



RAND WATER

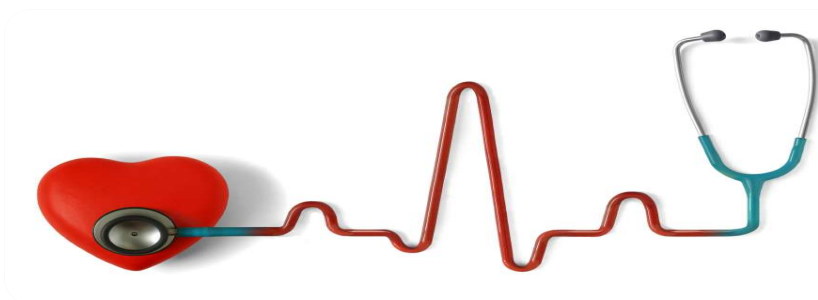
2022

Medical Scheme

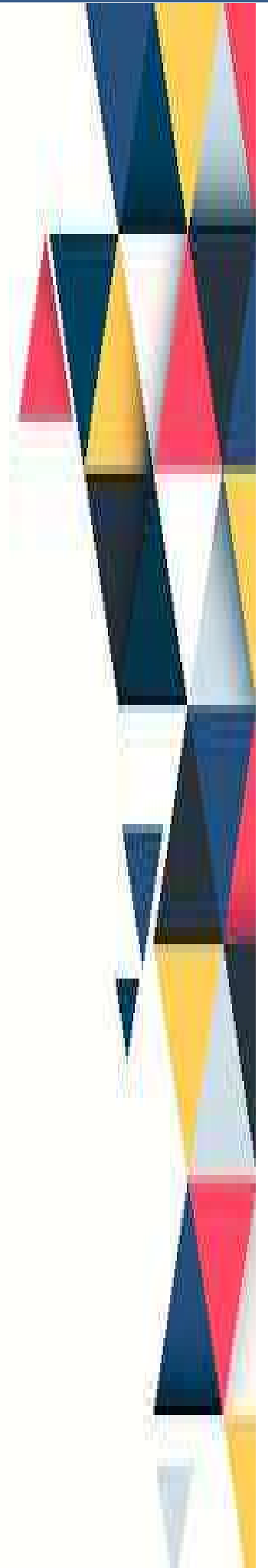
Benefit Brochure

And

Scheme Rules



Looking after you and your family



POPI ACT – Protection of Personal Information Act

The Rand Water Group (“the Group”) values your privacy and wants to be transparent on how your Personal Information will be processed when interacting with you. With this Privacy Notice, the Group informs you and provides you with an overview of how it will process your Personal Information and by doing so the Group is fulfilling its notification obligation in terms of the Protection of Personal Information Act 4 of 2013 (“POPI Act”).

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SUMMARY OF CONTRIBUTION INCREASE FOR 2022

The Trustees have adopted a change to the pricing philosophy applied historically. The pricing philosophy adopted for the 2022 benefit year is to break-even before investment income. The following contribution increases effective 1 January 2022 and was approved as such by the Council for Medical Schemes:

| | |
|---------------|------|
| Option A | 3.5% |
| Option B Plus | 0% |

- * **Please be advised the Contribution Increase, and Benefit Limit amendments has been approved by the Council of Medical Schemes.**
- * **The National Department of Health (NDoH), in collaboration with the National Institute for Communicable Diseases (NICD), World Health Organisation (WHO) has been providing the nation with guidance in respect of the management of the COVID-19 pandemic within the Republic of South Africa and across the world.**
The Minister of Health approved a submission from the Council for Medical Schemes (CMS) for the inclusion of COVID-19 as a Prescribed Minimum Benefit (PMB). As such, the Minister of Health, in terms of section 67 of the Medical Schemes Act, 1998 (Act No. 131 of 1998), published an amendment to the Medical Schemes Act Regulations in Notice 515 in Government Gazette 4329.

IMPORTANT INFORMATION

1. The Scheme does not cover medical expenses incurred outside the borders of South Africa
2. All hospital claims are paid subject to pre-authorisation and clinical protocols, out of hospital claims are paid subject to available benefits and confirmation.
3. The Scheme Website available for your convenience to track claims, view payments, download remittance advices or statement and membership confirmation, Tax Certificate etc. Kindly register by utilising the below web link.
<https://hosting.cumulusis.com/Randwater/home/login.asp>
4. We encourage you to share the content of this brochure with your family members who are members of the Scheme.

COVID-19 PROCESS – TESTING

Medication & Virtual Consultation

1. We encourage members to utilise any nearest Laboratory within SA. Should Drive Through services run by Pharmacies be used, the supporting information should be provided including but not limited to the following, all required information as per Legislated requirements to process the claim e.g., the correct tariff code/s for COVID-19 and Dr's practice number required.
2. Some Laboratories will request an Authorisation with before testing, while other Laboratories will not - the claim will be processed by the Scheme irrespective.
3. The prescription received from the Dr will be processed subject to available benefits with an ICD10 Code on the script.
4. No Pre-Authorisation is required for the prescription to dispense the medication, the Pharmacist will process the medication respectively.
5. A Script for COVID-19 medication is valid for 21 days (i.e., claim within 21 days of receipt from the DR)
6. If medication is completed with no improvement, kindly visit the DR, or consult virtually, the Scheme will pay for the Virtual Consultation for GP'S Specialists and Psychologists.
7. Scheme will cover two (2) Covid-19 tests. For 3 or more tests Medical Motivation will be required.

REGISTERED NURSES CLINIC ATTACHED TO PHARMACIES

We are excited to offer our members the option to receive adequate and appropriate treatment where it is most convenient

| NO | MEDICAL SERVICE DESCRIPTION |
|----|--|
| 1 | Immunisation (15MIN) |
| 2 | Administration of Injection |
| 3 | Administration of Vaccine |
| 4 | Pap Smear Including Breast Exam 30MIN |
| 05 | Minor Ailment Consult (0-15MIN) |
| 06 | Minor Ailment Consult 16-30MIN |
| 07 | Minor Ailment Consult (30MIN) |
| 08 | Well Baby Immunisation W Consult (30MIN) |
| 09 | Blood Pressure Test |
| 10 | Glucose Test with Consult 15MIN |
| 11 | Cholesterol Test and Cons 15MIN |
| 12 | Family Plan Consult Return 10MIN |
| 13 | Pregnancy Urine Test + Consultation (Inc C/O Test) |
| 14 | Urine Test 15MIN |
| 15 | NEBULISATION 15MIN |
| 16 | HIV Screening (Pre/Post Test) |
| 17 | Wound Care Simple/Dressing Only |
| 18 | Wellness Screening (GLUC/BP/BMI/CHOL) |
| 19 | Observation: Temp, Pulse, Respiratory |
| 20 | Prostate Test and Discussion |
| 21 | PCDT Pharmacist Consultation |
| 22 | Fixed Fee Minor Ailment |
| 23 | Fixed Fee Visit Referral |
| 24 | Doctor fee component for video-medicine enabled multidisciplinary intervention |
| 25 | Nurse fee component for video-medicine enabled multidisciplinary intervention |

What are the Medical Benefits for Registered Nurses?

- Convenience for Members and their Beneficiaries:
 - Trading hours
 - Only 1 place for consultation and medicine
 - Shorter waiting period
 - Both Nurse and Doctor consultation cost less than 1 GP consultation

Annual Medical Screening

- Full medical history; Clinical examination; Body mass index; Cholesterol (random); Glucose (random); Blood pressure; Temperature; Pulse; Oxygen saturation.

1. MEMBERSHIP CONTRIBUTIONS

Rand Water 2021 & 2021 Contributions Table Option A (Before Subsidy)

| Option A | Below R 8,100 | | R 8,101 to R 13,600 | | R 13,601 to R 19,400 | | R 19,401 to R 24,900 | | Above R 24,901 | |
|---------------------|---------------|-------|---------------------|-------|----------------------|-------|----------------------|-------|----------------|-------|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| Member | 2,844 | 2,943 | 3,315 | 3,432 | 3,762 | 3,894 | 4,242 | 4,389 | 4,527 | 4,686 |
| Per Adult Dependant | 1,842 | 1,905 | 2,157 | 2,232 | 2,448 | 2,535 | 2,766 | 2,862 | 2,937 | 3,039 |
| Per Child Dependant | 483 | 501 | 558 | 579 | 639 | 660 | 717 | 741 | 771 | 798 |

| Family Size | Below R 8,100 | | R 8,101 to R 13,600 | | R 13,601 to R 19,400 | | R 19,401 to R 24,600 | | Above R 24,601 | |
|------------------------------|---------------|--------|---------------------|--------|----------------------|--------|----------------------|--------|----------------|--------|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| Member | 2,844 | 2,943 | 3,315 | 3,432 | 3,762 | 3,894 | 4,242 | 4,389 | 4,527 | 4,686 |
| Member, Adult | 4,686 | 4,848 | 5,472 | 5,664 | 6,210 | 6,429 | 7,008 | 7,251 | 7,464 | 7,725 |
| Member, Adult, 1 Child | 5,169 | 5,349 | 6,030 | 6,243 | 6,849 | 7,089 | 7,725 | 7,992 | 8,235 | 8,523 |
| Member, Adult, 2 Children | 5,652 | 5,850 | 6,588 | 6,822 | 7,488 | 7,749 | 8,442 | 8,733 | 9,006 | 9,321 |
| Member, Adult, 3 Children | 6,135 | 6,351 | 7,146 | 7,401 | 8,127 | 8,409 | 9,159 | 9,474 | 9,777 | 10,119 |
| Member, Adult, 4 Children | 6,618 | 6,852 | 7,704 | 7,980 | 8,766 | 9,069 | 9,876 | 10,215 | 10,548 | 10,917 |
| Member, Adult, 5 Children | 7,101 | 7,353 | 8,262 | 8,559 | 9,405 | 9,729 | 10,593 | 10,956 | 11,319 | 11,715 |
| Member, 1 Child | 3,327 | 3,444 | 3,873 | 4,011 | 4,401 | 4,554 | 4,959 | 5,130 | 5,298 | 5,484 |
| Member, 2 Children | 3,810 | 3,945 | 4,431 | 4,590 | 5,040 | 5,214 | 5,676 | 5,871 | 6,069 | 6,282 |
| Member, 3 Children | 4,293 | 4,446 | 4,989 | 5,169 | 5,679 | 5,874 | 6,393 | 6,612 | 6,840 | 7,080 |
| Member, 4 Children | 4,776 | 4,947 | 5,547 | 5,748 | 6,318 | 6,534 | 7,110 | 7,353 | 7,611 | 7,878 |
| Member, 5 Children | 5,259 | 5,448 | 6,105 | 6,327 | 6,957 | 7,194 | 7,827 | 8,094 | 8,382 | 8,676 |
| Member, 2 Adults | 6,528 | 6,753 | 7,629 | 7,896 | 8,658 | 8,964 | 9,774 | 10,113 | 10,401 | 10,764 |
| Member, 3 Adults | 8,370 | 8,658 | 9,786 | 10,128 | 11,106 | 11,499 | 12,540 | 12,975 | 13,338 | 13,803 |
| Member, 2 Adults, 1 Child | 7,011 | 7,254 | 8,187 | 8,475 | 9,297 | 9,624 | 10,491 | 10,854 | 11,172 | 11,562 |
| Member, 2 Adults, 2 Children | 7,494 | 7,755 | 8,745 | 9,054 | 9,936 | 10,284 | 11,208 | 11,595 | 11,943 | 12,360 |
| Member, 2 Adults, 3 Children | 7,977 | 8,256 | 9,303 | 9,633 | 10,575 | 10,944 | 11,925 | 12,336 | 12,714 | 13,158 |
| Member, 2 Adults, 4 Children | 8,460 | 8,757 | 9,861 | 10,212 | 11,214 | 11,604 | 12,642 | 13,077 | 13,485 | 13,956 |
| Member, 2 Adults, 5 Children | 8,943 | 9,258 | 10,419 | 10,791 | 11,853 | 12,264 | 13,359 | 13,818 | 14,256 | 14,754 |
| Member, 3 Adults, 1 Child | 8,853 | 9,159 | 10,344 | 10,707 | 11,745 | 12,159 | 13,257 | 13,716 | 14,109 | 14,601 |
| Member, 3 Adults, 2 Children | 9,336 | 9,660 | 10,902 | 11,286 | 12,384 | 12,819 | 13,974 | 14,457 | 14,880 | 15,399 |
| Member, 3 Adults, 3 Children | 9,819 | 10,161 | 11,460 | 11,865 | 13,023 | 13,479 | 14,691 | 15,198 | 15,651 | 16,197 |
| Member, 3 Adults, 4 Children | 10,302 | 10,662 | 12,018 | 12,444 | 13,662 | 14,139 | 15,408 | 15,939 | 16,422 | 16,995 |
| Member, 3 Adults, 5 Children | 10,785 | 11,163 | 12,576 | 13,023 | 14,301 | 14,799 | 16,125 | 16,680 | 17,193 | 17,793 |

Rand Water 2021 & 2022 Contributions Table Option B+ (Before Subsidy)

| | Below R 13,600 | | R 13,601 to R 19,400 | | Above R 19,401 | |
|------------------------------|----------------|-------|----------------------|-------|----------------|--------|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| Member | 2,196 | 2,196 | 2,346 | 2,346 | 3,228 | 3,228 |
| Per Adult Dependant | 1,536 | 1,536 | 1,644 | 1,644 | 2,256 | 2,256 |
| Per Child Dependant | 348 | 348 | 369 | 369 | 507 | 507 |
| Family Size | | | | | | |
| | Below R 12,300 | | R 12,301 to R 17,600 | | Above R 17,601 | |
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| Member | 2,196 | 2,196 | 2,346 | 2,346 | 3,228 | 3,228 |
| Member, Adult | 3,732 | 3,732 | 3,990 | 3,990 | 5,484 | 5,484 |
| Member, Adult, 1 Child | 4,080 | 4,080 | 4,359 | 4,359 | 5,991 | 5,991 |
| Member, Adult, 2 Children | 4,428 | 4,428 | 4,728 | 4,728 | 6,498 | 6,498 |
| Member, Adult, 3 Children | 4,776 | 4,776 | 5,097 | 5,097 | 7,005 | 7,005 |
| Member, Adult, 4 Children | 5,124 | 5,124 | 5,466 | 5,466 | 7,512 | 7,512 |
| Member, Adult, 5 Children | 5,472 | 5,472 | 5,835 | 5,835 | 8,019 | 8,019 |
| Member, 1 Child | 2,544 | 2,544 | 2,715 | 2,715 | 3,735 | 3,735 |
| Member, 2 Children | 2,892 | 2,892 | 3,084 | 3,084 | 4,242 | 4,242 |
| Member, 3 Children | 3,240 | 3,240 | 3,453 | 3,453 | 4,749 | 4,749 |
| Member, 4 Children | 3,588 | 3,588 | 3,822 | 3,822 | 5,256 | 5,256 |
| Member, 5 Children | 3,936 | 3,936 | 4,191 | 4,191 | 5,763 | 5,763 |
| Member, 2 Adults | 5,268 | 5,268 | 5,634 | 5,634 | 7,740 | 7,740 |
| Member, 3 Adults | 6,804 | 6,804 | 7,278 | 7,278 | 9,996 | 9,996 |
| Member, 2 Adults, 1 Child | 5,616 | 5,616 | 6,003 | 6,003 | 8,247 | 8,247 |
| Member, 2 Adults, 2 Children | 5,964 | 5,964 | 6,372 | 6,372 | 8,754 | 8,754 |
| Member, 2 Adults, 3 Children | 6,312 | 6,312 | 6,741 | 6,741 | 9,261 | 9,261 |
| Member, 2 Adults, 4 Children | 6,660 | 6,660 | 7,110 | 7,110 | 9,768 | 9,768 |
| Member, 2 Adults, 5 Children | 7,008 | 7,008 | 7,479 | 7,479 | 10,275 | 10,275 |
| Member, 3 Adults, 1 Child | 7,152 | 7,152 | 7,647 | 7,647 | 10,503 | 10,503 |
| Member, 3 Adults, 2 Children | 7,500 | 7,500 | 8,016 | 8,016 | 11,010 | 11,010 |
| Member, 3 Adults, 3 Children | 7,848 | 7,848 | 8,385 | 8,385 | 11,517 | 11,517 |
| Member, 3 Adults, 4 Children | 8,196 | 8,196 | 8,754 | 8,754 | 12,024 | 12,024 |
| Member, 3 Adults, 5 Children | 8,544 | 8,544 | 9,123 | 9,123 | 12,531 | 12,531 |

