WITBANK COALFIELDS MEDICAL SCHEME

RULES

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 parings 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, energy, 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, energy, 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 ensuring 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, of 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 is 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: COMPREHENSIVE CONTRIBUTION RATES AND PENALTIES

1. RATES OF CONTRIBUTION W.E.F. 1 JANUARY 2026

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	R2,933	R2,933	R778
B	2001 – 3000	R3,358	R3,358	R778
C	3001 – 4000	R4,173	R4,173	R778
D	4001 – 5000	R4,173	R4,173	R778
E	5001 – 6000	R4,569	R4,569	R778
F	6001 – 7000	R4,569	R4,569	R778
G	7001 – 8000	R4,569	R4,569	R778
H	8001 – 9000	R4,749	R4,749	R778
I	9001 – 10000	R4,749	R4,749	R778
J	10001 +	R5,212	R5,212	R778

1.1. **Child Dependants:**

The Scheme will charge contributions for a maximum of 3 (three) child dependants per membership, with any additional child dependants joining as beneficiaries of the Scheme at no additional cost.

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:-

Penalty Bands	Maximum Penalty
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 24% 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: COMPREHENSIVE OPTION BENEFITS

COMPREHENSIVE BENEFITS W.E.F. 1 JANUARY 2026

Note: All benefit limits reflected are per beneficiary per benefit year, unless otherwise stated.

SERVICE	% BENEFIT	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		
1. Consultations out of hospital	100% SR	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. Consultations in hospital	100% SR	-
3. Non-Surgical Treatments	100% SR	-
4. Surgical Procedures	100% SR	-
5. Anaesthetics	100% SR	-
6. Confinements	100% SR	-
7. Maternity consultations	100% SR	12 ante-natal visits per pregnancy. 1 post-natal visit per pregnancy. .
C. SPECIALIST SERVICES		(Including Psychiatry consultations)
1. Consultations out of hospital	100% SR	MSA Member 10 visits after threshold M + 12 visits after threshold (Limits applicable only after threshold has been reached)
2. Consultations in hospital	100% SR	-
3. Non-Surgical Treatments	100% SR	-
4. Surgical Procedures	100% SR	-
5. Pre-operative Assessment	100% SR	-
6. Anaesthetics	100% SR	-
7. Confinements	100% SR	-
8. Maternity Consultations	100% SR	12 ante-natal visits per pregnancy. 1 post-natal visit per pregnancy.
9. Paediatric consultations	100% SR	Limited to age 16 years
D. PRESCRIBED MEDICINE		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.
1. Chronic Medication (Non-PMB Non-PPO)	85% SEP	MMAP and Reference Pricing
2. Chronic Medication (Non-PMB – PPO)	100% SEP	MMAP and Reference Pricing
3. Acute Medication	100% SEP	MSA MMAP and Reference Pricing Member R8,410 after threshold M + 1 R11,620 after threshold

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
		M + 2 R16,700 after threshold M + 3 R17,720 after threshold M 4 + R18,890 after threshold (Limits applicable only after threshold has been reached)
E. DENTAL SERVICES (Including Orthodontic treatment)		All dental procedures in hospital to be pre-authorised.
1. Consultations	100% SR	MSA
2. Procedures (in rooms)	100% SR	MSA
3. Orthodontics	100% SR	MSA Initial fee of R7,510 per treatment plan from insured benefits.
4. Non-Surgical Procedures	100% SR	MSA
5. Dental Technician's Fees	100% SR	MSA
6. Dentures	100% SR	MSA Member R8,410 after threshold M + 1 R11,620 after threshold M + 2 R16,700 after threshold M + 3 R17,720 after threshold M 4 + R18,890 after threshold (Limits applicable only after threshold has been reached)
7. Implants	100% SR	MSA One implant per beneficiary per year paid from insured benefits.
8. Surgical procedures in hospital (e.g. removal of impacted teeth, periodontics, etc.)	100% SR	Paid from Insured benefits. Subject to pre-authorisation.
F. HOSPITALS Non-emergency admissions to be pre-authorised 72 hours prior to admission.		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. Ward Fees / Intensive Care / High Care / Step-down	100% SR	-
2. Theatre Fees	100% SR	-
3. Drugs Material and Equipment	100% SR	-
4. Out-Patient Fees	100% SR	-
5. Fixed Fee Procedures	100% SR	-
6. Per Diem/Global Fees	100% SR	-
7. Cochlear implants	100% SR	Limited to R180,760 per beneficiary every 5 years and subject to clinical protocols.
8. Other internal Prostheses/appliances	100% SR	Limited to R96,410 per beneficiary per year.
9. T.T.O.'s	100% SEP	Limited to one month's supply.
10. Psychiatric admissions	100% SR	35 days per year.
G. RADIOLOGY		
1. X-Rays – Out of hospital	100% SR	R2,700 per beneficiary per year from insured benefits. Thereafter MSA.
2. X-Rays – In hospital	100% SR	-

