RHODES UNIVERSITY MEDICAL SCHEME

Rules

Amendment with effect from 1 January 2025

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RHODES UNIVERSITY MEDICAL SCHEME RULES

1. NAME

The name of the Scheme is **RHODES UNIVERSITY MEDICAL SCHEME**, also known as **"RUMed"**, hereinafter referred to as the "Scheme".

[Amended with effect from 2006/01/01]

2. LEGAL PERSONA

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

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 7 Lutman Street, Richmond Hill, Port Elizabeth, but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

[Amended with effect from 2008/01/01]

4. DEFINITIONS

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

(a) a word in the singular number includes the plural, and *vice versa*; and

(b) the following expressions have the following meanings:

4.1. **"Act"**,

the Medical Schemes Act, (Act No 131 of 1998), and the regulations framed thereunder, as amended from time to time.

4.2. **"Adult Dependant"**,

a Dependant other than a Child Dependant.

4.3. **"Approval"**,

prior written approval in terms of these Rules.

4.4 **"Auditor"**,

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

4.5 **"Beneficiary"**,

a Member or a person admitted as a Dependant of a Member.

4.6 **"Benefit"**,

a health provision or payment in terms of these Rules.

4.7 **"Board"**,

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

4.8 **"Centre Provider"**,

a provider employed by the Scheme who consults at a Medical Centre as authorised by the Board.

4.9 **"Child"**,

a Member's natural child, or a stepchild or legally adopted child or a child in the process of being legally adopted, or, a child who has been placed in the legal custody[1] of the Member or the spouse or partner and who is not a beneficiary of any other medical scheme.

[Amended with effect from 2015/01/01]

4.10 **"Child Dependant"**,

a ~~child~~ person under the age of 21 who is wholly dependant on the member; ~~and who is not in receipt of a regular remuneration of more than the maximum relevant social grant per month;~~ or, a person aged 21 but under the age of 27, who is not self supporting, is a registered ~~full-time~~ student at an educational institution recognised by the Board; or, a registered dependant who, due to a mental or physical disability, is wholly dependent upon the Member.

[Amended and Footnotes added 2015/01/01]

[1] Ref: Child Care Act [No 74 of 1983]; Welfare Laws Amendment Act [No 106 of 1997]; Criminal Procedure Act [No 51 of 1977] [s290]

4.11 **"Condition Specific Waiting Period"**,

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

4.12 **"Continuation Member"**,

a Member who retains membership of the Scheme in terms of Rule 6.2 or a Dependant who becomes a Member of the Scheme in terms of Rule 6.3.

4.13 **"Contracted Fee"**,

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

[Added with effect from 2004/01/01]

4.14 **"Contribution"**,

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

[Amended with effect from 2004/01/01]

4.15 **"Cost"**,

in relation to a benefit, the net amount payable in respect of health service rendered in terms of these Rules.

4.16 **"Council"**,

the Council for Medical Schemes as contemplated in the Act.

[Amend with effect from 2004/01/01]

4.17 **"Creditable Coverage"**,

any period during which a late joiner was –

4.17.1 a member or dependant of a South African registered medical scheme;
[**Amended with effect from 2016/01/01]**

4.17.2 a member or 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;

4.17.3 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,

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

[Added with effect from 2004/01/01]

4.18 "Day",

unless otherwise stated day means working day.

[Added with effect from 2015/01/01]

4.19 "Dependant",

4.19.1 a Member's Spouse or partner who is not :

- a Member; nor,
- a member of another medical scheme; nor,
- a registered dependant of a member of another medical scheme;

[**Amended with effect from 2015/01/01]**

4.19.4 a dependent child;

[**Amended with effect from 2004/01/01]**

4.19.5 the immediate family of a Member in respect of whom the Member is liable for family care and support;

4.19.6 any such other person who is recognised by the Board as a Dependant for purposes of these Rules.

~~**4.19.7** To be eligible as a Dependant, other than as the Member's spouse or partner, a dependant must not be in receipt of a regular income in excess~~

~~of the State Social Pension, a person who is in receipt of a State Disability Grant is eligible.~~

[CMS DELETED with effect from 2015/01/01]

4.20 "Designated Service Provider (DSP)",

a health care provider or group of providers selected by the Scheme as preferred provider/s to provide to the Beneficiaries with Health Services in respect of one or more prescribed minimum conditions.

[Amended with effect from 2015/01/01]

4.21 "Domicilium Citandi et Executandi",

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

[Added with effect from 2004/01/01]

4.22 "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.

[Added with effect from 2004/01/01]

4.23 "Employee",

a person in the employment of an Employer for whom it is a condition of employment to become a Member.

[Amended with effect from 2015/01/01]

4.24 "Employer",

Rhodes University and it's formally affiliated institution/s, recognised by the Board, which contracts with the Scheme for the purpose of admission of it's Employees as members of the Scheme.

[Amended with effect from 2015/01/01]

4.25 "General Waiting Period",

a period, as provided in the Act, during which a Beneficiary is not entitled to claim any benefits.

[Amended with effect from 2015/01/01]

4.26 "Health Services",

any services rendered by a registered provider in terms of these Rules.

4.27 "Income",

for the purposes of calculating contributions in respect of –

4.27.1 a Member who is an employee – gross monthly salary/pensionable earnings;

4.27.2 a Continuation Member – total annual earnings from all sources including employment; and,

- in the absence of proof being provided in respect of 4.27.1 contribution will be deemed to be at the highest level**.**

[Amended with effect from 2015/01/01]

4.28 "Late Joiner",

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

4.29 "Medical Centre",

a Medical Centre staffed, funded and managed by the Scheme for the provision of primary care services.

4.30 "Member",

any person who is admitted as a Member of the Scheme in terms of these Rules and is regarded as the person responsible for: the payment of monthly Contributions for, and, the healthcare of, all the Member's registered Beneficiaries.

[Amended with effect from 2015/01/01]

4.31 **"Member Family"**,

the Member and all registered Dependants.

4.32 **"Partner"**,

one person with whom the Member has

4.32.1 a Civil Partnership in terms of the Civil Union Act, (Act No 17 of 2006); or,

[Amended with effect from 2015/01/01]

4.32.2 a committed relationship, akin to a civil partnership, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party, which is confirmed and supported by a jointly signed and notarised affidavit.

[Amended with effect from 2015/01/01]

4.33 **"Prescribed Minimum Benefits"**,

the benefits contemplated in terms of section 29(1)(o) of the Act relating to the provision of the diagnosis, treatment and care cost for –

(a) the Diagnosis and Treatment Pairs listed in Annexure A of the Act and its Regulations, subject to any limitations specified therein, and;

(b) any Emergency Medical Condition. (as defined in 4.22).

[Amended with effect from 2015/01/01]

4.34 **"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.

4.35 **"Provider"**,

a registered person or institution supplying health services.

4.36 **"Preferred provider"**,

a provider approved by the Board as a preferred supplier of health services.

4.37 "Registrar",

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

4.38 "Rhodes University Medical Scheme Tariff",

the tariff payable for health services as determined by the Board of Trustees.

[Added with effect from 2011/01/01]

~~**4.39 "Social Pension",**~~

~~the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act (Act No. 13 of 2004) as amended from time to time.~~

~~**[Amended with effect from 2015/01/01]**~~

4.40 "Spouse",

one person to whom the Member is married in terms of any law or custom[2].

5 OBJECTS

5.1 The objects of the Scheme are to undertake liability, in respect of its Members and their Dependants,

a) to make provision for the obtaining of any relevant health service;

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

c) to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme;

in return for a contribution or premium.

[Amended with effect from 2015/01/01]

[2] Marriage Act (Act 25 of 1961); Recognition of Customary Marriages Act (Act 120 of 1998).

6 MEMBERSHIP

6.1 Eligibility

6.1.1 Subject to Rule 8, membership of the Scheme is restricted to Employees of an Employer or continuation members subject to Rule 6.2.1.

[Amended with effect from 2015/01/01]

6.1.2 A Member, or Continuation Member, who voluntarily terminates membership, for whatever reason, will not be eligible for readmission as a Member unless that person has been reemployed by an Employer and membership of the scheme is contractual.

[Added with effect from 2015/01/01]

6.2 Continuation Member

6.2.1 A Member may retain membership of the Scheme with registered Dependants, if any, in the event of :

6.2.1.1 retirement from the service of an Employer; or,

6.2.1.2 employment being terminated by the Employer on account of ill-health or disability.

[Amended with effect from 2015/01/01]

6.2.2 Subject to 6.2.1 a Member whose employment terminates shall inform the Board of the intention to continue Membership as a Continuation Member or to terminate membership at least 30 days prior to the scheduled retirement or termination date.

[Amended with effect from 2015/01/01]

6.2.2.1 On receipt of notification the Scheme shall inform the Member of the contribution payable from the date of retirement or termination of employment on account of ill-health or disability.

[Amended with effect from 2015/01/01]

6.3 Dependants of deceased members

6.3.1 Subject to 6.3.3, the registered Dependants of a deceased Member, at the time of such Member's death, shall be entitled to membership of the Scheme without any new restrictions, limitations or waiting periods.

[Amended with effect from 2015/01/01]

6.3.2 The Scheme shall inform the Dependant of the right to membership and of the Contributions payable in respect thereof.

