COUNCIL FOR MEDICAL SCHEMES

MODEL RULES FOR MEDICAL SCHEMES REGISTERED UNDER THE MEDICAL SCHEMES ACT, 1998 (ACT NO. 131 OF 1998)

TABLE OF CONTENTS

MODEL RULES

1. NAME {Sec 23}

The name of the Scheme is ....., hereinafter referred to as the "Scheme".

The abbreviated name is ..... *(if applicable*)

2. LEGAL PERSONA {Sec 26}

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 {Sec 26(10)}

The registered office of the Scheme is situated at *(...physical address in the Republic.....)*, but the Board may transfer such office to any other location in 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 in the singular number includes the plural, and *vice versa*; and
(b) 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 "Approval"

prior written approval of the Board or its authorised representative.

4.3 "Auditor"

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

4.4 "Beneficiary"

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

4.5 "Board"

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

4.6 "Child" {Sec 1: Definition of dependant; Sec 28 }

a member's natural child, or a stepchild or legally adopted child or a child in the process of being legally adopted or a child in the process of being placed in foster care, or a child for whom the member has a duty of support or a child who has been placed in the custody of the member or his/her spouse or partner and who is not a beneficiary of any other medical scheme.

4.7 "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.

4.8 "Continuation member"

a member who retains his/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.

4.9 "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.

4.10 "Contribution"

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

4.11 "Council"

the Council for Medical Schemes as contemplated in the Act.

4.12 "Cost"

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

4.13 "Creditable coverage"

any period during which a late joiner was —

4.13.1 a member or a dependant of a medical scheme;

4.13.2 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;

4.13.3 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

4.13.4 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.

4.14 "Dependant" {Sec 1(1); Sec 28 of the Act and Sec 1 of the Regulations}

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

4.14.2 a dependent child;

4.14.3 the immediate family of a member in respect of whom the member is liable for family care and support;

4.14.4 any other person who is recognised by the Board as a dependant for purposes of these Rules.

4.15 "Dependent"

in relation to a dependant other than the member's spouse or partner, a dependant who is not in receipt of a regular remuneration of more than the maximum social pension per month or a child who, due to a mental or physical disability, is dependent upon the member. {Note: *a scheme may specify an amount greater than the maximum social pension*}

4.16 "Designated service provider"

A healthcare provider or group of providers selected by the scheme as preferred provider/s to provide to the members, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions. (Reg 7)

4.17 "Domicilium citandi et executandi"

the member's chosen physical address at which notices in terms of rules 11 and 13 as well as legal process, or any action arising therefrom, may be validly delivered and served.

4.18 "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. (Reg 7)

4.19 "Employee"

a person in the employment of an employer.

4.20 **"Employer"** …… {*name the employer and associated employers, if any, in the case of a restricted membership scheme*}

a participating employer who has contracted with the Scheme for purposes of admission of its employees as members of the Scheme. (*in the case of any other scheme*);

4.21 "General waiting period"

a period during which a beneficiary is not entitled to claim any benefits.

4.22 "Income"

for the purposes of calculating contributions in respect of —

4.22.1 an individual member - gross monthly earnings;

4.22.2 a member who registers a spouse or partner as a dependant — the higher of the member or spouse's or partner's earnings;

4.23 "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. (Reg 11)

4.24 "Member"

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

4.25 "Member family"

the member and all the registered dependants.

4.26 "National Health Reference Price List (NHRPL)"

the reference price list for health services published by the Council for Medical Schemes

4.27 "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.

4.28 "Prescribed minimum benefits" (Reg 7).

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.

4.29 "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. (Reg 7)

4.30 "Registrar"

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

4.31 "Social pension"

the appropriate maximum basic social pension prescribed by the Social Pensions Act, 1992 (Act No. 59 of 1992).

4.32 "Spouse"

the person to whom the member is married in terms of any law or custom.

5. OBJECTS {Definition: *"business of a medical scheme"* }

The objects of the Scheme are to:

(a) undertake liability, in respect of its members and their dependants, in return for a contribution or premium;

(b) make provision for the obtaining of any relevant health service;

(c) grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/ or

(d) 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 is open to any person or group of persons.

{NOTE: In the case of a restricted membership scheme, use the following wording}:

Subject to rule 8, membership of the Scheme is restricted to:

- ♦ employment or former employment of the member by the employer or his/her predecessor or successor in title as defined in these rules, and is either voluntary or compulsory, depending on the employee's conditions of employment.