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
3. Scopes – Diagnostic	100% SR	Pre-authorisation required.
4. Scans – MRI, CAT & PET	100% SR	R37,670 per year. Pre-authorisation required.
5. Scans – Sonars (Ultrasounds)	100% SR	Pre-authorisation required.
6. Scans – Sonars for Maternity	100% SR	3 per pregnancy Including 4D scans.
H. PATHOLOGY		
1. Out of hospital	100% SR	R3,600 per beneficiary per year from insured benefits. Thereafter MSA.
2. In hospital	100% SR	-
I. ONCOLOGY:		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. Treatment	100% SR	Subject to the ICON Core protocol.
2. Social workers	100% SR	Subject to protocols.
J. OTHER		NAPPI codes to apply on all appliances, aids and prostheses. Subject to pre-authorisation and protocols.
1.1 Medical Appliances and Prostheses		
a) Internal Prostheses/Appliances	100% SR	R96,410 per year.
b) Hearing Aids	100% SR	R55,410 every three years. Repairs limited to R2,360 per year.
c) Wheelchairs	100% SR	R8,920 every two years.
d) Artificial eyes/limbs	100% SR	R60,250 every two years.
e) Breast prostheses and bras	100% SR	R6,020 per year Sublimit of R4,830 applicable to bras
f) Orthopaedic braces and other similar aids.	100% SR	R16,330 per year.
g) Insulin pumps	100% SR	R69,900 every five years.
h) Oxygen and home ventilation	100% SR	Rental: R1,370 per month. Purchase: R37,440 every 3 years.
i) Hyperbaric Oxygen treatment	100% SR	-
j) CPAP (including mask)	100% SR	R13,870 every 5 years.
1.2 Other Medical/ Surgical Appliances/Aids		
a) Overall limit	100% SR	MSA
b) Above threshold benefit	100% SR	R5,250 per year after threshold has been reached.
c) Nebulizers	100% SR	R830 per family every 5 years.
d) Blood pressure monitors	100% SR	R920 per family every 5 years.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
e) Glucose monitors	100% SR	R680 per family every 2 years.
2. Blood Transfusions	100% SR	-
3. Psychiatry		
a) Consultation	100% SR	MSA Member 10 visits after threshold M + 12 visits after threshold (Included in Specialist visit limits) (Limits applicable only after threshold has been reached)
b) Therapy	100% SR	-
4. Psychology		
a) Consultation	100% SR	MSA
b) Therapy	100% SR	MSA R4,870 after threshold has been reached.
5. Speech Therapy		
a) Consultation	100% SR	MSA
b) Therapy and Treatment	100% SR	MSA R4,870 after threshold has been reached.
6. Audiology		
a) Consultation	100% SR	MSA
b) Assessment	100% SR	MSA R4,870 after threshold has been reached.
7. Dietetics		
a) Consultation	100% SR	MSA R1,260 after threshold has been reached.
8. Ambulance and Emergency evacuation	100% SR	-
9. Chiropodist/Podiatrists		
a) Consultation	100% SR	MSA
b) Treatment	100% SR	MSA R4,870 after threshold has been reached.
10. Occupational Therapy		
a) Consultation	100% SR	MSA
b) Treatment and Therapy	100% SR	MSA R4,870 after threshold has been reached.
11. Sub-Acute Facilities		Subject to pre-authorisation.
11.1 Overall limit	100% SR	R67,900 per year.
11.2 Private Nursing	100% SR	R1,140 per day further for up to 60 days.
11.3 Frail Care	100% SR	R190 per beneficiary per day.
11.4 Hospice	100% SR	R2,070 per day in hospital R630 per day at home
11.5 Step down or rehabilitation	100% SR	-

