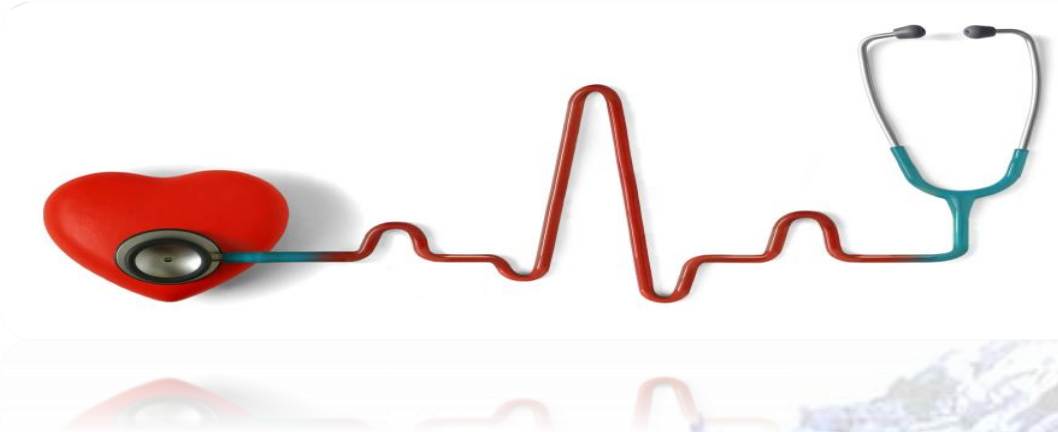
RAND WATER

2020 MEDICAL SCHEME BENEFITS CONTRIBUTIONS AND RULES



Looking after you and your family

SUMMARY OF CONTRIBUTION INCREASE FOR 2020

The Trustees have adopted a change to the pricing philosophy applied historically. The pricing philosophy adopted for the 2020 benefit year is to break-even before investment income. The following contribution increases effective 1 January 2020 and was approved as such by the Council for Medical Schemes:

Option A	5.50%
Option B Plus	4.50%

* **Please be advised the Contribution Increase, and Benefit Limit amendments has been approved by the Council of Medical Schemes**

IMPORTANT INFORMATION

1. **Please read Rule 18 for the amended Scheme process on Third Party Recoveries**
2. **The Scheme does not cover medical expenses incurred outside the boarders of South Africa**

We encourage you to share the content of this brochure with your family members who are members of the Scheme

1. MEMEBERSHIP CONTRIBUTIONS

Rand Water 2019 & 2020 Contributions Table Option A (Before Subsidy)

Option A	Below R 7,400		R 7,401 to R 12,300		R 12,301 to R 17,600		R 17,601 to R 22,600		Above R 22,601	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Member	2,592	2,736	3,027	3,192	3,432	3,621	3,870	4,083	4,128	4,356
Per Adult Dependant	1,680	1,773	1,968	2,076	2,232	2,355	2,523	2,661	2,679	2,826
Per Child Dependant	441	465	510	537	582	615	654	690	702	741

Family Size	Below R 7,400		R 7,401 to R 12,300		R 12,301 to R 17,600		R 17,601 to R 22,600		Above R 22,601	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Member	2,592	2,736	3,027	3,192	3,432	3,621	3,870	4,083	4,128	4,356
Member, Adult	4,272	4,509	4,995	5,268	5,664	5,976	6,393	6,744	6,807	7,182
Member, Adult, 1 Child	4,713	4,974	5,505	5,805	6,246	6,591	7,047	7,434	7,509	7,923
Member, Adult, 2 Children	5,154	5,439	6,015	6,342	6,828	7,206	7,701	8,124	8,211	8,664
Member, Adult, 3 Children	5,595	5,904	6,525	6,879	7,410	7,821	8,355	8,814	8,913	9,405
Member, Adult, 4 Children	6,036	6,369	7,035	7,416	7,992	8,436	9,009	9,504	9,615	10,146
Member, Adult, 5 Children	6,477	6,834	7,545	7,953	8,574	9,051	9,663	10,194	10,317	10,887
Member, 1 Child	3,033	3,201	3,537	3,729	4,014	4,236	4,524	4,773	4,830	5,097
Member, 2 Children	3,474	3,666	4,047	4,266	4,596	4,851	5,178	5,463	5,532	5,838
Member, 3 Children	3,915	4,131	4,557	4,803	5,178	5,466	5,832	6,153	6,234	6,579
Member, 4 Children	4,356	4,596	5,067	5,340	5,760	6,081	6,486	6,843	6,936	7,320
Member, 5 Children	4,797	5,061	5,577	5,877	6,342	6,696	7,140	7,533	7,638	8,061
Member, 2 Adults	5,952	6,282	6,963	7,344	7,896	8,331	8,916	9,405	9,486	10,008
Member, 3 Adults	7,632	8,055	8,931	9,420	10,128	10,686	11,439	12,066	12,165	12,834
Member, 2 Adults, 1 Child	6,393	6,747	7,473	7,881	8,478	8,946	9,570	10,095	10,188	10,749
Member, 2 Adults, 2 Children	6,834	7,212	7,983	8,418	9,060	9,561	10,224	10,785	10,890	11,490
Member, 2 Adults, 3 Children	7,275	7,677	8,493	8,955	9,642	10,176	10,878	11,475	11,592	12,231
Member, 2 Adults, 4 Children	7,716	8,142	9,003	9,492	10,224	10,791	11,532	12,165	12,294	12,972
Member, 2 Adults, 5 Children	8,157	8,607	9,513	10,029	10,806	11,406	12,186	12,855	12,996	13,713
Member, 3 Adults, 1 Child	8,073	8,520	9,441	9,957	10,710	11,301	12,093	12,756	12,867	13,575
Member, 3 Adults, 2 Children	8,514	8,985	9,951	10,494	11,292	11,916	12,747	13,446	13,569	14,316
Member, 3 Adults, 3 Children	8,955	9,450	10,461	11,031	11,874	12,531	13,401	14,136	14,271	15,057
Member, 3 Adults, 4 Children	9,396	9,915	10,971	11,568	12,456	13,146	14,055	14,826	14,973	15,798
Member, 3 Adults, 5 Children	9,837	10,380	11,481	12,105	13,038	13,761	14,709	15,516	15,675	16,539

Rand Water 2019 & 2020 Contributions Table Option B Plus (Before Subsidy)

Option B Plus	Below R 12,300		R 12,301 to R 17,600		Above R 17,601	
	2019	2020	2019	2020	2019	2020
Member	2,025	2,115	2,163	2,259	2,973	3,108
Per Adult Dependant	1,416	1,479	1,512	1,581	2,079	2,172
Per Child Dependant	321	336	339	354	468	489

Family Size	Below R 12,300		R 12,301 to R 17,600		Above R 17,601	
	2019	2020	2019	2020	2019	2020
Member	2,025	2,115	2,163	2,259	2,973	3,108
Member, Adult	3,441	3,594	3,675	3,840	5,052	5,280
Member, Adult, 1 Child	3,762	3,930	4,014	4,194	5,520	5,769
Member, Adult, 2 Children	4,083	4,266	4,353	4,548	5,988	6,258
Member, Adult, 3 Children	4,404	4,602	4,692	4,902	6,456	6,747
Member, Adult, 4 Children	4,725	4,938	5,031	5,256	6,924	7,236
Member, Adult, 5 Children	5,046	5,274	5,370	5,610	7,392	7,725
Member, 1 Child	2,346	2,451	2,502	2,613	3,441	3,597
Member, 2 Children	2,667	2,787	2,841	2,967	3,909	4,086
Member, 3 Children	2,988	3,123	3,180	3,321	4,377	4,575
Member, 4 Children	3,309	3,459	3,519	3,675	4,845	5,064
Member, 5 Children	3,630	3,795	3,858	4,029	5,313	5,553
Member, 2 Adults	4,857	5,073	5,187	5,421	7,131	7,452
Member, 3 Adults	6,273	6,552	6,699	7,002	9,210	9,624
Member, 2 Adults, 1 Child	5,178	5,409	5,526	5,775	7,599	7,941
Member, 2 Adults, 2 Children	5,499	5,745	5,865	6,129	8,067	8,430
Member, 2 Adults, 3 Children	5,820	6,081	6,204	6,483	8,535	8,919
Member, 2 Adults, 4 Children	6,141	6,417	6,543	6,837	9,003	9,408
Member, 2 Adults, 5 Children	6,462	6,753	6,882	7,191	9,471	9,897
Member, 3 Adults, 1 Child	6,594	6,888	7,038	7,356	9,678	10,113
Member, 3 Adults, 2 Children	6,915	7,224	7,377	7,710	10,146	10,602
Member, 3 Adults, 3 Children	7,236	7,560	7,716	8,064	10,614	11,091
Member, 3 Adults, 4 Children	7,557	7,896	8,055	8,418	11,082	11,580
Member, 3 Adults, 5 Children	7,878	8,232	8,394	8,772	11,550	12,069

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

No.	Change	Description of Change	Option
1	Preventative Care	PSA Screening (Once a year for Men).	Option A
			Option B Plus
		Pap Smear (Once a year for Females).	Option A
			Option B Plus
		HPV Vaccine (For young girls between the ages of 12-16 yrs.).	Option A
			Option B Plus
2	OH Auxiliary	Includes a Dieticians benefit for chronic conditions (Diabetes Mellitus both Type 1&2, Hypertension and Hyperlipidaemia).	Option A
			Option B Plus
3	OH Maternity	Increase the number of 3D scans from 2 scans to 3 scans (Per pregnancy).	Option A
			Option B Plus
4	OH Maternity	Include a benefit for 6 Ante-natal Classes per pregnancy, with the exception of more, should the pregnancy present with complications.	Option A
			Option B Plus
5	OH Auxiliary	Sports Physiotherapy (sublimit of Physiotherapy benefit)	Option A
			Option B Plus
6	OH Auxiliary	Educational psychologist (sublimit of Psychology benefit)	Option A
7	OH Optometry	Optical benefit for Albinism(**separate benefit limit, Frame 2-year cycle, Lens benefit yearly**	Option A
8	Compulsory Health Care Screening	A seasonal Pneumococcal Vaccine and One Health Screening per annum ,covering blood pressure, blood glucose, cholesterol and HIV screening per beneficiary.	Option A
			Option B Plus

Note: OH (Out of Hospital)

2. BENEFITS AND LIMITS:

OPTION A

The Scheme Tariff (ST) refers to the fee or rate set by the Scheme or agreed between the Scheme and the relevant health care provider/s for the reimbursement of benefit claims. Subject to the limitations and exclusions of benefits as stipulated in Scheme Rules paragraph 16 and in Annexure C, a member who receives benefits under this section of the Scheme Rules his and or her dependents shall be entitled to the following benefits:

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

1. GENERAL PRACTITIONER, HOMEOPATH AND SPECIALIST BENEFITS

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

Member with no dependants	R 9,500 per annum
Member with one dependent	R 12,800 per annum
Member with two or more dependants	R 16,280 per annum

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

2. OPTICAL BENEFITS

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

b) 100% (one hundred per cent) of the negotiated SAOA tariff, of the benefit limit for frames, lenses and contact lenses as prescribed in terms of (a) above:

- The maximum benefit for lenses and contact lenses is R3,030 per beneficiary per annum.
- The maximum benefit for frames is R 1,680 per beneficiary **every two years**
  The fitting of lenses to the frames, is limited to frame benefit limit per annum.

c) Albinism; maximum benefit limit of R9,490

- For high power prescription lenses including tint per eye per beneficiary per annum.
- One set of frames subject to available maximum benefit per beneficiary **every two years**.

d) A combined maximum benefit of R 11,310 per annum per family is payable for refractive surgery and intraocular lenses.