NEW ENHANCED BENEFITS FOR PREVENTATIVE CARE (Option A and B Plus)

| No. | Change | Description of Change | Option |
|-----|---|--|---------------------------|
| 1 | Preventative Care | PSA Screening (Once a year for Men) | Option A Option B Plus |
| | | COVID-19 – members have a preventative benefit for vitamins available to them from day to day. Immuno-compromised individuals will be eligible to receive an additional dose as part of their primary COVID-19 vaccine schedule to enhance immune protection. Additional doses should only be administered to individuals 18 years and older. Covid-19 vitamins paying from PMB up to the limit of R210.00, thereafter subject to day to day available medicine benefit. | Option A Option B Plus |
| | | Pap Smear (Once a year) | Option A Option B Plus |
| | | HPV Vaccine (For young girls between the ages of 12-16 yrs.) | Option A Option B Plus |
| 2 | OH Auxiliary | Includes a Dieticians benefit for chronic conditions (Diabetes Mellitus both type 1&2, Hypertension and Hyperlipidaemia) | Option A Option B Plus |
| 3 | OH Contraceptives Access to Pharmacy Clinic | Merina Device will be covered subject to Clinical Protocol. Oral Contraceptives & Injectables may be purchased over the Counter. | Option A Option B Plus |
| 4 | OH Maternity | Offers 3 Scans of which 1 is a 3D scan per pregnancy, should the pregnancy present with complications, Drs motivation letter is required. 6 Ante-natal Classes per pregnancy per annum. | Option A Option B Plus |
| 5 | OH Auxiliary | Sports Physiotherapy (sublimit of Physiotherapy benefit limit) Physiotherapy | Option A Option B Plus |
| 6 | OH Auxiliary | Educational Psychologist (sublimit of Psychology benefit) Virtual Consults | Option A |
| 7 | OH Optometry | Optical benefit for Albinism (separate from benefit limit, Frame 2-year cycle, yearly eye test) | Option A |
| 8 | Compulsory Health Care Screening-access to Clinics Pharmacies | A seasonal Pneumococcal vaccine and one Health Screening covering Blood Pressure, Blood Glucose, Cholesterol and HIV& Aids per beneficiary, Child Immunisations | Option A |
| | | | Option B Plus |

Note: OH (Out of Hospital)

2. BENEFITS AND LIMITS:

OPTION A

The Scheme Tariff (ST) refers to the fee or rate set by the Scheme or agreed between the Scheme and the relevant health care provider/s for the reimbursement of benefit claims. Subject to the limitations and exclusions of benefits as stipulated in Scheme Rules paragraph 16.7 to 16.10 and in Annexure C, a member who receives benefits under this section of the Scheme Rules his and or her dependents shall be entitled to the following benefits:

Any stipulated benefit limits or sub-limits do not apply to Prescribed Minimum Benefits (PMB). These are covered at cost when treatment is provided through any Service Provider (Scheme has no Designated Service Provider's (DSP's)).

1. GENERAL PRACTITIONER, HOMEOPATH AND SPECIALIST BENEFITS

- a) 100% (one hundred per cent) of the Scheme Tariff (ST) for general practitioner, homeopath and specialist consultations. The maximum benefits collectively are:

| | |
|------------------------------------|--------------------|
| Member with no dependants | R 10,380 per annum |
| Member with one dependent | R 13,980 per annum |
| Member with two or more dependants | R 17,780 per annum |

- b) 100% (one hundred per cent) of the Scheme Tariff (ST) for all other services and procedures rendered by a general practitioner, homeopath, and specialist. The maximum benefit is subject to the overall General Practitioner, Homeopath and Specialist limit.

NB: Consultations may be done through Telehealth/ Virtual Consultations (GP 'S, Specialist Physicians and Psychologist Consultation).

2. OPTICAL BENEFITS

- a) 100% (one hundred per cent) of the negotiated SAOA tariff for eye testing by a registered ophthalmologist or an optometrist, not exceeding one (1) eye test per annum per beneficiary.

- b) 100% (one hundred per cent) of the negotiated SAOA tariff, on the production of a receipted account from a spectacle maker, of the benefit limit for frames, lenses and contact lenses as prescribed in terms of (a) above:

- The maximum benefit for lenses and contact lenses is R3,310 per beneficiary per annum.
- The maximum benefit for frames is R 1,840 per beneficiary **every two years** (Anniversary of the previous Claim)
- The fitting of lenses to the frames, is limited to lens benefit limit per annum.
 - **No benefit for tinting of lenses**
 - Albinism benefit - maximum benefit limit of R9918.00 for high power prescription lenses including tinting, per beneficiary per annum **subject to clinical protocols.**
 - One set of frames subject to available maximum benefit per beneficiary **every two years.**

- c) A combined maximum benefit of R 12352.00 per annum per family is payable for refractive surgery and intraocular lenses.

3. HOSPITALISATION

100% (one hundred per cent) of the negotiated Scheme Tariff (ST).

The maximum benefit for hospitalisation is R2,228,560.00 per annum per family.

Prescribed Minimum Benefits (PMB) are payable at cost subject to clinical protocols.

Hospitalisation for PMB is covered at cost. Pre-authorisation must be obtained from the Scheme's managed healthcare provider, Afrocentric Integrated Solutions.

3.1. ONCOLOGY DISEASE MANAGEMENT PROGRAMME

Oncology Benefit is limited to R411,270.00 per family per annum, except for PMB's payable at cost subject to clinical protocols.

Pre-authorisation must be obtained from the Scheme's Managed Healthcare Provider for the above,

***NB: Specialist and Anaesthesiologists bill/ charge Private Rates (i.e., above Scheme Rates, Members are advised to negotiate upfront for Scheme Rates to avoid short payment).**

4. THEATRE FEES

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) for theatre fees.

The maximum benefit limit for theatre fees is included in the hospitalization benefit of R2,228,560.00 per annum per family.

5. INTERNAL PROSTHESIS

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) for internal prosthesis subject to R71,210.00 except for Prescribed Minimum Benefits (PMB) and Clinical Protocols per beneficiary per annum and Pre-authorization required.

6. DENTAL SERVICES

100% (one hundred per cent) of the Scheme Tariff (ST) for dental services in respect of:

- a) Ordinary fillings (such as cement, silicate, silver-alloy)
- b) Examinations, scaling and polishing, extractions, root treatment and X-rays.
- c) Dentures, repair of dentures, crowns, bridge work and dental implants.
- d) Orthodontics and Maxillo-Facial and Oral surgery, unless for a PMB condition subject to pre-authorisation.

NB: Pre-Authorization is required for Dental Trauma cases, Removal of Impacted Wisdom teeth and 3rd Molars as well as children under the age of 7.

The maximum benefits for Basic Dentistry (a), (b) are:

| | |
|-------------------------------------|--------------------|
| Member with no dependants | R 5,180 per annum |
| Member with one dependant | R 6,660 per annum |
| Member with two dependants | R 8,150 per annum |
| Member with three dependants | R 9,380 per annum |
| Member with four or more dependants | R 10,710 per annum |

The maximum benefits for Specialized Dentistry (c), (d) above are as follows:

| | |
|-------------------------------------|--------------------|
| Member with no dependants | R 8,150 per annum |
| Member with one dependant | R 10,290 per annum |
| Member with two dependants | R 12,700 per annum |
| Member with three dependants | R 15,320 per annum |
| Member with four or more dependants | R 17,780 per annum |

- **Consultations for dental visits relating to polishing and oral examinations are limited to one visit per beneficiary every 6 months.**
- **Dentures are limited to only beneficiaries 16 years of age and above.**

***All Dental Treatment is subject to Dental Clinical Protocols cited on page 16 to 18.**

7. PRESCRIBED MEDICATION NON PMB

7.1 Acute Medication

100% (one hundred per cent) of the legislated Single Exit Price (SEP) subject to Maximum Medical Aid Price (MMAP) plus the relevant dispensing fee.

To-Take-Out (TTO) medication prescribed on discharge from hospital will be limited to a seven (7) day supply only.

7.2 The maximum benefits applicable to Acute Medicine are:

- Member with no dependants R 11,200 per annum
- Member with one dependant R 16,240 per annum
- Member with two dependants R 17,040 per annum
- Member with three dependants R 18,270 per annum
- Member with four or more dependants R 19,000 per annum

7.3 Over the Counter (OTC) Medication (out of hospital)

R240.00 per script within a seven (7) day period, subject to the Acute Medication benefit limits and the following sub-limits:

- Member with no dependants R 1,330 per annum
- Member with one dependant R 1,930 per annum
- Member with two dependants R 2,030 per annum
- Member with three dependants R 2,170 per annum
- Member with four or more dependants R 2,260 per annum

7.4 Chronic Medicine Benefit Limit

100% (one hundred per cent) of the legislated Single Exit Price (SEP) prescribed chronic medicine up to a maximum benefit of R 15,270 per annum per beneficiary, plus the relevant dispensing fee.

NB: Prescribed Minimum Benefits are subject to available chronic benefit limit and Clinical Protocols once the chronic limit is reached, will pay from Risk.

7.5 Biological Drugs (Scheme Exclusion)

The treatments are subject to clinical protocols, paid subject to available medicine benefit limit (i.e., Acute, and chronic Benefit allocated per family per annum, balance to be paid by Member)

NB: Specialist and Anaesthesiologist bill Private Rates (i.e., above Scheme Rates, Members are advised to negotiate upfront for Scheme Rates

The Prescribed Minimum Benefit (PMB) chronic conditions are detailed in TABLE 1 below and non-PMB chronic conditions in TABLE 2.

TABLE 1: PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

| | |
|--|----------------------------------|
| 1. Addison's Disease | 14. Epilepsy |
| 2. Asthma | 15. Glaucoma |
| 3. Bronchiectasis | 16. Haemophilia |
| 4. Bipolar Mood Disorder | 17. Hyperlipidaemia |
| 5. Cardiomyopathy Disease | 18. Hypertension |
| 6. Chronic Renal Disease | 19. Hypothyroidism |
| 7. Cardiac Failure | 20. Multiple Sclerosis |
| 8. Coronary Artery Disease | 21. Parkinson's Disease |
| 9. Crohn's Disease | 22. Rheumatoid Arthritis |
| 10. Chronic Obstructive Pulmonary Disorder | 23. Schizophrenia |
| 11. Diabetes Insipidus | 24. Systemic Lupus Erythematosus |
| 12. Diabetes Mellitus Type 1 and 2 | 25. Ulcerative colitis |
| 13. Dysrhythmias | 26. HIV/Aids |

TABLE 2: NON-PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

(↓)

| | |
|---|-------------------------------------|
| 1. Acne* | 14. Iron Deficiency Anaemia* |
| 2. Allergic Rhinitis** | 15. Major Depression* |
| 3. Alzheimer's Disease* | 16. Meniere's Disease* |
| 4. Ankylosing Spondylitis | 17. Menopausal Disorder* |
| 5. Benign Prostatic Hypertrophy | 18. Migraine |
| 6. Cushing's Disease* | 19. Myasthenia Gravis* |
| 7. Cystic fibrosis | 20. Osteoporosis # |
| 8. Gastro-oesophageal Reflux Disorder ♦ | 21. Paraplegia, quadriplegia ##* |
| 9. Gout*** | 22. Peripheral Vascular Disease* |
| 10. Hyperkinesia (Attention Deficit Disorder) * | 23. Osteoarthritis |
| 11. Hyperparathyroidism | 24. Urinary incontinence |
| 12. Hyperthyroidism | 25. Stroke/Cerebrovascular Accident |
| 13. Interstitial Fibrosis | 26. Deep Vein thrombosis |

Included in addition to the tables:

- Cancer (**Stage 1 to stage 3 is a PMB**), meanwhile **Stage 4 is Non PMB –Metastases** and is untreatable
- Organ Transplant including work up treatment.

NB: For Non-PMB Chronic Medicine payment is subject to the available chronic benefit limit.

Chronic medication approval will be subject to clinical protocols

Chronic medication requests for certain conditions (*) will only be considered if prescribed and motivated by an appropriate specialist e.g.:

- A **Dermatologist** prescription and motivation is required for chronic medication for **Acne and Psoriasis**.
- An **ENT or Neurologist** prescription and motivation is required for chronic medication for Meniere's Disease
- A **Neurologist or Psychiatrist** prescription and motivation is required for chronic medication for **Alzheimer's disease**
- For **Attention Deficit Disorder (ADD)**, applications will only be considered if prescribed and motivated by a **Paediatrician, Neurologist or Psychiatrist**

Chronic medication for **Allergic Rhinitis (**)** will only be considered if prescribed and motivated by a Specialist (ENT, Paediatrician or Physician).

Medication for Gastro-Oesophageal Reflux Disease (GORD) (♦) will only be considered if prescribed and motivated by a gastroenterologist, physician, or general surgeon.

For **Gout (***)** only allopurinol and probenecid-containing products may be considered.

Chronic medication for **Osteoporosis (#)** may only be considered on submission of a Bone Mineral Density (BMD) scan report.

Chronic medication for **Paraplegics and Quadriplegics (##)** may be considered for urinary and bowel complications.