6.3.3 A Dependant, or, a legally appointed person in charge of the affairs of an adult Dependant, or, subject to the Child Care Act [No 74 of 1983] a minor Dependant's guardian, shall inform the Board of the intention to continue Membership as a Member or to terminate membership within 30 days or receipt of this notice.

[Amended with effect from 2015/01/01]

6.3.4 Such a Member's membership, in terms of 6.3.1, terminates if that Member becomes a member or a dependant of a member of another medical scheme, or when such Member ceases to qualify as a Child Dependant.

6.3.5 Subject to 8.1 below 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.

[Amended with effect from 2015/01/01]

7 REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 REGISTRATION OF DEPENDANTS

7.1.1 A Member may apply for the registration of any dependants at the time of application for membership in terms of Rule 8.

7.1.2 No Dependant shall qualify for benefits until such time as the Member qualifies for benefits.

[Amended with effect from 2015/01/01]

7.1.3 If a Member applies to register a new born or newly adopted or fostered child within 30 days of the date of birth or adoption of the child, or appointment as a foster parent or guardian, such child shall thereupon be registered by the Scheme as a Dependant.

[Amended with effect from 2015/01/01]

7.1.3.1 Increased Contributions shall then be due as from the first day of the month following the month of birth or adoption or assumption of fostering or guardianship arrangements and benefits will accrue as from the same date.

[Amended with effect from 2015/01/01]

7.1.4 If a Member who marries or enters into a partnership in terms of 4.32 above subsequent to joining the Scheme applies within 30 days of the date of such marriage, registration of Civil Partnership, or, submission of an affidavit, to register a spouse or partner as a Dependant, the Spouse or partner shall thereupon be registered by the Scheme as a Dependant.

[Amended with effect from 2015/01/01]

7.1.4.1 Increased contributions shall then be due as from the first day of the month following the month of marriage, of partnership registration or submission of affidavit, and benefits will accrue as from the same date. The Spouse or partner shall not qualify for benefits until such time as the Member qualifies for benefits.

[Amended with effect from 2015/01/01]

~~**7.1.5** To be eligible as a Dependant, other than as the Member's spouse or partner, a dependant must not be in receipt of a regular income in excess of the maximum relevant social grant in terms of the Social Assistance Act [No. 13 of 2004] [s4, a-g].~~

[CMS deleted 2015/01/01]

7.2 De-registration of Dependants

7.2.1 A Member shall inform the Scheme within 30 days of the occurrence of any event which results in any Dependant no longer satisfying the conditions in terms of which they may be a Dependant.

[Amended with effect from 2015/01/01]

7.2.2 When a Dependant ceases to be eligible to be a Dependant, that Dependant shall no longer be deemed to be registered as such for the purpose of these Rules nor 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 a parent or guardian.

8.2 No person/s may:

8.2.1 be a member or dependant of another medical scheme in addition to this scheme; or,

8.2.2 be a dependant of more than one member of a particular medical scheme; or,

8.2.3 claim or accept benefits in respect of themselves, or their dependant/s, from any medical scheme in relation to which they are not a member**.**

[Amended with effect from 2015/01/01]

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 the Member's income ~~themself and any dependants of~~ and, at least, the age, ~~income,~~ state of health and, any prior membership of, or,

admission to, any other medical scheme, of the prospective Member and dependant/s. ~~of any other medical scheme~~.

[Amended with effect from 2015/01/01]

8.3.1 The Scheme may require an applicant to provide the Scheme with a medical report in respect of any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made.

8.3.2 The cost 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.

[Amended with effect from 2015/01/01]

8.4 Waiting periods

In terms of the Act the Scheme is entitled to apply general and/or conditions specific waiting periods as prescribed therein upon applicants for :

- Membership; or,
- admission as a Dependant; or,
- in respect of any person where an unexpired waiting period which had been imposed by the previous medical scheme exists, but not exceeding the unexpired period;

and,

without limiting the scope or entitlement of the Scheme, and, provided that it is consistent with the Act, Annexure D : Application of Waiting Periods, as amended from time-to-time, shall be the general principles in use;

and,

is not entitled to apply waiting periods in respect of any treatment or diagnostic procedures covered within the Prescribed Minimum Benefits as defined in the Act.

[Amended with effect from 2015/01/01]

8.4.1 No waiting periods may be imposed on:

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

8.4.1.1.1 change of employment; or,

8.4.1.1.2 an employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the Scheme ~~to which an application is made~~ for such transfer to occur at the beginning of the financial year; or,

[Amended with effect from 2015/01/01]

8.4.1.1.3 where the former medical scheme had imposed a general or condition specific waiting period in respect of persons referred to in this Rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme; or,

8.4.1.1.4 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 balance of the remaining period may be applied; or,

[Amended with effect from 2015/01/01]

8.4.1.1.5 a child dependant born during the period of membership.

8.5 The registered Dependants of a Member must participate in the same benefits option as the Member.

8.6 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.

8.7 Members and their Dependants ~~and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming,~~ who claim any benefit under these Rules are bound by these Rules as amended from time-to-time.

[Amended with effect from 2015/01/01]

8.8 A Member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which that Member may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a Member is entitled under these Rules, or any right in respect of such benefit or payment of such benefit to such Member, if a Member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.

~~**8.9** The Scheme shall in no circumstances be obliged to re-establish membership of a Member whose membership has been terminated in terms of Rule 12.4 and 12.5.~~

[Deleted with effect from 2015/01/01]

9 TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

9.1 If the members of a medical scheme who are members of that group scheme by virtue of their current employment by a particular employer, as defined above, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Board may at its own discretion, after considering the group's risk profile, admit those members and any continuation members of such first-mentioned scheme and also admit any currently registered dependant of such members as a dependant; without a waiting period.

[Amended with effect from 2015/01/01]

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 a provider of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership.

10.2 The utilisation of a membership card by any person other than the Member or a registered Dependant, with the knowledge or consent of the Member or a Dependant, is not permitted and is an abuse of the privileges of membership of the Scheme.

[Amended with effect from 2015/01/01]

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

11 CHANGE OF ADDRESS OF MEMBER

11.1 A Member must notify the Scheme within 30 days of any change of address including 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.

[Amended with effect from 2004/01/01]

12 TERMINATION OF MEMBERSHIP

12.1 Resignation

12.1.1 A Member who, in terms of the conditions of employment is required to be a Member of the Scheme, may not terminate membership while remaining an Employee without the prior written consent of the Employer and the Board.

12.1.2 A Member who resigns from the service of an 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 within the four months prior thereto.

[Amended with effect from 2015/01/01]

12.2 Voluntary termination of employer participation

12.2.1 An Employer may terminate its participation with the Scheme on giving three (3) months written notice.

[Added with effect from 2015/01/01]

12.3 Death

12.3.1 A Member's Membership terminates on death, subject to 6.3.

12.4 Failure to pay amounts due to the Scheme

12.4.1 If a Member fails to pay amounts due to the Scheme, membership and beneficiary benefits may be suspended pending payment, subject to ratification by the Board, and the provisions of 13.2 below shall be applied.

[Amended with effect from 2015/01/01]

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

12.5.1 The Board may exclude or suspend from benefits or terminate the membership of a Member or Dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information. In such event the Member may be required by the Board to refund to the Scheme any moneys which, but for abuse of the benefits or privileges of the Scheme, would not have been disbursed on the Member's behalf and the Scheme must refund all the contributions paid by the member. **[Amended with effect from 2019/01/01]**

12.5.2 The Scheme must be advised of any change in dependant status, number of dependants, or, other changes relevant to the contribution rate, listed dependents or medical circumstances of a Member or Dependant within 30 days of the change.

[Amended with effect from 2015/01/01]

12.6 Undesirable Business Practices

The Scheme shall be entitled to decline any application for membership or for the admission of a person as a Dependant, alternatively, the Scheme may give notice of the termination of an employer's participation in the Scheme should there be any change in membership if, in the opinion of the Board, such application or change in membership is a consequence of, or will result in:

12.6.1 Splitting an Employer group by allowing Employees to join more than one scheme or by allowing voluntary membership which has the effect of splitting low risk members from high risk members;

12.6.2 Moving an entire Employer group out of one scheme and splitting the group into two or more groups, which groups are then placed with different schemes with high risk members directed to one scheme and low risk members to another;

12.6.3 Encouraging this behaviour by financial incentives, including differential commission structures or subsidy policies which discriminate between low risk and high risk members or on any other basis provided for in terms of Section 29(1)(n) of the Act; or,

12.6.4 Any undesirable business practice.

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.

[Amended with effect from 2004/01/01]

13.2 Contributions shall be due monthly in arrears and be payable by not later than the 7th working day of each month. Where Contributions or any other debt owing to the scheme, have not been paid within 30 days of the due date, the Scheme shall have the right to:

[Amended with effect from 2004/01/01]

13.2.1 suspend all benefit payments which have accrued to such Member irrespective of when the claim for such benefit arose; and,

[Amended with effect from 2015/01/01]

13.2.2 give the Member and/or Employer written notice at the domicilium citandi et executandi that if Contributions or such other debts are not paid up to date within 14 days of such notice, membership may be cancelled.