3. HOSPITALISATION

100% (one hundred per cent) of the negotiated Scheme Tariff (ST).
The maximum benefit for hospitalisation is R2,040,760.00 per annum per family.
Prescribed Minimum Benefits (PMB) are payable at cost subject to clinical protocols

3.1. ONCOLOGY DISEASE MANAGEMENT PROGRAMME

Oncology Benefit is limited to R376,610.00 per family per annum, except for PMB's payable at cost subject to clinical protocols.

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

***NB: Specialist and Anaesthesiologist bill Private Rates (i.e. above Scheme Rates)**

4. THEATRE FEES

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) for theatre fees.
The maximum benefit limit for theatre fees is included in the hospitalization benefit of R2,040,760.00 per annum per family.

5. INTERNAL PROSTHESIS

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) for internal prosthesis subject to R65,210.00 except for Prescribed Minimum Benefits (PMB) and Clinical Protocols per beneficiary per annum and Pre-authorization required.

6. DENTAL SERVICES

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

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

NB: Pre-Authorization is required for dental trauma cases, removal of impacted wisdom teeth and 3rd molars as well as children under 7 years of age.

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

Member with no dependants	R 4,750 per annum
Member with one dependant	R 6,100 per annum
Member with two dependants	R 7,460 per annum
Member with three dependants	R 8,590 per annum
Member with four or more dependants	R 9,810 per annum

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

Member with no dependants	R 7,460 per annum
Member with one dependant	R 9,430 per annum
Member with two dependants	R 11,690 per annum
Member with three dependants	R 14,030 per annum
Member with four or more dependants	R 16,280 per annum

Consultations for dental visits relating to polishing and oral examinations are limited to one visit per beneficiary every 6 months.

***All dental treatment is subject to Dental Protocols on page 15 to 19.**

7. PRESCRIBED MEDICATION NON PMB

7.1 Acute Medication

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

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

7.2 The maximum benefits applicable to Acute Medicine are:

- Member with no dependants R 10,260 per annum
- Member with one dependant R 14,870 per annum
- Member with two dependants R 15,610 per annum
- Member with three dependants R 16,730 per annum
- Member with four or more dependants R 17,400 per annum

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

R220 per script within a seven (7) day period, subject to the Acute Medication benefit limits and the following sub-limits:

- Member with no dependants R 1,220 per annum
- Member with one dependant R 1,770 per annum
- Member with two dependants R 1,860 per annum
- Member with three dependants R 1,990 per annum
- Member with four or more dependants R 2,070 per annum

7.4 Chronic Medicine

100% (one hundred per cent) of the legislated Single Exit Price (SEP) prescribed chronic medicine up to a maximum benefit of R 13,980 per annum per beneficiary, plus the relevant dispensing fee. **NB: Prescribed Minimum Benefits are subject to Clinical Protocols once the chronic limit is reached.**

7.5 Biological Drugs

- Non PMB are paid subject to available benefit limit
- PMB's are paid from available benefit limit first, followed by PMB and PMB level of care (ICD10)

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

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

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

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

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

Included in addition to the tables:

- Cancer (all types)
- Organ transplant

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

Chronic medication approval will be subject to clinical protocols

Chronic medication requests for certain conditions (*) will only be considered if prescribed and motivated by an appropriate specialist e.g.: A dermatologist prescription and motivation is required for chronic medication for acne and psoriasis.

- An ENT or neurologist prescription and motivation is required for chronic medication for Meniere's disease
- A neurologist or psychiatrist prescription and motivation is required for chronic medication for Alzheimer's disease
- For attention deficit disorder, applications will only be considered if prescribed and motivated by a paediatrician, neurologist or psychiatrist

Chronic medication for **Allergic Rhinitis** (**) will only be considered if prescribed and motivated by a specialist (ENT, paediatrician or physician).

Medication for gastro-oesophageal reflux disease **(GORD)** (♦) will only be considered if prescribed and motivated by a gastroenterologist, physician or general surgeon.

For **Gout** (***) only allopurinol and probenecid-containing products may be considered.
Chronic medication for **Osteoporosis** (**#**) may only be considered on submission of a Bone Mineral Density (BMD) scan.

Chronic medication for **paraplegics and quadriplegics** (**##**) may be considered for urinary and bowel complications.

Exclusions from the Chronic Disease Benefit:

- Vitamins and mineral preparations (subject to approval for HIV/Aids; Oncology; post menopause; hypoparathyroidism and chronic renal disease)
- Homeopathic medication
- Hypnotics and anxiolytics
- Mucolytic and decongestants

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

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

9 DIAGNOSTIC BENEFITS

100% (one hundred per cent) of the Scheme Tariff (ST) for basic Radiology, Pathology, Specialised Radiology scans (including PET, MRI and CT scans), and clinical technologist services.

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

- The maximum combined benefit is R 44,920 per annum per family subject to PMB.
- A combined sub-limit of R11, 230 per beneficiary per annum applies.

9.2 Specialised Radiology (PET, MRI & CT Scans) is subject to a limit of R15,000 per family per annum, which is shared for in-hospital and out -of-hospital benefits.

Benefits for specialised radiology including PET, MRI and CT Scans both in and out of hospital are made available upon confirmation of pre-authorisation obtained from the Scheme's preferred managed healthcare provider.

9.3 Annual Preventative Wellness Benefits (from Scheme Risk Benefits)

- See **Preventative Care Benefits** page 5

10 MATERNITY SCANS

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

10.1 ANTE-NATAL

- 6 Ante-Natal classes to the maximum benefit limit of R5 000.00 per beneficiary per annum.

11 BLOOD PRODUCTS

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

12 NURSING & STEP-DOWN FACILITIES IN LIEU OF HOSPITALISATION

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) for nursing in lieu of hospitalisation and step-down facilities prescribed by a medical practitioner, for a registered nurse or enrolled auxiliary nurse with a maximum collective benefit of R 48,430 per beneficiary per annum.

***Pre-authorisation must be obtained from Afrocentric Integrated Solutions, the Scheme's managed healthcare provider.**

13 AUXILIARY CONSULTATION AND PROCEDURES

100% (one hundred per cent) of the Scheme Tariff (ST) limited to R 10,830 per beneficiary per annum with a sub-limit of R 7,250 per discipline for the following services:

- Physiotherapy (including Sports Physiotherapy and Bio Kinetics)
- Occupational Therapy;
- Audiometry (Must be referred by ENT Specialist)
- Psychological treatment (includes Educational Psychologist for children)
- Orthoptist (must be referred by a Specialist)
- Chiropractic treatment by a chiropractor;
- Podiatry;

- Dietician (includes Diabetes Mellitus both type 1 and 2, hypertension and hyperlipidaemia)
- Speech Therapy

14 EXTERNAL APPLIANCES

a) 100% (one hundred per cent) of the Scheme Tariff (ST) for all orthopaedic appliances prescribed by a medical practitioner subject to benefit availability.

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

a.	Hearing aids	One (1) set **every two (2) years** (**ENT referral required for all new requests**)
b.	Wheelchairs	One (1) **every four (4) years**
c.	Artificial limbs	One (1) **every five (5) years**

The maximum annual collective benefit per family per annum in respect of (a) and (b) is R 44,100. The cost of repairs to appliances will be considered up to the overall limit.

15 EMERGENCY TRANSPORT SERVICES

100% (one hundred per cent) of the cost for ambulance services, fully capitated through the designated service providers (Netcare 911) 082911

16 HIV / AIDS

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

17 PRESCRIBED MINIMUM BENEFITS (PMB)

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

18 BENEFIT EXCLUSIONS

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

1. All slimming preparations and preparations used to treat obesity.
2. Contact lens solutions.
3. Food supplements including baby food and special milk preparations.
4. Homeopathic and herbal medicines and household remedies or other miscellaneous household products of a medical nature.
5. Medicines to specifically treat infertility. (Except for PMBs)
6. Medicines used to specifically treat alcoholism and habit forming substances. (Except for PMBs)
7. Anabolic steroids.
8. Anti-malaria used for prophylaxis against malaria.
9. Diabetes test strips. (Except for PMBs)
10. Non-medical essential treatment.
11. Wilfully self-inflicted injuries, e.g.: attempted suicide. (Except for PMBs)
12. Injury arising from sport or speed contests. (Except for PMBs)
13. Ptosis.
14. Injuries sustained during participation in a strike, during illegal picketing or riot or during physical struggle. (Except for PMBs)
15. Frail Care Facilities or Old Age Home
16. Mental disorders. (Except for PMBs)
17. Contraceptives Preparations and Devices
18. Syringes and Needles – only on prescription
19. Aphrodisiacs
20. Cosmetic preparations medicated or otherwise
21. Immunosuppressive – pre-authorisation required
22. Stimulant laxatives
23. Anti-diarrheal micro-organisms – only on prescription
24. Immune sera and immunoglobulins – pre-authorisation required
25. Allergens
26. Haematinics – iron supplements – pre-authorisation required
27. Vitamin products (Except for HIV, Pregnancy and Menopause)
28. Essentially fatty acid preparations and combinations – only on prescription
29. Over the counter reading glasses
30. Stomatherapy products – pre-authorisation required
31. Botox injections – pre-authorisation required
32. Gold fillings
33. Dental Implants Except for PMB's
34. Facility Fee, except for PMB's and life threatening treatment and conditions