Exclusions from the Chronic Disease Benefit:

- Except for Vitamins and Mineral preparations (subject to approval for HIV/Aids; Oncology; Maternity i.e., during Pregnancy ONLY; COVID-19+ve Post Menopause; Hypoparathyroidism and Chronic Renal Disease)
- Homeopathic Medication
- Hypnotics and Anxiolytics
- Mucolytic and Decongestants

8 DIABETES DISEASE MANAGEMENT PROGRAMMES (Both Type1 & Type 2)

100% (one hundred per cent) of the Scheme Tariffs (ST) subject to registration on the Scheme's diabetes disease management programme.

9 DIAGNOSTIC BENEFITS

100% (one hundred per cent) of the Scheme Tariff (ST) for basic Radiology, Pathology, Specialised Radiology i.e. (PET, MRI and CT scans), and Clinical Technologist services.

9.1 Out of Hospital Basic Radiology and Pathology are subject to the following benefit limits:

- The maximum combined benefit is R 49,050 per annum per family subject to PMB.
- A combined sub-limit of R12,270 per beneficiary per annum applies.

9.2 Specialised Radiology (**PET, MRI & CT Scans**) is subject to a limit of R16,390 per family per annum, which is shared for in-hospital and out-of-hospital benefits.

Benefits for Specialised Radiology including PET, MRI and CT Scans both in and out of hospital are made available upon confirmation of pre-authorisation obtained from the Scheme's Preferred Managed Healthcare Provider.

9.3 Annual Preventative Wellness Benefits (from Scheme Risk Benefits)

- See **Preventative Care Benefits** page 5

10 MATERNITY SCANS

100% (one hundred per cent) of the Scheme Tariff (ST) limited to a maximum of three (3) scans per pregnancy of which a maximum of one (1) scan can be a 3D scan. Motivation from the attending healthcare practitioner is required for additional scans subject to Clinical Protocols.

10.1 ANTE-NATAL

- 6 Ante-Natal classes to the maximum benefit limit of R5 455.00 per beneficiary per annum.

11 BLOOD PRODUCTS

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) of blood transfusions (cost of material, apparatus and operator's fees). The maximum benefit is subject to the overall hospital limit per annum.

12 NURSING & STEP-DOWN FACILITIES IN LIEU OF HOSPITALISATION

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) for nursing in lieu of hospitalisation and step-down facilities prescribed by a medical practitioner, for a registered nurse or enrolled auxiliary nurse with a maximum collective benefit of R 52,890 per beneficiary per annum.

***Pre-authorisation must be obtained from the Scheme's Managed Healthcare Provider.**

13 AUXILIARY CONSULTATION AND PROCEDURES

100% (one hundred per cent) of the Scheme Tariff (ST) limited to R 11,830 per beneficiary per annum with a sub-limit of R 7,920 per discipline for the following services:

- Physiotherapy (including Sports Physiotherapy and Bio Kinetics)
- Occupational Therapy.
- Audiometry (Must be referred by ENT Specialist, for appliances 3 quotations from different suppliers)
- Psychological treatment (includes Educational Psychologist for children) **Virtual Consultation**
- Orthoptist (must be referred by a GP or a Specialist)
- Chiropractic treatment by a chiropractor.
- Podiatry.
- Dietician (includes Diabetes Mellitus both type 1 and 2, Hypertension and Hyperlipidaemia)
- Speech Therapy

14 EXTERNAL APPLIANCES

- a) 100% (one hundred per cent) of the Scheme Tariff (ST) for all Orthopaedic appliances prescribed by a medical practitioner subject to benefit available.
- b) 100% (one hundred per cent) of the Scheme Tariff (ST) for hearing aids and artificial limb(s), Wheelchairs and other Large Orthopaedic Appliances prescribed by an appropriate medical practitioner, subject to authorization.

- a. Hearing Aids One (1) set **every two (2) years (ENT referral required and 3 quotations from different suppliers)**
- b. Wheelchairs One (1) **every four (4) years ;3 quotations from different suppliers)**
- c. Artificial Limbs One (1) **every five (5) years; 3 quotations from different suppliers)**

The maximum annual collective benefit per family per annum in respect of (a) and (b) is R 48,150. The cost of repairs to appliances will be subject to the Warranty of the Device/ Appliance.

NB: ALL EXTERNAL APPLIANCES; Three (3) Different Quotations from different supplier's subject to clinical protocols required with Motivation and pre-authorisation.

15 EMERGENCY TRANSPORT SERVICES

100% (one hundred per cent) of the cost for ambulance services, fully capitated through the designated service providers (**Maponya 911**)

16 HIV / AIDS

Costs relating to HIV / AIDS are subject to Chronic Disease Management Programme for HIV / AIDS established per resolution passed by the Board of Trustees on 30 November 2000 covered at 100% of cost for PMB related services including medication formulary and clinical protocols.

17 PRESCRIBED MINIMUM BENEFITS (PMB)

Any stipulated benefit limits or sub-limits do not apply to Prescribed Minimum Benefits (PMB). These are covered at cost subject to clinical protocols, when treatment is provided by any service provider (i.e., the Scheme does not have a contracted/designated service provider for Prescribed Minimum Benefit)

With due regard to the prescribed minimum benefits the following treatments and services are excluded from the benefits provided in terms of this option.

1. All slimming preparations and preparations used to treat obesity.
2. Contact lens solutions.
3. Food supplements including baby food and special milk preparations. (Except for HIV/AIDS up to six (6) months).
4. Homeopathic and herbal medicines and household remedies or other miscellaneous household products of a medical nature.
5. Medicines to specifically treat infertility. (Except for PMBs)
6. Medicines used to specifically treat alcoholism and habit-forming substances. (Except for PMBs)
7. Anabolic steroids.
8. Anti-Malaria used for prophylaxis against malaria.
9. Diabetes test strips. (Except for PMBs)
10. Non-Medical essential treatment.
11. Wilfully self-inflicted injuries, e.g.: attempted suicide. (Except for PMBs)
12. Ptosis.
13. Frail Care Facilities or Old Age Home
14. Syringes and Needles – only on prescription (Except on Prescriptions)
15. Aphrodisiacs
16. Cosmetic preparations medicated or otherwise
17. Immunosuppressive – (Pre-authorisation required)
18. Stimulant laxatives (Except for Paraplegics and Quadriplegics)
19. Anti-diarrheal micro-organisms – only on prescription
20. Immune sera and immunoglobulins – (Pre-authorisation required)
21. Haematinics – iron supplements – (Pre-authorisation required)
22. Vitamin products (Except for HIV, COVID-19+ve, Pregnancy and Menopause)
23. Essentially fatty acid preparations and combinations – only on prescription
24. Over the counter reading glasses
25. Stoma therapy products – (Pre-authorisation required)
26. Botox injections – (Pre-authorisation required based on Clinically appropriate for dropping eye/s)
27. Gold fillings and Gold teeth
28. Jaw Reconstruction (Except for PMB's)
29. Facility Fee, except for PMB's and life threatening Medical/ surgical condition

***Refer to Annexure C**

NB: Specialist and Anaesthesiologist bill Private Rates (i.e., above Scheme Rates, Members are advised to negotiate upfront for Scheme Rates

**Option A
2021 Benefit and Limit Summary**

| | In-Hospital Limit Private Hospital |
|---|---|
| General Ward * Subject to Pre-Authorisation | 100% of the Scheme Tariff in a General Ward Limited to R 2,228,560 Per Family per annum |
| | Related Hospital |
| Medical Tests in hospital Includes Radiology and Pathology in hospital | 100% of the Scheme Tariff Subject to overall Hospital Limit |
| Specialised Radiology (MRI and CT Scans , PET) (In- and Out-of-Hospital) | Sub-limit of R 16,390 per family, subject to pre-authorisation & overall annual limit, except for PMBs |
| Blood Transfusions | 100% of cost Subject to overall Hospital Limit |
| Internal Prosthesis | 100% of the Scheme tariff Subject to Pre-Authorisation Subject to limit of R 71,210 per beneficiary per annum, except for PMB's |
| Oncology | 100% of the Scheme tariff Subject to Pre-Authorisation, included in the Overall Hospital Limit Limited to R 411,270 per family per annum |
| Renal Dialysis | Included in the overall annual limit Subject to pre-authorisation & state protocols |
| Maternity Includes Confinement, Foetal scans in hospital & midwife confinements | 100% of the Scheme tariff Subject to overall Hospital Limit *Pre-Authorisation required 6 Ante-Natal classes per pregnancy. Benefit limited to R5,220 per pregnancy per beneficiary per annum. |
| Step-down Facilities in Lieu of Hospitalisation * Subject to referral by a Medical Practitioner | 100% of Scheme tariff Limited to R 52,890 per beneficiary per annum Benefit usage in Lieu of Hospitalisation (Subject to Pre-Authorisation) |
| | Disease Management Programmes |
| HIV/ AIDS Subject to registration on the HIV/AIDS benefit programme | 100% of cost for PMB treatment in line with prescribed minimum benefit (PMB) protocols. |
| Diabetes Mellitus , Oncology subject to registration on Chronic Disease management programme | 100% of the Scheme Tariff |

Day to Day Benefit and Limits Summary

| | | |
|--|--|-----------------------------------|
| GP's, Homeopaths & Specialist consultations | Doctor Consultations | |
| | 100% of the Scheme tariff | |
| | Combined limit | |
| | Limited to: | |
| | M0 = R 10,380 | |
| | M1 = R 13,980 | |
| | M2 = R 17,780 | |
| | Medication | |
| | 100% of SEP plus applicable Dispensing Fee Limited to: | |
| | Acute (Prescribed Medication) | OTC (Subject to Acute Medication) |
| M0 = R 11,200 | M0 = R 1,330 | |
| M1 = R 16,240 | M1 = R 1,930 | |
| M2 = R 17,040 | M2 = R 2,030 | |
| M3 = R 18,270 | M3 = R 2,170 | |
| M4 = R 19,000 | M4 = R 2,260 | |
| Subject to 100% of MMAP tariffs | | |
| 100% of the SEP | | |
| Limited to: R 15,270 per beneficiary for non-PMBs | | |
| Unlimited for PMB Chronic Conditions (26 CDL'S) | | |
| Acute medication Dispensing fees paid in line with the applicable legislation OTC Medication: R240 per script within a seven (7) day period *Subject to the Acute Medication benefit limits. | Medical Tests Out of Hospital | |
| | 100% of the Scheme tariff | |
| | Sub-limit of R 11,740 per beneficiary per annum for Radiotherapy and Pathological services | |
| | Combined limit of R 46,940 per family | |
| | Dentistry | |
| Chronic Medication Subject to registration & approval for non PMB chronic conditions Radiology & Pathological Services Basic Dentistry (Examinations; X-rays; extractions; ordinary fillings; root treatment; prophylaxis) Specialised Dentistry (Maxillo Facial; Oral Surgery; Orthodontics; Dentures; Crowns & Bridge work; Repair of dentures) | 100% of the Scheme tariff | |
| | Limited to: | |
| | M0 = R 5,180 | |
| | M1 = R 6,660 | |
| | M2 = R 8,150 | |
| | M3 = R 9,380 | |
| | M4 = R 10,710 | |
| | Consultations for dental visits relating to scaling and polishing and oral examinations are limited to 1 visit per beneficiary every 6 months (anniversary of the previous consultation) | |
| | 100% of the Scheme tariff, subject to pre-authorisation | |
| | Limited to: | |
| | M0 = R 8,150 | |
| | M1 = R 10,290 | |
| | M2 = R 12,770 | |
| | M3 = R 15,320 | |
| | M4 = R 17,780 | |

Day to Day Benefits and Limits Summary

| Optical | |
|---|--|
| Eye Test YEARLY | 100% of SAOA tariff |
| | Limited to one test per beneficiary per annum |
| Lenses & Contact Lenses | 100% of SAOA tariff |
| | Limited to: |
| | R 3,310 per beneficiary per annum |
| Frames | 100% of SAOA tariff |
| | Subject to a sub-limit of R 1,840 per beneficiary every Two years (2) anniversary |
| Albinism | Maximum benefit limit of R9,490 for high power prescription lenses per beneficiary per annum. One set of frames subject to availability of benefits per beneficiary every two years. |
| Auxiliary Services | |
| Auxiliary Services | 100% of Scheme tariff |
| | Limited to R 11,830 per beneficiary per annum |
| | Subject to sub-limit of R 7,920 per discipline |
| Occupational Therapy | See combined Auxiliary Services |
| Physiotherapist | See combined Auxiliary Services |
| Including Sports Physiotherapy | |
| Chiropractor | See combined Auxiliary Services |
| Orthoptists | See combined Auxiliary Services |
| Psychologist | See combined Auxiliary Services |
| Including Educational psychologist (children with learning difficulties) | |
| Speech Therapy & Audiometry | See combined Auxiliary Services |
| Dietician | See combined Auxiliary Services |
| Podiatry | See combined Auxiliary Services |
| Appliances | |
| External Appliances | 100% of the Scheme tariff |
| (Includes oxygen equipment; hearing aids; artificial limb; wheelchairs & other equipment) | Limited to R 48,150 per family |
| | Repairs to be considered to Warranty of the device and /or appliance |
| Ambulances | |
| Ambulances | 100% of cost |
| | Provided by Maponya 911 |

BENEFITS AND LIMITS:

OPTION B Plus

The Scheme Tariff (ST) refers to the fee or rate set by the Scheme or agreed between the Scheme and the relevant health care provider/s for the reimbursement of benefit claims. Subject to the limitations and exclusions of benefits as stipulated in Rules 16.7 to 16.10 and in Annexure C, a member who receives benefits under this section of the Rules and his/her dependents shall be entitled to the following benefits.

Any stipulated benefit limits or sub-limits do not apply to Prescribed Minimum Benefits (PMB). These are covered at cost when treatment is provided through any Service Provider (Scheme has no Designated Service Provider's (DSP's)).

1. GENERAL PRACTITIONER BENEFITS

- a) 100% (100 hundred present) of the Scheme Tariff (ST) for general practitioner consultations.

The maximum benefits collectively are:

| | |
|------------------------------------|---------|
| Member with no dependants | R 3,120 |
| Member with one dependant | R 4,780 |
| Member with two or more dependants | R 6,330 |

- b) 100% (one hundred per cent) of the Scheme Tariff (ST) for other services and procedures rendered by a general practitioner.

NB: NB: Consultations may be done through Telehealth/ Virtual Consultations (GP 'S, Specialist TO BE referred by GP, Physicians and Psychologist Consultation)

2. SPECIALISTS BENEFITS (INCLUDING PHYSIOTHERAPISTS AND OCCUPATIONAL THERAPISTS).

100% (one hundred per cent) of the Scheme Tariff (ST) for Specialist, Physiotherapist and Occupational Therapist consultations limited to three (3) visits or R 3,540 per beneficiary per annum and five (5) visits or R 4,940 per family per annum.

