVICES 1. General Dentistry 2. Specialised Dentistry e.g. orthodontic treatment	All dental procedures (e.g. removal of impacted teeth, implants, periodontics, etc.) in hospital to be pre-authorized Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
<ul style="list-style-type: none"> - Laminectomy and Spinal fusion - Nissen Fundoplication (Reflux surgery) - Hysterectomy (Except for cancer) - Laparoscopic Hemi colectomy - Laparoscopic inguinal hernia repair - Laparoscopic appendectomy <p>All other accounts other than the hospital account</p>	<ul style="list-style-type: none"> - R9,410 - R9,410 - R4,705 - R2,350 - R2,350 - R2,350 <p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost</p>
<p>G - SUB-ACUTE FACILITIES</p> <p>1. Hospice</p> <ul style="list-style-type: none"> • Imminent death regardless of the diagnosis • Step down or rehabilitation <p>2. Private Nursing</p>	<p>Paid at 100% of cost for PMB's. Subject to pre-authorisation, protocols and case management</p> <p>PMB cases Unlimited. Non-PMB cases limited to R1,620 per beneficiary per day in hospital care and limited to R510 per beneficiary per day for home visits. (To be recommended by medical practitioner and must be pro-authorised)</p> <p>Limited to R870 per beneficiary per day for a maximum of 60 days. Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost subject to pre-authorisation.</p>
<p>H - ONCOLOGY</p>	<p>PMB cases paid at 100% of cost. Subject to protocols and authorisation on the Schemes Oncology programme (ICON Essential Protocol)</p>
<p>I - MEDICAL AND SURGICAL APPLIANCES AND PROSTHESIS</p> <p>1. Coronary artery stents – max of 3</p> <p>2. Coronary artery stents – medicated stents max 3</p> <p>3. Abdominal aortic aneurism stents:</p> <ul style="list-style-type: none"> - carotid stents - renal stents - aneurysm coils <p>4. Heart valves (Mitral etc.)</p> <p>5. Orthopaedic prosthesis:</p> <ul style="list-style-type: none"> - Hip or knee prostheses - Shoulder prosthesis - Elbow prosthesis - Ankle or wrist prosthesis - Finger prosthesis - Spinal cages - Spinal implantable devices - Internal fixators for fractures - Spinal instrumentation – per level limited to 2 levels and 1 procedure per beneficiary per annum <p>6. Artificial limbs:</p>	<p>Subject to a combined overall limit of R47,000; sub limits and NAPPI codes will apply</p> <p>Sub-limit of R14,840 per stent</p> <p>Sub-limit of R22,890 per stent</p> <p>Sub-limit of R20,220</p> <p>Sub-limit of R6,740</p> <p>Sub-limit of R47,000</p> <p>Sub-limit of R29,680</p> <p>Sub-limit of R47,000</p> <p>Sub-limit of R47,000</p> <p>Sub-limit of R47,000</p> <p>Sub-limit of R33,640</p> <p>Sub-limit of R26,910</p> <p>Sub-limit of R14,810</p> <p>Sub-limit of R33,640</p> <p>Sub-limit of R33,640</p> <p>Sub-limit of R29,620</p> <p>Prescribed by medical practitioner</p>

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
<ul style="list-style-type: none"> - Through Knee - below knee - above knee - below elbow - above elbow - Partial foot - Partial hand 	<ul style="list-style-type: none"> Sub-limit of R47,000 Sub-limit of R47,000 Sub-limit of R47,000 Sub-limit of R47,000 Sub-limit of R47,000 Sub-limit of R25,570 Sub-limit of R16,150
7. Other prosthesis:	
<ul style="list-style-type: none"> - Intra ocular lenses - Bladder sling - Hernia mesh - Vascular grafts 	<ul style="list-style-type: none"> Sub-limit of R5,380 Sub-limit of R8,080 Sub-limit of R10,770 Sub-limit of R32,990
8. Electronic and Nuclear devices:-	
<ul style="list-style-type: none"> - Internal cardiac defibrillator - Single chamber pacemaker - Dual chamber pacemaker 	<ul style="list-style-type: none"> Subject to overall limit of R47,000 Subject to overall limit of R47,000 Subject to overall limit of R47,0000
9. Internal nerve stimulators and insulin pumps	Excluded
10. Surgical appliances:	Prescribed by medical practitioner and condition registration
<ul style="list-style-type: none"> - Hearing aids per ear every 3 years - Artificial eyes every 5 year interval - BP monitor every 3 year interval - Glucometer every 3 year interval - Humidifier every 3 year interval - Nebuliser every 3 year interval - Moonboot – annual - Elbow crutches – annual - CPAP machines every 3 year interval - Braces callipers – annual - Rigid back brace – annual - Sling clavicle brace – annual - Wigs – annual - Bra's (for breast prosthesis mastectomy – 2 per annum) after - Breast prosthesis - annual - Commodes every 3 year interval - Wheelchairs every 3 year interval - Walking frames – annual - Rehabilitative foot orthotics – annual 	<ul style="list-style-type: none"> Sub-limit of R17,970 Sub-limit of R10,770 Sub-limit of R800 Sub-limit of R800 Sub-limit of R340 Sub-limit of R680 Sub-limit of R2,700 Sub-limit of R800 Sub-limit of R11,500 Sub-limit of R880 Sub-limit of R6,730 Sub-limit of R260 Sub-limit of R2,430 Sub-limit of R3,360 Sub-limit of R4,040 Sub-limit of R1,220 Sub-limit of R5,380 Sub-limit of R800 Sub-limit of R4,040
11. Stockings:	To be prescribed by medical practitioner
<ul style="list-style-type: none"> - Elastic stockings - 2 per annum - Full length stockings – 2 per annum - Anti-embolic stockings - annual 	<ul style="list-style-type: none"> Sub-limit of R1,000 Sub-limit of R880 Sub-limit of R1,340
12. Oxygen treatment	Limited to R1,200 per beneficiary per month subject to pre-authorisation