13.3 In the event that payments are brought up to date, and provided membership has not been cancelled in terms of 13.2.2 above, 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, or Dependants, from the date of default and any such benefit paid may be recovered by the Scheme.

[Amended with effect from 2015/01/01]

13.4 The balance standing to the credit of a Member in terms of an option which provides for Medical Savings Accounts shall, at all times remain the property of the Member.

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 of the Scheme is limited to the amount of any unpaid Contributions plus any disbursements made by the Scheme to, or in respect of claims by, the Member or a Dependant which the Scheme is not liable in terms of the Rules to pay, and which have not been repaid to the Scheme.

[Amended with effect from 2015/01/01]

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 health service as contemplated in these Rules, must be accompanied by an account or statement as prescribed by regulation. (Regulation 5)

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

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

15.3 In order to qualify for benefits, where a member submits a claim:

15.3.1 any hardcopy claim must be signed verifying the services rendered;

15.3.2 any claim submitted electronically must be accompanied by a statement verifying the services rendered;

15.3.3 all claims 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.

[Amended with effect from 2015/01/01]

15.4 Where a Member has paid an account, the member shall, in support of that claim, submit a receipt.

15.5 Accounts for treatment of injuries or expenses recoverable from third parties, must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained.

15.6 If the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the Member and the relevant health care provider, within 30 days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and provider the opportunity to resubmit a corrected account or statement to the Scheme within 60 days following the date from which it was returned for correction.

[Amended with effect from 2004/01/01]

16 BENEFITS

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the Member to any registered Dependants.

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

16.3 Any benefit option in Annexure B covers the cost of services rendered in respect of the Prescribed Minimum Benefits.

Amended with effect from 2004/01/01]

16.4 No limitations or exclusions will be applied to the Prescribed Minimum Benefits.

[Added with effect from 2004/01/01]

16.6 The Scheme may exclude services from benefits as set out in Annexure C.

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.

[Added with effect from 2004/01/01]

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.

[Added with effect from 2004/01/01]

17 PAYMENT OF ACCOUNTS

17.1 Payment of accounts or reimbursement of claims is restricted to the nett 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.

[Amended with effect from 2004/01/01]

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

[Added with effect from 2004/01/01]

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

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

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

18 GOVERNANCE

18.1 The affairs of the Scheme must be managed according to these Rules by a Board consisting of at least six persons appointed, or elected, in terms of these Rules to be Trustees.

[Amended with effect from 2015/01/01]

18.2 Half of such Trustees may be appointed by the Employer. In the event of there being more than one Employer, each Employer shall have at least one representative as a Trustee.

18.3 The other half of the Trustees must be elected by Members from amongst Members to serve terms of office of three years each. ~~Should there be more than one Employer at least one Trustee must be elected from the Members of each Employer.~~ **[Deleted with effect from 2016/01/01]**

18.3 Eligibility as member of the Board

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

18.3.1 a person under the age of 21 years;

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

18.3.3 a broker;

18.3.4 the Principal Officer of the Scheme; and,

18.3.5 the auditor of the Scheme.

18.4 Retiring members of the Board are eligible for re-election.

18.4.1 Retiring Trustees will be eligble for re-election provided no person shall serve more than two consecutive terms and no more than three terms all together. **[Amended with effect from 2019/01/01]**

18.6 Temporary replacement of member of the Board

18.6.1 The Board may fill by appointment any vacancy arising during the term of office of the Board due one of its members resigning in terms of Rule 18.13 or ceasing to hold office in terms of Rule 18.14.

[Amended with effect from 2015/01/01]

18.6.2 A person so appointed must retire at the first ensuing Annual General Meeting and that meeting shall fill the vacancy for the unexpired period of office of the vacating member of the Board.

[Amended with effect from 2015/01/01]

18.7 Election of the Board of Trustees

18.7.1 The election of the Board of Trustees must be carried out by the Members present at an Annual General Meeting of the Scheme.

18.7.2 Written nominations to fill vacancies in an election year may be submitted to the Principal Officer, either:

~~**18.7.2.1** at the start of an Annual General Meeting; or,~~ **[Amended with effect from 2022/01/01]**

18.7.2.2 7 days prior to an Annual General Meeting; and, **[Amended with effect from 2022/01/01]**

18.7.2.3 must be signed by the candidate signifying consent to stand for election.

[Amended with effect from 2015/01/01]

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

18.9 Half of the members of the Board plus one is a quorum at meetings of the Board. Co-opted persons do not form part of the quorum.

18.10 The Board must elect from it's number a Chairperson and Vice- Chairperson, who shall be elected at the first Board meeting after an AGM. Each shall hold office for a period of three years. **[Amended with effect from 2022/01/01]**

[Amended with effect from 2015/01/01]

18.11 In the absence of the Chairperson and Vice-Chairperson, the Board members present must elect one of their number to preside.

18.12 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the matter must be carried over for 6 months.

18.12.1 Should the issue relate to the financial viability of the scheme or a member's health the Trustees shall reconvene not later than 7 days later to resolve the impasse.

18.12.1.1 Should this meeting fail to resolve the matter it shall be put to a Special General Meeting of the members who shall vote on the matter and a majority vote of those present shall prevail provided the meeting is quorate, and, Board of Trustees members shall not be required to vote.

~~**18.12.2** Should the issue relate to an unresolvable difference of opinion between Members' Trustees and Employer Trustees the matter must be referred to the Registrar for a final decision.~~

[Deleted with effect from 2016/01/01]

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

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

18.14.1 declared mentally ill or incapable of managing their affairs;

18.14.2 declared insolvent or has surrendered their estate for the benefit of their creditors;

18.14.3 convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;

18.14.4 removed by the court from any office of trust on account of misconduct;

18.14.5 disqualified under any law from carrying on their profession;

18.14.6 removed from office in terms of Rule 18.20.1.

[Added with effect from 2004/01/01]

18.14.7 absenting from three consecutive meetings of the Board without the permission of the Chairperson;

18.14.8 removed from office by the Council in terms of Section 46 of the Act; or,

18.14.9 ceasing to be an appointee by the Employer, or being a Board member elected by Members of the Scheme, or by terminating membership of the Scheme.

18.15 The Board shall meet quarterly or at such intervals as it may deem necessary.

18.16 The chairperson may convene a special meeting should the necessity arise. Any three members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

18.17 The Board may, subject to participation by sufficient members to form a quorum, discuss and resolve matters by telephone or electronic conferencing means and may adopt resolutions on that basis. Such decision to be documented and minuted at the next Board Meeting.

[Added with effect from 2004/01/01]

18.18 Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as Trustees approved by the Board.

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

18.20 A member of the Board who acts in a manner which is seriously prejudicial to the interests of beneficiaries of the medical scheme may be removed by the Board, provided that –

18.20.1 before a decision is taken to remove the member of the Board, the Board shall furnish that member with full details of the evidence which the Board has at its disposal regarding the prejudicial conduct, and allow such member a period of not less than 30 days in which to respond to the allegations;

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

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

[Added with effect from 2004/01/01]

19 DUTIES OF BOARD OF TRUSTEES

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

19.2 The Board must act with due care, diligence, skill and in good faith.

19.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.

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

19.5 The Board shall appoint a Principal Officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the Principal Officer and of any person employed by the Scheme.

19.6 The Chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

19.7 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.

19.8 The Board must ensure that proper control systems are employed by and on behalf of the Scheme.

19.9 The Board must ensure that adequate and appropriate information is communicated to the Members regarding their rights, Benefits, Contributions and duties in terms of the Rules.

19.10 The Board must take all reasonable steps to ensure that Contributions are paid timeously to the Scheme in accordance with the Act and the Rules.

19.11 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

19.12 The Board must obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.

19.13 The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.

19.14 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any Member or Dependant's state of health.

19.15 Subject to 20.5 below the Board must approve all disbursements.

[Amended with effect from 2015/01/01]

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

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

19.18 The Board shall disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme.

20 POWERS OF BOARD

The Board has the power —

20.1 to appoint employees of the scheme and cause the termination of the services of any employee of the Scheme;

[Amended with effect from 2015/01/01]

20.2 to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations;

20.3 to appoint a committee consisting of such Board members and other experts as it may deem appropriate;

20.4 to appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the regulations;

20.5 to delegate any functions to a third party which it deems necessary for the proper, efficient and effective running of the Scheme, without abrogating any power vesting in the Board.

[Amended with effect from 2015/01/01]

20.6 to appoint, compensate and contract with any accredited broker for the introduction or admission of a member to the Scheme;

20.7 to contract with managed health care organisations subject to the provisions of the Act and its regulations;

20.8 to purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it;

20.9 to let or hire movable or immovable property;

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

[Added with effect from 2004/01/01]

20.11 in respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such moneys upon security and to realise, re-invest or otherwise deal with such monies and investments;

20.12 with the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

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

20.14 to donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all of the Beneficiaries;

[Amended with effect from 2015/01/01]

20.15 to grant repayable loans to members or to make *ex gratia* payments on behalf of Members in order to assist such members to meet commitments in regard to any matter specified in Rule 5;

20.16 to contribute to any fund conducted for the benefit of employees of the Scheme;

20.17 to reinsure obligations in terms of the benefits provided for in these Rules;

20.18 to authorise the Principal Officer and /or such members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;

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

20.20 in general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.