- a) **No benefit is payable where the member self-refers to a specialist, without consulting a general practitioner first.**
- b) Pre-authorisation from the Scheme's Managed Healthcare Provider is required for each visit and for any other referrals or procedures.
- c) Subject to pre-authorisation the Scheme's Managed Healthcare Provider, 2 additional Gynaecologist visits are provided per beneficiary per pregnancy per annum.
- d) In-hospital physiotherapy is limited to R 10,630 per family per annum.

NB: Specialist and Anaesthesiologist bill Private Rates (i.e., above Scheme Rates, Members are advised to negotiate upfront for Scheme Rates)

3. OPTICAL BENEFITS

- a) 100% (one hundred per cent) of the negotiated Scheme Tariff (ST), for Eye Testing by a registered Ophthalmologist or, in the case of eye testing by an optometrist, 100% (one hundred per cent) of the guide to fees of the Optometric Association of South Africa, not exceeding one eye test per financial year per beneficiary
- b) 100% (one hundred per cent) of the SAOA tariff, on production of a receipted account from a spectacle maker, of the cost of frames, lenses and contact lenses prescribed at a test paid for in terms of (a) above. **Tinting not covered by the Scheme.**

The maximum collective benefit for frames, lenses and contact lenses is R 1,620 per beneficiary per annum

- Albinism; maximum benefit limit of R9917.00 for high power prescription lenses including tint per eye per beneficiary per annum.
- One set of frames subject to available maximum benefit per beneficiary per annum as per point above.

4. HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) for hospital and nursing home fees at a general ward high care and ICU rate as appropriate. The maximum benefit limit for hospitalisation is R 1,090,620 per annum per family. Hospitalisation for PMB including Oncology and Renal Dialysis is covered at 100% of cost all public hospitals and private hospitals. Pre-authorisation must be obtained from the Schemes Managed Health Care Provider.

5. THEATRE FEES

100% (one hundred per cent) of the Scheme Tariff (ST) for theatre fees including anaesthetics, disinfectants, bandages and materials applied in the theatre. The maximum benefits for Theatre fees are included in the hospitalisation benefit of R 1,090,620 per annum per family

NB: Specialist and Anaesthesiologist bill Private Rates (i.e., above Scheme Rates, Members are advised to negotiate upfront for Scheme Rates.

6. INTERNAL PROSTHESIS

100% (one hundred per cent) of the Scheme Tariff (ST) for internal prosthesis, subject to a maximum annual benefit limit of R 32,750 per family per annum except for PMBs.

7. DENTAL SERVICES

100% (one hundred per cent) of the Scheme Tariff (ST) for Dental Services in respect of:

- a. Ordinary fillings (such as cement, silicate, silver-alloy) and root canal treatment.
- b. Examinations, prophylaxis, restorations, extractions, X-rays.
- c. Dentures (**16 years and above**), repair of dentures, crown, bridge work and dental implants.
- d. Orthodontics, Maxillo-Facial and Oral Surgery, unless for a PMB condition and subject to Pre-authorisation.
- e. Dental X-rays.

NB: The benefit for (b) does not have an amount limit subject to Overall Annual Limit once in six months (anniversary of the first claim or benefit for basic dentistry).

The maximum benefit limits for (a), (c), (d) and (e) are:

| | |
|------------------------------|---------|
| Member with no dependants | R 1,720 |
| Member with one dependant | R 2,630 |
| Member with two dependants | R 3,040 |
| Member with three dependants | R 3,550 |
| Member with four dependants | R 3,950 |

- **Consultations for dental visits relating to scaling and polishing and oral examinations are limited to one visit per beneficiary every 6 months.**
- Maxillo-Facial Surgery is limited to R 17,660 per family, per annum subject to the Overall Hospital limit.
- Hospitalisation for dental services is limited to only trauma cases, treatment of impacted 3rd molars for children under 7 (seven) years of age at day theatres and all public and private hospitals.

NB: Pre-Authorisation is required from the Schemes Managed Healthcare Provider.

8. PRESCRIBED MEDICATION NON-PMB

a) 100% (one hundred percent) of the Single Exit Price (SEP) subject to MMAP (Maximum Medical Scheme Price) for non-PMB medicines, Pharmacy supplies and materials for injections in a hospital or nursing home.

b) 100% (one hundred percent) of the Single Exit Price (SEP) subject to MMAP (Maximum Medical Aid Price) for non PMB prescribed **acute medicine** plus the relevant dispensing fee.

The maximum benefits applicable:

| | |
|------------------------------------|-------------------|
| Member with no dependants | R 2,510 per annum |
| Member with one dependant | R 4,290 per annum |
| Member with two or more dependants | R 6,010 per annum |

c) **Over the Counter (OTC) Medication:**

R230 per script within a seven (7) day period subject to the Acute Medication benefit limits and the following sub-limits:

| | |
|------------------------------------|-------------------|
| Member with no dependants | R 1,190 per annum |
| Member with one dependant | R 2,030 per annum |
| Member with two or more dependants | R 2,350 per annum |

d) 100% (one hundred per cent) of the Single Exit Price (SEP) for PMB prescribed **chronic medicine** plus the relevant dispensing fee, subject to MMAP tariffs.

9. PRESCRIBED MINIMUM BENEFITS

The diagnosis, treatment and care cost of the Prescribed Minimum Benefits (PMB's) rendered by a Public Hospital, Private Hospital or any Service Provider, shall be covered as the Scheme does not have a Designated Service Provider.

TABLE 1: PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

| | |
|---|---|
| 1. Addison’s Disease | 2. Epilepsy |
| 3. Asthma | 4. Glaucoma |
| 5. Bronchiectasis | 6. Haemophilia |
| 7. Bipolar Mood Disorder | 8. Hyperlipidaemia |
| 9. Cardiomyopathy Disease | 10. Hypertension |
| 11. Chronic Renal Disease | 12. Hypothyroidism |
| 13. Cardiac Failure | 14. Multiple Sclerosis |
| 15. Coronary Artery Disease | 16. Parkinson’s Disease |
| 17. Crohn’s Disease | 18. Rheumatoid Arthritis |
| 19. Chronic Obstructive Pulmonary Disorder | 20. Schizophrenia |
| 21. Diabetes Insipidus | 22. Systemic Lupus Erythematosus |
| 23. Diabetes Mellitus Type 1 and 2 | 24. Ulcerative colitis |
| 25. Dysrhythmias | 26. HIV/Aids |

The following medicines are excluded from the Chronic Disease Benefit:

- Vitamins and mineral preparations (excluding calcium for postmenopausal females and patients with hyperparathyroidism; HIV; Maternity; COVID-19+ve Oncology and Chronic Renal Disease) unless medically necessary
- Homeopathic Medication
- Hypnotics and Anxiolytics
- Mucolytic. and Decongestants

The following conditions require special pre-authorisation prior to treatment from the Scheme’s managed healthcare provider. PMB benefits apply to these PMB conditions.

- Cancer (Oncology treatment subject to clinical protocols)
- Organ Transplant including the work up treatment and Immunosuppressive.

10. HIV/AIDS DISEASE MANAGEMENT PROGRAMME.

HIV/AIDS costs relating to an AIDS programme, established per resolution passed by the Board of Trustees on 30 November 2000 will be covered, at 100% of cost for PMB related service according to a formulary and protocols.

11. DIAGNOSTIC BENEFITS

100% (One Hundred per Cent) of the Scheme Tariff (ST) for Basic Radiology, Pathology, Specialised Radiology (including PET, MRI and CT scans) and Medical Technology services. This benefit is subject to a combined limit of R32,750 per family per annum (subject to PMB’s and clinical protocols) which is shared for in-hospital and out-of-hospital benefits. The following sub-limits also apply:

- Basic Radiology and Pathology Services (in-hospital and out-of-hospital) are subject to a combined sub-limit of R 9,710 per beneficiary per annum.
- Specialised Radiology (in-hospital and out-of-hospital) is limited to R 13,090 per family per annum, subject to Pre-Authorisation (PET, MRI, CT and Radio Isotope scans).

Once these sub-limits are reached, benefits are limited to Medical Technology services up to the combined limit of R 38,790 per family per annum. Except for PMB’s subject to Clinical Protocols.

Annual Preventative Wellness Benefits (from Scheme Risk Benefits ONE Consultation Per Annum)

- See Preventative Care Benefits page 5

12. MATERNITY SCANS

100% (one hundred per cent) of the Scheme Tariff (ST) limited to a maximum of three (3) scans per pregnancy per annum, of which a maximum of one (1) scan can be a 3D scan. Motivation from the attending healthcare practitioner is required for additional scans subject to Clinical Protocols.

12.1 ANTE-NATAL

6 Ante-Natal classes to the maximum benefit limit of R5 455.00 per beneficiary per annum.

13. CLINICAL TECHNOLOGISTS

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) limited to R 23,890 per family per annum.

14. BLOOD PRODUCTS

100% (one hundred percent) of the negotiated Scheme Tariff (ST) for blood transfusions limited to R 23,890 per family per annum, except for PMB's and clinical Protocols. Transportation costs are included in the limit.

15. NURSING AND STEP-DOWN FACILITIES IN LIEU OF HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) Step-Down Facilities & Nursing in Lieu of hospitalisation prescribed by a Medical Practitioner, for a Registered Nurse or Enrolled Auxiliary nurse with a maximum collective benefit Limited to R 24,220 per family per annum. Pre-authorisation must be obtained from the Scheme's Managed Healthcare Provider.

16. SURGICAL APPLIANCES AND EXTERNAL PROSTHESIS.

100% (one hundred per cent) of the Scheme Tariff (ST) for surgical and orthopaedic appliances and external prosthesis. The maximum annual benefit is R11,310 per family per annum.

100% (one hundred per cent) of the Scheme Tariff (ST)) for hearing aids and artificial limb(s), wheelchairs and other large orthopaedic appliances prescribed by an appropriate medical practitioner, subject to authorization.

The number of applications per beneficiary is limited in terms of cycles:

| | |
|------------------|---|
| Hearing aids | One (1) set every two (2) years (ENT referral required for all new requests) |
| Wheelchairs | One (1) every four (4) years |
| Artificial limbs | One (1) every five (5) years |

The cost of repairs to appliances is subject to the Warranty of the Device/ Appliance.

NB: Three (3) Different Quotations required with Motivation

17. EMERGENCY TRANSPORT SERVICES

100% (one hundred percent) of the cost for ambulance services, fully capitated through the designated service provider (Maponya 911).

NB: Specialist and Anaesthesiologist bill Private Rates (i.e., above Scheme Rates, Members are advised to negotiate upfront for Scheme Rates)

18. BENEFIT EXCLUSIONS

With due regard to the prescribed minimum benefits the following treatments and services are excluded from the benefits provided in terms of this option.

1. All slimming preparations and preparations used to treat obesity.
2. Contact lens solutions.
3. Food supplements including baby food and special milk preparations. (Except for HIV/AIDS up to six (6) months).
4. Homeopathic and herbal medicines and household remedies or other miscellaneous household products of a medical nature.
5. Medicines to specifically treat infertility. (Except for PMBs)
6. Medicines used to specifically treat alcoholism and habit-forming substances. (Except for PMBs)
7. Anabolic steroids.
8. Anti-malaria used for prophylaxis against malaria.
9. Diabetes test strips. (Except for PMBs)
10. Non-medical essential treatment.
11. Wilfully self-inflicted injuries, e.g.: attempted suicide. (Except for PMBs)
12. Ptosis.
13. Frail Care Facilities or Old Age Home
14. Syringes and Needles – only on prescription (Except on Prescriptions)
15. Aphrodisiacs
16. Cosmetic preparations medicated or otherwise
17. Immunosuppressive – (Pre-authorisation required)
18. Stimulant Laxatives (Except for Paraplegics and Quadriplegics)
19. Anti-diarrheal micro-organisms – only on prescription
20. Immune sera and immunoglobulins – (Pre-authorisation required)
21. Haematinics – Iron supplements – (Pre-authorisation required)
22. Vitamin products (Except for HIV, COVID-19+ve, Pregnancy and Menopause)
23. Essentially fatty acid preparations and combinations – only on prescription
24. Over the counter reading glasses
25. Stoma therapy products – (Pre-authorisation required)
26. Botox injections – (Pre-authorisation required based on Clinical appropriation)
27. Gold fillings
28. Jaw Reconstruction (Except for PMB's)
29. Facility Fee, except for PMB's and life threatening medical /surgical treatment and conditions

***Refer to Annexure C**

**Option B Plus
2021 Benefit and Limit Summary**

| In-Hospital Benefits | |
|---|--|
| Hospitalisation | Overall limit R 1,090,620 per family. |
| Surgical and non-Surgical procedures | Subject to Overall Hospital limit. |
| Materials and medicine | Subject to overall Annual Hospital limit. |
| Physiotherapy | Limited to R 10,630 Per Family per annum. |
| Basic Radiology, Basic Pathology and medical technology | Limited to R 32,750 Per Family per annum. |
| Maxillofacial Surgery | Sub-limit of R 9,710 per beneficiary per annum for Radiotherapy and Pathological claims. |
| | Limited to R 17,660 Per Family per annum, subject to pre- authorisation |
| Specialised Radiology (MRI & CT Scan) | MRI and CT Scans combined limit for in and out of Hospital. |
| | Sub-limit of R 13,530 Per Family per annum, subject to pre- authorisation. |
| Surgical and Orthopaedic appliances | Limited to R 10,170 Per Family per annum. |
| Oxygen | Subject to Overall Hospital limit. |
| Maternity | Subject to Overall Hospital limit. |
| Treatment of Mental Health | All Public Hospitals and limited Private Hospitals. |
| | Limited to PMB only. |
| Renal Dialysis (acute and chronic) | All Public Hospitals and limited Private Hospitals. |
| | Limited to PMB's only. |
| Internal Prosthesis | Limited to R 32,750 Per Family per annum. |
| Organ Transplants | Limited to PMB's only. |
| Neonates | Limited to PMB's only. |
| External Prosthesis | Subject to Surgical and Orthopaedic Appliances. |
| Emergency Transport | 100% of cost Provided by Maponya 911. |
| | Limited to R 23,890 per family per annum. |
| Blood Transfusion | Includes transport costs. |
| Dental Services | Hospitalisation only for trauma and impacted 3rd molars. Only children aged under 7 years. Subject to pre- authorisation |
| | Day Theatres and hospitals only. |
| Clinical Technologists | Limited to R 23,890 Per Family per annum. |
| Alternatives to Hospitalisation (Step Down and Home Nursing) | Limited to R 24,220 Per Family per annum. |
| Disease Management Programmes | |
| HIV/ AIDS | 100% of cost for PMB treatment in line with prescribed minimum benefit (PMB) protocols. |
| Subject to registration on the HIV/AIDS benefit programme | |
| Diabetes | 100% of the Scheme tariff |
| Subject to registration on disease management programme | |
| Oncology Treatment | All Public Hospitals and Private Hospitals. |
| | Limited to PMB's only. Stage 1 to 3 is PMB and Stage 4 is Non – PMB payable subject to available |