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
12. Optometric Services		Limits applicable only after threshold has been reached.
a) Eye Tests	100% SR	MSA 1 after threshold has been reached.
b) Frames	100% SR	MSA R1,470 after threshold has been reached.
c) Lenses	100% SR	MSA R3,190 after threshold has been reached.
d) Contact Lenses	100% SR	MSA R3,190 after threshold has been reached.
13. Clinical Technologists	100% SR	-
14. Chiropractic Services		
a) Consultation	100% SR	MSA
b) Treatment	100% SR	MSA R4,870 after threshold has been reached.
15. Homeopathic and Naturopathic Services a) Consultations & Medicine	100% SR	R1,760 per family paid from insured benefits. Thereafter MSA. R10,110 per family after threshold has been reached.
16. Physiotherapy & Biokinetic Treatment		
a) In hospital	100% SR	-
b) Out of hospital	100% SR	MSA Member – R4,870 after threshold M+ -- R9,720 after threshold
c) Post-operative physiotherapy out of hospital	100% SR	R3,780 Within 60 days of operation. Subject to pre-authorisation.
K. LIMITS ON SPECIFIC ILLNESS CONDITIONS:-		
1. Excimer Laser Procedures	100% SR	R16,970 per eye Subject to pre-authorisation and protocols.
2. Narcotism, Alcoholism, Drug Addiction and Sexually Transmitted Diseases.	100% SR	30 days Subject to pre-authorisation and protocols.
3. Chronic Renal Dialysis	100% SR	R106,000 per year. Subject to pre-authorisation and protocols
4. Acquired Immune Deficiency Syndrome (AIDS)	100% SR	Subject to pre-authorisation and protocols
5. HIV/Aids Vitamins – script required	100% SEP	30 day supply per month. Subject to pre-authorisation and protocols.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
L. WELLNESS BENEFITS **L1. MEN'S WELLNESS PACKAGE** For all male beneficiaries 18 years and older, unless otherwise stated.		**Paid from insured benefits.**
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year.
2. **Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**	200% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis)	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
7. **Colon cancer screening** **For male beneficiaries ages 45 to 75:** 7.1 One faecal occult test per annum 7.2 Colonoscopy	 200% SR 200% SR	 One per year. One every ten years in an outpatient setting, subject to clinical protocols and pre-authorisation.
8. **Cardiovascular screening:** **For male beneficiaries 35 years and older:** 8.1 Lipogram	 200% SR	 One per year.
9. **Smoking/vaping cessation program.**	100% SR	One per lifetime at a DSP.
L2. WOMEN'S WELLNESS PACKAGE For all female beneficiaries 18 years and older, unless otherwise stated.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
6. PrEP (pre-exposure prophylaxis)	100% SEP	Oral PrEP medication, subject to protocols and formularies.
	200% SR	Five HIV tests per year.
7. **Cervical and breast cancer screening**:		
7.1 Pelvic exam and breast exam by a gynaecologist, GP or nurse.	200% SR	One per year.
7.2 Pap test.	200% SR	One per year.
7.3 HPV test.	200% SR	One per year.
8**. Breast cancer screening**:		
For female beneficiaries ages 40 to 70:		
8.1 Mammogram	200% SR	One every two years.
9. Colon cancer screening:		
For female beneficiaries ages 45 to 75:		
9.1 One faecal occult test per annum	200% SR	One per year.
9.2 Colonoscopy	200% SR	One every ten years in an outpatient setting, subject to clinical protocols and pre-authorisation.
10. Cardiovascular screening:		
For female beneficiaries 35 years and older:		
10.1 Lipogram	200% SR	One per year.
11. Smoking/vaping cessation program.	100% SR	One per lifetime at a DSP.
L3. TEEN'S WELLNESS PACKAGE		
For all beneficiaries ages 13 to 17 years old.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis).	100% SEP	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
L4. CHILDHOOD WELLNESS PACKAGE		
For beneficiaries ages 2 to 12 years old.		
1. **Wellness check** – General check up by a GP, nurse or at a pharmacy.	200% SR	One per year.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Childhood vaccines**.	100% SEP 200% SR	NDoH expanded vaccination program, subject to protocols. Dispensing and administration fee.
L4. BABY & TODDLERS WELLNESS PACKAGE For beneficiaries under the age of 2 years old.		
1. **Wellness check** – Growth and development checks and administration of vaccines by a GP, nurse or at a pharmacy.	200% SR	Eight per year.
2**. Visual screening** – red reflex test.	200% SR	One per year.
3. **Hearing screening –** OAE or ABR.	200% SR	One per year.
4**. Baby vaccines**.	100% SEP 200% SR	NDoH expanded vaccination program, subject to protocols. Dispensing and administration fee.
L5. MOTHER TO BE WELLNESS PACKAGE For pregnant women who enrol via the WCMAS Mobile App or WCMAS client services.		
1. **Pre-natal pathology**	200% SR	Hepatitis B once per pregnancy Syphilis once per pregnancy Blood grouping once per pregnancy Rhesus factor incompatibility screening once per pregnancy; and HIV screening up to 12 times per pregnancy.
2. **Antenatal supplements** Vitamins classified as antenatal supplements (folate and iron).	100% SEP	R200 per month during pregnancy. Subject to MMAP and formularies.
3. **Breast pump** bought at a pharmacy.	200% SR	R1,500 per family every three years.
L6. OTHER WELLNESS BENEFITS		
1. Flu vaccines	100% SEP	One per year.
2. DBC Back and Neck Program	100% SR	Subject to protocols and preauthorisation.
3. Mental Health Program	100% SR	Subject to protocols and preauthorisation.
M. WELLNESS REWARD FUND Additional benefit for out of hospital healthcare services. The accumulation of healthcare benefits based on submitting a valid claim during the current benefit year for an item which falls within the wellness packages listed in L1 to L5**.**	100% SR	. Accumulates at an amount of R250 per event limited to: - R1,500 per adult per year. - R1,000 per child per year; and - Limited to R2,500 per family per year. Subject to the protocols.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
N. EX-GRATIA PAYMENTS	-	In special circumstances where financial hardship is evident, the Board of Trustees may consider ex-gratia payments.
O. 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:-

% Benefit	=	Reimbursement rate
CDL	=	Chronic Disease List – refer to Annexure E
DSP	=	Designated Service Provider
M +	=	Member with Dependants
Member	=	Single Member
MMAP	=	Maximum Medical Aid Price
MSA	=	Medical Savings Account
NDoH	=	National Department of Health
PMB	=	Prescribed Minimum Benefits
PPO	=	Preferred Pharmacy Network Provider
SEP	=	Single Exit Price
SR	=	Scheme Rate

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
35 Seriti Power

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: NTSIKA CONTRIBUTION RATES AND PENALTIES

1. RATES OF CONTRIBUTION W.E.F. 1 JANUARY 2026

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	R1,199	R1,199	R505
B	10,001 – 15,000	R1,257	R1,257	R569
C	15,001 +	R1,895	R1,895	R763

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:-

Penalty Bands	Maximum Penalty
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: NTSIKA OPTION BENEFITS