***Refer to Annexure C**

Option A 2020 Benefit and Limit Summary	
	In-Hospital Limit Private Hospital
General ward * Subject to pre-authorisation	100% of the Scheme tariff in a general ward
	Limited to R 2,040,760 per family per annum
	Related Hospital
Medical tests in hospital Includes Radiology and Pathology in hospital	100% of the Scheme tariff
	Subject to overall hospital limit
Specialised Radiology (MRI and CT Scans) (In- and Out-of-Hospital)	Sub-limit of R 15,000 per family, subject to pre-authorisation & overall annual limit, except for PMBs
Blood Transfusions	100% of cost
	Subject to overall hospital limit
Internal Prosthesis	100% of the Scheme tariff Subject to pre-authorisation Subject to limit of R 65,210 per beneficiary per annum, except for PMB's
Oncology	100% of the Scheme tariff
	Subject to pre-authorsation, included in the overall hospital limit
	Limited to R 376,610 per family per annum
Renal Dialysis	Included in the overall annual limit Subject to pre-authorisation & state protocols
Maternity Includes Confinement, Foetal scans in hospital & midwife confinements	100% of the Scheme tariff Subject to overall hospital limit *Pre-authorisation required 6 Ante-Natal classes per pregnancy. Benefit limited to R5,000 per pregnancy per beneficiary.
Step-down facilities * Subject to referral by a medical practitioner	100% of Scheme tariff
	Limited to R 48,430 per beneficiary
	Benefit usage in lieu of hospitalisation
	(Subject to pre-authorisation)
Disease Management Programmes	
HIV/ AIDS Subject to registration on the HIV/AIDS benefit programme	100% of cost for PMB treatment in line with prescribed minimum benefit (PMB) protocols.
Diabetes Subject to registration on disease management programme	100% of the Scheme tariff

Day to Day		
Doctor Consultations		
GP's, Homeopaths & Specialist consultations	100% of the Scheme tariff	
	Combined limit	
	Limited to:	
	M0 = R 9,500	
	M1 = R 12,800	
	M2 = R 16,280	
Medication		
Acute medication **Dispensing fees paid in line with the applicable legislation** **OTC Medication: R220 per script within a seven (7) day period** ***Subject to the Acute Medication benefit limits.**	100% of SEP plus PDF Limited to:	
	Acute (Prescribed Medication)	OTC (Subject to Acute Medication)
	M0 = R 10,260	M0 = R 1,220
	M1 = R 14,870	M1 = R 1,770
	M2 = R 15,610	M2 = R 1,860
	M3 = R 16,730	M3 = R 1,990
	M4 = R 17,400	M4 = R 2,070
	Subject to 100% of MMAP tariffs	
Chronic medication **Subject to registration & approval for non PMB chronic conditions**	100% of the SEP	
	Limited to: R 13,980 per beneficiary for non-PMBs	
	Unlimited for PMB chronic conditions	
Medical tests out of Hospital		
Radiotherapy & Pathological Services	100% of the Scheme tariff	
	Sub-limit of R 11,230 per beneficiary per annum for Radiotherapy and Pathological services	
	Combined limit of R 44,920 per family	
Dentistry		
Basic dentistry **(Examinations; X-rays; extractions; ordinary fillings; root treatment; prophylaxis)**	100% of the Scheme tariff	
	Limited to:	
	M0 = R 4,750	
	M1 = R 6,100	
	M2 = R 7,460	
	M3 = R 8,590	
	M4 = R 9,810	
	Consultations for dental visits relating to scaling and polishing and oral examinations are limited to 1 visit per beneficiary every 6 months	
Specialised dentistry **(Maxillo Facial; Oral Surgery; Orthodontics; Dentures; Crowns & Bridge work; Repair of dentures)**	100% of the Scheme tariff, subject to pre-authorisation	
	Limited to:	
	M0 = R 7,460	
	M1 = R 9,430	
	M2 = R 11,690	
	M3 = R 14,030	
	M4 = R 16,280	

Day to Day	
Optical	
Eye test	100% of SAOA tariff
	Limited to one test per beneficiary per annum
Lenses & Contact Lenses	100% of SAOA tariff
	Limited to:
	R 3,030 per beneficiary per annum
Frames	100% of SAOA tariff
	Subject to a sub-limit of R 1,680 per beneficiary every two years
Albinism	Maximum benefit limit of R9,490 for high power prescription lenses per beneficiary per annum. One set of frames subject to availability of benefits per beneficiary every two years.
Auxillary Services	
Auxillary Services	100% of Scheme tariff
	Limited to R 10,830 per beneficiary per annum
	Subject to sub-limit of R 7,250 per discipline
Occupational Therapy	See combined Auxillary Services
Physiotherapist Including Sports Physiotherapy	See combined Auxillary Services
Chiropractor	See combined Auxillary Services
Orthoptists	See combined Auxillary Services
Psychologist Including Educational psychologist (children with learning difficulties)	See combined Auxillary Services
Speech Therapy & Audiometry	See combined Auxillary Services
Dietician	See combined Auxillary Services
Podiatry	See combined Auxillary Services
Appliances	
External Appliances (Includes oxygen equipment; hearing aids; artificial limb; wheelchairs & other equipment)	100% of the Scheme tariff
	Limited to R 44,100 per family
	Repairs to be considered up to overall limit Subject to protocols
Ambulances	
Ambulances	100% of cost
	Provided by Netcare 911

BENEFITS AND LIMITS:

OPTION B Plus

The Scheme Tariff (ST) refers to the fee or rate set by the Scheme or agreed between the Scheme and the relevant health care provider/s for the reimbursement of benefit claims. Subject to the limitations and exclusions of benefits as stipulated in Rules 16 and in Annexure C, a member who receives benefits under this section of the Rules and his/her dependents shall be entitled to the following benefits.

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

1. GENERAL PRACTITIONER BENEFITS

a) 100% (100 hundred present) of the Scheme Tariff (ST) for general practitioner consultations.
The maximum benefits collectively are:

Member with no dependants	R 2,860
Member with one dependant	R 4,370
Member with two or more dependants	R 5,800

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

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

100% (one hundred per cent) of the Scheme Tariff (ST) for Specialist, Physiotherapist and Occupational Therapist consultations limited to three (3) visits or R 3,243 per beneficiary per annum and five (5) visits or R 4,530 per family per annum.

a) No benefit is payable where the member self-refers without consulting a general practitioner first.
b) Pre-authorisation from Afrocentric Integrated Solutions, the Scheme's Managed Healthcare Provider is required for each visit and for any other referrals or procedures.
c) Subject to pre-authorisation by Afrocentric Integrated Solutions, the Scheme's Managed Healthcare Provider, 2 additional Gynaecologist visits are provided per beneficiary per pregnancy.
d) In-hospital physiotherapy is limited to R 9,730 per family per annum.

3. OPTICAL BENEFITS

a) 100% (one hundred per cent) of the negotiated Scheme Tariff (ST), for eye testing by a registered ophthalmologist or, in the case of eye testing by an optometrist, 100% (one hundred per cent) of the guide to fees of the Optometric Association of South Africa, not exceeding one eye test per financial year per beneficiary

b) 100% (one hundred per cent) of the SAOA tariff, on production of a receipted account from a spectacle maker, of the cost of frames, lenses and contact lenses prescribed at a test paid for in terms of (a) above:

The maximum collective benefit for frames, lenses and contact lenses is R 1,480 per beneficiary per annum

c) Albinism; maximum benefit limit of R9,490

- For high power prescription lenses including tint per eye per beneficiary per annum.
- One set of frames subject to available maximum benefit per beneficiary per annum as per point above.

4. HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) for hospital and nursing home fees at a general ward high care and ICU rate as appropriate. The maximum benefit limit for hospitalisation is R 998,720 per annum per family.

Hospitalisation for PMB including Oncology and Renal Dialysis is covered at 100% of cost all public hospitals and private hospitals. Pre-authorisation must be obtained from Sanlam Health Care,

5. THEATRE FEES

100% (one hundred per cent) of the Scheme Tariff (ST) for theatre fees including anaesthetics, disinfectants, bandages and materials applied in the theatre. The maximum benefits for theatre fees are included in the hospitalisation benefit of R 998,720 per annum per family.

6. INTERNAL PROSTHESIS

100% (one hundred per cent) of the Scheme Tariff (ST) for internal prosthesis, subject to a maximum annual benefit per family of R 29,990 per family per annum except for PMBs.

7. DENTAL SERVICES

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

a. Ordinary fillings (such as cement, silicate, silver-alloy)
b. Examinations, prophylaxis, extractions, X-rays.
c. Dentures, repair of dentures, root treatment, crown and bridge work.
d. Orthodontics, maxillo-facial and oral surgery unless for a PMB condition and subject to Pre-authorisation.

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

Member with no dependants	R 1,580
Member with one dependant	R 2,410
Member with two dependants	R 2,780
Member with three dependants	R 3,250
Member with four dependants	R 3,620

Consultations for dental visits relating to scaling and polishing and oral examinations are limited to one visit per beneficiary every 6 months.

Maxillo-facial surgery is limited to R 16,170 per family, per annum subject to the overall hospital limit.

NB: Pre-Authorisation is required for hospitalisation related to dental trauma cases, removal of impacted wisdom teeth and 3rd molars as well as children under 7 years of age.