21 DUTIES OF PRINCIPAL OFFICER AND STAFF

21.1 The staff of the Scheme must ensure the confidentiality of all information regarding its Members.

21.2 The Principal Officer is the executive officer of the Scheme and as such shall ensure :

[Amended from2004/01/01]

21.2.1 proper performance in the best interests of the members of the Scheme at all times;

[Added with effect from 2004/01/01]

21.2.2 the decisions and instructions of the Board are executed without unnecessary delay;

21.2.3 where necessary, there is proper and appropriate communication between the Scheme and those parties, affected by the decisions and instructions of the Board;

21.2.4 the Board is kept sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in Section 57(4) of the Act;

21.2.5 the Board is kept sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of Section 57(6) of the Act;

21.2.6 no decisions are taken concerning the affairs of the Scheme without prior authorisation by the Board and that at all times the authority of the Board is observed in its governance of the Scheme.

21.3 The Principal Officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme unless the Board appoints another entity to handle this responsibility.

[Amended with effect from 2004/01/01]

21.4 The Principal Officer shall ensure the carrying out of all duties as are necessary for the proper execution of the business of the Scheme. The Principal Officer, or nominee, shall attend all meetings of the Board, and any other duly appointed committee where attendance of the Principal Officer may be required, and ensure proper recording of the proceedings of all meetings.

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

21.6 The Principal Officer shall keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions

of the Scheme unless the Board appoints another entity to handle this responsibility.

[Amended with effect from 2004/01/01]

21.7 The Principal Officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto unless the Board appoints another entity to handle this responsibility.

[Amended with effect from 2004/01/01]

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

21.8.1 An employee, director, officer, consultant or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator.

21.8.2 A broker.

21.9 The provision of Rules 18.14.1 to 18.14.8 apply mutatis mutandis to the Principal Officer.

[Added with effect from 2004/01/01]

22 INDEMNIFICATION AND FIDELITY GUARANTEE

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

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

23 FINANCIAL YEAR OF THE SCHEME

23.1 The financial year of the Scheme extends from the 1st day of January to the 31st day of December of that year.

24 BANKING ACCOUNT

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

[Amended with effect from 2015/01/01]

25 AUDITOR AND AUDIT COMMITTEE

25.6 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.

26.1 The following persons are not eligible to serve as auditor of the Scheme –

25.2.1 a member of the Board;

25.2.2 an employee, officer or contractor of the Scheme;

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

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

25.2.5 a person who is disqualified from acting as an auditor in terms of the relevant legislation or professional code.

[Amended with effect from 2015/01/01]

25.3 Whenever for any reason an Auditor vacates office prior to the expiration of the period for which they have been appointed, the Board must within 30 days appoint another Auditor to fill the vacancy for the unexpired period.

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

25.5 The Auditor of the Scheme at all times has a right of access to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from the Board and the other officers of the Scheme such information and explanations as deemed necessary for the performance of their duties.

25.6 The Auditor must report to the Members of the Scheme on the accounts examined and on the financial statements laid before the Scheme in general meeting.

25.7 The Board must appoint an audit committee of at least five members of whom at least two must be members of the Board, one member representative and one employer representative.

26 GENERAL MEETINGS

26.1 Annual General Meeting

26.1.1 The Annual General Meeting of Members must be held not later than 30th June of each year on a date which may be shown to permit reasonable attendance by members and shall be chaired by the Board Chairperson.

[Amended with effect from 2004/01/01]

26.1.2 The notice convening the Annual General Meeting and agenda must be furnished to Members at least 21 days before the date of the meeting. Members will be furnished on request, copies of the annual financial statements, auditors report and annual report and these documents will be distributed at the Annual General 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.

[Amended with effect from 2004/01/01]

26.1.3 At least 30 Members of the Scheme present or virtually constitute a quorum. If a quorum is not present after the lapse of 60 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 in terms of Rule 26.1.2 and the Members then present will constitute a quorum.

[Amended with effect from 2022/01/01]

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

26.1.5 Notices of motions to be placed before the Annual General Meeting must reach the Principal Officer not later than 7 days prior to the date of the meeting.

26.2 Special General Meeting

26.2.1 The Board may call a Special General Meeting of Members if it is deemed necessary.

[Amended with effect from 2015/01/01]

26.2.2 On the requisition of at least 15 Members of the Scheme, the Board must cause a Special General Meeting to be called within 30 days of the receipt of the requisition by the Principal Officer. The requisition must state the objects of the meeting and must be signed by all the requisitionists and deposited at the registered office of the Scheme.

Only those matters forming the objects of the meeting may be discussed.

[Amended with effect from 2015/01/01]

26.2.3 The notice convening the Special General Meeting, containing the agenda, must be furnished to Members at least 14 days before the date of the meeting. The non-receipt of such notice by a Member does not invalidate the proceedings at such a meeting provided that the notice procedure followed by the Board was reasonable.

[Amended with effect from 2004/01/01]

26.2.4 At least 50 Members not counting Board members present in person or virtually constitute a quorum. If a quorum is not present at a Special General Meeting after the lapse of 60 minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled and the matter shall fall away provided that the viability of the scheme or the health provisions for any members are not negatively affected. If viability or negative effect on health provision is in question the meeting shall be postponed for 7 days and this meeting shall be quorate.

[Amended with effect from 2022/01/01]

27 VOTING AT MEETINGS

27.1 Every Member who is present at a general meeting of the Scheme and whose contribution is not in arrears has the right to vote, or may, subject to this Rule, appoint another Member of the Scheme as proxy to attend, speak and vote in their stead.

27.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the Member and the person appointed as the proxy.

27.3 The chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson if a member, shall have a casting vote in addition to a deliberative vote.

28 COMPLAINTS AND DISPUTES

28.1 Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators shall also provide a telephone number which may be used for dealing with telephonic complaints.

28.2 All complaints received in writing will be responded to by the Scheme in writing within 30 days of receipt thereof.

28.3 A disputes committee ~~of three members~~, chaired by the Dean of Law of Rhodes University, who will co-opt two additional members with relevant knowledge, on a case by case basis, who may not be members of the Board, employees of the administrator of the Scheme or officers of the Scheme, must be established.~~must be appointed by the Board to serve a term of office of 3 years. At least one of such members shall be a person with legal expertise~~. **[Amended with effect from 2016/01/01]**

28.4 Any dispute, which may arise between a Member, prospective Member, former Member, or a person claiming by virtue of such Member and the Scheme or an officer of the Scheme, must be referred by the Principal Officer to the disputes committee for adjudication.

28.5 On receipt of a request in terms of this Rule, the Principal Officer must convene a meeting of the disputes committee by giving not less than 21 days notice in writing to the complainant and all the members of the disputes committee, stating the date, time, and venue of the meeting and particulars of the dispute.

28.6 The disputes committee may determine the procedure to be followed.

28.7 The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.

28.8 An aggrieved person has the right to appeal to the Council against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than three

months after the date on which the decision concerned was made or such further period as the Council may for good cause shown allow.

[Amended with effect from 2004/01/01]

28.9 The operation of any decision which is the subject of an appeal under Rule 28.8 shall be suspended pending the decision of the Council on such appeal.

[Added with effect from 2004/01/01]

29 TERMINATION OR DISSOLUTION

29.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution.

29.2 Members in 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. Unless the majority of members decide that the Scheme must continue, the Scheme must be liquidated in terms of section 64 of the Act.

29.3 Pursuant to a decision by Members taken in terms of Rule 29.2 the Principal Officer must, in consultation with the Registrar, furnish to every Member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

29.4 Every Member must be requested to return their ballot paper duly completed before a set date. If at least 75 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, in consultation with the Registrar, a competent person as liquidator.

30 AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities

of any other medical scheme or person. 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.

[Amended with effect from 2004/01/01]

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

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

[Added with effect from 2004/01/01]

31 RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any Beneficiary must on request and on payment of a fee of R50 per printed copy be supplied by the Scheme with a copy of the following documents:

31.1.1 the Rules of the Scheme;

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

31.1.3 the management accounts in respect of the Scheme.

31.2 A Beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 31.1 and to make extracts there from. A hardcopy and electronic copy of the Rules to be lodged with each Employer.

[Amended with effect from 2015/01/01]

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

[Added with effect from 2004/01/01]

32 AMENDMENT OF RULES

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

32.2 No alteration, rescission or addition which affects the objects of the Scheme, or, which increases the rates of Contribution or decreases the extent of benefits of any particular benefit option of the Scheme by more than the National Treasury project of CPI plus 3% during any financial year, is valid unless it has been approved by the Registrar who shall be provided with a detailed motivation for such an increase. Such motivation should include, for example, matters such as changes in demographics, benefit changes and the need to reach prescribed reserving levels.

[Amended with effect from 2015/01/01]

32.3 Members must be furnished with a summary of such amendments within 14 days after registration thereof. Should the Members' rights, obligations, contributions or benefits be amended, they shall be given 30 days advance notice of such change.