NTSIKA BENEFITS W.E.F. 1 JANUARY 2026

Note: All benefit limits reflected are per beneficiary per benefit year, unless otherwise stated.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
A - STATUTORY PRESCRIBED MINIMUM BENEFITS	100% cost	No limit. Services rendered by Hospitals and Designated Service Providers
B - GENERAL PRACTITIONER SERVICES		
1. Consultations out of hospital	100% SR	Unlimited visits at the beneficiary's nominated network GP. Motivation may be required after the 6th visit in a benefit year. A beneficiary may nominate up to 3 network GPs at a time.
2. Consultations in hospital	100% SR	-
3. Acute medication	100% SEP	Dispensed or prescribed by a nominated network GP and filled at a PPO. Subject to the network formulary, MMAP and reference pricing.
4. General practitioners out-of-area/network	100% SR	2 visits per beneficiary per year. A maximum of R1,530 per event.
5. Emergency room/casualty	100% SR	Medical conditions: R1,460 per beneficiary per year Injuries and trauma (not resulting in hospitalisation): Unlimited for life threatening injuries Subject to PMB/DTP protocols. Emergency transportation and stabilisation: Unlimited for life threatening injuries Subject to PMB/DTP protocols.
6. Maternity consultations	100% SR	12 ante-natal visits per pregnancy. 1 post-natal visit per pregnancy. Either at a nominated network GP or specialist.
C. SPECIALIST SERVICES		
1. Consultations	100% SR	2 visits up to an annual limit of R2,120 per member. 3 visits up to an annual limit of R4,630 per family.
2. Consultations in hospital	100% SR	-
3. Paediatric consultations	100% SR	Only beneficiaries ages 16 years and under. Subject to specialist consultations limits.
4. Maternity consultations	100% SR	12 ante-natal visits per pregnancy. 1 post-natal visit per pregnancy. Either at a nominated network GP or specialist.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
D. MEDICATION		
1. CDL chronic conditions	100% SEP	27 CDL conditions covered. Dispensed or prescribed by a nominated network GP and filled at a PPO. Subject to a network formulary and reference pricing. Non-formulary medicines must pre-authorised and is subject to a 30% co-payment.
2. Non-CDL chronic conditions and Acute medication	100% SEP	Dispensed or prescribed by a nominated network GP and filled at a PPO. Subject to a network formulary and reference pricing.
3. Over the counter / pharmacy advised medication	100% SEP	R420 per beneficiary per year from a PPO.
E. HOSPITALS **PRIVATE/PROVINICAL HOSPITALS / DAY CLINICS** Non-emergency admissions to be pre-authorised 72 hours prior to admission.		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. Ward Fees-General/Intensive Care/High Care	100% SR	-
2. Theatre Fees	100% SR	-
3. Medicines	100% SEP	-
4. Specialised radiology including MRI, CT scans	100% SR	-
5. Basic radiology (x-rays) including black and white x-rays and ultrasound	100% SR	-
6. Pathology	100% SR	-
7. Blood transfusion	100% SR	-
8. Physiotherapy in hospital	100% SR	Post-operative treatment to be pre-authorised and is subject to protocols.
9. Medicine on discharge - T.T.O.'s	100% SEP	7 days' supply up to R480 per discharge. Subject to formulary and reference pricing.
10. Psychiatric treatment in hospital	100% SR	21 days per family. Subject to use of a DSP and protocols.
11. Maternity confinements	100% SR	Subject to use of a DSP and protocols. A R6,700 co-payment applies to elective Caesarean sections.
12. Associated providers accounts	100% SR	Subject to protocols.
13. In-Hospital procedure exclusions: - 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		No benefit unless a PMB