8. PRESCRIBED MEDICATION NON-PMB

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

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

Member with no dependants	R 2,300 per annum
Member with one dependant	R 3,930 per annum
Member with two or more dependants	R 5,500 per annum

c) **Over the Counter** (OTC)Medication:
R210 per script within a seven (7) day period subject to the Acute Medication benefit limits and the following sub-limits:

Member with no dependants	R 1,090 per annum
Member with one dependant	R 1,860 per annum
Member with two or more dependants	R 2,610 per annum

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

9. PRESCRIBED MINIMUM BENEFITS

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

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

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

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

The following medicines are excluded from the Chronic Disease Benefit:

- Vitamins and mineral preparations (excluding calcium for postmenopausal females and patients with hyperparathyroidism; HIV; Oncology and chronic renal disease) unless medically necessary
- Homeopathic medication
- Hypnotics and anxiolytics
- Mucolytic. and decongestants

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

- Cancer
- Organ transplant

10. HIV/AIDS DISEASE MANAGEMENT PROGRAMME.

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

11. DIAGNOSTIC BENEFITS

100% (one hundred per cent) of the Scheme Tariff (ST) for basic radiology, pathology, specialised radiology (including PET, MRI and CT scans) and medical technology services. This benefit is subject to a combined limit of R29,990 per family per annum (subject to PMB's and clinical protocols) which is shared for in-hospital and out-of-hospital benefits. The following sub-limits also apply:

- Basic radiology and Pathology Services (in-hospital and out-of-hospital) are subject to a combined sub-limit of R 8,890 per beneficiary per annum.
- Specialised Radiology (in-hospital and out-of-hospital) is limited to R 11,990 per family per annum, subject to pre-authorisation (PET, MRI, CT and Radio Isotope scans).

Once these sub-limits are reached, benefits are limited to medical technology services up to the combined limit of R 35,520 per family per annum. Except for PMB's subject to Clinical Protocols.

Annual Preventative Wellness Benefits (from Scheme Risk Benefits)

- See **Preventative Care Benefits** page 5

12. MATERNITY SCANS

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

13. CLINICAL TECHNOLOGISTS

100% (one hundred per cent) of the negotiated Scheme Tariff (ST) limited to R 21,880 per family per annum.

14. BLOOD PRODUCTS

100% (one hundred percent) of the negotiated Scheme Tariff (ST) for blood transfusions limited to R 21,880 per family per annum, except for PMB's and clinical Protocols. Transportation costs are included in the limit.

15. NURSING AND STEP DOWN FACILITIES IN LIEU OF HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) Step-Down Facilities & Nursing in Lieu of hospitalisation prescribed by a Medical Practitioner, for a Registered Nurse or Enrolled Auxiliary nurse with a maximum collective benefit Limited to R 22,180 per family per annum. Pre-authorisation must be obtained from Afrocentric Integrated Solutions, the Scheme's Managed Healthcare Provider.

16. SURGICAL APPLIANCES AND EXTERNAL PROSTHESIS.

100% (one hundred per cent) of the Scheme Tariff (ST) for surgical and orthopaedic appliances and external prosthesis. The maximum annual benefit is R10,350 per family per annum.

17. EMERGENCY TRANSPORT SERVICES

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

18. BENEFIT EXCLUSIONS

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

1. All slimming preparations and preparations used to treat obesity.
2. Contact lens solutions.
3. Food supplements including baby food and special milk preparations.
4. Homeopathic and herbal medicines and household remedies or other miscellaneous household products of a medical nature.
5. Medicines to specifically treat infertility. (Except for PMBs)
6. Medicines used to specifically treat alcoholism and habit forming substances. (Except for PMBs)
7. Anabolic steroids.
8. Anti-malaria used for prophylaxis against malaria.
9. Diabetes test strips. (Except for PMBs)
10. Non-medical essential treatment.
11. Wilfully self-inflicted injuries, e.g.: attempted suicide. (Except for PMBs)
12. Injury arising from sport or speed contests. (Except for PMBs)
13. Ptosis.
14. Injuries sustained during participation in a strike, during illegal picketing or riot or during physical struggle. (Except for PMBs)
15. Frail Care Facilities or Old Age Home
16. Mental disorders. (Except for PMBs)
17. Contraceptives Preparations and Devices
18. Syringes and Needles – only on prescription
19. Aphrodisiacs
20. Cosmetic preparations medicated or otherwise
21. Immunosuppressive – pre-authorisation required
22. Stimulant laxatives
23. Anti-diarrheal micro-organisms – only on prescription
24. Immune sera and immunoglobulins – pre-authorisation required
25. Allergens
26. Haematinics – iron supplements – pre-authorisation required
27. Vitamin products (Except for HIV, Pregnancy and Menopause)
28. Essentially fatty acid preparations and combinations – only on prescription
29. Over the counter reading glasses
30. Stomatherapy products – pre-authorisation required
31. Botox injections – pre-authorisation required
32. Gold fillings
33. Dental Implants Except for PMB's
34. Facility Fee, except for PMB's and life threatening treatment and conditions

***Refer to Annexure C**

Option B Plus 2020 Benefit and Limit Summary	
In-Hospital Benefits	
Hospitalisation	Overall limit R 998,720 per family.
Surgical and non-Surgical procedures	Subject to overall hospital limit.
Materials and medicine	Subject to overall annual hospital limit.
Physiotherapy	Limited to R 9,730 per family per annum.
Basic Radiology, Basic Pathology and medical technology	Limited to R 29,990 per family per annum.
	Sub-limit of R 8,890 per beneficiary per annum for Radiotherapy and Pathological claims.
Maxillofacial Surgery	Limited to R 16,170 per family per annum, subject to pre-authorisation
Specialised Radiology (MRI &CT Scan)	MRI and CT Scans combined limit for in and out of Hospital.
	Sub-limit of R 11,990 per family per annum, subject to pre-authorisation.
Surgical and Orthopaedic appliances	Limited to R 9,730 per family per annum.
Oxygen	Subject to overall hospital limit.
Maternity	Subject to overall hospital limit.
Treatment of Mental Health	All Public Hospitals and limited Private Hospitals.
	Limited to PMB only.
Renal Dialysis (acute and chronic)	All Public Hospitals and limited Private Hospitals.
	Limited to PMB's only.
Internal Prosthesis	Limited to R 29,990 per family per annum.
Organ Transplants	Limited to PMB's only.
Neonates	Limited to PMB's only.
External Prosthesis	Subject to Surgical and Orthopaedic appliances.
Emergency Transport	100% of cost Provided by Netcare 911.
Blood Transfusion	Limited to R 21,880 per family per annum.
	Includes transport costs.
Dental Services	Hospitalisation only for trauma and impacted 3rd molars. Only children aged under 7 years. Subject to pre-authorisation
	Day Theatres and DSPN hospitals only.
Clinical Technologists	Limited to R 21,880 per family per annum.
Alternatives to Hospitalisation (Step Down and Home Nursing)	Limited to R 22,180 per family per annum.
Disease Management Programmes	
HIV/ AIDS **Subject to registration on the HIV/AIDS benefit programme**	100% of cost for PMB treatment in line with prescribed minimum benefit (PMB) protocols.
Diabetes **Subject to registration on disease management programme**	100% of the Scheme tariff
Oncology	All Public Hospitals and Private Hospitals.
	Limited to PMB's only.

Out of Hospital Benefits		
Consultations		
GP Consultations	100% of the Scheme tariff.	
	Combined limit	
	Limited to:	
	M0 = R 2,860	
	M1 = R 4,370	
	M2 = R 5,800	
Emergency Visits	Unlimited without co-payment provided the episode meets the requirements of the definition on an emergency medical condition.	
	Any registered emergency medical facility. Excluding facility fees.	
Specialist Consultations (including Physiotherapists and Occupational Therapists)	Limited to 3 visits or R 3,243 per beneficiary and 5 visits or R 4,530 per family. No benefit where member self-refers without consulting a general practitioner first.	
	Unlimited consultations for PMB conditions.	
	Pre-Authorisation required for each visit and any other referrals or procedures.	
	2 additional Gynaecology visits per beneficiary per pregnancy per annum.	
Medication		
Acute medication **OTC Medication: R210 per script within a seven day period, subject to the Acute Medication benefit**	100% of SEP plus PDF Limited to:	
	Acute (Prescribed Medication)	OTC (Subject to Acute)
	M0 = R 2,300	M0 = R 1,090
	M1 = R 3,930	M1 = R 1,860
	M2 = R 5,500	M2 = R 2,610
Chronic medication	Subject to MMAP tariffs	
	Chronic Medication for the treatment of 26 PMB CDL conditions only.	
Medical Tests		
Basic Radiology, Specialised Radiology(MRI and CT Scan) and Pathology.	Combined limit for in and out-of-hospital limited to R 35,520 per family per annum.	
	Sub-limit of R 8,890per beneficiary per annum for Radiotherapy and Pathology.	
Dental Services		
Dental Services (Basic and Specialised) Specialised dentistry subject to pre-authorisation	100% of the Scheme tariff, Limited to:	
	M0 = R 1,580	
	M1 = R 2,410	
	M0 = R 2,780	
	M1 = R 3,250	
	M0 = R 3,620	

Out of Hospital Benefits	
Optical Services	
Optical Services	Limited to R 1,480 per beneficiary per annum i.e.
	• Eye Test • Lenses and contact lenses • Frame
Appliance	
Surgical appliances and external prosthesis	100% of the Scheme tariff
	Subject to limit of R 10,350 per family per annum, except for PMB's
Auxiliary Services	
Other auxiliary services	All other auxiliary services only covered on pre-authorisation and if a PMB.

EMERGENCY TRANSPORT SERVICES NETCARE 911

Ambulance authorisation procedure

In all instances, where possible, call Netcare 911. In the case of an inter-hospital transfer, when you are admitted to hospital, please inform the admitting hospital that you are a Netcare 911 member and that any transfers must be done through 082 911

What to do with the vehicle stickers you receive?