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

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

[Added with effect from 2004/01/01]

ANNEXURE A

1. Determination of Contributions

Contributions shall be determined according to a rate for an Adult Beneficiary and a Child Beneficiary according to the income of the Member.

2. Contribution Table

2.1 [Amended with effect from 2025/01/01]

Member's Monthly Income	Adult Beneficiary	Child Beneficiary
Less than R6000	2710	490
R6001 – R8000	2860	520
R8001 – R10 000	3090	540
R10 001 – R15 000	3330	560
R15 001 – R20 000	3420	590
R20 001 – R25 000	3540	620
R25 001 – R30 000	3580	630
R30 001 plus	3610	640

3. Premium penalties for person joining late in life with effect from 1 April 2001

Premium penalties may be applied to a Late Joiner. Such penalties shall be applied only to that portion of the Contribution relative to the Late Joiner and shall not exceed the following bands:

1 - 4 years @ 0.05 multiplied by the relevant contribution in 2 above

5 – 14 years @ 0.25 multiplied by the relevant contribution in 2 above

15 - 24 years @ 0.5 multiplied by the relevant contribution in 2 above

25 + @ 0.75 multiplied by the relevant contribution in 2 above

Any years of Creditable Coverage which can be demonstrated by the applicant or their dependant shall be subtracted from their current age in determining the applicable penalty. **[Amended with effect from 1 January 2021]**

ANNEXURE B

BENEFITS WITH EFFECT FROM 1 JANUARY 2022 [Amended with effect from 1 January 2024]

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

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100%	No limit	DSP is Public Sector Facilities
B.	BENEFITS OTHER THAN PRESCRIBED MINIMUM BENEFITS		No overall annual limit	Limits are prorated calculated according to the proportion at length of membership of the financial year.
C.	PRIVATE AND PUBLIC HOSPITALS, REGISTERED UNATTACHED OPERATING THEATRES and DAY CLINICS: 1. Accommodation in a general ward, high care ward and intensive care unit. 2. Theatre fees. 3. Medicines, materials and hospital equipment. 4. Visits by medical practitioners. 5. Confinement and midwives.	Preferred Provider - 100% Non-Preferred Provider - 100%	No limit No limit	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency and all PMB's) failing which a co-payment of R500 per admission shall apply. In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. b) The price paid by the Scheme for medicines shall be subject to a medicines formulary and / or reference price list as defined by the Scheme's designated agent.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
				c) In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the case or that the treatment could have been provided other than in-hospital, then, notwithstanding the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. d) Accommodation in an intensive care or high care unit is subject to a maximum period of six (6) days, whereafter authorisation must be obtained for further accommodation. e) The benefit for hospitalisation for psychiatric treatment is subject to pre-authorisation and limited to R12 000per Member family including psychiatric visits in hospital. **[Amended as from 1 January 2019]** f) A cash levy equal to 20% of the Hospital benefit described in this C, with a minimum of R250 and a maximum of R5000, shall be payable by the Beneficiary for each admission to a non-preferred provider hospital. The minimum levy of R250 shall be payable at the time of admission. g) Minor procedures and dressings which can be

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
				performed appropriately in a General Practitioner or specialist's surgery will not receive any hospitalisation benefit. h) In-hospital dental benefits will be paid to an annual limit of R14 000per beneficiary, including doctors costs, subject to authorisation**. [Amended as from 1 January 2023]** i) Under circumstances where a Beneficiary obtains admission to a non-preferred provider hospital, when a preferred provider hospital could have provided the appropriate services, no benefit will be paid.
D.	SPECIALIST SERVICES: 1. In-hospital services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of Hospital services 2.1 Consultations and visits (out-of-hospital) 2.2 All other services, including material supplied for injections, unless stated otherwise in this annexure.	1. Preferred Provider - 100% Non-Preferred Provider -70% 2. Preferred Providers -100% Non-preferred Providers - 100%	1. No limit 2. The first R2 500 PB paid at 100% thereafter at 80% to a max of R5 000 PB with a maximum limit of R10 000 PMF. **[Amended as from 1 January 2024]** 2.2 No limit	(a) Authorisation by the Scheme and referral from the GP is required before specialist services are provided, failing which no benefit will be paid. (b) In the event of an emergency the Scheme may provide authorisation retrospectively provided it is notified within one working day after admission, failing which no benefit will be paid. (c) A cash levy of 20%, except for PMB's in respect of preferred providers, and 30%, in respect of non-preferred providers, if services are voluntarily obtained, shall be payable at point of service by the beneficiary for consultations and visits. For the first R2 000 of the Specialist (D 2.1) and the General Practioner Services (E 2.1) no levy is payable,

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
E.	GENERAL PRACTITIONER SERVICES:			
	1. In-hospital services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital.	1. Preferred Provider - 100% Non-Preferred Provider -70%	1. No limit	A cash levy of 20%, in respect of preferred providers, and 30%, in respect of non-preferred providers for out-of-hospital services shall be payable at point of service by the Beneficiary for normal-hours consultations and visits. Alternatively, should a Beneficiary consult a Medical Centre provider, the levy payable by the Beneficiary will be R 10 for each consultation. An amount equal to R 40 will be deducted off the annual limit in respect of Medical Centre consultations.
	2. Out-of Hospital services. 2.1 Consultations and visits (out-of-hospital)	2. Preferred Providers -100%	2.1 To be included in limits of D2.1	
	2.2 All other services, including material supplied for injections, unless stated otherwise in this annexure.	Non-preferred Providers - 100%	2.2 No limit	
	.			

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
F.	CLINICAL TECHNOLOGISTS			
	1. For services provided in-hospital.	1. Preferred Provider - 100% Non-Preferred Provider - 80%	1. No limit	A cash levy of 20%, in respect of preferred providers, and 30%, in respect of non-preferred providers, shall be payable at point of service by the Beneficiary for out-of-hospital services.
	2. In all other cases other than in-hospital treatment.	2. Preferred Providers - 100% Non-preferred Providers - 100%	2. No limit	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
G.	DENTAL SERVICES 1. Conservative dentistry including ordinary fillings, extractions, x-rays and prophylaxis. 2. Specialised dentistry including dentures, crowns, bridges, orthodontic treatment, metal based dentures, periodontal treatment, non-precious metal, osseo-integrated implants and ceramic inlays and dental technician fees.	Preferred Provider - 80% Non-Preferred Provider - 80%	1. No Limit. 2. R6 500 subject to a maximum of R14 000 PMF **Amended as from 1 January 2024]**	a) The first R1 400 of the Conservative Dentistry benefit is paid at 100% **Amended as from 1 January 2023]** b) Dentures shall be limited to one set PB per three consecutive financial year period. All orthodontic services are subject to authorisation from the Scheme's designated agent prior to treatment, failing which a co-payment of R500 shall be payable by the Member. Repairs to dentures will be paid up to the limit within the time period entitlement in lieu of new dentures c) After the per beneficiary limit is exceeded a further benefit up to the family limit will be paid after a levy of 30%

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
H.	**PRESCRIBED MEDICINE AND INJECTION MATERIAL:**			
	1. Acute sickness conditions.	1. Preferred Provider - 100% Non-Preferred Provider -100%	1. R4 400 PB subject to a maximum of R10 000 PMF. **[Amended as from 1 January 2023]**	a) Medicines to be prescribed by a person legally entitled to prescribe. b) To qualify for medicines for chronic sickness conditions authorisation must be obtained from the Scheme/Scheme's designated agent, failing which the medicines will be deemed to be for an Acute sickness condition.
	2. Chronic sickness conditions. 2.1 Chronic Disease List (CDL) included in PMB's	2.1 100%	2.1 No limit	c) A Chronic sickness condition is one that, due to its inherent pathological process/es remains unresolved and invariably requires prolonged medication and/or other therapy to sustain life or optimal physical status through arresting or retarding and occasionally causing remission (temporary or permanent) of the disease.
	2.2 Non CDL approved chronic medication	2.2 100%	2.2 No limit	d) The price paid by the Scheme shall be subject to a medicine formulary and / or reference price list as defined by the Scheme's designated agent

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
	3. To-Take-out medicines (TTO) 4. Pharmacist Advised Therapy (PAT)	3. Preferred Provider - 100% Non-Preferred Provider - 100% 4. Preferred Provider – 100% Non-Preferred Provider – 100%	3. Limited R500 per admission from the hospital benefit and thereafter included in limit for medicines for Acute sickness conditions. 4. Maximum of R200 per script paid at 100% subject to a maximum of R2 000PMF per annum **[Amended as from 1 January 2023]** PAT claims will be deducted off the limit for medicines for Acute sickness conditions.	e) The price paid by the Scheme for medicines shall be subject to a medicines formulary and / or reference price list as defined by the Scheme's designated agent. f)The levy payable per item, at point of service to a preferred provider, shall be 20% of the agreed net script value for acute medicines, and 10%, up to a maximum of R100 per item, of the agreed net script value for non-PMB chronic medicines. The levy payable, at point of service to a non-preferred provider, shall be 30% of the script value for acute sickness conditions. No levy is payable for the first R2200 of the acute medication benefit. Medicines that are authorised in respect of Chronic sickness conditions that are obtained from a non-preferred provider shall be deemed to be in respect of Acute sickness conditions, the benefits and annual limits of which shall apply. **[Amended as from 1 January 2022]** g) Contraceptive sublimit of R3500 within acute sickness limit, with IUDs only being claimable every 5 years. Oral contraceptives paid at R190 per script for 13 scripts per annum. **[Amended as from 1 January 2024]** h) Colostomy bags, diabetic test strips and injections are included in the chronic medicine benefit.