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
F. SUB-ACUTE FACILITIES		
1. Hospice • Imminent death regardless of the diagnosis	100% SR	Subject to pre-authorisation and protocols.
G. ONCOLOGY	100% 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). Subject to the ICON Essential protocol.
H. ORGAN TRANSPLANT AND RENAL DIALYSIS	100% Cost	PMB cases only. Subject to pre-authorisation and protocols.
I. MEDICAL APPLIANCES AND PROSTHESES		
1. Hearing Aids	100% SR	R12,050 every 3 years. Includes of repairs, excludes batteries.
J. DAY-TO-DAY BENEFITS NOT LISTED ELSEWHERE	100% SR	Day-to-day services are subject to use of a DSP.
K. DENTAL SERVICES		
1. Basic Dentistry	100% SR	2 consultations per beneficiary per year at a DSP. For the following basic dentistry procedures: - Cleaning - Fluoride treatment - Scaling - Polishing - Fillings - Dental x-rays - Emergency root canal treatment - Wisdom tooth extraction in rooms.
2. Basic Dentistry – out of network	100% SR	Out-of-network dental visits/procedures will be at 100% Scheme Rate, except for involuntary PMB emergencies, which will be paid at cost.
3. Specialised Dentistry	100% SR	No benefit unless PMB. Subject to pre-authorisation and protocols.
4. Dentures	100% SR	One set of plastic dentures per beneficiary every four years.
L. BASIC RADIOLOGY OUT OF HOSPITAL	100% SR	Unlimited subject to basic pathology protocol.
M. SPECIALISED RADIOLOGY OUT OF HOSPITAL		
1. MRI/CT/PET Scans	100% SR	Subject to pre-authorisation. R14 080 per beneficiary per year.
2. Scans - Sonars (Ultrasounds)	100% SR	Subject to pre-authorisation.
3. Scans – Sonars for Maternity	100% SR	3 per pregnancy. 2D scans only.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
N. BASIC PATHOLOGY OUT OF HOSPITAL	100% SR	Unlimited subject to basic pathology protocol. Authorisation required for specialised pathology.
O. OPTOMETRY		From a DSP only.
1. Eye test – part of wellness benefit (section L)	100% SR	-
2. Single vision lenses and frames OR contact lenses.	100% SR	R1,300 per beneficiary every two years.
3. Bi-focal/multi-focal lenses and frames.	100% SR	R1,910 per beneficiary every two years.
4. Overall limit		Subject to combined family limit per year: - M R3,260 - M+1 R3,260 - M+2 R4,390
P. HIV/AIDS	100% Cost	Subject to authorisation and protocols.
Q. AMBULANCE	100% SR	Subject to protocols.
R. AUXILLARY SERVICES OUT OF HOSPITAL		
1. Speech therapy, Social workers, Chiropodist, Podiatrists, Occupational therapy, Homeopaths & Naturopaths, Dieticians, Chiropractors, Audiologists and Bio-kinetics		No benefit unless a PMB.
2. Physiotherapy	100% SR	One consultation per beneficiary.
S. PSYCHOLOGY AND PSYCHIATRY		
1. Psychiatry	100% SR	Paid at 100% Scheme Rate.
2. Psychotherapy	100% SR	R3,990 per beneficiary per year.
3. Mental Wellbeing Programme	100% SR	Registration via WCMAS Mobile App.
T. WELLNESS BENEFITS **T1. MEN'S WELLNESS PACKAGE** For all male beneficiaries 18 years and older, unless otherwise stated.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year at a DSP.
2. **Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years at a DSP.
3. **Dental check up** at a dentist.	200% SR	One per year at a DSP.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis)	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
7. **Colon cancer screening** **For male beneficiaries ages 45 to 75:** 7.1 One faecal occult test per annum 7.2 Colonoscopy	 200% SR 200% SR	 One per year. One every ten years in an outpatient setting, subject to clinical protocols and pre-authorisation.
8. **Cardiovascular screening:** **For male beneficiaries 35 years and older:** 8.1 Lipogram	 200% SR	 One per year.
9. **Smoking/vaping cessation program.**	100% SR	One per lifetime at a DSP.
T2. WOMEN'S WELLNESS PACKAGE For all female beneficiaries 18 years and older, unless otherwise stated.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year at a DSP.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years at a DSP.
3. **Dental check up** at a dentist.	200% SR	One per year at a DSP.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis)	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
7. **Cervical and breast cancer screening**: 7.1 Pelvic exam and breast exam by a gynaecologist, GP or nurse. 7.2 Pap test. 7.3 HPV test.	 200% SR 200% SR 200% SR	 One per year at DSP or specialist. One per year. One per year.
8**. Breast cancer screening**: **For female beneficiaries ages 40 to 70:** 8.1 Mammogram	 200% SR	 One every two years.
9. Colon cancer screening: **For female beneficiaries ages 45 to 75:** 9.1 One faecal occult test per annum 9.2 Colonoscopy	 200% SR 200% SR	 One per year. One every ten years in an outpatient setting, subject to clinical protocols and pre-authorisation.
10. Cardiovascular screening: **For female beneficiaries 35 years and older:** 10.1 Lipogram	 200% SR	 One per year.
11. Smoking/vaping cessation program.	100% SR	One per lifetime at a DSP.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
T3. TEEN'S WELLNESS PACKAGE For all beneficiaries ages 13 to 17 years old.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis).	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
T4. CHILDHOOD WELLNESS PACKAGE For beneficiaries ages 2 to 12 years old.		
1. **Wellness check** – General check up by a GP, nurse or at a pharmacy.	200% SR	One per year at a DSP.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years at a DSP.
3. **Dental check up** at a dentist.	200% SR	One per year at a DSP.
4**. Childhood vaccines**.	100% SEP	NDoH expanded vaccination program, subject to protocols.
	200% SR	Dispensing and administration fee at a DSP.
T4. BABY & TODDLERS WELLNESS PACKAGE For beneficiaries under the age of 2 years old.		
1. **Wellness check** – Growth and development checks and administration of vaccines by a GP, nurse or at a pharmacy.	200% SR	Eight per year at a DSP.
2**. Visual screening** – red reflex test.	200% SR	One per year.
3. **Hearing screening –** OAE or ABR.	200% SR	One per year.
4**. Baby vaccines**.	100% SEP	NDoH expanded vaccination program, subject to protocols.
	200% SR	Dispensing and administration fee at a DSP.
T5. MOTHER TO BE WELLNESS PACKAGE For pregnant women who enrol via the WCMAS		