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
J - MEDICAL AND SURGICAL APPLIANCES AND PROSTHESIS 1. Cochlear implants	Not subject to a combined overall limit; sub limits, NAPPI codes and clinical protocols apply Payable at 100% Scheme Rate up to a limit of R158,550 per beneficiary every 5 years
K - MATERNITY PROGRAMME	Paid at 100% of Scheme rate, subject to Scheme protocols and authorisation 12 ante-natal visits Ante-natal pathology for risk screening (Qualitative bHCG, Blood glucose, HIV status, Syphilis, German measles, Hepatitis B, Anaemia, Blood group, Blood cross-matching) 2 x 2D scans 1 post-natal visit Ante-natal vitamins limited to R330 per beneficiary per month (script required)
L - AMBULANCE AND EMERGENCY EVACUATION	100% of Scheme Rate
M - HIV/AIDS	100% of cost, subject to protocols and authorisation
N - DIALYSIS	PMB Only subject to pre-authorisation and protocols
O - ORGAN TRANSPLANT	PMB Only, subject to pre-authorisation and protocols
P - PSYCHIATRY AND PSYCHOLOGY 1. Clinical psychologists and Psychiatrist	To be referred by medical practitioner Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost
Q - RADIOLOGY 1. X-rays 2. Radiographer	Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost Out of hospital limited to R1,320 per beneficiary per year
R - PATHOLOGY 1. Pathology and Histology	Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost
S - AUXILLIARY SERVICES 1. Physiotherapy 2. Chiropractor 3. Biokineticist 4. Dietician 5. Occupational therapist 6. Speech therapist 7. Audiologist 8. Chiropodist 9. Homeopath	Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost

SERVICE	SUB LIMITS APPLICABLE TO NON-PMB's
10. Naturopath 11. Osteopath 12. Podiatrist 13. Orthoptist 14. Optometry – single vision, frames, lenses, consult 15. Multifocals 16. Excimer laser – subject to clinical motivation	Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost Paid at 100% of Scheme Rate unless a PMB which is paid at cost Paid at 100% of Scheme Rate unless a PMB which is paid at cost Paid from MSA @ 100% of Scheme Rate unless a PMB which is paid from risk at cost. The minimum degree of myopia is -3.00 dioptres, astigmatism -2.5 dioptres, or combined myopia/astigmatism with a spherical equivalent of -4.00 dioptres.
T - WELLNESS BENEFITS 1. Back Treatment Program (DBC) 2. Wellness 360° Check 3. Emotional Wellness 4. Oral contraceptives and contraceptive injections (excludes treatment for skin conditions) 5. Pap Smear 6. Mammogram 7. Prostate Specific Antigen (PSA) Test 8. Flu vaccine 9. Childhood vaccinations	Paid from MSA @ 100% of Scheme Rate subject to pre-auth, protocols and DSP Limited to R230 per beneficiary per year Unlimited telephonic consultations Paid from MSA @ 100% of Scheme Rate 1 per adult female every three years 1 per annum for females aged 45 to 54 1 every 2 years for females aged 55+ 1 every 2 years males aged 45 to 75 Payable at 100% SEP plus a dispensing fee Ages 0 – 2 limited to R900 per beneficiary per year Ages 3 - 5 limited to R630 per beneficiary per year Age 6 - 12 limited to R480 per beneficiary per year
U - MEDICAL SAVINGS ACCOUNT (MSA)	Limited to a maximum of 22.5% of a member's annual contribution

LEGEND:	ADL	=	Additional Disease List
	CDL	=	Chronic Disease List
	PMB	=	Prescribed Minimum Benefits
	MSA	=	Medical Savings account
	TTO	=	To take out i.e. medicines taken out of hospital when discharged
	DSP	=	Designated Service Provider
	OTC	=	Over the Counter

ANNEXURE J: ADDITIONAL DISEASE LIST (“ADL”)

Diagnosis
Acne
Attention Deficit Hyperactivity Disorder
Eczema