6.2 Retirees {Sec 29(1)(s)}

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

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

6.3 Dependants of deceased members {Sec 29(1)(t) }

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

6.3.2 The Scheme shall inform the dependant of his/her right to membership and of the contributions payable in respect thereof. Unless such person informs the Board in writing of his/her intention not to become a member, he/she shall be admitted as a member of the Scheme.

6.3.3 Such a member's membership terminates if he/she becomes a member or a dependant of a member of another medical scheme.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

{Sec 28; Def. *"dependant"*}

7.1 Registration of dependants

7.1.1 A member may apply for the registration of his/her dependants at the time that he/she applies for membership in terms of Rule 8.

7.1.2 If a member applies to register a new born or newly adopted child as a dependant, within 30 days of the date of birth or adoption of the child, increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption.

7.2 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/her dependants no longer satisfying the conditions in terms of which he/she may be a dependant.

7.2.2 When a dependant ceases to be eligible to be a dependant, he/she 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 {Sec 29(1)(n)}

8.1 A minor may become a member with the consent of his/her parent or guardian. {Sec 30(1)(f)}

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;

8.2.3 claim or accept benefits in respect of himself or any of his/her dependants from any medical scheme in relation to which he/she is not a member. {Sec 28}

8.3 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/her 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 relation to 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. {Sec 29A(7) and reg 12}

8.4 Waiting periods

8.4.1 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—

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

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

8.4.2 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—

8.4.2.1 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;

8.4.2.2 in respect of any person contemplated in this subrule, 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.

8.4.3 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. {Sec 29A}

8.5 No waiting periods may be imposed on:

8.5.1 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-

8.5.1.1. change of employment; or

8.5.1.2. 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.

8.5.2 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;

8.5.3 a child dependant born during the period of membership; (Section 29 A)

8.6 The registered dependants of a member must participate in the same benefit option as the member.

8.7 Every member will, 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 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. {Sec 30(2) and 32}

8.8 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/she may have against the Scheme.

The Scheme may withhold, suspend or discontinue the payment of any benefit, or any right in respect of such benefit under these rules, if a member assigns, transfers, cedes, pledges or hypothecates such benefit. {Sec 34}

9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

{Sec 29(1)(u) }

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/her 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 {Reg 3}

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/her registered dependants, with the knowledge or consent of the member or his/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, within 30 days of such termination, 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 A member of a scheme (other than a restricted membership scheme) who resigns from the service of his/her employer shall, on the date of such termination, be eligible to continue as an individual member without re-applying or the imposition of any new restrictions that did not exist at the time of his/her resignation.

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

{Voluntary membership – The scheme may stipulate a notice period which may not exceed 3 months}

12.2.1 A member may terminate his/her membership of the Scheme on giving ……. months written notice. All rights to benefits cease after the last day of membership.

12.2.2 Such notice period shall be waived in substantiated cases where membership of another medical scheme is compulsory as a result of a condition of employment.

12.2.3 A participating employer may terminate its participation with the Scheme on giving …… months written notice.

12.3 Death

Membership of a member terminates on his/her death.

12.4 Failure to pay amounts due to the Scheme

If a member fails to pay amounts due to the Scheme, his/her membership may be terminated as provided in these rules. {Sec 29 (2)(b) }

12.5 Abuse of privileges, False claims, Misrepresentation and Non-disclosure of Factual information

{Sec 29 (2) and 66}

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

13. CONTRIBUTIONS {It is important that an Annexure, to be attached by each medical scheme, clearly determines the basis as contemplated in Sec 29(1)(n)}

13.1 The total monthly contributions payable to the Scheme by or in respect of a member are as stipulated in Annexure A**.** It shall be the responsibility of the member to notify the Scheme of changes in income that may necessitate a change in contribution in terms of Annexure A hereto.

13.2 Contributions shall be due monthly in advance and be payable by 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. {Sec 26(7)}

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 the 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**.**

13.4 Unless specifically provided for in the rules in respect of savings accounts, no refund of any assets of the Scheme or any portion of a contribution shall be paid to any person where such member's membership or cover in respect of any dependant terminates during the course of a month. {Sec 26(2) & (9) }

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 to the scheme 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 to the Scheme.

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 {Reg 5 and 6}

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 as prescribed.

15.2 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.

15.3 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.

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

15.5 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.

15.6 If the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the relevant health care provider, within 30 days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and provider the opportunity to resubmit such corrected account or statement to the Scheme within sixty days following the date from which it was returned for correction. (Reg 6 (2) and (3)

16. BENEFITS {An Annexure, styled annexure B, which sets out the benefits offered by the scheme must be attached. Benefits offered in terms of different benefit options must be contained in separately identifiable Annexures B., e.g. Annexures B1, B2, B3 etc, (Section 29(1)(q) of the Act) – See examples in Annexure B to these Model Rules.}

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the member to his/her registered dependants. A member must, on admission, elect to participate in any one of the available options, detailed in Annexure B.