Out of Hospital Benefits

| Out of Hospital Benefits | | | |
|---|--|---|--------------|
| GP Consultations | Consultations | | |
| | 100% of the Scheme tariff. | | |
| | Combined limit | | |
| | Limited to: | | |
| | M0 = R 3,120 | | |
| | M1 = R 4,780 | | |
| | M2 = R 6,330 | | |
| | Emergency Visits | Unlimited without co-payment provided the episode meets the requirements of the definition on an emergency medical condition. Any registered emergency medical facility. Excluding facility fees. | |
| | | Limited to 3 visits or R 3,540 per beneficiary and 5 visits or R 4,940 per family. No benefit where member self-refers to a specialist without consulting a general practitioner first. | |
| | | Unlimited consultations for PMB conditions. | |
| Pre-Authorisation required for each visit and any other referrals or procedures. | | | |
| Specialist Consultations (including Physiotherapists and Occupational Therapists) | 2 additional Gynaecology visits per beneficiary per pregnancy per annum. With the benefit of 6 Ante-Natal Classes per pregnancy per annum. | | |
| | Medication | | |
| | 100% of SEP plus PDF Limited to: | | |
| | Acute Medication | Acute (Prescribed Medication) OTC (Subject to Acute) | |
| | OTC Medication: R230 per script within a seven day period, subject to the Acute Medication benefit | M0 = R 2,510 | M0 = R 1,190 |
| | | M1 = R 4,290 | M1 = R 2,030 |
| | | M2 = R 6,010 | M2 = R 2,850 |
| | | Subject to MMAP tariffs | |
| | Chronic Medication | Chronic Medication for the treatment of 26 PMB CDL conditions only. | |
| | Medical Tests | | |
| Basic Radiology, Specialised Radiology(MRI and CT Scan) and Pathology. | Combined limit for in and out-of-hospital limited to R 38,790 per family per annum. | | |
| | Sub-limit of R 9,710 per beneficiary per annum for Radiotherapy and Pathology. | | |
| Dental Services | | | |
| Dental Services (Basic and Specialised) Specialised Dentistry subject to Pre-Authorisation | 100% of the Scheme tariff, Limited to: | | |
| | M0 = R 1,720 | | |
| | M1 = R 2,630 | | |
| | M2 = R 3,040 | | |
| | M3 = R 3,550 | | |
| | M4 = R 3,950 | | |

Out of Hospital Benefits

| | |
|--|---|
| Optical Services | Optical Services Limited to R 1,620 per beneficiary per annum i.e., <ul style="list-style-type: none">• Eye Test• Lenses and contact lenses• Frame Tint not covered |
| Surgical appliances and External Prosthesis | Appliance 100% of the Scheme tariff Subject to limit of R 11,310 per family per annum, except for PMB's |
| Other Auxiliary Services | Auxiliary Services All other auxiliary services only covered on pre-authorisation and if a PMB. |

EMERGENCY TRANSPORT SERVICES MAPONYA 911 RESCUE SERVICES

NB. Rand Water Medical Scheme is delighted to introduce the New Service Provider for 24 Hour Emergency Health Care Service, as part of an ongoing process to improve quality customer service to our members.



Ambulance authorisation procedure

In all instances, where possible, call Maponya 911. In the case of an inter-hospital transfer, when you are admitted to hospital, please inform the admitting hospital that you are a Maponya 911 member and that any transfers must be done through **0861 960 960**.

What to do with the vehicle stickers you receive?

Maponya 911 encourages you to place the vehicle window sticker you receive from your medical scheme on one of the side windows of your motor vehicle. This will alert any emergency service on the scene that you are a member of Maponya 911.

IMPORTANT CONTACT DETAILS

Maponya 911 Hotline: 011 958 9090 / 0861 960 960
Enquiries: 011 958 9080
Email: info@maponya911.co.za
Website: www.maponya911.co.za

Points to remember when calling Maponya 911

- Dial 0861 960 960 if there is a medical emergency.
- Give your name and the telephone number and where you are calling from.
- Give a brief description of what has happened and try to explain how serious the situation is.
- Give the address or location of the incident as well as the incident as well as the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please, if possible, tell the Call Taker which Medical Scheme you belong to.
- Do not put the phone down until the controller has disconnected.



Maponya 911 EMS Services

- In the event an emergency only Maponya 911 is to be contacted
- Maponya 911 is Rand Water dedicated medical service provider
- 24 Hour access to call centre (including nurse line trauma counselling)
- Emergency call incident management and triage
- Emergency response by road or air to scene of incident
- Transfer from scene, to closest, most appropriate facility
- Facilitation of medically justified inter-facility transfers
- EMS access cover provides the client with the peace of mind that Maponya 911 Emergency Medical Service infrastructure affords to its client.

24-Hours Contact Centre

All Maponya 911 RESCUE's operations are supported by our dedicated contact centre 24 hours a day, 365 days a year. Highly trained and super-efficient, our medical assistance dispatchers are your direct line to the help you need.

RAND WATER MEDICAL SCHEME DENTAL POLICY AND PROCEDURES PROTOCOL 2021

1. General Principles

- All dental procedures are covered as per the description of Rules for the specific Scheme option concerned.
- The Clinical Protocols of Dental Risk Company will take precedence and Rand Water Medical Scheme tariff will apply.
- All specialised dentistry and hospitalisation for dental procedures are subject to pre-authorisation by Dental Risk Company before treatment commences, except in the case of emergency hospital admissions. Such authorisation must be obtained within 48 hours or the following working day thereafter.
- A written authorisation is not a guarantee of payment and is issued subject to available benefit at the time when the claim/s is received. The authorisation includes a summary of benefit allocation.
- Hospital authorisations are only valid for one (1) month and all other authorisations are valid for three (3) months within the benefit year.

2. Orthodontic treatment

- Benefits are only applicable to functional treatment for beneficiaries below the age of 18 years.
- Once approved, payment will be made as an initial deposit and the balance over estimated time period according to member benefits.
- Re-treatment of orthodontics is not covered.
- Loss of appliances, repair, remounting or replacement of fixed orthodontic brackets is covered subject to motivation covered from the appliance benefit, should the benefit be exceeded member will be liable for the account.
- Lingual or ceramic orthodontics brackets are not covered.
- Retainers are limited to one pair per member per lifetime.

3. Periodontics

Benefits for periodontal disease management is limited to conservative (non-surgical) management and is subject to pre-authorisation using the CPITN index. Surgical periodontal treatment is not covered.

4. Procedure Limitations

- Benefits for conservative dental restorations are available where such restorations are clinically indicated and will be granted once per tooth in a 1-year period.
- More than 4 fillings per member per year where clinically motivated, a pre-authorisation is required.
- In the case of fillings on posterior teeth (molars and pre-molars) the Dental Risk Company tariff for amalgam fillings will apply, regardless of the material used.
- Fissure sealants are covered once every 2 years, up to 18 years only on permanent molars and pre-molars.
- One extra-oral radiograph per year, except for orthodontic treatment planning where 2 extra-oral radiographs will be covered.

5. Hospitalisation and Intravenous Sedation

- Hospitalisation or Intravenous Sedation for dentistry is subject to pre-authorisation where the following protocols apply:
- Hospitalisation cover is provided for children below the age of 7 years.
- Removal of impacted teeth requires pre-authorisation and is allowed once in a lifetime.

- Theatre visits for persons above 7 years for conservative dentistry and extractions will not be covered. The requirement of a sterile facility is not on its own an acceptable reason for hospitalisation for dental treatment.
- Hospitalisation cover will only be considered where an underlying medical condition exists.
- In-hospital apicectomies are limited to 1st and 2nd molars only.

6. The following will not be covered in hospital:

- Dentectomies
- Frenectomies
- Conservative dental treatments e.g., fillings on adults, fissure sealant, fluoride treatment and polishing of teeth.
- Periodontal procedures and surgery.
- Genioplasty
- Gingivectomy

7. Restrictions and Exclusions

The treatments and procedure codes listed below are not covered by the scheme. The member is liable for the total cost of these procedures. In the event of a dispute regarding exclusions and benefits, the rules of Rand Water medical scheme will prevail.

- Cosmetic dentistry.
- Mouthwash and toothpastes.
- Fissure sealants on patients from 7 years to 18 years.
- Professionally applied topical fluoride in adults 18 years and above
- Oral/facial image of dentist work is covered only for orthodontics
- Perio chip
- Ozone therapy
- Desensitising, resin or medicament will not be covered during the same visit as application of topical fluoride.
- Restorative treatment because of attrition or abrasion.
- Tariff for amalgam fillings will apply, regardless of the material used.
- Fixed prosthodontics will be pre-authorized according to DRC protocols.
- Composite or porcelain veneers.
- Laboratory fabricated crowns are not covered on primary teeth or third molars (wisdom teeth)
- Temporary /provisional and emergency crowns including lab costs
- Fixed prosthodontics where the members mouth is periodontal compromised
- Fixed prosthodontics used to restore teeth for cosmetic reasons
- Fixed prosthodontics used to repair occlusal wear (teeth damaged due to bruxism) erosions or fluorosis
- Cost of gold, precious metal, semi-precious metal and platinum foil.
- Lab costs where the associated dental procedure is not covered.
- Dentures will be pre-authorized according to DRC protocols.
- Orthodontics will be pre-authorized according to DRC protocols.
- Jaw correction surgery and related hospital costs (Orthognathic surgery)
- TMJ surgery and associated procedures.
- Osteotomy
- Surgical periodontal services
- Gingivectomy
- Dentectomies in hospital.

- Frenectomies in hospital.
- Removal of asymptomatic wisdom teeth.
- Fillings, extractions and root canal therapy in hospital over age of 7 years.
- Preventative dentistry procedures in hospital.
- Assistant fee to be assessed on individual cases
- MRI and CAT scans for any dento-alveolar procedures will not be covered
- Extra-oral radiograph only for orthodontic treatment planning and removal of impacted teeth
- Dental implants in or out of hospital and associated surgical procedures listed below are excluded,
 - Implant tooth replacement all phases
 - Cost of implant components
 - Bone augmentation, or tissue regeneration or cost of bone regeneration material
 - Sinus lifts

RAND WATER MEDICAL SCHEME WILL PAY A FACILITY FEE & CLINICAL UNDERWRITING IN LINE WITH SCHEME RULES AND THE MEDICAL SCHEME’S ACT NO131 OF 1998.

A. FACILITY FEE

1. The Scheme will pay a facility fee for Prescribed Minimum Benefits (PMB, Conditions 26 CDL), 270 DTP ‘s and Algorithm, subject to PMB level of care with ICD10 Code
2. The Scheme will pay a **Facility Fee** as outlined on the table below.
3. All hospital groups determine a facility fee through a triage, which works as follows:

| Triage Color Identification | Clarification/Description | Charged Facility Fee Cover |
|-----------------------------|---|--|
| Green | Cold Case E.g., Headache. This is not a PMB and members are encouraged to consult General Practitioner. | <u>Not covered</u> |
| Orange/Yellow | If the treatment falls under one of the 26 CDL conditions & or 270 DTP’s /algorithms, the facility fee will be covered. | Covered by the Scheme; for 26 CDL conditions and 270 DTP’s/ algorithms. |
| Red | An “Emergency” leading to hospital admission. | Covered by the Scheme (it would be linked to the Pre-Auth. Number& emergency code) with an emergency tariff code. |

Please Note:

A workup treatment (medical tests i.e. tariff) that led to a PMB diagnosis (ICD10 Code) will be paid by the Scheme as a PMB Condition & PMB Level of care. The claim payment is subject to clinical protocols and scheme rules.

PRESCRIBED MINIMUM BENEFITS

1. Designation of service providers

The medical scheme contracts with service provider(s) for the delivery of Prescribed Minimum Benefits in the following categories for both Option A and Option B Plus:

- (a) Hospitalisation: No DSP.
- (b) Out of hospital services: No DSP
- (c) Medicine benefit management (both chronic and acute): MediKredit
- (d) Medical Advisory Services Management: Schemes Managed Health Care Services.
- (e) Diabetes Mellitus (Type 1 and Type 2): - Schemes Managed Health Care Services and Chronic Disease Management Programme.
- (f) HIV/AIDS: Schemes Managed Health Care Services- Chronic Disease Management programme.
- (g) Oncology: Schemes Managed Health Care Services - Chronic Disease Management Programme
- (h) Dental Health Management both in and out of hospital. Dental Risk Company (DRC)
- (i) 24 Hour Emergency Health Care Services. (Maponya911)

2. Prescribed Minimum Benefits obtained from Designated Service Providers

The scheme covers for diagnosis, treatment and care costs of Prescribed Minimum Benefit conditions, subject to clinical protocols and medical appropriateness, if those services are obtained from any service provider, i.e., there is no designated service provider for Prescribed Minimum Benefits.

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 subject to clinical protocols and medical appropriateness, from any service provider the benefit payable in respect of such service is subject to:

No co-payment; benefits are payable subject to clinical protocols.

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 any service provider, the Medical Scheme will cover the cost subject to clinical protocols and medically appropriate.
- (b) For the purposes of paragraph (a,) a beneficiary will not be deemed to have involuntarily obtained a service from any service provider, no co-payment applies (i.e., Scheme do not have a Designated Service Provider for Prescribed Minimum Benefits (PMBs).
- (c) Except in the case of an Emergency Medical/Surgical condition, pre-authorisation shall be obtained by a member prior to voluntarily and or involuntarily obtaining a service from a provider to enable the Scheme to confirm that the circumstances contemplated in paragraph 2 and 3 are applicable.

5. Medication

- (a) Where a Prescribed Minimum Benefit includes medication, the Scheme will pay 100% of the Single Exit Price (SEP) of that medication plus relevant dispensing fee, if that medication is obtained from a service provider voluntarily or involuntarily.
- (b) Where a Prescribed Minimum Benefit includes medication and that medication is voluntarily obtained from a provider. A Single Exit Price plus relevant dispensing fee will apply.