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
Mobile App or WCMAS client services. 1. **Pre-natal pathology**	200% SR	Hepatitis B once per pregnancy Syphilis once per pregnancy Blood grouping once per pregnancy Rhesus factor incompatibility screening once per pregnancy; and HIV screening up to 12 times per pregnancy.
2. **Antenatal supplements** Vitamins classified as antenatal supplements (folate and iron).	100% SEP	R200 per month during pregnancy. Subject to MMAP and formularies.
3. **Breast pump** bought at a pharmacy.	200% SR	R1,500 per family every three years.
T6. OTHER WELLNESS BENEFITS		
1. Flu vaccines	100% SEP	One per year.
2. DBC Back and Neck Program	100% SR	Subject to protocols and preauthorisation.
3. Mental Health Program	100% SR	Subject to protocols and preauthorisation.
4. Contraceptives	100% SEP	Limited to R200 per beneficiary per month.
5. Prostate Specific Antigen (PSA) Test	100% SR	1 every 2 years for males aged 45 to 75.
U. WELLNESS REWARD FUND Additional benefit for out of hospital healthcare services. The accumulation of healthcare benefits based on submitting a valid claim during the current benefit year for an item which falls within the wellness packages listed in T1 to T5**.**	100% SR	. Accumulates at an amount of R250 per event limited to: - R1,500 per adult per year. - R1,000 per child per year; and - Limited to R2,500 per family per year. Subject to protocols.
V. EX-GRATIA PAYMENTS	-	In special circumstances where financial hardship is evident, the Board of Trustees may consider ex-gratia payments.

LEGEND:

% Benefit	=	Reimbursement Rate
CDL	=	Chronic Disease List – refer to Annexure E
DSP	=	Designated Service Provider (network provider)
NDoH	=	National Department of Health
PMB	=	Prescribed Minimum Benefits
PPO	=	Preferred Pharmacy Network Provider
SEP	=	Single Exit Price
SR	=	Scheme Rate
TTO	=	To take out i.e. medicines taken out of hospital when discharged

ANNEXURE H: MIDMAS CONTRIBUTION RATES AND PENALTIES

1. RATES OF CONTRIBUTION W.E.F. 1 JANUARY 2026

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

Principal Member	Adult Dependant	Child Dependant
R3,123	R2,894	R718

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:-

Penalty Bands	Maximum Penalty
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 24% 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: MIDMAS OPTION BENEFITS

MIDMAS BENEFITS W.E.F. 1 JANUARY 2026

Note: All benefit limits reflected are per beneficiary per benefit year, unless otherwise stated.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
A - STATUTORY PRESCRIBED MINIMUM BENEFITS	100% Cost	Unlimited. Services rendered by Hospitals and Designated Service Providers
B - GENERAL PRACTITIONER SERVICES		
1. Consultations out of hospital	100% SR	MSA
2. Above threshold benefit for consultations out of hospital	100% SR	Additional 4 GP visits per member and 6 GP visits per family paid from insured benefits once MSA has been depleted
3. Consultations in hospital	100% SR	-
4. Emergency room/casualty	100% SR	Medical conditions: MSA Injuries and trauma (not resulting in hospitalisation) paid from insured benefits. Unlimited for life threatening injuries. Subject to PMB/DTP protocols.
5. Maternity consultations	100% SR	Paid from insured benefits. 12 ante-natal visits per pregnancy. 1 post-natal visit per pregnancy.
C - SPECIALIST SERVICES		
1. Consultations out of hospital	100% SR	MSA
2. Consultations in hospital	100% SR	-
3. Paediatric consultations	100% SR	MSA Limited to age 16 years
4. Maternity consultations	100% SR	Paid from insured benefits. 12 ante-natal visits per pregnancy. 1 post-natal visit per pregnancy.
D - PRESCRIBED MEDICINE		Subject to managed care protocols and processes, the Scheme's medicine benefit management programme, formulary, reference pricing, MMAP and use of PPO's
1. Chronic Medication:	100% SEP	
1.1 CDL/PMB Conditions	100% SEP	-
1.2 ADL Conditions	100% SEP	-
1.3 Other Chronic Conditions	100% SEP	MSA
2. Acute Medication	100% SEP	MSA
3. Over the Counter Medication		MSA

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
E - DENTAL SERVICES		
1. In-hospital Dental Procedures	100% SR	- Subject to pre-authorisation and protocols.
2. General Dentistry	100% SR	MSA
3. Specialised Dentistry e.g. orthodontic treatment	100% SR	MSA
F - HOSPITALS Admissions to be pre-authorised 72 hours prior to admission (Intervention by Case Managers) **F1 - PRIVATE/PROVINICAL HOSPITALS / DAY CLINICS**		Services rendered by Hospitals and Designated Service Providers. Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for a co-payment(s).
1. Ward Fees (General/Intensive Care/High Care/ Step-down)	100% SR	-
2. Theatre Fees	100% SR	-
3. Medicines, materials and equipment	100% SR	-
4. Specialised radiology incl. MRI, CT scans	100% SR	Limited to R24,560 per year.
5. Basic radiology (x-rays)	100% SR	-
6. Pathology	100% SR	-
7. Blood transfusion	100% SR	-
8. Physiotherapy in hospital	100% SR	Post-operative treatment out of hospital limited to R2,760 within 60 days, and subject to pre-authorisation.
9. Medicine on discharge - T.T.O.'s	100% SEP	7 days' supply.
10. Psychiatric treatment in hospital	100% SR	21 days per year.
11. Narcotism, alcoholism drug addiction and treatment of STD's	100% SR	21 days per year.
12. Maternity	100% SR	-
13. Vasectomy	100% SR	-
14. Other associated claims	100% SR	-
F2 – COPAYMENTS APPLICABLE PROCEDURES The following procedures will have a co-payment payable to the hospital on admission: (Where two or more procedures are done simultaneously only the highest co-payment will apply)		
- Gastroscopy - Colonoscopy - Cystoscopy - Nasal/sinus Endoscopy - Functional Nasal surgery (Septoplasty) - Hysteroscopy - Flexible Sigmoidoscopy - Arthroscopy		- R1,970 - R1,970 - R1,970 - R1,970 - R1,970 - R1,970 - R1,970 - R1,970