16.2 A member is entitled to change from one to another benefit option subject to the following conditions:

16.2.1 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.

16.2.2 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. {Regulation 4(3)}

16.3 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. {Sec 59(2)}

16.4 Any benefit option in Annexure B covers the cost of services rendered in respect of the prescribed minimum benefits, in accordance with appendix 2.

16.5 No limitations or exclusions will be applied to the prescribed minimum benefits.

16.6 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:

16.6.1 All costs for operations, medicines, treatment and procedures for cosmetic purposes.

16.6.2 Holidays for recuperative purposes.

16.6.3 Purchase of the following unless prescribed:

- Medicines not registered with the Medicines Control Council;
- toiletries and beauty preparations;
- slimming products;
- homemade remedies; and
- alternative medicines.

16.6.4 All costs that are more than the annual maximum benefit to which a beneficiary is entitled in terms of the rules of the Scheme.

16.6.5 Charges for appointments which a beneficiary fails to keep.

16.6.6 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.

16.7 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.

16.8 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 or reimbursement of claims is restricted to the net amount payable in respect of such benefit and maximum amount of the benefit to which the member is entitled in terms of the applicable benefit.

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, pay the benefit to which the member is entitled, directly to the supplier (or group of suppliers) 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.

18. GOVERNANCE {Sec 29(1)(a); Sec 57}

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

{The following 2 clauses must be used when registering a new scheme.}

18.2 A steering committee of …… persons, duly appointed by {..... *the applicant*}, must deal with all matters relating to the registration of the Scheme. For that purpose, they are authorised to sign and execute all documents and to perform the duties of the Board in accordance with these rules until the election of the Board at the first general meeting of members.

18.3 All contracts entered into and actions performed by the steering committee of the Scheme are subject to subsequent ratification by the Board.

18.4 All trustees shall be elected by the members of the scheme provided that at least 50% of the trustees shall be members of the scheme.

18.5 Trustees serve terms of office of three years.

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; (Sec 57(3))

18.6.3 a broker; {Sec 57(3)}

18.6.4 the principal officer of the Scheme; and

18.6.5 the auditor of the Scheme.

18.7 Retiring members of the Board are eligible for re-election provided no person shall serve more than two consecutive terms and no more than a total of three terms.

18.8 The Board may fill by appointment, any vacancy arising during the term of office of a member of the Board due to such member resigning in terms of rule 18.15 or ceasing to hold office in terms of rule 18.16. A person so appointed must retire at the first ensuing annual general meeting and that meeting may fill the vacancy for the unexpired period of office of the vacating member of the Board.

18.9 Nominations to fill vacancies, signed by a proposer and seconder in good standing with the Scheme, must be signed by the candidate signifying his/her consent to stand for election and must be submitted to the Scheme together with a current curriculum vitae by 31 March of the year concerned and the election must be carried out by the members present at the annual general meeting of the Scheme.

18.10 The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.

18.11 A quorum is constituted by a number of members of the Board physically present at a meeting of that Board, which number shall be not less than half of the members of the Board plus one. Members of the Board will, for the purposes of constituting a quorum, not include suspended Board members.

18.12 The Board must elect from its number the chairperson and vice-chairperson.

18.13 In the absence of the chairperson and vice-chairperson, the Board members present must elect one of their numbers to preside.

18.14 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson has a casting vote in addition to his/her deliberative vote.

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

18.16 A member of the Board ceases to hold office if —

18.16.1 he becomes mentally ill or incapable of managing his/her affairs;

18.16.2 he/she is declared insolvent or has surrendered his/her estate for the benefit of his/her creditors;

18.16.3 he/she is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;

18.16.4 he/she is removed by the court from any office of trust on account of misconduct;

18.16.5 he/she is disqualified under any law from carrying on his/her profession;

18.16.6 he/she ceases to be an appointee by a participating employer, or being a Board member elected by members of the Scheme, he/she ceases to be a member of the Scheme;

18.16.7 he/she absents himself from three consecutive meetings of the Board without the permission of the Chairperson;

18.16.8 he/she is removed from office by the Council in terms of Section 46 of the Act; or

18.16.9 he/she is removed from office in terms of rule 18.22.

18.17 The Board must meet at least once every two months or at such intervals as it may deem necessary.

18.18 The chairperson may convene a special meeting should the necessity arise. Any (*scheme to insert number, which should not be less than two)* 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.

18.19 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.

18.20 Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as trustees. Such reimbursement must be disclosed to the members in the Annual General Meeting.