Netcare 911 encourages you to place the vehicle window sticker you receive from your medical scheme on one of the side windows of your motor vehicle. This will alert any emergency service on the scene that you are a member of Netcare911

Your benefits include

Health-On-Line - emergency telephonic medical advice and information.
Assistance and advice is just a phone call away through Netcare 911's Health-On-Line, which provides emergency as well as non-emergency telephonic medical advice to members by qualified nursing sisters via the Netcare 911 24-hour Emergency Operations Centre and in accordance with current clinical best practice.
Emergency medical responses by road or air from scene of medical emergency.
Immediate response, using the most appropriate and closest road or air medical resource, staffed by Doctors nurses and paramedics administering instant, life-saving treatment, resuscitation and stabilisation

Netcare 911 at you service

Netcare 911 is South Africa's largest private emergency service, with highly skilled medical staff and a national network of emergency vehicles.
Netcare 911's doctor-based helicopter and fixed wing aeroplanes can be dispatched, should it be required.
By simply by dialling 082 911 from any landline or cellular phone, you and your dependants have access to excellent emergency medical care

IMPORTANT CONTACT DETAILS

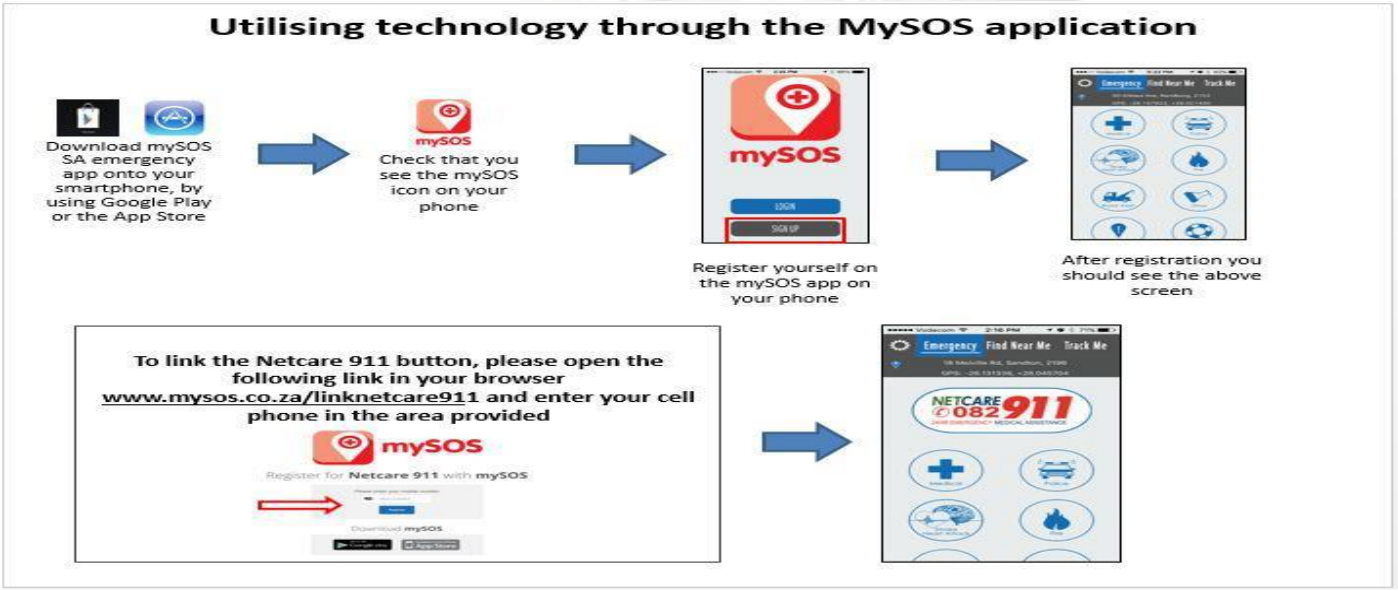
Netcare 911 Head office:	010 209 8911
Emergencies:	082 911
Health-On-Line:	082 911
Website:	www.netcare911.co.za
E-mail:	customer.service@netcare.co.za

Points to remember when calling Netcare 911

- Dial 082 911 if there is a medical emergency.
- Give your name and the telephone number you are calling from.
- Give a brief description of what has happened and try to explain how serious the situation is.
- Give the address or location of the incident as well as the incident as well as the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please, if possible, tell the Call Taker which medical scheme you belong to.
- Do not put the phone down until the controller has disconnected.

Netcare 911 EMS Services

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



My SOS EMS Application

- The app works on all android and IOS phones
- Is available for free to all Rand Water members
- Provides absolute GPS coordinates for location tracking
- Has many additional features

RAND WATER MEDICAL SCHEME DENTAL POLICY AND PROCEDURES PROTOCOL 2020

1. General Principles

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

2. Orthodontic treatment

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

3. Periodontics

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

4. Procedure Limitations

- No benefits for implants in and out of hospital on all option.
- Benefits for conservative dental restorations are available where such restorations are clinically indicated, and will be granted once per tooth in a 1-year period.
- More than 4 fillings per member per year where clinically motivated, a pre-authorisation is required.
- In the case of fillings on posterior teeth (molar and pre-molars) the Dental Risk Company tariff for amalgam fillings will apply, regardless of the material used.
- Fissure sealants are covered once every 2 years, up to 18 years only on permanent molars and pre-molars.
- One extra-oral radiograph per year, except for orthodontic treatment planning where 2 extra-oral radiographs will be covered.

5. Hospitalisation and Intravenous Sedation

- Hospitalisation or Intravenous Sedation for dentistry is subject to pre-authorisation where the following protocols apply:
- Hospitalisation cover is provided for children below the age of 7 years once in a life time.
- Root canal therapy and Removal of impacted teeth requires pre-authorisation.
- Theatre visits for persons above 7 years for conservative dentistry and extractions will not be covered. The requirement of a sterile facility is not on its own an acceptable reason for hospitalisation for dental treatment.
- Hospitalisation cover will only be considered where an underlying medical condition exists.
- In-hospital apisectomies are limited to 1st and 2nd molars only.

6. The following will not be covered in hospital:

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

7. Restrictions and Exclusions

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

- Cosmetic dentistry.
- Mouthwash and toothpastes.
- Fissure sealants on patients from 7 years to 18 years.
- Professionally applied topical fluoride in adults 18 years and above
- Oral/facial image of dentist work not covered only for orthodontics
- Perio chip
- Ozone therapy
- Desensitising, resin or medicament will not be covered during the same visit as application of topical fluoride.
- Restorative treatment of attrition or abrasion.
- Tariff for amalgam fillings will apply, regardless of the material used.
- Endodontic will be pre-authorised according to DRC protocols.
- Fixed prosthodontics will be pre-authorised according to DRC protocols.
- Composite or porcelain veneers.
- Laboratory fabricated crowns are not covered on primary teeth or third molars (wisdom teeth)
- Temporary /provisional and emergency crowns including lab costs
- Fixed prosthodontics where the members mouth is periodontal compromised

- Fixed prosthodontics used to restore teeth for cosmetic reasons
- Fixed prosthodontics used to repair occlusal wear (teeth damaged due to bruxism) erosions or fluorosis
- Cost of gold, precious metal, semi-precious metal and platinum foil.
- Lab costs where the associated dental procedure is not covered.
- Dentures will be pre-authorised according to DRC protocols.
- Orthodontics will be pre-authorised according to DRC protocols.
- Jaw correction surgery and related hospital costs (Orthognathic surgery)
- TMJ surgery and associated procedures.
- Osteotomy
- Surgical periodontal services
- Gingivectomy
- Dentectomies in hospital.
- Frenectomies in hospital.
- Removal of asymptomatic wisdom teeth.
- Fillings, extractions and root canal therapy in hospital over age of 7 years.
- Preventative dentistry procedures in hospital.
- Assistant fee to be assessed on individual cases
- MRI and CAT scans for any dento-alveolar procedures will not be covered
- Extra-oral radiograph only for orthodontic treatment planning and removal of impacted teeth
- Dental implants in or out of hospital and associated surgical procedures listed below are excluded,
  - Implant tooth replacement all phases
  - Cost of implant components
  - Bone augmentation, or tissue regeneration or cost of bone regeneration material
  - Sinus lifts

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

A. FACILLITY FEE

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

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

Please Note:

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

ANNEXURE C

PRESCRIBED MINIMUM BENEFITS

1. **Designation of service providers**
   The medical scheme contracts with service provider(s) for the delivery of Prescribed Minimum Benefits in the following categories for both Option A and Option B Plus:
   (a) Hospitalisation: Afrocentric Integrated Solutions.
   (b) Out of hospital services: No DSP
   (c) Medicine benefit management (both chronic and acute): Medikredit
   (d) Medical Advisory Services Management: Afrocentric Integrated Solutions.
   (e) Diabetes Mellitus (Type 1 and Type 2): Afrocentric Integrated Solutions - chronic disease management programme.
   (f) HIV/AIDS: Afrocentric Integrated Solutions - chronic disease management programme.
   (g) Oncology: Afrocentric Integrated Solutions - Chronic disease management programme
   (h) Dental Risk Company (DRC) - dental health management both in and out of hospital.
   (i) Net Care 911 (24 Hour Emergency Health Care Services).

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

3. **Prescribed minimum benefits voluntarily obtained from other providers**
   If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition subject to clinical protocols and medical appropriateness, from any service provider the benefit payable in respect of such service is subject to:

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

4. **Prescribed minimum benefits involuntarily obtained from other providers**
   (a) If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition from any service provider, the medical scheme will cover the cost subject to clinical protocols and medically appropriate.
   (b) For the purposes of paragraph **(a,)** a beneficiary will not be deemed to have involuntarily obtained a service from any service provider, no co-payment applies (i.e. Scheme do not have a designated service provider for Prescribed Minimum Benefits (PMBs).
   (c) Except in the case of an Emergency Medical/Surgical condition, preauthorisation shall be obtained by a member prior to voluntarily and or involuntarily obtaining a service from a provider to enable the Scheme to confirm that the circumstances contemplated in paragraph 2 and 3 are applicable

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

(b) Where a Prescribed Minimum Benefit includes medication and that medication is voluntarily obtained from a provider. A Single Exit Price plus relevant dispensing fee will apply.

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

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

ANNEXURE C

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. EXCLUSIONS

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

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

1.2 The testing of eyes except when undertaken by a medical practitioner or registered ophthalmologist or optometrist.

1.3 Treatment for wilful self-injury, illness or injury resulting from attempted suicide, or injury sustained during participation in a strike, during illegal picketing or riot except for PMB.

1.4 Treatment for illness or injury resulting from participation in sport for monetary reward or prize money except for PMB.

1.5 Treatment for illness or injury resulting from participation in any contest of speed, excluding amateur athletics except for PMB.

1.6 Purchase or hire of medical, surgical or other appliance except as provided for in Annexure B.

1.7 Purchase of medicine, bandages, dressings and other similar aids not included in a prescription from a medical practitioner or a dentist.

1.8 Operations, procedures and treatment performed upon and at the desire of the member or dependant in respect of whom the claim is made but which are not essential, in the opinion of the medical practitioner nominated by the Scheme and such member's or dependant's medical practitioner in consultation, for the treatment of the illness in respect of which the claim is made.

