Rules of Alliance-Midmed Medical Scheme

Valid from 1 January 2021

"Alliance-Midmed Tariff", 100% of the National Health Price list (NHRPL/RPL) for health services published by the Council for Medical Schemes in 2006, plus an annual inflationary factor as indicated:-

- 2007 4.9%
- 2008 5.4%
- 2009 10.7%
- 2010 7.9%
- 2011 5.5%
- 2012 7.5%
- 2013 6%
- 2014 6%
- 2015 6%,
- 2016 6%,
- 2017 6%,
- 2018 5,5%
- 2019 - 3%
- 2020 - 4,5%
- 2021 – 2.9%

hereinafter referred to as the scheme rate, recommended tariff, negotiated fee or agreed tariff.

"annual limit", the maximum benefits to which a member and his registered dependants are entitled in terms of these Rules, and shall be calculated annually to coincide with the financial year of the Scheme;

"approval", prior written approval of the Board of Trustees or its authorised representative;

"auditor", an individual or firm that is a registered auditor in terms of Section 1 of the Auditing Professional Act, 2005 and authorised by the Registrar;

"authorisation"

(a) in the case of hospitalisation; the authorisation by or on behalf of the Scheme for a case to be managed under the hospital benefit management programme and for which application has been made by or on behalf of a beneficiary prior to admission to a hospital or day clinic (including mental health and alcohol and drug dependency treatment facilities) or for such other specific services and or procedures as may be determined by the Scheme from time to time and such authorisation shall be deemed to authorise all procedures and services as may be necessary by that facility, provided that these have been clearly stipulated in the pre-authorisation request and approved;

(a) (1) Service providers that are not in the employment of the hospital or facility (including diagnostic, therapeutic, and other auxiliary services e.g. Dieticians, Physiotherapists, etcetera, must obtain pre-authorisation prior to the service being rendered, especially where the service was not included in the pre-authorisation request of the treating physician. The Scheme will consider the whole of the planned intervention and the individual services and approve the funding thereof separately.

(a) (2) In the event of other services that require a patient to stay over, including stepdown and hospice facilities, an all-inclusive request for all the services must be submitted for pre-authorisation.

(b) in the case of medication; the authorisation of a medicine prescribed for a chronic sickness condition based on the reimbursement guidelines set by the chronic medication programme or disease management programme;

"beneficiary", the member or person admitted as a dependant of a member;

"Board", the Board of Trustees constituted to manage the Scheme in terms of the Act and these Rules;

"case", the treatment of a sickness condition required on an admission of a beneficiary to a hospital or day clinic and for any ongoing treatment stipulated under the hospital benefit management programme;

10 CHANGE OF ADDRESS OF MEMBER AND CONTACT INFORMATION

A member shall notify the Scheme within 30 (thirty) days of any change of address and contact information including his *domicilium citandi et executandi*. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited because the member neglected to comply with the requirements of this Rule.

11 TERMINATION OF MEMBERSHIP

11.1 Resignation

11.1.1 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.

11.1.2 A member who resigns from the service of the participating 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.

11.2 Voluntary termination of membership

11.2.1 A member who is registered as a dependant of the member's spouse on another medical Scheme will be entitled, subject to the provisions of Rule 6, to rejoin the Scheme at a later date.

11.2.2 A continuation member in terms of Rule 6.2 or Rule 6.3 may, on 1 (one) month's written notice, resign from the Scheme. All rights to benefits shall cease after the last day of membership.

11.2.3 A participating employer may terminate his participation with the Scheme on giving three months' written notice.

11.3 Death

11.5 **Submission of fraudulent claims, committing or any fraudulent act and/or non-disclosure of material information.**

11.5.1 An applicant is obliged to disclose all material information to the medical scheme with regards to any matter concerning the state of health or medical history of the member concerned or that of any of his/her dependants, which arose or occurred during the period 12 (twelve) months preceding the date of application for membership.

11.5.2 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.

11.5.3 In such event the Scheme may institute legal proceedings against the member to recover any sum which, but for his abuse of the benefits or privileges of the Scheme, would have been disbursed on his behalf.

11.5.4 Fraudulent acts referred to in Rule 11.5.1 shall include, without limitation:-

11.5.4.1 the use of a membership card by any person other than the Member or his registered Dependants, where the Member or Dependants knows, or ought reasonably to have known of such use, it being deemed, unless the Member or Dependant proves to the contrary, that any use of a membership card was with the knowledge of the Member or Dependant;

11.5.4.2 where the Member or Dependant makes or causes to be made any claim for the payment of any Benefit allegedly due in terms of the Rules, and the Member or Dependant knows, or ought reasonably to have known, such claim to be false, the onus being on the Member to prove that the claim is true and correct;

11.5.4.3 where the Member or Dependant, makes or causes to be made a false representation of any fact that is material to the Scheme in determining whether any right to a Benefit is due in terms of the Rules, the onus being on the Member to prove that the representation is true and correct.