18.21 An honorarium as may from time to time be determined at the annual general meeting may be paid to members of the Board. {Sec 29(1)(c)}

alternative

members of the Board are not entitled to any remuneration, honorarium or any other fee in respect of services rendered in their capacity as members of the Board.

alternative

members of the Board may be remunerated as determined from time to time at the annual general meeting. All remuneration must be disclosed by the Board to members at the Annual General Meeting.

18.22 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 –

18.22.1 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;

18.22.2 the resolution to remove that member is taken by at least two thirds of the members of the Board;

18.22.3 the member shall have recourse to disputes procedures of the scheme or complaints and appeal procedures provided for in the Act.

19. DUTIES OF BOARD OF TRUSTEES {Sec 57(4)}

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

19.2 The Board must act with due care, diligence, skill and in good faith. {Sec 57(6)(b)}

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. {Sec 57 (6)(c)}

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

19.5 The Board must 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; {Sec 57(4)(a)}

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. {Sec 26(9) & 57(4)(b)}

19.8 The Board must ensure that proper control systems are employed by and on behalf of the scheme. {Sec 57(4)(c)}.

19.9 The Board must ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the Rules. {Sec 57(4)(d)}

19.10 The Board must take all reasonable steps to ensure that contributions are paid timeously to the scheme in accordance with the Act and the Rules. {Sec 57(4)(e)}

19.11 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance. {Sec 57(4)(f)}.

19.12 The Board may 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. {Sec 57(4)(g)}.

19.13 The Board must ensure that the Rules and the operation and administration of the scheme comply with the provisions of the Act and all other applicable laws. {Sec 57(4)(h)}

19.14 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any beneficiary's state of health. {Sec 57(4)(l)}

19.15 The Board must approve all disbursements.

19.16 The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme. {Sec 29(1)(e)}

19.17 The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.

19.18 The Board must disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme as prescribed. {Sec 57(8) and Reg 6A}

20. POWERS OF BOARD {Sec 29(1)(b) & (c)}

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 fulfillment 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 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; {Sec 58 & 67 (1)(j); Chapter 6 of 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 the Regulations thereto provided that a broker contract with an accredited broker will not be unreasonable withheld; {Sec 65 (1); Chapter 7 of the regulations}

20.6 to appoint, contract with and compensate any accredited managed health care organisation in the prescribed manner;

20.7 to purchase movable and immovable property for the use of the Scheme {Sec 26(1)(a)};

20.8 to let or hire movable or immovable property;

20.9 to sell movable and immovable property of the Scheme subject to sound business practice and fair value principles ;

20.10 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; {Sec 29(1)(g) ; Annexure B of the regulations}

20.11 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; {Sec 35 (6)}

20.12 subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the members of the Scheme;

20.13 to donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the beneficiaries;
{Sec 30(1)(a)}

20.14 to grant repayable loans to members or to make *ex gratia* payments on behalf of members in order to assist such members to meet commitments in regard to any matter specified in Rule 5; {Sec 30(1)(b)}

20.15 to contribute to any fund conducted for the benefit of employees of the Scheme; {Sec 30(1)(d)}

20.16 to reinsure obligations in terms of the benefits provided for in these rules in the prescribed manner; {Sec 20(2)-(7) }

20.17 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; {Sec 26(1)(a) and 29 (1)(d) & 57(4)(a)}

20.18 to contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes; {Sec 30(1)(c)}

20.19 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 {Sec 29(1)(b)}

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 keeps the Board sufficiently and timeously informed of the affairs of the Scheme concerning any matter relating to the duties of the Board as stated in section 57(4) of the Act;

21.2.5 he/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 does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he/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/her duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the

Board, and any other duly appointed committee where his/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 The principal officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

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

21.8.1 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.

21.8.2 A broker. {Sec 57(7)}

21.9 The provisions of rules 18.16.1 – 18.16.5 apply *mutatis mutandis* to the principal officer.

22. INDEMNIFICATION & FIDELITY GUARANTEE {Sec 57(4)(f)}

22.1 The Board and any officer of the Scheme is indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim against/by 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.

23. FINANCIAL YEAR OF THE SCHEME {Sec 1(1) Definition: *"Financial Year"*}

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

24. BANK ACCOUNT {Sec 26 (1)(c)} and (Reg 23(3)

The Scheme must establish and maintain a bank account in the name of the Scheme and under its direct control with a registered commercial bank. All moneys received must be deposited directly to the credit of such account. 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 & AUDIT COMMITTEE {Sec 29(1)(f); Sec 36}

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. {Sec 36(3)}

25.3 Whenever for any reason an auditor vacates his/her office prior to the expiration of the period for which he/she 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 has a right of access to the books, records, accounts, documents and other effects of the Scheme at all times and is entitled to require from the Board and the officers of the Scheme such information and explanations as he deems necessary for the performance of his/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 in the prescribed manner.