1.9 Prescription sunglasses.

2. LIMITATION OF BENEFITS

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

2.1 In a case of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant consulting a specialist whom the Board may nominate in consultation with the attending medical practitioner. If such a specialist's advice is not acted upon, no further benefits shall be granted in respect of such illness.

2.2 In a case where a specialist is consulted without the recommendation of a general practitioner, the benefit may be limited to the amount that would have been paid to a general practitioner for the same service: provided that an Ophthalmologist, Optometrist all Specialist may be consulted without the recommendation of a general practitioner except for Option B Plus.

2.3 In a case where major Osteo-surgery is required i e Joint Replacements or Spinal Fusions, the Board shall have the right to insist upon a member or dependant having to obtain a second medical opinion.

2.4 Participation in the Diabetic, Oncology programme is subject to pre-registration.

2.5 Should a beneficiary suffer from any of the chronic conditions listed under Paragraph 8 of Annexure B and wishes to obtain the relevant benefits, he/she will be obliged to participate in the Chronic Disease Management Programme provided by the Scheme.

GLOSSARY

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

RAND WATER MEDICAL SCHEME
MAIN SCHEME RULES

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

RULES

1. NAME

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

2. LEGAL PERSONA

The Scheme, in its own name, is a body corporate, capable of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act, 131 of 1998 and regulations and these rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 522 Impala Road, Glenvista, Johannesburg but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

4. DEFINITIONS

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

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

(b) The following expressions have the following meanings:

4.1 "Act",

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

4.2 "Adult Dependant"

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

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

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

4.2.1.2 Mentally or physically handicapped;

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

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

4.3 "Approval"

Prior written approval of the Board or its authorised representative.

4.4 "Auditor"

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

4.5 "Accounting Firm"

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

4.6 "Authorised representative"

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

4.7 "Beneficiary"

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

4.8 "Board"

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

4.9 "Child Dependent"

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

4.10 "Condition specific waiting period"

A period not exceeding 12 months during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made.

4.11 "Continuation member"

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

4.12 "Contribution"

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

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

4.13 "Council"

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

4.14 "Cost"

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

4.15 "Creditable coverage"

Any period during which a late joiner was:

4.15.1 a member or a dependant of a medical scheme;

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

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

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

4.16 "Date of Service" means: -

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

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

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

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

4.17 "Dependant"

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

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

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

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

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

4.18 "Designated service provider"

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

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

Those treatment pairs listed in Annexure A of the Regulations in terms of the Act, subject to any limitations specified therein. By way of information, these DTPs link a specific diagnosis to a treatment or procedure and therefore broadly indicate how each of the270 PMB conditions should be treated.

4.19 "Domicilium citandi et executandi"

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

4.20 "Emergency medical condition

The sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

4.21 "Employee"

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

4.22 "Employer",

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

4.23 "Fit and proper"

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

4.24 "General waiting period"

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

4.25 "Generic drugs"

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

4.26 "Original drug"

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

4.27 "Immediate family member"

4.27.1 a member's spouse or life partner;

4.27.2 a member's dependent children;

4.27.3 a member's legally adopted children; or

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

4.28 "Income" For the purposes of calculating contributions in respect of:

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

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

4.28.3 Continuation member:

a. A member who is due for retirement (excluding ill health retirement) effective from January 2015 his /her monthly contribution will be based on 70% of last known salary as approved by The Board of Trustee of Rand Water Medical Scheme,

b. This will apply to all members who choose to continue with the medical scheme post retirement i.e. for members who were on Option A (since inception and never change option or move to another medical Scheme) before January 2002 will qualify for Rand Water 2/3 subsidy upon retirement. Members are not allowed to re-join the scheme once they have retired and opted not to continue with the medical scheme cover

c. A continuation member, who has left employment and is classified as a pensioner will continue to receive subsidy of 2/3 of contributions. The subsidy is inclusive of the disposable income of a typical pensioner including temporary or permanent income from another employer in exchange for the performance of services by the employee or

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

4.29 "Member"

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

4.30 "Member family"

The member and all the registered dependents.

4.31 "Managed Health Care"

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

4.32 "Managed Health Care Organisation"

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

4.33 "**Medicines Pricing Regulations**"

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

4.34 "Payment in full"

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

4.35 " Partner"

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

4.36 "Pre-authorisation"

Shall have the meaning assigned to it in Rule 19

4.37 "Prescribed Minimum Benefits"

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

4.37.1 the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and

4.37.2 any emergency medical condition.

4.38 "Pre-existing Medical Condition"

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

4.39 "Prescribed Minimum Benefit condition"

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

4.40 "Principal Officer"

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

4.41 "Registrar"

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

4.42 "Relevant health care provider"

A person providing a relevant health services

4.43 "Scheme Tariff" or "Scheme tariff" means:

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

4.44 "Single Exit Price"

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

4.45 "Supplier of service"

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

4.46 "Spouse"

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

4.47 "Third Party Claims"

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

4.48 "Waiting Period"

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

5. BUSINESS OF A MEDICAL SCHEME

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

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

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

5.3 where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.
Registered rules are binding in terms of section 31(4)

6. MEMBERSHIP

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

6.1 Eligibility

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

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

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

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

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

6.1.6 Prospective members shall, prior to admission, complete and submit the application forms required by the scheme, together with satisfactory evidence in respect of himself and his/her dependants, of age, income state of health and of any prior membership or admission as dependant of any other medical scheme. The scheme may require an applicant to provide the scheme with a medical report in relation to any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made. The costs of any medical tests or examinations required to provide such medical report will be paid for in full by the scheme. The scheme may however designate a provider to conduct such tests or examinations.

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

6.2 CONTINUATION MEMBERSHIP

6.2.1 Retirees

6.2.1.1 A member shall retain his/her membership of the Scheme with his/her registered dependants, if any, in the event of his/her retiring from the service of his/her employer or his/her employment being terminated by his/her employer on account of age, ill health or other disability. No addition of dependant is allowed once the member has retired.

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

6.2.1.3 This excludes members who voluntarily resigned from a restricted medical scheme on retirement, upon their re-application for membership at a later stage.

6.2.2 Surviving Dependants

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

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

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

6.2.2.4 Where a child dependant/s has been orphaned, the eldest child may be deemed to be the member, and any younger siblings, the child dependant/s. Such membership shall terminate if such a member shall;

6.2.2.4.1 Become a member of, or is accepted as a dependant of a member of another registered medical scheme;

6.2.2.4.2 Inform the Scheme in writing of his intention not to become a member, or;

6.2.2.4.3 Reach the age of 21 (twenty-one) years, unless the criteria set out in 4.17.2 and 4.17.3 is met.

7 REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of dependants

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

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

the date of birth or adoption. However, failure to comply with this Rule may render such child ineligible for the full period of non-compliance.

7.1.3 Should:

7.1.3.1 a new member not register any eligible dependants immediately upon his admission to the Scheme or;

7.1.3.2 a member at any time acquire an eligible dependant whether by birth, adoption, marriage or otherwise, and not register such new dependant within 30 days of the eligibility of such dependant, the Scheme shall subject to the provisions contained in Rule 8.4 and 8.5., be entitled to impose, upon later registration as a dependant, a waiting period (general or condition specific) during which period no benefit shall accrue to such dependant, but subscriptions shall be paid to the Scheme.

7.1.3.3 If a member who marries subsequent to joining the Scheme, applies within 30 (thirty) days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month of marriage and benefits will accrue as from the date of commencement of membership. The spouse shall not qualify for benefits until such time as the member qualifies for benefits.

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

7.2 De-registration of Dependants

7.2.1 A member shall inform the Scheme within 30 (thirty) days of the occurrence of any event which results in any one of his/her dependants no longer satisfying the conditions in terms of which he/she may be a dependant.

7.2.2 When a dependant ceases to be eligible to be a dependant, he/she shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.

8 TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

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

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

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

8.2.2 members of different medical schemes, or

8.2.3 claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member

8.3 Prospective members shall, prior to admission, complete and submit the application forms, required by the Scheme, together with satisfactory evidence in respect of himself/herself and his/her dependants, of age, income, state of health and of any prior membership or admission as dependant of any other medical scheme. The Scheme may require an applicant to provide the

Scheme with a medical report in respect of any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care of treatment was recommended or received within the12 (twelve) month period ending on the date on which an application for membership was made. The costs of any medical tests or examinations required to provide such medical report will be paid for by the Scheme. The Scheme may however designate a provider to conduct such tests or examinations.

8.4 Waiting periods

8.4.1 The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application;

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

8.4.1.2 a condition-specific waiting period of up to 12 (twelve) months

8.4.2 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application;

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

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

8.4.2.3 PMBs may also be excluded during the waiting period.

8.4.3 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application, a general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

8.5 No waiting period may be imposed on:

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

8.5.1.1 change of employment; or

8.5.1.2 an employer changing or terminating the medical scheme of its employees, in which case such a transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the Scheme to which an

application is made for such transfer to occur at the beginning of the financial year.

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

8.5.2 a beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;

8.5.3 a child dependant born during the period of membership;

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

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

8.8 Every member will, on admission to membership, receive a detailed summary of these Rules which shall include contributions, benefits, limitations, the member's rights and obligations. Members and their dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.

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

8.10 A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he/she may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of any benefit, or any right in respect of such benefit under these rules, if a member assigns, transfers, cedes, pledges or hypothecates such benefit

9 TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

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

10 MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

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

10.2 In submitting a receipt for such card a member shall be deemed;

10.2.1 to have bound himself/herself and his/her dependants to comply with these Rules and any amendments thereof;

10.2.2 to have authorized the Board to deduct from the moneys due to him/her by the Scheme, by the employer, by the Rand Water Superannuation Fund, or by Rand Water Provident Fund, surcharges or any other amounts due by him/her to the Scheme;

10.2.3 to have authorized practitioners to disclose to the Scheme the nature of any illness in respect of which a claim is made.

10.3 A member who loses his/her membership card and is issued with a duplicate card, or a member who fails to surrender his/her membership card on termination, shall be charged R50.00.

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

10.5 On termination of membership or on de-registration of a dependant, the Scheme must, within 30 (thirty) days of such termination, or at any time on request, furnish such person with a certificate of membership and cover, containing such particulars as may be prescribed.