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
- Minor gynaecological laparoscopic procedure		- R1,970
- Dental		- R1,970
- Excision Lesion (Benign & Malignant)		- R1,310
- Joint replacements (Arthroplasty)		- R10,520
- Conservative back and neck treatment (spinal cord injections)		- R1,970
- Laminectomy and Spinal fusion		- R10,520
- Nissen Fundoplication (Reflux surgery)		- R10,520
- Hysterectomy (Except for cancer)		- R5,250
- Laparoscopic Hemi colectomy		- R2,630
- Laparoscopic inguinal hernia repair		- R2,630
- Laparoscopic appendectomy		- R2,630
G - SUB-ACUTE FACILITIES		Subject to pre-authorisation, protocols and case management
1. Hospice Imminent death regardless of the diagnosis	100% Cost	-
2. Step down or rehabilitation	100% SR	Limited to R1,930 per day in hospital care. Limited to R580 per day for home visits.
3. Private Nursing	100% SR	MSA Limited to R990 per day. Maximum of 60 days.
H - ONCOLOGY	100% SR	Subject to pre-authorisation and the ICON Essential Protocol
I - MEDICAL AND SURGICAL APPLIANCES AND PROSTHESIS		
1. Combined overall limit	100% SR	R53,580 per year
2. Sub-limits:		
2.1 Coronary artery stents – max of 3	100% SR	R16,920 per stent
2.2 Coronary artery stents – medicated stents max 3	100% SR	R26,090 per stent
2.3 Abdominal aortic aneurism stents:		
- carotid stents	100% SR	R23,050
- renal stents	100% SR	R7,690
2.4 Heart valves (Mitral etc.)	100% SR	R33,830
2.5 Orthopaedic prosthesis:		
- Ankle or wrist prosthesis	100% SR	R38,340
- Finger prosthesis	100% SR	R30,680
- Spinal cages	100% SR	R16,880
- Spinal implantable devices	100% SR	R38,340
- Internal fixators for fractures	100% SR	R38,340
- Spinal instrumentation – per level limited to 2 levels and 1 procedure per beneficiary per annum	100% SR	R33,770
2.6 Artificial limbs:		
- Partial foot	100% SR	R29,150
- Partial hand	100% SR	R18,420
2.7 Other prosthesis:	-	
- Intra ocular lenses		R6,140
- Bladder sling	-	R9,200
- Hernia mesh		R12,280

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
- Vascular grafts		R37,610
2.8 Internal nerve stimulators		Excluded
2.9 Insulin pumps		Excluded
J – EXTERNAL APPLIANCES		Not subject to a combined overall limit; sub limits, NAPPI codes and clinical protocols apply
Cochlear implants	100% SR	R180,760 per beneficiary every 5 years
Hearing aids	100% SR	R20,490 every 3 years
Artificial eyes	100% SR	R12,280 every 5 years
BP monitor	100% SR	R920 every 3 years
Glucometer	100% SR	R920 every 3 years
Humidifier	100% SR	R400 every 3 years
Nebuliser	100% SR	R770 every 3 years
Moonboot	100% SR	R3,080 per year
Elbow crutches	100% SR	R920 per year
CPAP machine	100% SR	R13,110 every 3 years
Braces, callipers	100% SR	R1,000 per year
Rigid back brace	100% SR	R7,680 per year
Sling clavicle brace	100% SR	R290 per year
Wigs	100% SR	R2,770 per year
Bra's (for breast prosthesis after mastectomy)	100% SR	R3,840 per year for up to 2
Breast prosthesis	100% SR	R4,610 per year
Commodes	100% SR	R1,390 every 3 years
Wheelchairs	100% SR	R6,140 every 3 years
Walking frames	100% SR	R920 per year
Rehabilitative foot orthotics	100% SR	R4,610 per year
Stockings: - Elastic stockings - 2 per annum - Full length stockings – 2 per annum - Anti-embolic stockings – annual	 100% SR 100% SR 100% SR	 R1,140 per year for up to 2 R1,000 per year for up to 2 R1,530 per year
Oxygen treatment	100% SR	R1,370 per month
K - AMBULANCE AND EMERGENCY EVACUATION	100% SR	-
L - HIV/AIDS	100% Cost	Subject to protocols and authorisation
M – DIALYSIS	100% Cost	PMB only Subject to pre-authorisation and protocols
N - ORGAN TRANSPLANT	100% Cost	PMB only Subject to pre-authorisation and protocols