26. GENERAL MEETINGS {Sec 29(1)(m); Only members of the Scheme may constitute a quorum and vote at such meetings}

26.1 Annual general meeting

26.1.1 The annual general meeting of members must be held not later than 30 June of each year on a date which may be shown to permit reasonable attendance by members.

26.1.2 The notice convening the annual general meeting, containing the agenda, the annual financial statements, auditor's report and annual report, must be furnished to members at least 21 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such meeting provided that the notice procedure followed by the Board was reasonable.

26.1.3 At least __% of members of the Scheme present in person constitute a quorum. If a quorum is not present after a 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.

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

26.1.5 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 {Sec 29 (1)(m) }

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 … 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 objects 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 objects of the meeting may be discussed.

26.2.3 The notice convening the special general meeting, containing the agenda, 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.

26.2.4 At least … members present in person constitute a quorum. If a quorum is not present at a special general meeting after a lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled.

27. VOTING AT MEETINGS {Sec 29(1)(m) }

27.1 Every member who is present at a general meeting of the Scheme 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/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.

27.3 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/her deliberative vote.

28. COMPLAINTS AND DISPUTES { Sec 29(1)(j); Sec 48 }

28.1 Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators 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 will 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 or officers of the Scheme or the administrator, must be appointed by the Board to serve a term of office of …. years. 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, must 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 Council and shall be furnished to 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 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. (Sec 48 (2))

29. DISSOLUTION {Sec 53; Sec 29(1)(h)}

29.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution**.** {Sec 64; Sec 29 (1)(i) }

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. {Sec 64}

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/her ballot paper duly completed before a set date. If at least 50 per cent 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, subject to the approval of the Registrar, a competent person as liquidator.

30. AMALGAMATION AND TRANSFER OF BUSINESS {Sec 63}

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. The Board must arrange for members to be furnished with an exposition of the proposed transaction for consideration and to decide by ballot whether the proposed transaction should be proceeded with or not.

30.2 If at least 50% of the members return their ballot papers duly completed and if the majority thereof is in favour of the amalgamation or the transfer, the transaction may be concluded in the prescribed manner.

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

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS {Sec 41}

31.1 Any beneficiary must on request and on payment of a fee of RX per copy, 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 accompanying management accounts in respect of it's 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 rights in terms of the Promotion of Access to Information Act, Act No 2 of 2000.

32. AMENDMENT OF RULES {Sec 31; Sec 20(1)(k) and (l) }

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

32.2 No amendment, rescission or addition which affects the objects of the Scheme or which increases the rates of contribution or decreases the extent of benefits of any particular benefit option by more than the National Treasury projection of CPIX plus 3% in respect of any financial year, is valid unless it has been approved by a majority of members present in a general meeting or by ballot.

32.3 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 shall be given 30 days advance notice of such change.

32.4 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.

32.5 No amendment, rescission or addition of any rule shall be valid unless it has been approved and registered by the Registrar.

ANNEXURE A

CONTRIBUTIONS AND LATE JOINER PENALTIES

(Contributions in terms of rule 13 must be indicated. See section 29(1)(n) of the Act)

1. Example:

Member	Rx
Adult dependant	Rx
Child dependant	Rx

(An income grid plus number of dependants may also be utilised.)

2. Premium penalties for persons joining late in life. (Reg 13)

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. (Reg 13 (4))

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. (Reg 13 (6))

ANNEXURE B

(Benefit schedules and options must be indicated by the medical scheme concerned. See section 29(1) q of the Act)