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	RADIOLOGY			
	1. For services provided in-hospital	1. Preferred Provider - 100% Non-Preferred Provider - 80%	1. No limit	a) MRI, CAT, GALLIUM Scans and/or bone density tests must be authorised by the Scheme/Scheme's designated agent, except in emergencies, failing which a co-payment of R500 per scan or test shall apply. b) In the event of an emergency the Scheme shall be notified of such emergency within one working date after admission failing which the R500 co-payment shall apply. c) Should pre-authorisation for MRI/CAT, GALLIUM scans and/or bone density tests not be obtained and the scans would, under normal circumstances, not have been authorised, no benefit will be paid.
	2. For services provided out-of-hospital	2. Preferred Provider – 80% Non-Preferred Provider – 70%	2. No limit, except in the case of ultra sound scans in which case a maximum of two scans per pregnancy is available.	
	3. MRI, CAT, GALLIUM SCANS and/or BONE DENSITY TESTS	3. Preferred Provider -100% Non-Preferred Provider - 80%	3. No limit	

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
J.	PATHOLOGY and MEDICAL TECHNOLOGY 1. For services provided in-hospital	1. Preferred Provider - 100% Non-Preferred Provider - 80%	1. No limit	
	2. For services provided out-of-hospital	2. Preferred Provider – 80% Non-Preferred Provider – 70%	2. No limit	
K.	CHEMOTHERAPY and RADIOTHERAPY	1. Preferred Provider - 100% Non-Preferred Provider - 80%	1. R350 000 PMF **[Amended as from 1 January 2025]**	Authorisation shall be obtained from the Scheme/Scheme's designated agent prior to commencement of treatment, failing which no benefit will apply.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
L.	KIDNEY DIALYSIS	Preferred Provider – 100% Non-Preferred Provider - 80%	Unlimited PMF subject to a cost per treatment as negotiated with the provider. **[Amended as from 1 January 2020]**	a) Authorisation shall be obtained from the Scheme/Scheme's designated agent before treatment, failing which a co-payment of R100 per treatment shall apply. b) Should preauthorisation not be obtained and the treatment would, under normal circumstances, not have been authorised, no benefit will be paid. c) At the time of authorisation consideration will be given to the following: – Beneficiaries under the age of 8 or over the age of 55 years will only be eligible if biologically fit as certified by a specialist nephrologist, the Beneficiary must be free of significant ischaemic heart disease, cerebral vascular disease, chronic liver disease and chronic lung or malignant disease, – There must be no history of non-compliance with medical treatment for this condition.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
M.	PHYSIOTHERAPY 1.Out-of-hospital 2.In-hospital	Preferred Provider – 100% Non-Preferred Provider – 100%	Included in limit of Q. 2. Limited to R4 000 per family(included in limit of Q) **[Amended as from 1 January 2015]**	a) Referral by a general practitioner or specialist is required. b) A cash levy of 20%, in respect of preferred providers, and 30%, in respect of non-preferred providers, shall be payable at point of service by the Beneficiary for each out-of-hospital services. Alternatively, should a Beneficiary consult a Medical Centre provider the levy payable by the Beneficiary will be R10 for each consultation. c) In-hospital services must be authorised by the Scheme's designated agent failing which no benefit will apply.
N.	BLOOD TRANSFUSIONS	Preferred Provider - 100% Non-Preferred Provider - 80%	No limit	Includes the cost of blood, blood equivalents, blood products and the transport of blood.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
O.	AMBULANCE SERVICES and EMERGENCY TRANSPORT SERVICES (Road and Air)	Preferred Provider - 100% Non-Preferred Provider - 0%	No limit provided pre-authorisation is obtained.	a) Authorisation must be obtained from the contracted preferred provider before use is made of an ambulance service (except in the case of emergency) failing which the Scheme's liability will be to the cost of the service at a DSP, unless PMB's apply. b) In the event of an emergency the contracted preferred provider shall be notified of such emergency within one working day after the transport is provided, failing which the Scheme's liability will be limited to the cost of the service at a DSP, unless PMB'. **[Amended as from 1 January 2019]**
P.	ALTERNATIVES TO HOSPITALISATION: 1. Private Nursing 2. Step-down Nursing Facilities 3. Hospice 4. Compassionate Care Benefit	Preferred Provider - 100% Non-Preferred Provider - 0%	1. R10 000 PB **[Amended as from 1 January 2019]** 2. Included in Private Nursing limit 3. Included in Private Nursing limit, subject to a daily maximum accommodation limit of R200 Unless in accordance with the Prescribed Minimum Benefits **[Amended as from 1 January 2019]** 4. Limited to R20 000 per family **[Added as from 1 January 2018]**	

	SERVICE	**% BENEFIT**	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
Q.	AUXILIARY SERVICES Includes all registered service provides other than those specified in this annexure. 1. In hospital 2. Out of hospital	Preferred Provider - 100% Non-Preferred Provider - 100%	1. R4 000 PMF **[Amended as from 1 January 2019]** 2. R4 000 PB to a maximum of R10 000 PMF. Psychology benefit can be utilized over the beneficiary limit up to the family limit. **[Amended as from 1 January 2023]**	1. Pre-authorised by the Scheme's designated agent 2.1 Referral must have been made by a general practitioner or specialist. 2.2 A cash levy of 20%, in respect of preferred providers, and 30%, in respect of non-preferred providers, shall be payable at point of service by the Beneficiary for each out-of-hospital consultation. Alternatively, should a Beneficiary consult a Medical Centre provider the levy payable by the Beneficiary will be R10 for each consultation.
R.	INTERNAL SURGICAL IMPLANTS	Preferred Provider – 100% Non-preferred Provider – 80%	R44 000 per PB **[Amended as from 1 January 2019]**	a) Subject to authorisation from the Scheme failing which a co-payment of R 500 will apply. Subject to a levy of 20% payable at point of service, which levy may be waived provided the Scheme supplies the accessory.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
S.	OTHER MEDICAL AND SURGICAL APPLIANCES 1. Hearing Aids 2. Wheelchairs 3. Nebulisers/Glucometers	Preferred Provider – 100% Non-Preferred Provider – 100%	Combined limit for all appliances of R5 000 PMF **[Amended as from 1 January 2025]**	A cash levy of 20%, in respect of preferred providers, and 30% in respect of non-preferred providers shall be payable at point of service by the Beneficiary. Subject to pre-authorisation from the Scheme. An amount of R18 000 paid at 90% per ear per 4 year cycle is added to the annual limit for hearing aids.
T.	OXYGEN (Including cylinders)	Preferred Provider – 100% Non-preferred Provider – 0%	R10 000 PMF. **[Amended as from 1 January 2019]**	Subject to pre-authorisation from the Scheme **[Amended as from 1 January 2018]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
U.	EXTERNAL ORTHOPAEDIC APPLIANCE Post-Operative Appliance Corrective Appliance	Preferred Provider – 100% Non-Preferred Provider – 80%	R6 000 PB **[Amended as from 1 January 2015]**	a) Authorisation shall be obtained from the Scheme's designated agent, failing which a 20% co-payment shall apply. b) No benefit will be paid unless the invoice for the appliance is accompanied by a specialist practitioner's prescription and the appliances supplied by a registered Orthopod.
V.	OPTICAL 1. Eye examinations 2. Lenses 3. Frames 4. Contact Lenses	Preferred Provider - 100% Non-Preferred Provider - 100%	1. Eye Examinations limited to one per beneficiary per annum. **[Amended as from 1 January 2019]** 2. Single vision - R640 PB Bifocal –R1 490 PB Multifocal –R2 540 PB 3. R1060 PB 4. Contact lenses – R1 900-PB **[Amended as from 1 January 2025]**	a) Benefits for lenses shall not exceed the tariff. b) Spectacles limited to one pair PB every two years. c) Should the frame benefit not be fully utilised tints, hardening and non –reflective coatings can be claimed from this benefit. **[Amended as from 1 January 2021]** d) Contact lenses benefit is per annum. e) Optical benefit is limited to either contact lenses or spectacles in a year. f) **[Amended as from 1 January 2019]**

	GENERAL	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
1.	ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) and RELATED ILLNESSES	Benefits payable in terms of the relevant paragraphs above	Benefits payable in terms of the relevant paragraphs above	a) Benefit is subject to Beneficiary participating in and complying with the Scheme's Wellness Programme.
2.	ALCOHOLISM AND DRUG DEPENDENCY	Benefits payable in terms of the relevant paragraphs above	R3000 PMF	a) Benefit is subject to Beneficiary obtaining authorisation from the Scheme's designated agent through Wellness program. b) All services included in limit. Unless in accordance with the Prescribed Minimum Benefits. **[Amended as from 1 January 2019]**
3.	ORGAN TRANSPLANTS	Benefits payable in terms of the relevant paragraphs above	R100 000 PMF	All services included in limit. Unless in accordance with the Prescribed Minimum Benefits. **[Amended as from 1 January 2019]**
4.	4.1 OSSEO-INTEGRATED IMPLANTS 4.2 COCHLEAR IMPLANTS		4.1 Included in in-hospital dentistry benefit. 4.2 No benefit	4.1 Benefit subject to Beneficiary obtaining authorisation from the Scheme's designated agent.