The list of PMB chronic conditions in respect of Option A and Option B Plus is as follows:

| | |
|--|----------------------------------|
| 1. Addison's Disease | 14. Epilepsy |
| 2. Asthma | 15. Glaucoma |
| 3. Bronchiectasis | 16. Haemophilia |
| 4. Bipolar Mood Disorder | 17. Hyperlipidaemia |
| 5. Cardiomyopathy Disease | 18. Hypertension |
| 6. Chronic Renal Disease | 19. Hypothyroidism |
| 7. Cardiac Failure | 20. Multiple Sclerosis |
| 8. Coronary Artery Disease | 21. Parkinson's Disease |
| 9. Crohn's Disease | 22. Rheumatoid Arthritis |
| 10. Chronic Obstructive Pulmonary Disorder | 23. Schizophrenia |
| 11. Diabetes Insipidus | 24. Systemic Lupus Erythematosus |
| 12. Diabetes Mellitus Type 1 and 2 | 25. Ulcerative colitis |
| 13. Dysrhythmias | 26. HIV/Aids |

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. EXCLUSIONS

Unless otherwise decided by the Board, expenses incurred by a member or dependant in terms of Rule 16.8 as well as in connection with any of the following, but excluding any prescribed minimum benefits, or preferred provider benefits which are described in Annexure B of the Rules, shall not be paid by the Scheme:

- 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 however 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 by the Scheme in respect of this benefit.
- 1.2 The testing of eyes except when undertaken by a medical practitioner or registered ophthalmologist or optometrist.
- 1.3 Purchase or hire of medical, surgical or other appliance except as provided for in Annexure B.
- 1.4 Purchase of medicine, bandages, dressings and other similar aids not included in a prescription from a medical practitioner or a dentist.
- 1.5 Operations, procedures and treatment performed upon and at the desire of the member or dependant in respect of whom the claim is made but which are not essential, in the opinion of the medical practitioner nominated by the Scheme and such member's or dependant's medical practitioner in consultation, for the treatment of the illness in respect of which the claim is made.
- 1.6 Prescription sunglasses.

2. LIMITATION OF BENEFITS

The limitations below apply to members to whom Option A and Option B Plus benefits apply, but do not apply to the prescribed minimum benefits in respect of services provided at any public hospital or designated service provider.

- 2.1 In a case of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant consulting a specialist whom the Board may nominate in consultation with the attending medical practitioner. If such a specialist's advice is not acted upon, no further benefits shall be granted in respect of such illness.
- 2.2 In a case where a specialist is consulted without the recommendation of a general practitioner, the benefit may be limited to the amount that would have been paid to a general practitioner for the same service: provided that an Ophthalmologist, Optometrist all Specialist may be consulted without the recommendation of a general practitioner except for Option B Plus.
- 2.3 In a case where major Osteo-surgery is required i.e Joint Replacements or Spinal Fusions, the Board shall have the right to insist upon a member or dependant having to obtain a second medical opinion.
- 2.4 Participation in the Diabetic, Oncology programme is subject to pre-registration.
- 2.5 Should a beneficiary suffer from any of the chronic conditions listed under Paragraph 8 of Annexure B and wishes to obtain the relevant benefits, he/she will be obliged to participate in the Chronic Disease Management Programme provided by the Scheme.

- BOT – Board of Trustees
- CDL – Chronic Disease List
- CMS - Council for Medical Schemes
- DSP – Designated Service Provider
- GP – General Practitioner
- MMAP - Maximum Medical Aid Price
- OAL - Overall Annual Limit
- OTC - Over the Counter
- PDF - Pharmacy Dispensing Fee
- PMB - Prescribed Minimum Benefits
- SAOA - South African Optometric Association
- SEP - Single Exit Price
- TTO - Treatment to Take Out

RAND WATER MEDICAL SCHEME

MAIN SCHEME RULES

RULES OF RAND WATER MEDICAL SCHEME
(Registration No. 1201) (Established 1 January 1918)

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RULES

1. NAME

The name of the scheme is Rand Water Medical Scheme, hereinafter referred to as the “Scheme”.
The abbreviated name is RWMS as per Council of Medical Schemes.

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, 131 of 1998 and regulations and these rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 522 Impala Road, Glenvista, Johannesburg 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*.
- (b) The following expressions have the following meanings:

4.1 “Act”,

The Medical Schemes Act (Act No 131 of 1998) including any regulations framed under

4.2 “Adult Dependant”

A person other than the spouse, partner or child of the member, who is dependent on the member for family care and support, is related to the member whether by affinity or consanguinity (blood, marriage, adoption) and who is registered in terms of these rules as an adult dependant including, but not limited to.

4.2.1 The child dependant of a member who is over the age of 21 (twenty-one) years and who is:

4.2.1.1 A full-time student aged 25 (twenty-five) years or less; or

4.2.1.2 Mentally or physically handicapped.

4.2.2 The relative, whether by affinity or consanguinity (blood, marriage or adoption), of the member.

4.2.3 Any other person who is recognised by the Board as an adult dependant for the purposes of these rules

4.3 “Approval”

Prior written approval of the Board or its authorised representative.

4.4 “Auditor”

An individual or firm that is a registered auditor as defined in Section 1 of the Auditing Professional Act of 2005 as authorised by the Registrar.

4.5 “Accounting Firm”

Means an accounting or auditing firm which provides any of the services provided from time to time by any of the major accounting or auditing firm in South Africa (such firms being for example Deloitte, KPMG, PWC, SNG, etc.) or their Allied Companies and includes (without limiting the foregoing) accounting and secretarial services, auditing and assurance, corporate finance, financial management, forensic accounting, information technology, insolvency and business rescue services, insurance advisory services, management accounting, legal services, management consultancy, risk advisory and tax.

4.6 “Authorised representative”

The Principal Officer or any member of the Board of Trustees, authorised by the Board to act on its behalf.

4.7 “Beneficiary”

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

4.8 “Board”

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

4.9 “Child Dependent”

A member’s natural child, or a stepchild or a legally adopted child or a child in the process of being legally adopted or a child placed in the custody of the member or his/her spouse or partner and for whom the member has a duty of support and who is not a beneficiary of any other medical scheme. A dependant who is under the age of 21 (twenty-one) and who is not a beneficiary of any other medical scheme. A dependant who is under the age of 21 (twenty-one) or older if he or she is permitted under the rules of the medical scheme to remain as a dependent.

4.10 “Condition specific waiting period”

A period not exceeding 12 months 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.

4.11 “Continuation member”

A member who retains his/her membership of the Scheme after his/her retirement or the termination of employment due to age, ill-health or other disability or a surviving dependant who becomes the principal member after the death of the original member.

4.12 “Contribution”

In relation to a member, the amount exclusive of interest, paid by or in respect of the member and his registered dependents if any, as membership fees. Amount payable by a member on a monthly

basis a membership fee to the medical scheme in return for medical coverage and in accordance with the payment structure Annexure A of these rules for the purpose of qualifying for benefits offered by the medical scheme in terms of its rules.

4.13 “Council”

The Council for Medical Schemes established by Section 3 of the Medical Schemes Act.

4.14 “Cost”

In relation to a benefit, the total invoice amount payable in respect of relevant health service charged.

4.15 “Creditable coverage”

Any period during which a late joiner was:

4.15.1 a member or a dependant of a medical scheme.

4.15.2 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.

4.15.3 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

4.15.4 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.

4.16 “Date of Service” means: -

4.16.1. In event of a consultation, visit or treatment by a medical practitioner, dental or medical assistant, the date on which each consultation, visit or treatment occurred, whether for the same illness or not.

4.16.2. In the event of an operation, procedure or confinement, the date on which each operation, procedure or confinement occurred.

4.16.3. In the event of hospitalisation, the date of each discharge from Hospital, or the date of cessation of membership in terms of these Rules, whichever event occurs first;

4.16.4. In the event of any other service or requirement, the date on which such service was rendered or requirement obtained

4.17 “Dependant”

The Spouse or Partner, dependent children or other members of the member’s immediate family in respect of whom the member is liable for family care and support; or any other person who, under these rules is recognised as a dependant of a member.

4.17.1 In relation to a child, a child under the age of 21 (twenty-one) years.

4.17.2 In relation to a child who is over the age of 21 (twenty-one) years, but not over the age of 25 (twenty-five) years, who is not self-supporting and who is registered as a student at a recognised institution for higher learning, provided that evidence of such registration is submitted to the Board at the commencement of each academic year. Contributions are subject to adult dependant rates.

4.17.3 In relation to a child over the age of 21 (twenty-one) years who, due to a mental or physical disability is not self-supporting and is dependent on the member for family care and support.

4.17.4 In relation to a dependant other than the member's spouse or partner.

4.18 "Designated service provider"

A healthcare provider or a group of providers selected by the scheme as preferred provider/s to provide services to the members concerning, diagnosis, treatment and care in respect of one or more prescribed minimum benefit condition.

4.18.1 "Diagnosis and Treatment Pairs (DTPs)" – means

Those treatment pairs listed in Annexure A of the Regulations in terms of the Act, subject to any limitations specified therein. By way of information, these DTPs link a specific diagnosis to a treatment or procedure and therefore broadly indicate how each of the 270 PMB conditions should be treated.

4.19 "Domicilium citandi et executandi"

The member's chosen physical address at which notices in terms of rule 11 as well as legal process or any action arising therefrom, may be validly delivered and served to the scheme's registered office in terms of rule 3.

4.20 "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.

4.21 "Employee"

An Employee is defined as a person who is employed as a permanent, full-time or part-time employee and a person who is employed in terms of a fixed contract of no less than 2 (two) years (continuous)

4.22 "Employer",

Rand Water established in terms of Section B of the Water Services Act (Act 108 of 1997).

4.23 "Fit and proper"

The regulatory eligibility of a person to hold an important position of trust in a medical scheme and the regulated entities with whom it contracts, including that person's character, integrity, competence and ability to do the job

4.24 "General waiting period"

A maximum period of 3 (three) months during which a beneficiary is not entitled to claim any benefits.

4.25 “Generic drugs”

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, and side effects, route of administration, risks, safety, and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts. The only difference is that the generic drugs are much more affordable than the ethical (original brand name product) drugs.

4.26 “Original drug”

Is an international term used for a new drug that has been proven to have a positive effect on a particular disease after extensive research and clinical studies, which are based on a patented molecule and which previously had no other similar drug. Original drugs are protected for a certain period by strong laws, under the umbrella of patent and data protection rights. Within this period, it is not permitted for any other pharmaceutical company to manufacture this drug. Thus, manufacturers of an original drug are able to meet their Research and Development expenses and create resources for further research. When the legal protection period for the original drug expires, pharmaceutical companies may launch its equivalents. These are called “generic drugs”.

4.27 “Immediate family member”

4.27.1 a member’s spouse or life partner.

4.27.2 a member’s dependent children.

4.27.3 a member’s legally adopted children; or

4.27.4 in the absence of a spouse, life partner or dependent children, the member’s siblings and parents in respect of whom the member is liable for family care and support.

4.28 “Income” For the purposes of calculating contributions in respect of:

4.28.1 A member who is an employee – the substantive salary paid to an employee by the employer. Salary shall not include any interest or dividend from investment or any allowance received while acting temporarily in any post, the value of free quarters or any allowance in lieu thereof, or any bonus, commission, overtime payment, travelling allowance or cost of living allowance.

4.28.2 A member who registers a spouse or partner (who is employed by Rand Water as well) as a dependent — the higher of member or spouse’s or partner’s earnings.

4.28.3 Continuation member:

- a. A member who is due for retirement (excluding ill health retirement) effective from January 2015 his /her monthly contribution will be based on 70% of last known salary as approved by The Board of Trustee of Rand Water Medical Scheme,
- b. This will apply to all members who choose to continue with the medical scheme post retirement i.e. for members who were on Option A (since inception and never change option or move to another medical Scheme) before January 2002 will qualify for Rand Water 2/3 subsidy upon retirement. Members are not allowed to re-join the scheme once they have retired and opted not to continue with the medical scheme cover
- c. A continuation member, who has left employment and is classified as a pensioner will continue to receive subsidy of 2/3 of contributions. The subsidy is inclusive of the disposable income of a typical pensioner including temporary or permanent income from another employer in exchange for the performance of services by the employee or

self-employment. Pensioners should update their income status on the yearly basis with the Scheme should they get employed either on permanent or temporary basis.

4.29 “Member”

A person who has been enrolled or admitted as a member of a medical scheme, or who, in terms of the rules of a medical scheme is a member of such medical scheme.

4.30 “Member family”

The member and all the registered dependents.

4.31 “Managed Health Care”

Means a health care delivery arrangement designed to reduce unnecessary utilisation of services, to contain costs and to measure performance while providing accessible, quality and effective health care.

4.32 “Managed Health Care Organisation”

Means a person or organization who has contracted with the Fund to provide a Managed Health Care service.

4.33 “Medicines Pricing Regulations”

Means the regulations relating to the Transparent Pricing System for medicines and Scheduled Substances, made and in force under the Medicines and Related Substances Act, 101 of 1965.

4.34 “Payment in full”

In relation to a prescribed minimum benefit (PMB), means payment according to the service provider’s invoice (i.e., cost) for relevant healthcare services rendered, subject to the use of protocols, designated service providers (DSPs), formularies, pre-authorisation or such other managed care initiatives in place and provided for in these rules.

4.35 “Partner”

A person with whom the member has a committed relationship based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

4.36 “Pre-authorisation”

Shall have the meaning assigned to it in Rule 19

4.37 “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:

- 4.37.1** the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and
- 4.37.2** any emergency medical condition.

4.38 “Pre-existing Medical Condition”

Means 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.

4.39 “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.

4.40 “Principal Officer”

Means the Principal Officer of the Fund, or a person acting in that capacity by direction of the Board.

4.41 “Registrar”

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

4.42 “Relevant health care provider”

A person providing a relevant health service.

4.43 “Scheme Tariff” or “Scheme tariff” means:

The Tariff negotiated from time to time by the Scheme with provider of service, such as those for certain hospital services, and step-down facilities. In regard to this negotiated tariff, the terms “100% of Scheme Tariff” or “the maximum amount in the applicable Scheme Tariff”, means that, unless otherwise stated in these Rules or an Annexure to the Rules. Member shall not be liable for co-payment in respect of items charged at Scheme tariff. For non-negotiated tariff the Scheme will use the 2018 tariff plus applicable CPI.

4.44 “Single Exit Price”

Means the price set by the manufacturer or importer of a medicine or scheduled substance in terms of the Medicine Pricing Regulations combined with the logistics fee (as defined in the Medicine Pricing Regulations) and VAT and is the price of the lowest unit of the medicine or scheduled substance within a pack multiplied by the number of units in the pack.

4.45 “Supplier of service”

All registered healthcare providers and institutions for the provision of relevant healthcare services

4.46 “Spouse”

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

4.47 “Third Party Claims”

Shall have the meaning as assigned to it by Rule 18.

4.48 “Waiting Period”

A period of membership during which a member is liable to pay contributions but will not be entitled to claim any benefits for either a 3 month and/or a 12-month period.

5. BUSINESS OF A MEDICAL SCHEME

Means the business of undertaking liability in return for a premium or contribution.

5.1 to make provision for the obtaining of any relevant health service.

5.2 to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and

5.3 where applicable, to render a relevant health service, either by the medical 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 a medical scheme.

Registered rules are binding in terms of section 31(4)

6. MEMBERSHIP

Subject to Rule 8, membership of the Scheme is restricted to: Employment or former employment with the employer by the employee or his predecessor or successor in title as defined in these Rules, and is either voluntary or compulsory, depending on the employee’s conditions of employment.