ANNEXURE B

EXAMPLE 1 - COMPREHENSIVE PACKAGE

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER APPENDIX 2	100% of cost	No limit	Services rendered by Public Hospitals **And/or designated service providers.**
			Overall annual limit M R..... M+ R.....	Limits are prorated calculated from the date of admission to the end of the financial year.
B.	PRIVATE & PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES and DAY CLINICS: 1. Accommodation in a general ward, high care ward and intensive care unit. 2. Theatre fees. 3. Medicines, materials and hospital equipment. 4. Visits by medical practitioners. 5. Outpatient services. 6. Confinement and midwives.	100%	Overall Annual Limit.	1 Authorisation shall be obtained from the scheme/scheme's designated agent before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R..... per admission shall apply. 2 In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. 3 Accommodation in a private ward is subject to certification by the attending practitioner as essential for the recovery of the patient.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
C.	SURGICAL PROCEDURES INCLUDING MAXILLO FACIAL SURGERY	100%	Overall Annual Limit.	Excludes Osseo-integrated implants (see General paragraph 5.)
D.	SPECIALIST SERVICES: 1. Consultations and visits (out of hospital) 2 All other services unless stated otherwise in this annexure.	100%	..... Consultations PB *or* R ..... PMF	To be recommended by a general practitioner with the exception of services by an ophthalmologist or gynecologist.
E.	GENERAL PRACTITIONER SERVICES: 1. Consultations and visits (out of hospital). 2. All other services unless stated otherwise in this annexure.	100%	..... consultations PB or R ..... PMF	
F.	CLINICAL TECHNOLOGISTS	100%	Overall Annual Limit.	
	SERVICE	**% BENEFIT**	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
G.	DENTAL SERVICES 1. Conservative and Restorative dentistry (includes plastic dentures). 2. Special dentistry (Including metal base dentures)	100% 100%	M R ..... M+ R ..... M R ..... M+ R	1 Dentures shall be limited to one set PB per two consecutive financial year period. All orthodontic services are subject to prior approval by the Board. 2. General anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of seven years and impacted 3rd molars.
H.	**PRESCRIBED MEDICINE AND INJECTION MATERIAL:** 1. Acute sickness conditions. 2. Pharmacy advised therapy.(PAT) 3. Chronic sickness conditions.	100% Levy 100% 100%	M R ..... M+ R ..... R..... per prescription M R ..... M+ R ..... R ..... PBPA	1. Prescribed by a person legally entitled to prescribe. Includes medicines given to a patient to take home (TTO). 2. Subject to prior application and approval by the Board. Only authorised medication for the treatment of approved chronic illness.

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	RADIOLOGY 1. X-Rays 2. Scopes – Diagnostic 3. Scans - MRI and CAT 4. Scans - Ultra Sound 5. Angiography	100%	Overall Annual Limit *Maximum ..... scans per pregnancy*	1. MRI and CAT Scans must be authorised by or on behalf of the scheme except in emergencies failing which a co payment of R..... per procedure shall apply. In the event of an emergency the Scheme shall be notified on the first working day following the procedure.
J.	PATHOLOGY and MEDICAL TECHNOLOGY	100%	Overall Annual Limit	
K.	CHEMOTHERAPY, RADIOTHERAPY, ORGAN TRANSPLANTS and KIDNEY DIALYSIS	100%	Overall Annual Limit	Subject to prior approval by the Board
L.	PSYCHOLOGICAL and PSYCHIATRIC TREATMENT	100%	R ..... PMF	All services included in limit.
M.	PHYSIOTHERAPY	100%	..... Treatments PB or R ..... PMF	To be recommended by a medical practitioner
	SERVICE	**% BENEFIT**	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
N.	BLOOD TRANSFUSIONS	100%	Overall Annual Limit	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
O.	AMBULANCE SERVICES (Road and Air)	100%	Scheme's preferred provider – none Other providers R..... PMF	Such transport is to be certified by a medical practitioner as being essential.
P.	ALTERNATIVES TO HOSPITALISATION: 1. Registered Frail Care Facilities 2. Step-down Nursing Facilities 3. Private Nursing 4. Hospice	100 %	Combined Limit R ..... PMF	Subject to the approval by the Board.

Q.	ALLIED HEALTH SERVICES 1. Audiology 2. Occupational therapy 3. Speech therapy 4. Chiropody/ Podiatry 5. Dieticians 6, Homeopaths 7. Naturopaths 8. Chiropractors 9. Orthoptists 10. Reflexologist 11. Acupuncturist 12. Ayurvedic Practitioner 13. Osteopath 14. Phytotherapist 15. Aromatherapist 16. Therapeutic Massage Therapist 17. Chinese Medicine	100%	Combined Limit M R ..... M+ R	
	SERVICE	**% BENEFIT**	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
R.	PROSTHESES Internal and External	100%	Combined Limit R ..... PMF	
S.	MEDICAL and SURGICAL APPLIANCES: 1. Hearing Aids 2. Wheelchairs 3. Oxygen, cylinders 4. Nebulisers/ Glucometers 5. Colostomy kits; and 6. Diabetic equipment	100%	Combined Limit R ..... PMF	Subject to the approval by the Board.
T.	OPTICAL SERVICES 1. Frames, Lenses, contact lenses and disposable contact lenses 2. Eye examinations 3. Refractive surgery	 100% 100% 100%	 R..... PB R ..... PMF	 3. All services included in limit.