5.	INFERTILITY	Benefits payable in terms of the relevant paragraphs above.	Only in a Public Hospital	Benefit in respect of investigation and treatment only.
6.	PREVENTATIVE CARE AND WELLNESS BENEFIT	100%	R2 000 PB R4 000PMF **[Amended as from 1 January 2025]**	Subject to pre-authorisation by the Scheme's designated agent the preventative care that will be covered includes: mammograms (women aged 40 and older, every two years), PAP smears, prostate examinations, , cholesterol blood test, blood sugar test, HIV test and a glaucoma test and includes immunisations and HPV vaccines funded as per registered indications.. An additional R2 000PB allocated for child and HPV immunisations and which does not accumulate to the family limit of R3 000. HPV vaccines funded as per registered indications. **[Amended as from 1 January 2023]**
7.	MATERNITY BENEFIT **[New benefit as of 1 January 2019]**	100%	1. 4 GP / Gynaecology/ Midwives visits 2. 2 2D scans 3. 1 Paediatrician visit 4. Maternity bag	Subject to registration on the maternity programme. Gynaecologist confinement fee is limited to 200%. Home delivery is limited to ~~R3000~~ R12 000 if successful and if not successful R1200. Antenatal vitamins are limited to ~~R65~~ R100 per month for 9 months and are included in the acute medication limit. **[Amended as from 1 January 2023]**

			[Amended as from 1 January 2025]	

Legend:

% Benefit	=	Scale of Benefits/ Guide/ Cost/ Negotiated Cost with the provider {whichever is applicable or the lesser}.
PB	=	Per Beneficiary
PMF	=	Per Member Family

ANNEXURE C1
MEDICAL SAVINGS ACCOUNT (MSA)

1. On admission to the Scheme, a Personal Medical Savings Account (MSA), held by the Scheme, shall be established in the name of the Member concerned into which the contributions payable in respect of the MSA components shall be credited and benefits withdrawn in respect thereof, shall be debited.

2. Subject to sufficient funds being available at the date on which a claim is processed Members shall be entitled to use their MSA to pay for all healthcare services indicated and any co-payments or shortfalls for which the Member is responsible.

3. Any balance in the MSA account at the end of a financial year remains the property of the Member and accumulates to the Member's account.

4. Upon the death of the Member, the balance due to the Member will be transferred to any Dependants who continue membership of the Scheme, or, be paid into the Member's estate in the absence of such Dependants.

5. Should a Member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme which does not provide for a MSA, the balance due to the Member must be refunded to the Member within five months after termination of membership, and subject to applicable laws.

6. Should a Member be admitted to membership of another medical scheme, which provides for a similar account, the balance due to the Member must be transferred to such scheme within five months after termination of membership.

ANNEXURE C2

(Benefits available under the Prescribed Minimum Benefits are payable without limitation where services are rendered by public hospitals)

EXCLUSIONS

1. Unless otherwise provided for in the Act or its regulations (including Prescribed Minimum Benefits) or decided by the Board and not inconsistent with the Medical Scheme's Act, expenses incurred in connection with any of the following will 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 may be liable, unless the Board is satisfied that there is no reasonable prospect of the Member or Dependant recovering such costs from the other party. Where claim against such other party for costs, after deliberation, is repudiated or short-paid, the Member is entitled to such benefits as would have been allowed in terms of the Rules under normal conditions, irrespective of the lapse of time.

1.2 All costs of whatsoever nature incurred for treatment of self-inflicted sickness conditions or injuries, or the excessive use of intoxicating substance or drug or material violation of the law, unless in accordance with Prescribed Minimum Benefits;

1.3 All costs in respect of injuries arising from professional sport, speed contests and speed trials, unless regulated as a Prescribed Minimum Benefit.

1.4 All costs for operations, medicines, treatment and procedures for cosmetic purposes, and the treatment of obesity and its direct implications (includes sclerotherapy except in the case of haemorrhoids), unless in accordance with Prescribed Minimum Benefits.

1.5 Holidays and/or treatment in headache and stress-relief clinics,spas and resorts for health ,slimming, recuperative or similar purposes.

1.7 All costs that are more than the annual maximum benefit to which a Member is entitled in terms of the Rules.

1.8 Charges for appointments which a Member or Dependant fails to keep.

1.9 Costs for services rendered by —

1.9.1 persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

1.9.2 any institution, nursing home or similar institution except a state or provincial hospital not registered in terms of any law.

1.10 Travelling expenses incurred by practitioners.

1.10 Any benefits that are not available under the Prescribed Minimum Benefits and not included in Annexure B hereof.

1.11 Medication provided in terms of the Auxiliary Services benefit except if:

1.11.1 The medication is supplied to treat a condition diagnosed by a medical doctor, and

1.11.2 The medication is authorised by the Scheme's designated agent.

1.12 Frailcare. Including Accommodation in convalescent or old age homes or similar institutions catering for the aged.

1.13 Infertility tests and treatments, unless in accordance with Prescribed Minimum Benefits. Such treatments include histero-salpynograms, hormone tests, laparoscopies, histeroscopes, surgery (uterus and tubal), manipulation of oculation, semen analysis, basic counseling and advice on sexual behavior, temperature charts and the treatment of local infections.

1.14 Medical treatment necessitated as a result of non-compliance with prescribed therapy.

1.15 Medical examinations or evaluations for employers or employment and/or insurance, and/or school readiness tests and/or legal purposes.

1.16 Hire of medical, surgical and other appliances unless authorised by Scheme's designated agent, unless in accordance with Prescribed Benefits

1.17 Medicines not on the formulary if a formulary is applicable.

1.18 Immunosuppressants unless post organ transplant.

1.19 Immunization unless authorised by the Board.

1.20 The treatment of Tuberculosis except surgical treatment in hospital as per the Prescribed Minimum Benefits unless services provided through Wellness Program.

1.21 Chemotherapy, Radiotherapy and Dialysis where the Beneficiary is immuno-compromised will only be funded according to documented criteria if the beneficiary is enrolled on the Scheme's Wellness Program subject to a PMB.

1.22 Services in respect of which claims are received more than 4 months after the date of service.

1.23 Injuries sustained during participation in a strike, illegal picketing or riot or during a physical struggle, unless in accordance with Prescribed Minimum Benefits**.**

1.24 Medication, material and procedures appearing on the Scheme's exclusions list subject to a Prescribed Minimum Benefit.

1.25 All cost in respect of medicine not approved by the Medicines Control Council.

1.26 All cost in respect of the use of medication for indications not registered by the Medicines Control Council.

1.27 Organ and tissue donations to any person other than to a member or dependant of a member.

1.28 Interest charges on overdue accounts or legal fees incurred as a result of delayed or non-payment of accounts due to it being the member's fault.

1.29 Any expenses in respect of sickness conditions that were subject to waiting periods when the Member joined the Scheme.

1.30 Costs associated with vocational guidance, marriage guidance, school therapy or attendance at remedial educational schools or clinics.

1.31 Expenses arising from experimental, unproven or unregistered treatment practices.

1.32 Compensation for pain and suffering, loss of income, funeral expenses or any other claim for damages.

1.33 Accommodation in a private room of a hospital, unless clinically indicated and prescribed by a medical practitioner and authorised by the Scheme.

1.34 Telephonic consultations, writing of prescriptions or motivational letters and costs for confirming of medical aid benefits.

1.35 Payment of claims for additional and/or alternative procedures performed which are not in accordance with the original authorization and for which a motivation confirming the medical appropriateness of said procedure(s) was not received.

1.36 All costs in respect of an authorised procedure which is not completed due to a decision by the member or the member's family. All costs already incurred prior to this decision being taken will be for the member's own account.

1.37 All costs in respect of an authorised procedure which is not completed due to a hospital limitation, for example, faulty equipment or lack of prescribed medication. Any costs already incurred in preparation for this procedure will be for the hospital's own account.

1.38 ~~Accommodation in a private room of a hospital, unless clinically indicated and prescribed by a medical practitioner and authorised by the Scheme.~~
[Deleted with effect from 1 January 2018 – duplicate of 1.33]

1.39 Any costs associated with search and rescue.

1.40 ~~Interest charges on overdue accounts or legal fees incurred as a result of delayed or non-payment of accounts due to it being the member's fault~~
[Deleted with effect from 1 January 2018 – duplicate of 1.28]

1.41 Services provides outside of a practitioners registered scope of practice.

1.42 X-Rays performed by chiropractors.

1.43 Costs for investigations done in hospital that could be done on an outpatient basis.

1.44 ~~All costs for healthcare services which, in the opinion of the Scheme's clinical committee, are not appropriate and necessary for the diagnosis or treatment of a health condition at an affordable level of service and cost.~~
[Deleted with effect from 1 January 2018 – duplicate of 1.45]

1.45 All costs for healthcare services which, in the opinion of the Scheme's clinical committee, are not appropriate and necessary for the diagnosis or treatment of a health condition.