6.1 Eligibility

6.1.1 Persons in the employment or retired employees of the employer Rand Water

6.1.2 Former employment is relevant for continuation members who retired from the services of his/her employer or whose employment is terminated by his/her employer on account of age, ill health or other disability and his/her dependants.

6.1.3 Surviving dependants, subject to such conditions as may be prescribed, after the death of a member and who were registered as such at the time of the member’s death.

6.1.4 A member whose membership is terminated for any reasons other than those stipulated in rule 6.2 below, does not qualify as a continuation member on the scheme.

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

6.1.6 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 in full by the scheme. The scheme may however designate a provider to conduct such tests or examinations.

6.1.7 Every member will, on admission to membership, receive a detailed summary of these rules which shall include contributions, benefits, limitations and exclusions, the member’s rights and obligations.

6.2 CONTINUATION MEMBERSHIP

6.2.1 Retirees

- 6.2.1.1** 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. No addition of dependant is allowed once the member has retired.
- 6.2.1.2** The Scheme shall inform the member at the time of retirement 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 on account of ill- health. 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.
- 6.2.1.3** This excludes members who voluntarily resigned from a restricted medical scheme on retirement, upon their re-application for membership at a later stage.

6.2.2 Surviving Dependants

- 6.2.2.1** The surviving dependants 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
- 6.2.2.2** 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.
- 6.2.2.3** Such a member's membership terminates if he/she becomes a member or a dependant of a member of another medical scheme
- 6.2.2.4** 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. Such membership shall terminate if such a member shall.
 - 6.2.2.4.1** Become a member of, or is accepted as a dependant of a member of another registered medical scheme.
 - 6.2.2.4.2** Inform the Scheme in writing of his intention not to become a member, or;
 - 6.2.2.4.3** Reach the age of 21 (twenty-one) years, unless the criteria set out in 4.17.2 and 4.17.3 is met.

7 REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

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 and submits the birth certificate or a certified copy thereof within 30 (thirty) 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. However, failure to comply with this Rule may render such child ineligible for the full period of non-compliance.

7.1.3 Should:

- 7.1.3.1** a new member does not register any eligible dependants immediately upon his admission to the Scheme or;
- 7.1.3.2** a member at any time acquires an eligible dependant whether by birth, adoption, marriage or otherwise, and not register such new dependant within 30 days of the eligibility of such dependant, the Scheme shall subject to the provisions contained in Rule 8.4 and 8.5., be entitled to impose, upon later registration as a dependant, a waiting period (general or condition specific) during which period no benefit shall accrue to such dependant, but subscriptions shall be paid to the Scheme.
- 7.1.3.3** If a member who marries subsequent to joining the Scheme, applies within 30 (thirty) days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month of marriage and benefits will accrue as from the date of commencement of membership. The spouse shall not qualify for benefits until such time as the member qualifies for benefits.
- 7.1.3.4** 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 7.1.4, 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.

7.2 De-registration of Dependants

- 7.2.1** A member shall inform the Scheme within 30 (thirty) 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

- 8.1** A minor may become a member with the consent of his/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** members of different medical schemes, or
 - 8.2.3** 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
- 8.3** Prospective members shall, prior to admission, complete and submit the application forms, required by the Scheme, together with satisfactory evidence in respect of himself/herself 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 respect of any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care of treatment was recommended or received within the 12

(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.

8.4 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 (ninety) days preceding the date of application.

8.4.1.1 a general waiting period of up to 3 (three) months; and

8.4.1.2 a condition-specific waiting period of up to 12 (twelve) 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 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application.

8.4.2.1 a condition-specific waiting period of up to 12 (twelve) 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 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.

8.4.2.3 PMBs may also be excluded during the waiting period.

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 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application, a general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

8.5 No waiting period 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 (ninety) 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 a 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.

8.5.1.3 Where the former medical scheme had imposed a general or condition-specific waiting period in respect of person or persons referred to in this Rule and such waiting period has not expired at the time of termination of membership, the Scheme may impose such a 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.

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

8.7 Should a member elect not to register his eligible dependants, on admission to membership such dependants will upon future application for registration as dependants of the member be subject to the application of Rules 8.3 to 8.5.

8.8 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 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 Member may not have access to benefits as per the rules of the Scheme during his/her suspension.

8.10 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

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/her past employment by the particular employer and admit any person who has been a registered dependant of such a 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** In submitting a receipt for such card a member shall be deemed;
- 10.2.1** to have bound himself/herself and his/her dependants to comply with these Rules and any amendments thereof.
 - 10.2.2** to have authorized the Board to deduct from the moneys due to him/her by the Scheme, by the employer, by the Rand Water Superannuation Fund, or by Rand Water Provident Fund, surcharges or any other amounts due by him/her to the Scheme.
 - 10.2.3** to have authorized practitioners to disclose to the Scheme the nature of any illness in respect of which a claim is made.
- 10.3** A member who loses his/her membership card and is issued with a duplicate card, or a member who fails to surrender his/her membership card on termination, shall be charged R50.00.
- 10.4** 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 is not permitted and it is construed as fraud.
- 10.5** On termination of membership or on de-registration of a dependant, the Scheme must, within 30 (thirty) days of such termination, or at any time on request, 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 (thirty) 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 AND SUSPENSION OF MEMBERSHIP

12.1 Resignation

- i. A member who, in terms of his conditions of employment is required to be a member of the Scheme, may not terminate his membership while he remains an employee without the prior written consent of his employer.
- ii. 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.
- iii. 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.

- iv. A member may terminate his/her membership of the scheme on giving 30 Days written notice. All rights to benefits cease after the last day of membership.

12.2 Death

Membership of a member terminates on the last day of the month within which he/she died.

12.3 Involuntary termination

12.3.1 Amounts due to the scheme

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 to;

1. suspend all benefit payments in respect of claims which arose during the period of default.
2. give the member written notice at his/her domicilium citandi et executandi or by means of an electronic means agreed upon, 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))
3. notice sent by prepaid registered post to the member and his/her domicilium citandi et executandi or by any electronic means 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, or provide and electronic mail address or facsimile, the members postal or residential address on his/her application form shall be deemed to be his/her domicilium citandi et executandi.
4. In the event that payments are brought up to date and provided membership has not been cancelled in accordance with rule **12.3.1.2**, benefits shall be reinstated without any break in continuity. 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.
5. Any amount due and owing to the medical scheme in respect of a member or a dependant of the member after reasonable demands for payment have been issued, becomes a debt due to the scheme and is recoverable by it

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.

12.5 Submission of fraudulent claims; committing of any fraudulent act and/or non-disclosure of material information.

The Board may suspend or terminate the membership of a beneficiary who submitted fraudulent claims, committed any fraudulent act or failed to disclose material information when applying for membership.

An applicant is obliged to disclose all material information to the medical scheme with regard to any matter concerning the state of health or medical history of the member concerned or that of any of his or her dependants, which arose or occurred during the period of 12 months preceding the date of application for membership. In such event, the member must refund the scheme any claims paid

out by the scheme and the scheme must refund all the contributions paid to the member.

13 CONTRIBUTIONS

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 arrears and be payable by not later than the third day of each month. Where contributions or any other debt owing to the Scheme, have not been paid within 30 (thirty) 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, and

13.2.2 to give the member and/or employer written notice at his/her/its domicilium citandi and executandi that if contributions or such other debts are not paid within 21 (twenty-one) 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 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.

13.2.3 In the event that payments are brought up to date and provided benefits have 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.

13.3 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.

13.4 In terms of employees who are on a Total Cost to Company remuneration package, the total contribution of 3/3 (three thirds) will be deducted from the employee.

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

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 in Regulation 5.

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 name of the beneficiary to whom the service was provided
- d) The final date of service rendered by the supplier of service on the account or statement which is covered by the payment;
- e) The total amount charged for the service concerned; and
- f) The amount of the benefit awarded for such service.

15.2 If a member becomes eligible for a third-party claim, the member undertakes to submit same and refund the scheme.

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

15.4 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.

15.5 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 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 and the relevant health care provider, within 30 (thirty) days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and provider the opportunity to submit such corrected account or statement to the Scheme within 60 (sixty) days following the date from which it was returned for correction.

16 BENEFITS

16.1 Members are entitled to benefits during a financial year, as per Annexure A, B & C 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 A, B & C.

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

16.2.1.1 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.

- 16.2.1.2** 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 (thirty) days prior notification of any intended changes in benefits or contributions for the next year.
- 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 (thirty) days of receipt of the claim pertaining to such benefit.
- 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 of the Regulations.
- 16.5** No limitations or exclusions will be applied to the prescribed minimum benefits.
- 16.6** Pre-authorisation is a clinical decision based on the information provided and not a guarantee of payment of relevant healthcare services to be rendered.
- 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 as follows:
- 17.1.1** self-insured up to the relevant benefit limit payable at scheme tariff; and
 - 17.1.2** in full for prescribed minimum benefits
- 17.2** 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 or group of suppliers who rendered the service.
- 17.3** All accounts in respect of services rendered in terms of the prescribed minimum benefits at a public hospital as well as services provided in terms of a preferred provider contract will be settled by the Scheme in full and with the provider direct without any limitations.
- 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 within 3 years 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** The Scheme will be responsible for claims and/ or cost incurred under the benefits and limits specific to the membership within the borders of the Republic of South Africa only.

18 THIRD PARTY CLAIMS RECOVERY

- 18.1** In the event that the member or dependant becomes entitled to any benefit for medical services rendered in the treatment of an injury sustained as a result of or arising out of the negligent driving of a motor vehicle by a person within the borders of Republic of South Africa (RSA), the member or dependent shall:

18.1.1 Be obliged to take all the necessary steps to timeously submit to the Road Accident Fund (RAF) establish in terms of Act 56 of 1996, a claim for compensation for the costs of any health care services performed and which in the future maybe necessitated in connection with such injury; and

18.1.2 Advise and keep the Scheme update of the progress in relation to such claim for compensation; on admission of such claim by RAF, advise the Scheme of such admission, including any terms relating to any undertaking by the RAF to make payments of the costs of any future medical expenses, in which event the Scheme shall be entitled to recover payment of any benefit in respect of health care services for which the RAF has undertaken to make payment.

- 18.2** In the event that the member or dependant becomes entitled to any benefit for medical services rendered in the treatment of an injury or disease sustained or contracted in the course of his employment, the member or dependant shall:

18.2.1 Be obliged to take all steps which are necessary to timeously submit a claim for compensation to the Compensation Commissioner ("Commissioner") as provided for in terms of the Compensation for Occupational Injury and Diseases Act 130 of 1993, a claim for compensation for the cost of any health care services performed and which in the future may necessitated in with such injury or disease and;

- 18.3** Advise and keep the Scheme advised of the progress in relation to such claim for compensation ;on admission of such claim to the Commissioner, advise the Scheme of such submission, including any terms relating to any undertaking by the Commissioner to make payments of the costs of any future medical expenses ,in which event the Scheme shall be absolved from any liability to make payment of any benefits in respect of healthcare services for which the Commissioner has undertaken to make payments entitled to recover payment of any benefit in respect of health care services for which the Compensation Commissioner has undertaken to make payment.

18.4 Categories of Motor Vehicle Accidents

- Class A – Member who signed the undertaking and claims from RAF
- Class B – Member who signed the undertaking and does not lodge a claim against RAF
- Class C - Member who signed the undertaking claims from RAF and resigned before pay-out.
- Class D - Member who signed the undertaking claim from RAF after they resigned from Rand Water Medical Scheme.

19 PRE-AUTHORISATION

19.1 Pre-Authorisation:

In all cases where prior approval and authorisation by the Fund or by any service provider on its behalf ("Pre-authorisation") is required in respect of any benefit, even though such pre-authorisation may be given, the payment of any claim relating thereto will always be subject to:

- 19.1.1** sufficient benefits being available to the Member at the time of payment,
- 19.1.2** that the Member has made full disclosure of relevant information in his or her application for such pre-authorisation; and
- 19.1.3** Further that his or her membership has not been terminated or suspended for any reason. Benefits that are subject to pre-authorisation are set out in the annexures to this document.

20 GOVERNANCE

20.1 The affairs of the Scheme must be managed according to these Rules by a Board consisting of 10(ten) persons who are fit and proper to be trustees.

20.2 Five of such trustees must be elected by members from amongst members herein after also referred to as elected trustees. The other five trustees shall be appointed by the employer as appointed trustees.

20.3 Trustees serve term of office for three years

20.4 Persons so elected/appointed shall disclose annually all interests they have in relation to the scheme /related entities

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

- 20.5.1** A person under the age of 21 (twenty-one) years;
- 20.5.2** 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.
- 20.5.3** a broker
- 20.5.4** an employee of the Scheme
- 20.5.5** the Principal Officer of the Scheme; and
- 20.5.6** the authorised auditor of the Scheme or
- 20.5.7** any person that is already serving as a trustee of any other registered medical scheme.

20.6 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.

20.7 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 20.17 or ceasing to hold office in terms of Rule 20.18. 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.

- 20.8** 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 20.17 or ceasing to hold office in terms of Rule 20.18. 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.
- 20.9** 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 vita by ... (indicate a date) of the year concerned and the election must be carried out by the members present at the annual general meeting of the scheme.
- 20.10** The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.
- 20.11** 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.
- 20.12** The Board must elect from among itself the chairperson and vice-chairperson.
- 20.13** 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.
- 20.14** The Board must elect from its number the Chairperson and Vice-chairperson.
- 20.15** In the absence of the Chairperson and Vice-chairperson, the Board members present must elect one of their numbers to preside.
- 20.16** 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.
- 20.17** A member of the Board may resign at any time by giving written notice to the Board.
- 20.18** A member of the Board ceases to hold office if;
- 20.18.1** he becomes mentally ill or incapable of managing his/her affairs.
 - 20.18.2** he/she is declared insolvent or has surrendered his/her estate for the benefit of his/her creditors.
 - 20.18.3** he/she is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury.
 - 20.18.4** he/she is removed by the court from any office of trust on account of misconduct.
 - 20.18.5** he/she is disqualified under any law from carrying on his profession,
 - 20.18.6** he/she ceases to be an appointee by the employer or being a Board member elected by members of the scheme, he/she ceases to be a member of the Scheme.