	GENERAL	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
1.	ACQUIRED IMMUNE DEFICIENCY SYNDROME and RELATED ILLNESS	Benefits payable in terms of the relevant paragraphs above	R ..... PMF	All services included in limit
2.	ALCOHOLISM AND DRUG DEPENDANCY	Benefits payable in terms of the relevant paragraphs above	R ..... PMF	All services included in limit
3.	INFERTILITY	Benefits payable in terms of the relevant paragraphs above	R ..... PMF	All services included in limit Benefit in respect of Investigation and Treatment only.
4.	COCHLEAR IMPLANTS	Benefits payable in terms of the relevant paragraphs above	R ..... PMF	All services included in limit
5.	OSSEO-INTEGRATED IMPLANTS	Benefits payable in terms of the relevant paragraphs above	R ..... PMF	All services included in limit

Legend:

% Benefit	=	NHRPL /contracted fee/cost (whichever is applicable)
PB	=	Per Beneficiary
PMF	=	Per Member Family
M	=	Single Member
M+	=	Member with dependants.

EXAMPLE 2

SERVICE	M.H.C. % BENEFIT	SUB LIMIT
A. STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER APPENDIX 2	100% of cost	Services rendered by Public Hospitals and/or designated service providers no limit.
B. GENERAL PRACTITIONER SERVICES		
1. Consultative	100%	PMSA
2. Non-Surgical Treatments	100%	PMSA
3. Surgical Procedures	100%	
4. Anaesthetics	100%	
C. SPECIALIST SERVICES		
1. Consultative	100%	PMSA
2. Non-surgical Treatments	100%	PMSA
3. Surgical Procedures	100%	
4. Pre-op Assessment	100%	
5. Anaesthetics	100%	
B&C		
1. Visits by medical practitioners in hospital	100%	
D. MEDICATION AND REMEDIES		
1. Chronic - for specified illness conditions, **see General**, **paragraph B**.	100%	R X P.B.P.A
2. Other		PMSA
E. DENTAL SERVICES		
1. Consultative	100%	PMSA
2. Surgical Procedures	100%	
3. Orthodontics	100%	RX P.B.P.A.
4. Non-Surgical Procedures	100%	RX P.B.P.A. RX P.M.P.A.
5. Dental Technicians Fees	100%	Included in D4
6. Dentures	100%	Included in D4 Limited to one set P.B.P.2
F. HOSPITALS		
***F1* PRIVATE**		
1. Ward Fees	100%	
2. Theatre Fees	100%	
3. Drugs, Material and Equipment	100%	
4. Out-Patient Fees	100%	PMSA
***F2* PROVINCIAL**		
5. Ward Fees	100%	
6. Theatre Fees	100%	
7. Drugs, Material and Equipment	100%	
8. Out-patient Fees	100%	PMSA
F3 DAY CLINICS		
9. Ward Fees	100%	
10. Theatre Fees	100%	
11. Drugs, Material and Equipment	100%	

SERVICE	M.H.C. % BENEFIT	SUB LIMIT
F4 OTHER		
12. Fixed Fee Procedures	100%	
13. Prostheses		
a) Internal and Implantable	100%	RX P.M.P.A.
b) External	100%	Included in 13(a)
Dentures, Dental Implants and Prostheses specified elsewhere are excluded.		
G. RADIOLOGY		
1. X-Rays	100%	
2. Scopes – Diagnostic	100%	
3. Scans - MRI and CAT	100%	
4. Scans - Ultra Sound	100%	Maximum of X scans per pregnancy
H. PATHOLOGY	100%	
I. RADIOTHERAPY, CHEMOTHERAPY and KIDNEY DIALYSIS	100%	
J. OTHER		
1. Medical and Surgical Appliances		
a) Hearing Aids		
b) Diabetic equipment		
c) Orthoptics		Combined limit of
d) Nebulisers/ Glucometers	100%	RX P.B.P.A.
e) Oxygen Cylinders	100%	RX P.M.P.A.
f) Incontinence Equipment	100%	
2. Blood Transfusion	100%	
3. Psychiatric/ Psychology		
a) Consultation	100%	PMSA
b) Therapy	100%	RX P.M.P.A.
4. Speech Therapy		
a) Consultation	100%	PMSA
b) Therapy and treatment	100%	PMSA
5. Audiology		
a) Consultation	100%	PMSA
b) Assessment	100%	PMSA
6. Orthoptists	100%	PMSA
7. Ambulance		
a) Road and Air	100%	Limit RX P.M.P.A..
8. Chiropodist		
a) Consultation	100%	PMSA
b) Treatment	100%	PMSA
9. Occupational Therapy		
a) Consultation	100%	PMSA
b) Treatment and Therapy	100%	PMSA
10. Home Nursing	100%	Limit RX P.M.P.A. Board approval required
11. Clinical Services	100%	PMSA