11 CHANGE OF ADDRESS OF MEMBER

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

12 TERMINATION AND SUSPENSION OF MEMBERSHIP

12.1 Resignation

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

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

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

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

12.2 Death

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

12.3 Involuntary termination

12.3.1 Amounts due to the scheme

Where contributions or any other debt owing to the scheme, have not been paid within thirty (30) days of the due date, the scheme shall have the right to;

1. suspend all benefit payments in respect of claims which arose during the period of default;
2. give the member written notice at his/her domicilium citandi et executandi or by means of an electronic means agreed upon, that if contributions or such other debts are not paid within twenty-one (21) days of posting of such notice, membership may be cancelled. (Sec 26(7))
3. notice sent by prepaid registered post to the member and his/her domicilium citandi et executandi or by any electronic means shall be deemed to have been received by the member on the 7th day after the date of posting. In the event that the member fails to nominate a domicilium citandi et executandi, or provide and electronic mail address or facsimile, the members postal or residential address on his/her application form shall be deemed to be his/her domicilium citandi et executandi.
4. In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with rule **12.3.1.2,** benefits shall be reinstated without any break in continuity. If such payments are not brought up to date, no benefits shall be due to the member from the date of default and any such benefit paid will be recovered by the scheme.
5. Any amount due and owing to the medical scheme in respect of a member or a dependant of the member after reasonable demands for payment have been issued, becomes a debt due to the scheme and is recoverable by it

12.4 Failure to pay amounts due to the Scheme

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

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

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

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

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

13 CONTRIBUTIONS

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

13.2 Contributions shall be due monthly in arrears and be payable by not later than the third day of each month. Where contributions or any other debt owing to the Scheme, have not been paid within 30 (thirty) days of the due date, the Scheme shall have the right;

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

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

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

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

13.3 Unless specifically provided for in the rules in respect of savings accounts, no refund of any assets of the Scheme or any portion of a contribution shall be paid to any person where such member's membership or cover in respect of any dependant terminates during the course of a month.

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

14 LIABILITIES OF EMPLOYER AND MEMBER

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

14.2 The liability of a member to the Scheme is limited to the amount of his/her unpaid contributions together with any sum disbursed by the Scheme on his/her behalf or on behalf of his/her dependants which has not been repaid to the Scheme.

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

15 CLAIMS PROCEDURE

15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement as prescribed in Regulation 5.

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

a) The name and the membership number of the member;

b) The name of the supplier of service;

c) The name of the beneficiary to whom the service was provided

d) The final date of service rendered by the supplier of service on the account or statement which is covered by the payment;

e) The total amount charged for the service concerned; and

f) The amount of the benefit awarded for such service.

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

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

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

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

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

16 BENEFITS

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

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

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

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

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

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

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

16.6 Pre-authorisation is a clinical decision based on the information provided and not a guarantee of payment of relevant healthcare services to be rendered.

16.7 Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

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

17 PAYMENT OF ACCOUNTS

17.1 Payment of accounts or reimbursement of claims is restricted to the net amount payable in respect of such benefit and maximum amount of the benefit to which the member is entitled in terms of the applicable benefit as follows:

17.1.1 self-insured up to the relevant benefit limit payable at scheme tariff; and

17.1.2 in full for prescribed minimum benefits

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

17.3 All accounts in respect of services rendered in terms of the prescribed minimum benefits at a public hospital as well as services provided in terms of a preferred provider contract will be settled by the Scheme in full and with the provider direct without any limitations.

17.4 Where the Scheme has paid an account or portion of an account or any benefit to which a member is not entitled, whether payment is made to the member or to the supplier of service, the amount of any such overpayment is recoverable within 3 years by the Scheme.

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

17.6 The Scheme will be responsible for claims and/ or cost incurred under the benefits and limits specific to the membership within the borders of the Republic of South Africa only.

18 THIRD PARTY CLAIMS RECOVERY

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

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

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

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

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

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

18.4 Categories of Motor Vehicle Accidents

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

19 PRE-AUTHORISATION

19.1 Pre-Authorisation:

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

19.1.1 sufficient benefits being available to the Member at the time of payment,

19.1.2 that the Member has made full disclosure of relevant information in his or her application for such pre-authorisation; and

19.1.3 Further that his or her membership has not been terminated or suspended for any reason. Benefits that are subject to pre-authorisation are set out in the annexures to this document.

20 GOVERNANCE

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

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

20.3 Trustees serve term of office for three years

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

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

20.5.1 A person under the age of 21 (twenty-one) years;

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

20.5.3 a broker

20.5.4 an employee of the Scheme

20.5.5 the Principal Officer of the Scheme; and

20.5.6 the authorised auditor of the Scheme or

20.5.7 any person that is already serving as a trustee of any other registered medical scheme.

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

20.7 The Board may fill by appointment any vacancy arising during the term of office of a member of the Board due to such member resigning in terms of Rule 20. 1 7 or ceasing to hold office in terms of Rule 20.18. A person so appointed must retire at the first ensuing Annual General Meeting and that meeting must fill the vacancy for the unexpired period of office of the vacating member of the Board.

20.8 The Board may fill by appointment any vacancy arising during the term of office of a member of the Board due to such member resigning in terms of Rule 20.17 or ceasing to hold office in terms of Rule 20.18. A person so appointed must retire at the first ensuing Annual General Meeting and that meeting must fill the vacancy for the unexpired period of office of the vacating member of the Board.

20.9 Nominations to fill vacancies, signed by a proposer and seconder in good standing with the Scheme, must be signed by the candidate signifying his/her consent to stand for election and must be submitted to the scheme together with a current curriculum vita by … (indicate a date) of the year concerned and the election must be carried out by the members present at the annual general meeting of the scheme.

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

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

20.12 The Board must elect from among itself the chairperson and vice-chairperson.

20.13 A quorum is constituted by a number of members of the Board physically present at a meeting of that Board, which number shall be not less than half of the members of the Board plus one.

20.14 The Board must elect from its number the Chairperson and Vice-chairperson.

20.15 In the absence of the Chairperson and Vice-chairperson, the Board members present must elect one of their numbers to preside.

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

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

20.18 A member of the Board ceases to hold office if;

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

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

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

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

20.18.5 he/she is disqualified under any law from carrying on his profession,

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

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

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

20.18.9 he/she is removed from office in terms of Rule 20.18.

20.19 The Board must meet at least once every 2 (two) months or at such intervals as it may deem necessary.

20.20 The Chairperson may convene a special meeting should the necessity arise. Any 2 members of the Board may request the Chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

20.21 The Board may, subject to participation by sufficient members to form a quorum, discuss and resolve matters by telephonic or electronic conferencing means and may adopt resolutions on that basis.

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

20.23 A member of the Board who acts in a manner which is seriously prejudicial to the interests of the beneficiaries of the medical scheme may be removed by members of the Board after following a due process that is consistent with provisions of section 46 of the Medical Schemes Act or of the provisions of just administrative action; by way of a special resolution taken at a special general meeting, provided that:

20.23.1 Special notice shall be lodged with the Board accompanying the requisition at date of lodgement, and on receipt of notice of such a proposed resolution, the Board shall forthwith deliver a copy thereof to the trustee concerned, who shall, be entitled to be heard on the proposed resolution at the meeting.

20.23.2 The notice convening the special general meeting containing the agenda and proposed special resolution must be furnished to members at least 14 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such a meeting, provided that the notice procedure followed by the board was reasonable.

20.23.3 Where the trustee concerned makes representation in writing which is of a reasonable length and requests dissemination to members, the Board shall unless the representations are received by it too late for it to do so, state that such representations have been made in its notice to members in terms of rule and send a copy of the representations to all members, whether such notice was sent before or after the receipt of representations by the Board.

20.23.4 Where the representation was not sent due to late receipt, the trustee concerned may require that the representations be read at the meeting.

20.23.5 50% + 1 of members of the board of trustees present in person constitute a quorum.

20.23.6 The resolution to remove the trustee/s must be passed by at least 2/3 of members present in person or by proxy entitled to vote.

20.23.7 Rule 17.17 applies mutatis mutandis.

21 FIDUCIARY DUTIES OF BOARD OF TRUSTEES

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

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

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

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

21.5 The Board shall appoint a principal officer who is fit and proper person, as defined in section 57, to hold such office and within 30 days of such appointment, give notice thereof in writing to the Registrar. The Board must determine the terms and conditions of employment of the person so appointed.

21.6 The Board may authorise the appointment of any staff by the Principal Officer, which in its opinion are required for the proper execution of the business of the scheme and must determine the terms and conditions of service of any person employed by the scheme.

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

21.8 The Board must cause to be kept such minutes of all resolutions passed, accounts, entries, registers and records as are essential for the proper functioning of the scheme.

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

21.10 The Board must ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules.

21.11 The Board must take all reasonable steps to ensure that contributions are paid timeously to the scheme in accordance with the Act and the rules.

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

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

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

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

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

21.17 The Board must approve all disbursements.

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

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

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

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

21.22 The Board must disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme, as prescribed.

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

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

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

22 POWERS OF BOARD

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

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

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

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

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

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

22.7 to let or hire movable or immovable property;

22.8 subject to section 63 to sell movable and immovable property of the Scheme subject to sound business practice and fair value principles;

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

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

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

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

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

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

22.15 to authorise the Principal Officer and/or such members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or

other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;

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

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

23 DUTIES OF PRINCIPAL OFFICER AND STAFF

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

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

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

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

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

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

23.2.5 He/she keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of Section 57(6) of the Act.

23.2.6 He/she does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he/she at all times observes the authority of the Board in its governance of the Scheme.

23.3 The Principal Officer shall be the Accounting Officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.

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

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

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

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

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

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

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

23.8.2 A broker or an employee, director, officer, consultant or contractor of any person contracted by the scheme to provide broker services;

23.8.3 A Principal Officer or office bearer of another medical scheme; or

23.8.4 Otherwise has a material relationship with any person contracted by the scheme to provide administrative, marketing, broker, managed healthcare or other services or with its holding company, subsidiary, joint venture or associate.

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

24 INDEMNIFICATION AND FIDELITY GUARANTEE

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

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

25 FINANCIAL YEAR OF THE SCHEME

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

26 BANKING ACCOUNT

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

27 AUDITOR AND AUDIT COMMITTEE

27.1 An auditor (who must be approved in terms of Section 36 of the Act) must be appointed by resolution at each Annual General Meeting, to hold office from the conclusion of that meeting to the conclusion of the next Annual General Meeting.