- 20.18.7** he/she absents himself/herself from three consecutive meetings of the Board without the permission of the Chairperson.
- 20.18.8** he/she is removed from office by the Council in terms of Section 46 of the Act; or
- 20.18.9** he/she is removed from office in terms of Rule 20.18.
- 20.19** The Board must meet at least once every 2 (two) months or at such intervals as it may deem necessary.
- 20.20** The Chairperson may convene a special meeting should the necessity arise. Any 2 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.
- 20.21** The Board may, subject to participation by sufficient members to form a quorum, discuss and resolve matters by telephonic or electronic conferencing means and may adopt resolutions on that basis.
- 20.22** Members of the Board shall not be entitled to any remuneration, honorarium or any other fee in respect of services rendered in their capacity as members of the Board.
- 20.23** A member of the Board who acts in a manner which is seriously prejudicial to the interests of the beneficiaries of the medical scheme may be removed by members of the Board after following a due process that is consistent with provisions of section 46 of the Medical Schemes Act or of the provisions of just administrative action; by way of a special resolution taken at a special general meeting, provided that:
- 20.23.1** Special notice shall be lodged with the Board accompanying the requisition at date of lodgement, and on receipt of notice of such a proposed resolution, the Board shall forthwith deliver a copy thereof to the trustee concerned, who shall, be entitled to be heard on the proposed resolution at the meeting.
- 20.23.2** The notice convening the special general meeting containing the agenda and proposed special resolution 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.
- 20.23.3** Where the trustee concerned makes representation in writing which is of a reasonable length and requests dissemination to members, the Board shall unless the representations are received by it too late for it to do so, state that such representations have been made in its notice to members in terms of rule and send a copy of the representations to all members, whether such notice was sent before or after the receipt of representations by the Board.
- 20.23.4** Where the representation was not sent due to late receipt, the trustee concerned may require that the representations be read at the meeting.
- 20.23.5** 50% + 1 of members of the board of trustees present in person constitute a quorum.
- 20.23.6** The resolution to remove the trustee/s must be passed by at least 2/3 of members present in person or by proxy entitled to vote.
- 20.23.7** Rule 17.17 applies mutatis mutandis.

21 FIDUCIARY DUTIES OF BOARD OF TRUSTEES

- 21.1** The Board is responsible for the proper and sound management of the Scheme, in terms of these Rules.
- 21.2** The Board must act with due care, diligence, and skill and in good faith.
- 21.3** 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.
- 21.4** The Board must apply sound business principles and ensure the financial soundness of the Scheme.
- 21.5** The Board shall appoint a principal officer who is fit and proper person, as defined in section 57, to hold such office and within 30 days of such appointment, give notice thereof in writing to the Registrar. The Board must determine the terms and conditions of employment of the person so appointed.
- 21.6** The Board may authorise the appointment of any staff by the Principal Officer, which in its opinion are required for the proper execution of the business of the scheme and must determine the terms and conditions of service of any person employed by the scheme.
- 21.7** The Chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.
- 21.8** The Board must cause to be kept such minutes of all resolutions passed, accounts, entries, registers and records as are essential for the proper functioning of the scheme.
- 21.9** The Board must ensure that proper control systems are employed by and on behalf of the scheme.
- 21.10** 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.
- 21.11** 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.
- 21.12** The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.
- 21.13** 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.
- 21.14** 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.

21.15 The Board must take steps to ensure the integrity of all documents, data and information transferred to the new administrator and managed care organisation. The change in administrator must comply with the Board Notice (BN) 73 of 2004.

21.16 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any beneficiary's state of health in terms of the Protection of Personal Information Act.

21.17 The Board must approve all disbursements.

21.18 The Board shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

21.19 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.

21.20 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.

21.21 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.

21.22 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.

21.23 The Board shall cause to be done a "Board effectiveness self-assessment" on an annual basis and an independent assessment every three (3) years with due regard to normal practice and recommended guidelines pertaining to improving the Board's effectiveness.

21.24 The Board must appoint the authorised auditor and the audit committee annually.

21.25 The Board shall ensure that every existing and newly appointed/elected Board member undergoes trustee training in the form of induction training and attendance of the accredited skills programme provided by the Council.

22 POWERS OF BOARD

22.1 The Board has the power; to suspend or remove the Principal Officer or a Trustee from office on good cause shown;

22.2 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;

- 22.3** to appoint a committee consisting of such Board members and other experts as it may deem appropriate.
- 22.4** 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.
- 22.5** to appoint, contract with and compensate any accredited managed health care organisation in the prescribed manner.
- 22.6** to purchase movable and immovable property for the use of the scheme or otherwise, and to sell it or any of it.
- 22.7** to let or hire movable or immovable property.
- 22.8** subject to section 63 to sell movable and immovable property of the Scheme subject to sound business practice and fair value principles.
- 22.9** 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.
- 22.10** 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.
- 22.11** 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.
- 22.12** 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.
- 22.13** to contribute to any fund conducted for the benefit of employees of the Scheme.
- 22.14** to reinsure obligations in terms of the benefits provided for in these Rules.
- 22.15** 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.

22.16 to contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes.

22.17 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.

23 DUTIES OF PRINCIPAL OFFICER AND STAFF

23.1 The staff of the scheme must, in terms of the Protection of Personal Information Act, ensure the confidentiality of all information regarding its members.

23.2 The Principal Officer is the Executive Officer of the Scheme and as such shall ensure that:

23.2.1 He/she acts in the best interests of the members of the scheme at all times.

23.2.2 The decisions and instructions of the Board are executed without unnecessary delay.

23.2.3 Where necessary, there is proper and appropriate communication between the Scheme and those parties affected by the decisions and instructions of the Board.

23.2.4 He/she keeps the Board sufficiently and timeously informed of the affairs of the Scheme concerning any matters relating to the duties of the Board as stated in Section 57(4) of the Act.

23.2.5 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.

23.2.6 He/she 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.

23.3 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.

23.4 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/she 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.

23.4.1 The Principal Officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

23.5 The principal officer shall, with the concurrence of the Board, cause the termination of the services of any employee of the scheme.

23.6 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.

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

23.8 The following persons are not eligible to be a Principal Officer:

- 23.8.1** 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.
- 23.8.2** A broker or an employee, director, officer, consultant or contractor of any person contracted by the scheme to provide broker services.
- 23.8.3** A Principal Officer or office bearer of another medical scheme; or
- 23.8.4** Otherwise has a material relationship with any person contracted by the scheme to provide administrative, marketing, broker, managed healthcare or other services or with its holding company, subsidiary, joint venture or associate.

23.9 The provisions of Rules 21.5.1 - 21.5.6 apply mutatis mutandis to the Principal Officer

24 INDEMNIFICATION AND FIDELITY GUARANTEE

24.1 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.

24.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers.

25 FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the 1st (first) day of January to the 31st (thirty-first) day of December of that year.

26 BANKING ACCOUNT

The Scheme must establish and maintain a bank account 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.

27 AUDITOR AND AUDIT COMMITTEE

- 27.1** An auditor (who must be approved 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.
- 27.2** The Board must appoint an audit committee in the prescribed manner.
- 27.3** The audit committee shall be responsible for recommending the appointment of the external auditor to the board of trustee as well as overseeing the external audit process.
- 27.4** An auditor (who must be authorised and approved by the Registrar in terms of section 36 of the Act) who is a registered auditor as defined in the Auditing Profession Act, 2005, must be recommended by the board resolution and appointed by members at every Annual General Meeting, to hold office from the conclusion of that meeting.
- 27.5** 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.
- 27.6** If the members of the scheme at a general meeting fail to appoint an auditor required to be appointed in terms of section 36(1) of the Medical Schemes Act, the Board must within 30 days recommend to the Registrar for an appointment in terms of section 36(9) of the Act.
- 27.7** The following persons are not eligible to serve as auditor of the Scheme:
- 27.7.1** Officers of the scheme.
 - 27.7.2** Contractor of the scheme.
 - 27.7.3** An employee, director, officer or contractor of the scheme's administrator, or of the holding company, subsidiary, joint venture or associate of the administrator.
 - 27.7.4** A person not registered and engaged in public practice as an auditor.
 - 27.7.5** A person who is disqualified from acting as an auditor in terms section 90 of the Companies Act, 2008.
 - 27.7.6** Any person who has a material relationship with the medical scheme or any of its contractors.
- 27.8** The authorised 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.
- 27.9** The authorised auditor must report to the audit committee of the scheme on the accounts examined by him and on the financial statements laid before the scheme in general meeting.

28 GENERAL MEETINGS

28.1 Annual General Meeting

- 28.1.1** 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.

- 28.1.2** 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 (twenty-one) 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.
- 28.1.3** At least 15 (fifteen) members of the Scheme present in person constitute a quorum. If a quorum is not present after a lapse of 30 (thirty) 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 29 (b)iii, and members then present constitute a quorum.
- 28.1.4** The financial statements and reports specified in rule 28 (a) ii. must be laid before the meeting. A full set of Annual Financial Statements (comprising the Trustees' report, auditor's report and AFS) will be made available to the meeting.
- 28.1.5** Notices of motions to be placed before the annual general meeting must reach the Principal Officer not later than 7 (seven) days prior to the date of the meeting.

28.2 Special General Meeting

- 28.2.1** The Board may call a Special General Meeting of members if it is deemed necessary.
- 28.2.2** Only members in good standing will be permitted to attend the meeting on presenting proof of membership and identity
- 28.2.3** On the requisition of at least 100 members of the Scheme, the Board must cause a Special General Meeting to be called within 30 (thirty) days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitioners and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.
- 28.2.4** The notice convening the Special General Meeting, containing the agenda, must be furnished to members at least 14 (fourteen) days before the date of the meeting provided that the notice procedure followed by the Board was reasonable.
- 28.2.5** At least 50 members present shall constitute a quorum. If a quorum is not present after a lapse of 30 (thirty) minutes from the time fixed for commencement of the meeting, the meeting shall be cancelled.

29 VOTING AT MEETINGS

- 29.1** 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.
- 29.2** 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.
- 29.3** 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/she is a member, has a casting vote in addition to his/her deliberative vote.

30. COMPLAINTS AND DISPUTES

- 30.1** Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators shall also provide a dedicated telephone number to be used for dealing with telephonic enquiries and complaints 011 682 0985.
- 30.2** All complaints received in writing will be responded to by the Scheme in writing within 30 (thirty) days of receipt thereof.
- 30.3** A disputes committee of three members, who may not be members of the Board, employees of the administrator, must be appointed by the Board to serve a term of office of 3 (three) years. At least one of such members shall be a person with legal expertise.
- 30.4** 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.
- 30.5** 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 (twenty-one) 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.
- 30.6** The disputes committee may determine the procedure to be followed.
- 30.7** The decision taken in terms of rule 31 (b) or that of the dispute committee must be communicated to all parties in writing and where a dispute arises, this must be lodged in writing with the Registrar, indicating their right to appeal in terms of section 47.
- 30.8** The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.
- 30.9** 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 3 (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.
- 30.10** The operation of any decision which is the subject of an appeal under Rule 31(g) shall be suspended pending the decision of the Council on such appeal.

31 DISSOLUTION

- 31.1** The Scheme may be dissolved by order of a competent court or by voluntary dissolution.
- 31.2** Members in a 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.

- 31.3** Pursuant to a decision by members taken in terms of Rule 32(b) 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.
- 31.4** Every member must be requested to return his/her ballot paper duly completed before a set date. If at least 50% (fifty 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.
- 31.5** The Registrar may, on good cause shown, ratify a lower percentage

32 AMALGAMATION AND TRANSFER OF BUSINESS

- 32.1** 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.
- 32.2** It at least 50% (fifty per cent) of the members return their ballot papers duly completed and if the majority thereof are in favour of the amalgamation or transfer, the transaction may be concluded in the prescribed manner.
- 32.3** The Registrar may, on good cause shown, ratify a lower percentage.
- 32.4** The amalgamating Board must submit signed copies of a final audited set of financial statements and annual statutory return to the CMS.

33 RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

- 33.1** Any beneficiary must on request and on payment of a fee of 50 (fifty) cent per copy, be supplied by the Scheme with a copy of the following documents:
 - 33.1.1** The rules of the Scheme.
 - 33.1.2** The latest audited annual financial statements, returns, Trustees reports and auditors report of the Scheme and the accompanying management accounts in respect of the Scheme and all of its benefit options.
 - 33.1.3** protocols and formularies documents
 - 33.1.4** A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 34(a) and to make extracts therefrom.
- 33.2** 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.

34 AMENDMENT OF RULES

- 34.1** The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

- 34.2** 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 the Scheme or 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.
- 34.3** Members must be furnished with a copy of such amendment within 14 (fourteen) days after registration thereof. Should a member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 (thirty) days advance notice of such change.
- 34.4** Notwithstanding the provisions of Rule 35(a) 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 and all other laws.
- 34.5** No alteration, rescission or addition of any rule shall be valid unless it has been approved and registered by the Registrar

Scheme Contact Details

| | |
|-----------------------------------|---|
| Telephone Number | 011 682 0985 |
| Fax Number | 011 682 0671 |
| Authorisation | 086 111 4476 |
| Email: Claims | Paidclaims@randwater.co.za |
| Queries | Claimqueries@randwater.co.za |
| Membership | Membership@randwater.co.za |
| Contributions | Contributions@randwater.co.za |
| Benefits for Appliance | Benefitappliance@randwater.co.za |
| Provider's Banking Details Update | providers@afrocentric-ics.com |
| Web Site | https://hosting.cumulusis.com/Randwater/home/login.asp |
| Postal Address | P O Box 1127 Johannesburg 2000 |

Dental Risk Company

| Dental Department | E-mail Address | Fax Number | Telephone Number |
|-------------------------|--|--------------|------------------|
| Pre-authorisation | auth@dentalrisk.com | 086 687 1285 | 087 943 9611 |
| Dental Enquiries | enquiries@dentalrisk.com | 086 687 1285 | 087 943 9611 |
| Dental Claims | claims@dentalrisk.com | 086 687 1285 | 087 943 9611 |
| Dental Provider Queries | network@dentalrisk.com | 086 687 1285 | 087 943 9611 |

Afrocentric Integrated Solutions

| Department | E-Mail Address | Fax Number | Telephone Number |
|---------------------------------------|--|--------------|--------------------------|
| Hospital pre-authorisation | rdw.preauth@afrocentric-ics.com | 011 707 8473 | 086 111 4476 Option 1 |
| Chronic Disease Management Programmes | rdw.oncology@afrocentric-ics.com | 011 707 8472 | 086 111 4475 Option 3 |
| | rdw.hiv@afrocentric-ics.com | 011 707 8469 | |
| | rdw.diabetes@afrocentric-ics.com | 011 707 8467 | |

Medikredit

| Department | E-Mail Address | Number for Members | Number for Providers |
|--------------------------------|--|--------------------|----------------------|
| Chronic Medicine Authorization | chronic@medikredit.co.za | 0800 132 345 | 086 093 2273 |

Council for Medical Schemes Contact Details

| | |
|-------------------------|--|
| Postal Address | Private Bag X34, Hatfield, 0028 |
| Telephone Number | 0861 123 267 |
| Fax Number | 012 431 0608 |
| Email Address | complaints@medicalschemes.com |
| Web Site | www.medicalschemes.com |

Maponya 911 EMS

| | |
|-------------------------|--|
| Telephone Number | 011 958 9090/ 0861 960 960 |
| Enquiries | 011 958 9080 |
| Email Address | info@maponya911.co.za |
| Web Site | www.maponya911.co.za |
| | |