SERVICE	M.H.C. % BENEFIT	SUB LIMIT
12. Optical Services a) Eye Test b) Optical Wear (Lenses and frames, including contact lenses)	 100%	 PMSA R X P.B.P.2
13. Clinical Technologists	100%	
14. Chiropractic and Osteopathic Services a) Consultation b) Treatment	 100% 100%	 PMSA PMSA
15. Homeopathic and Naturopathic Services	100%	PMSA
16. Physiotherapy	100%	Limited to maximum of X treatments P.B.P.A.
17. OVERALL Annual Limit **M** **M +**		 R X P.A. R X P.A.

Legend:

% Benefit	**=**	**NHRPL/contracted fee/cost (whichever is applicable)**	**P.M.P.A.** **PMSA**	**=**	**Per Member per annum** **Personal Member's Savings Account**
P.B.P.A.	**=**	**Per Beneficiary per annum**	**M.H.C.**	**=**	**Major Health Care**
M	**=**	**Member without dependants**	**P.B.P.2.**	**=**	**Per beneficiary per two**
M+	**=**	**Member with dependants**		**=**	**consecutive financial year**
P.A.	**=**	**Per Annum**			**Period**

APPENDIX I

PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA) (Reg 10)

1. On admission to the Scheme, a PMSA, held by the Scheme, shall be established in the name of the member concerned into which the contributions allocated by the Scheme in respect of the PMSA shall be credited and benefits in respect thereof, shall be debited.

2. The amount allocated to the PMSA by the Scheme for the benefit of the member may not exceed 25% of the total gross contributions in respect of the member during the financial year concerned.

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 PMSA in Annexure B, at 100% of the cost.

4. Funds allocated to the members PMSA shall be available for the exclusive benefit of the member and his/her dependants. Any credit balance in the PMSA at the end of a financial year accumulates for the benefit of the member**.**

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.

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 PMSA will be refunded to the member, not later than 4 months after such transfer and subject to applicable taxation laws.

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 PMSA, 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.

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.

9. The funds in the member's medical savings account may not be used to pay for the costs of a prescribed minimum benefit or to offset contributions.

10. On termination of membership, funds in the member's PMSA may be used to offset any debt owed by the member including outstanding contributions.

Appendix 2

Prescribed Minimum Benefits (PMB'S)

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 —

(c) the Diagnosis and Treatment Pairs listed in Annexure A of the regulations, subject to any limitations specified therein; and

(d) any emergency medical condition. (reg 7).

"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. (reg 7)

1. **Designation of service providers**

The medical scheme designates the following service provider(s) for the delivery of prescribed minimum benefits to its beneficiaries:[1]

a. _____
b. _____
c. _____

The above service provider(s) shall for the purposes of this Appendix be referred to as "designated service providers".

2. **Prescribed minimum benefits obtained from designated service providers**

100% of the cost in respect of diagnosis, treatment and care costs of prescribed minimum benefit conditions if those services are obtained from a designated service provider.

3. **Prescribed minimum benefits voluntarily obtained from other providers**

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to:

I. such benefit limitations as are normally applicable in terms of the relevant option chosen by the member.

alternative

[1] This may include public sector facilities, specific private providers or networks of private providers. Specific providers may be designated for specific types of service.

II. A co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the designated service provider been used.

4. **Prescribed minimum benefits involuntarily obtained from other providers**

a. If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the medical scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions.

b. For the purposes of paragraph a, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

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

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

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

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

5. **Medication**

a. Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of that medication if that medication is obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider, *and*

i. the medication is included on the applicable formulary in use by the Scheme; or

ii. the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.[2]

b. Where a prescribed minimum benefit includes medication, benefit limitations normally applicable in terms of the benefit option chosen by the member will apply if –

i. that medication is voluntarily obtained from a provider other than a designated service provider, or

ii. the formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead.

[2] This presumes the use of a formulary by the medical scheme. In the absence of a formulary, items (i) and (ii) would not be applicable.

Alternative

Where a prescribed minimum benefit includes medication and that medication is voluntary obtained from a provider other than a designated service provider, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will apply.

6. **Prescribed minimum benefits obtained from a public hospital**

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

7. **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.

8. **Co-payments**

Co- payments in respect of the costs for PMB's may not be paid out of medical savings accounts.

9. **Chronic conditions**

Any benefit option covers the full cost for services rendered in respect of the prescribed minimum benefits which includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions.

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	