27.2 The Board must appoint an audit committee in the prescribed manner.

27.3 The audit committee shall be responsible for recommending the appointment of the external auditor to the board of trustee as well as overseeing the external audit process.

27.4 An auditor (who must be authorised and approved by the Registrar in terms of section 36 of the Act) who is a registered auditor as defined in the Auditing Profession Act, 2005, must be recommended by the board resolution and appointed by members at every Annual General Meeting, to hold office from the conclusion of that meeting.

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

27.6 If the members of the scheme at a general meeting fail to appoint an auditor required to be appointed in terms of section 36(1) of the Medical Schemes Act, the Board must within 30 days recommend to the Registrar for an appointment in terms of section 36(9) of the Act.

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

27.7.1 Officers of the scheme;

27.7.2 Contractor of the scheme;

27.7.3 An employee, director, officer or contractor of the scheme's administrator, or of the holding company, subsidiary, joint venture or associate of the administrator;

27.7.4 A person not registered and engaged in public practice as an auditor;

27.7.5 A person who is disqualified from acting as an auditor in terms section 90 of the Companies Act, 2008.

27.7.6 Any person who has a material relationship with the medical scheme or any of its contractors.

27.8 The authorised auditor of the scheme has a right of access to the books, records, accounts, documents and other effects of the Scheme at all times and is entitled to require from the Board and the officers of the Scheme such information and explanations as he deems necessary for the performance of his/her duties.

27.9 The authorised auditor must report to the audit committee of the scheme on the accounts examined by him and on the financial statements laid before the scheme in general meeting.

28 GENERAL MEETINGS

28.1 Annual General Meeting

28.1.1 The Annual General Meeting of members must be held not later than 30 June of each year on a date which may be shown to permit reasonable attendance by members.

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

28.1.3 At least 15 (fifteen) members of the Scheme present in person constitute a quorum. If a quorum is not present after a lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting must be postponed to a date determined by the Board with notice of such postponed meeting being reissued in terms of Rule 29 (b)iii, and members then present constitute a quorum.

28.1.4 The financial statements and reports specified in rule 28 (a) ii. must be laid before the meeting. A full set of Annual Financial Statements (comprising the Trustees' report, auditor's report and AFS) will be made available to the meeting.

28.1.5 Notices of motions to be placed before the annual general meeting must reach the Principal Officer not later than 7 (seven) days prior to the date of the meeting.

28.2 Special General Meeting

28.2.1 The Board may call a Special General Meeting of members if it is deemed necessary.

28.2.2 Only members in good standing will be permitted to attend the meeting on presenting proof of membership and identity

28.2.3 On the requisition of at least 100 members of the Scheme, the Board must cause a Special General Meeting to be called within 30 (thirty) days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitions and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

28.2.4 The notice convening the Special General Meeting, containing the agenda, must be furnished to members at least 14 (fourteen) days before the date of the meeting provided that the notice procedure followed by the Board was reasonable.

28.2.5 At least 50 members present shall constitute a quorum. If a quorum is not present after a lapse of 30 (thirty) minutes from the time fixed for commencement of the meeting, the meeting shall be cancelled.

29 VOTING AT MEETINGS

29.1 Every member who is present at a General Meeting of the Scheme has the right to vote, or may, subject to this rule, appoint another member of the scheme as proxy to attend, speak and vote in his/her stead.

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

29.3 The Chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the Chairperson, if he/she is a member, has a casting vote in addition to his/her deliberative vote.

30. COMPLAINTS AND DISPUTES

30.1 Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators shall also provide a dedicated telephone number to be used for dealing with telephonic enquiries and complaints 011 682 0985.

30.2 All complaints received in writing will be responded to by the Scheme in writing within 30 (thirty) days of receipt thereof.

30.3 A disputes committee of three members, who may not be members of the Board, employees of the administrator, must be appointed by the Board to serve a term of office of 3 (three) years. At least one of such members shall be a person with legal expertise.

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

30.5 On receipt of a request in terms of this rule, the Principal Officer must convene a meeting of the disputes committee by giving not less than 21 (twenty-one) days' notice in writing to the complainant and all the members of the disputes committee, stating the date, time, and venue of the meeting and particulars of the dispute.

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

30.7 The decision taken in terms of rule 31 (b) or that of the dispute committee must be communicated to all parties in writing and where a dispute arises, this must be lodged in writing with the Registrar, indicating their right to appeal in terms of section 47.

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

30.9 An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than 3 (three) months after the date on which the decision concerned was made, or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.

30.10 The operation of any decision which is the subject of an appeal under Rule 31(g) shall be suspended pending the decision of the Council on such appeal.

31 DISSOLUTION

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

31.2 Members in a General Meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by ballot whether the Scheme must be liquidated.

31.3 Pursuant to a decision by members taken in terms of Rule 32(b) the Principal Officer must, in consultation with the Registrar, furnish to every member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

31.4 Every member must be requested to return his/her ballot paper duly completed before a set date. If at least 50% (fifty per cent) of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, subject to the approval of the Registrar, a competent person as liquidator.

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

32 AMALGAMATION AND TRANSFER OF BUSINESS

32.1 The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person. The Board must arrange for members to be furnished with an exposition of the proposed transaction for consideration and to decide by ballot whether the proposed transaction should be proceeded with or not.

32.2 It at least 50% (fifty per cent) of the members return their ballot papers duly completed and if the majority thereof are in favour of the amalgamation or transfer, the transaction may be concluded in the prescribed manner.

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

32.4 The amalgamating Board must submit signed copies of a final audited set of financial statements and annual statutory return to the CMS.

33 RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

33.1 Any beneficiary must on request and on payment of a fee of 50 (fifty) cent per copy, be supplied by the Scheme with a copy of the following documents:

33.1.1 The rules of the Scheme.

33.1.2 The latest audited annual financial statements, returns, Trustees reports and auditors report of the Scheme and the accompanying management accounts in respect of the Scheme and all of its benefit options.

33.1.3 protocols and formularies documents

33.1.4 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 34(a) and to make extracts therefrom.

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

34 AMENDMENT OF RULES

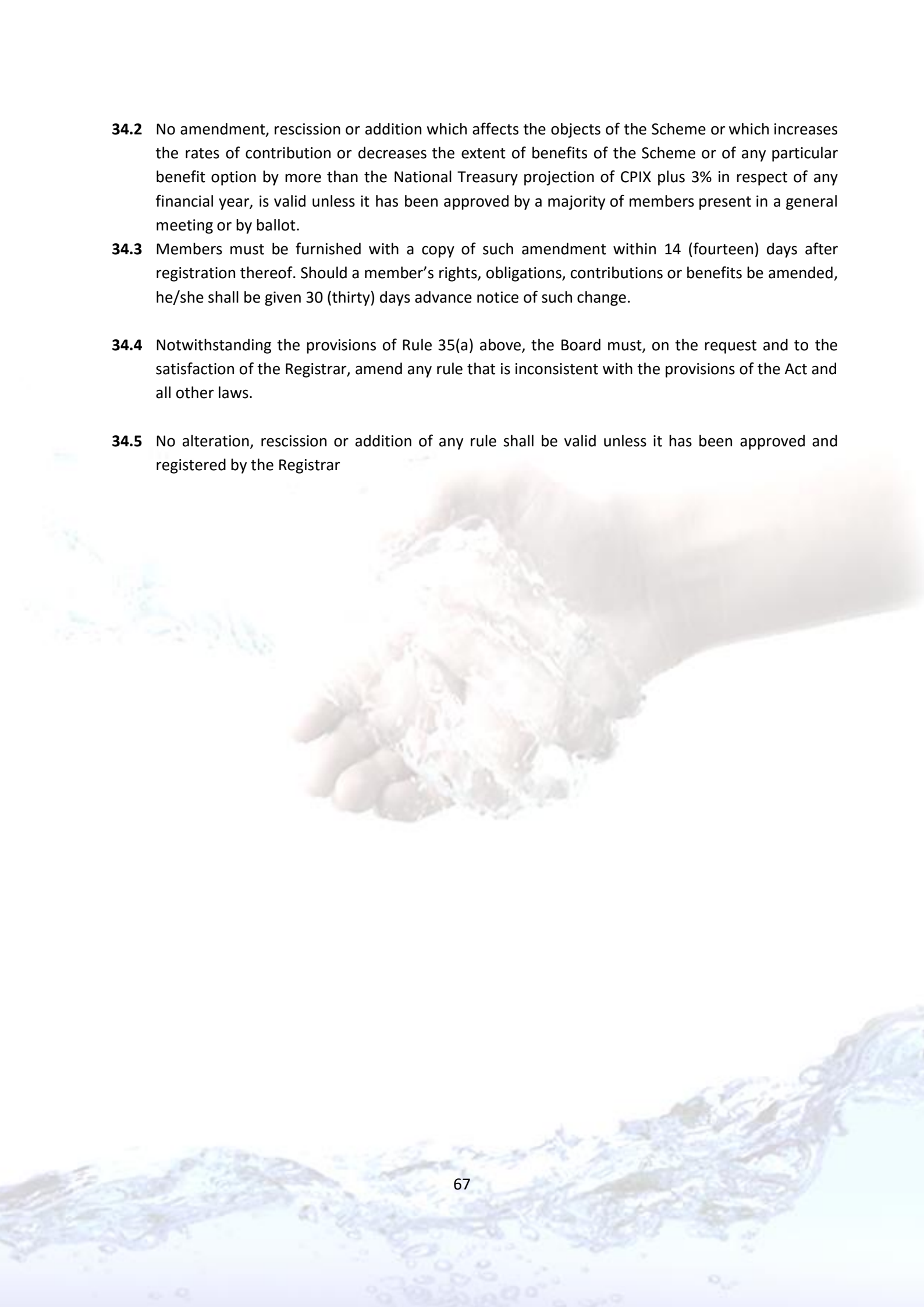
34.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

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

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

34.4 Notwithstanding the provisions of Rule 35(a) above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act and all other laws.

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



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Dental Risk Company

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Afrocentric Integrated Solutions

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	rdw.hiv@afrocentric-ics.com	011 707 8469	
	rdw.diabetes@afrocentric-ics.com	011 707 8467	

Medikredit

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