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
O - PSYCHIATRY AND PSYCHOLOGY		
1. Clinical psychologists and Psychiatrists	100% SR	MSA
P – RADIOLOGY OUT OF HOSPITAL		
1. Basic x-rays	100% SR	MSA
2. Specialised radiology incl. MRI, CT Scans	100% SR	Limited to R24,560 per year in or out of hospital. Subject to pre-authorisation.
3. Radiographer	100% SR	Limited to R1,510 per year.
4. Maternity scans	100% SR	2 2D scans per pregnancy.
R – PATHOLOGY OUT OF HOSPITAL		
1. Pathology and Histology	100% SR	MSA
S - AUXILLIARY SERVICES OUT OF HOSPITAL		
1. Physiotherapy	100% SR	MSA
2. Chiropractor	100% SR	MSA
3. Biokineticist	100% SR	MSA
4. Dietician	100% SR	MSA
5. Occupational therapist	100% SR	MSA
6. Speech therapist	100% SR	MSA
7. Audiologist	100% SR	MSA
8. Chiropodist	100% SR	MSA
9. Homeopath	100% SR	MSA
10. Naturopath	100% SR	MSA
11. Osteopath	100% SR	MSA
12. Podiatrist	100% SR	MSA
13. Orthoptist	100% SR	MSA
14. Optometry	100% SR	R2,500 paid from insured benefits. Thereafter paid from MSA.
16. Excimer laser	100% SR	MSA Subject to pre-authorisation and protocols.
T. WELLNESS BENEFITS **T1. MEN'S WELLNESS PACKAGE** For all male beneficiaries 18 years and older, unless otherwise stated. 1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year..

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
2. **Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis)	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
7. **Colon cancer screening** **For male beneficiaries ages 45 to 75:** 7.1 One faecal occult test per annum 7.2 Colonoscopy	 200% SR 200% SR	 One per year. One every ten years in an outpatient setting, subject to clinical protocols and pre-authorisation.
8. **Cardiovascular screening:** **For male beneficiaries 35 years and older:** 8.1 Lipogram	 200% SR	 One per year.
9. **Smoking/vaping cessation program.**	100% SR	One per lifetime at a DSP.
T2. WOMEN'S WELLNESS PACKAGE For all female beneficiaries 18 years and older, unless otherwise stated.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis)	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
7. **Cervical and breast cancer screening**: 7.1 Pelvic exam and breast exam by a gynaecologist, GP or nurse. 7.2 Pap test. 7.3 HPV test.	 200% SR 200% SR 200% SR	 One per year. One per year. One per year.
8**. Breast cancer screening**: **For female beneficiaries ages 40 to 70:** 8.1 Mammogram	 200% SR	 One every two years.
9. Colon cancer screening: **For female beneficiaries ages 45 to 75:** 9.1 One faecal occult test per annum	 200% SR	 One per year.

SERVICE	% BENEFIT	SUB LIMITS APPLICABLE TO NON-PMB's
9.2 Colonoscopy	200% SR	One every ten years in an outpatient setting, subject to clinical protocols and pre-authorisation.
10. Cardiovascular screening: **For female beneficiaries 35 years and older:** 10.1 Lipogram	200% SR	One per year.
11. Smoking/vaping cessation program.	100% SR	One per lifetime at a DSP.
T3. TEEN'S WELLNESS PACKAGE For all beneficiaries ages 13 to 17 years old.		
1. **Wellness check** – Basic screening and general check up consisting of: blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), by a GP, nurse or at a pharmacy.	200% SR	One per year.
2**. Visual screening** – visual screening check or eye exam by an optometrist.	200% SR	One every two years.
3. **Dental check up** at a dentist.	200% SR	One per year.
4**. Mental health screening**.	100% SR	Unlimited via the WCMAS Mental Wellbeing App.
5. **Sexual health screening** comprising STI counselling and testing for HIV, syphilis and chlamydia.	200% SR	One per year.
6. PrEP (pre-exposure prophylaxis).	100% SEP 200% SR	Oral PrEP medication, subject to protocols and formularies. Five HIV tests per year.
T4 – OTHER WELLNESS BENEFITS		
1. Back Treatment Program (DBC)	100% SR	MSA Subject to pre-auth, protocols and DSP
2. Contraceptives	100% SEP	MSA
3. Prostate Specific Antigen (PSA) Test	100% SR	1 every 2 years males ages 45 to 75
4. Flu vaccine	100% SEP	-
U. WELLNESS REWARD FUND Additional benefit for out of hospital healthcare services. The accumulation of healthcare benefits based on submitting a valid claim during the current benefit year for an item which falls within the wellness packages listed in T1 to T3**.**	100% SR	. Accumulates at an amount of R250 per event limited to: - R1,500 per adult per year. - R1,000 per child per year; and - Limited to R2,500 per family per year. Subject to the protocols.
V - MEDICAL SAVINGS ACCOUNT (MSA)		Limited to a maximum of 24% of a member's annual contribution
W. EX-GRATIA PAYMENTS	-	In special circumstances where financial hardship is evident, the Board of Trustees may consider ex-gratia payments.

LEGEND:	% benefit =	Reimbursement rate
	ADL =	Additional Disease List – refer to Annexure J to the Scheme Rules
	CDL =	Chronic Disease List – refer to Annexure E to the Scheme Rules
	DSP =	Designated Service Provider
	MSA =	Medical Savings account
	NDoH =	National Department of Health
	OTC =	Over the Counter
	PMB =	Prescribed Minimum Benefits
	PPO =	Preferred Pharmacy Network Provider
	SEP =	Single Exit Price
	SR =	Scheme Rate
	TTO =	To take out i.e. medicines taken out of hospital when discharged

ANNEXURE J: ADDITIONAL DISEASE LIST ("ADL")

Diagnosis
Acne
Attention Deficit Hyperactivity Disorder
Eczema