2. LIMITATION OF BENEFITS

2.1 The maximum benefits to which a Member and any Dependants are entitled in any financial year are limited as set out in Annexure B.

2.2 Members admitted during the course of a financial year are entitled to the benefits set out in Annexure B, 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.

2.3 In cases of illness of a protracted nature, the Board shall have the right to insist upon a Member or Dependant consulting any particular specialist the Board may nominate in consultation with the attending practitioner. In such cases, if such specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

2.4 All expenses incurred outside the Rand monetary area will not be covered by the Scheme. The Scheme has negotiated a benefit through a third party, and outsources a benefit to all members and their registered dependants (Emergency care, stabilizing and repatriation back to South Africa).

2.5 Costs in respect of organ and tissue donations for Scheme members will be funded to the maximum of the cost of South African donors.

2.6 Any authorised rehabilitation will only be considered, subject to the benefit limit, to the point where the beneficiary no longer shows clinical improvement.

2.7 For routine or scheduled elective surgery, a second opinion may be required, failing which the Scheme, in the discretion of the Board, may impose a percentage co-payment to the member. The Scheme will bear the consultation costs for such second opinion.

2.8 In cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.

2.9 If the Scheme or its managed health care organization has funding guidelines or protocols in respect of covered services and supplies, Beneficiaries will only

qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of clinical guidelines.

2.10 If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, Beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to those conditions as the Scheme or its managed healthcare organisation may impose. "Medically necessary" refers to services or supplies that meet all the following requirements:

(a) They should restore normal function of an affected limb, organ or system;

(b) No alternative exists that has a better outcome, is more cost-effective, or has a lower risk;

(c) They are accepted by the relevant service provider as optimal necessary for the specific condition and at an appropriate level to render safe and adequate care;

(d) They are not rendered or provided for the convenience of the relevant beneficiary or service provider and

(e) Outcome studies are available and acceptable to the Scheme in respect of such services or supplies.

2.11 The Scheme reserves the right not to pay for any new technology, investigational procedures/interventions or new drugs/medication as applied in clinical medicine unless motivation by means of clinical data has been presented to and accepted by the clinical committee in regard to the following aspects of such technology, procedures or drugs:

(a) Their therapeutic role in clinical medicine;

(b) Their cost-efficiency or affordability;

(c) Their value relative to existing services or supplies;

(d) Their local indications, application and outcome studies and

(e) Their role in drug therapy as established by the Scheme's managed healthcare organisation.

2.12 An exclusion period of one or more years may be imposed by the Scheme to assess the local indications, application and outcome figures on all new

medicines/technology/procedures or any instance where evidence is lacking or still under review before it can be considered for inclusion in relation to benefits paid.

2.5

ANNEXURE C3

PRESCRIBED MINIMUM BENEFITS (PMB's)

1. APPOINTMENT OF DESIGNATED SERVICE PROVIDERS

The Scheme appoints the following service providers as Designated Service Providers for the delivery of Prescribed Minimum Benefits to its Beneficiaries:

- State Healthcare facilities;
- Outpatient medical management and pathology from Prime Cure and
- Chronic medication form the chronic disease list (CDL) from Grahamstown Pharmacies, Dis-Chem and Clicks pharmacies.

Where public services are not accessible, the scheme will make arrangements with private providers who will be deemed designated service providers in such instances.

[Added as from 1 January 2016]

2. PRESCRIBED MINIMUM BENEFITS OBTAINED FROM DESIGNATED SERVICE PROVIDERS

100% of the cost in respect of diagnosis, treatment and care costs of Prescribed Minimum Benefit Conditions if those services are obtained from a Designated Service Provider, subject to the Scheme's Managed Care Protocols. Where no formal arrangement with a DSP exists for PMB conditions, members have freedom of choice of provider. The onus shall be on the Scheme to ensure that the services are available and have the patient admitted to the DSP.

3. PRESCRIBED MINIMUM BENEFITS VOLUNTARILY OBTAINED FROM OTHER PROVIDERS

If a Beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit Condition from a provider other than a Designated Service Provider, the benefit payable in respect of such service is subject to such benefit limitations and Scheme approved tariffs and co-payments as are normally applicable in terms of the relevant option chosen by the member.

4. PRESCRIBED MINIMUM BENEFITS INVOLUNTARILY OBTAINED FROM OTHER PROVIDERS

4.1 If a Beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit Condition from a provider other than a Designated Service Provider, the Scheme will pay 100% of the cost in relation to that Prescribed Minimum Benefit Condition.

4.2 For the purposes of paragraph 4.1, a Beneficiary will be deemed to have involuntarily obtained a service from a provider other than a Designated Service Provider, if:

4.2.1 the service was not available from the Designated Service Provider or would not be provided without unreasonable delay;

4.2.2 immediate medical or surgical treatment for a Prescribed Minimum Benefit Condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a Designated Service Provider; or

4.2.3 there was no Designated Service Provider within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

4.3 Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a Member prior to involuntarily obtaining a service from a provider other than a Designated Service Provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 4.2 are applicable.

5. MEDICATION

5.1 Where a Prescribed Minimum Benefit includes medication, the Scheme will pay 100% of the cost of the medication if that medication is obtained from a Designated Service Provider or is involuntarily obtained from a provider other than a Designated Service Provider, and

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

5.1.2 the formulary does not include medication which is clinically appropriate and effective for the treatment of the Prescribed Minimum Benefit Condition.

5.2 Where a Prescribed Minimum Benefit includes medication and:

5.2.1 That medication is voluntarily obtained from a provider other than a Designated Service Provider; or

5.2.2 The formulary includes a medication which is clinically appropriate and effective for the treatment of a Prescribed Minimum Benefit Condition suffered by a Beneficiary, and that Beneficiary knowingly declines the medication on the formulary and opts to use another medication instead,

then a co-payment equal to the difference between the cost of the medication so obtained and the reference price of the formulary medication will apply.

6. PRESCRIBED MINIMUM BENEFITS OBTAINED FROM A PUBLIC HOSPITAL

Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the costs of Prescribed Minimum Benefits obtained in a public hospital, without limitation.

7. DIAGNOSTIC TEST FOR AN UNCONFIRMED PMB DIAGNOSIS

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

8. CO-PAYMENTS

Co-payments in respect of the costs for PMB's may not be paid out of Medical Savings Accounts.

9. CHRONIC CONDITIONS

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

PRESCRIBED MINIMUM BENEFIT CONDITIONS

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

ANNEXURE D

Application of waiting periods				
Category	**Dependant type**	**3 month general**	**12 month pre-existing**	**Late Joiner penalty**
A new employee upon commencement of employment at Rhodes University *(Date of employment and the Scheme join date is the same)* *No Previous medical aid*	Employee	No	Yes	No
	Employee's immediate family *(spouse and biological children)*	No	Yes	No
	Employee's extended family *(mother, father, brother, sister)*	Yes	Yes	Yes
New employee upon commencement of employment at Rhodes University *(Date of employment and the Scheme join date is the same* *Previous medical aid (cover for more than 2 years and the break between that Scheme and RUMed is less than 90 days)*	Employee	No	No	No
	Employee's immediate family *(spouse and biological children)*	No	No	No
	Employee's extended family *(mother, father, brother, sister)*	Yes	No	Yes
New employee after commencement of employment at Rhodes University *(Date of employment and the Scheme join date is not the same)* *No previous medical aid*	Employee	Yes	Yes	No
	Employee's immediate family *(spouse and biological children)*	Yes	Yes	No
	Employee's extended family *(mother, father, brother, sister)*	Yes	Yes	Yes
New employee after commencement of employment Rhodes University *(Date of employment and the Scheme join date is not the same)* *Previous medical aid (cover for more than 2 years and the break between that Scheme and RUMed is less than 90 days)*	Employee	Yes	No	No
	Employee's immediate family *(spouse and biological children)*	Yes	No	No
	Employee's extended family *(mother, father, brother, sister)*	Yes	No	Yes

The following scenarios refer to the registration of dependants **after** the principal member has joined the Scheme:

Dependant type	3 month general	12 month pre-existing	Late Joiner penalty
Spouse Within 30 days of marriage No previous medical aid	No	Yes	No
Spouse Within 30 days of marriage Previous medical aid *(cover for more than 2 years and the break between that Scheme and RUMed is less than 90 days*	No	No	No
Spouse After 30 days of marriage No previous medical aid	Yes	Yes	No
Spouse After 30 days of marriage Previous medical aid	Yes	No	No
Common Law Spouse / Civil contract No previous medical aid	Yes	Yes	No
Common Law Spouse / Civil contract Previous medical aid	Yes	No	No
Newborn baby or adopted child registered within 30 days of birth / adoption	No	No	No
Newborn baby or adopted child registered after 30 days of birth / adoption	Yes	Yes	No
Biological children *(not newborn children)* Previous Medical Aid	Yes	No	No
Biological children *(not newborn children)* No Previous Medical Aid	Yes	Yes	No
Extended family *(mother, father, brother, sister)* Previous Medical Aid	Yes	No	Yes
Extended family (mother, father, brother, sister) No Previous Medical Aid	Yes	Yes	Yes