

RULES OF THE DISCOVERY HEALTH MEDICAL SCHEME
REGISTERED UNDER THE MEDICAL SCHEMES ACT NO. 131 OF 1998

TABLE OF CONTENTS

| RULES | PAGE |
|--|-------------|
| 1. NAME..... | 2 |
| 2. LEGAL PERSONA..... | 2 |
| 3. REGISTERED OFFICE..... | 2 |
| 4. DEFINITIONS..... | 2 |
| 5. OBJECTS..... | 12 |
| 6. MEMBERSHIP..... | 12 |
| 7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS..... | 13 |
| 8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP..... | 15 |
| 9. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP..... | 18 |
| 10. CHANGE OF ADDRESS OF MEMBER..... | 19 |
| 11. TERMINATION OF MEMBER..... | 19 |
| 12. CONTRIBUTIONS..... | 20 |
| 13. LIABILITIES OF EMPLOYER AND MEMBER..... | 22 |
| 14. CLAIMS PROCEDURE..... | 22 |
| 15. BENEFITS..... | 24 |
| 16. PAYMENT OF ACCOUNTS..... | 32 |
| 17. GOVERNANCE..... | 33 |
| 18. DUTIES OF BOARD OF TRUSTEES..... | 37 |
| 19. POWERS OF BOARD..... | 38 |
| 20. DUTIES OF PRINCIPLE OFFICER AND STAFF..... | 40 |
| 21. INDEMNIFICATION AND FIDELITY GUARANTEE..... | 42 |
| 22. FINANCIAL YEAR OF THE SCHEME..... | 42 |
| 23. BANKING ACCOUNT..... | 42 |
| 24. AUDITOR AND AUDITOR COMMITTEE..... | 42 |
| 25. GENERAL MEETINGS..... | 44 |
| 26. VOTING AT MEETINGS..... | 46 |
| 27. COMPLAINTS AND DISPUTES..... | 46 |
| 28. TERMINATION OR DISSOLUTION..... | 48 |
| 29. AMALGAMATION AND TRANSFER OF BUSINESS..... | 49 |
| 30. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS..... | 49 |
| 31. AMENDMENT OF RULES..... | 50 |

1. NAME

The name of the Scheme is the Discovery Health Medical Scheme, hereinafter referred to as the “Scheme”.

2. LEGAL PERSONA

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

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 16 Fredman Drive, Sandton, 2196 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 —

4.1. a word or expression in the masculine gender includes the feminine;

4.2. a word in the singular number includes the plural, and *vice versa*; and

4.3. the following expressions have the following meanings:

4.4. **“Act”**

the Medical Schemes Act (Act No 131 of 1998), and the regulations framed thereunder.

4.5. **“Admission date”**

the date upon which a person becomes a member or, in respect of a dependant, the date upon which such dependant is registered as a dependant in terms of these Rules or, in the case of an employer, the date on which such employer may participate in the Scheme in terms of these Rules.

4.6. **“Adult dependant”**

a person other than the spouse or partner of the member who is in fact wholly or partly dependent on a member for financial support and who, is registered in terms of these Rules as an adult dependant including, but not limited to:

4.6.1. the child aged 21 years or more of a member and who is:

4.6.1.1. a full-time student aged 25 years or less; or

4.6.1.2. mentally or physically handicapped;

4.6.2. the divorced spouse of a member;

4.6.3. the relative, whether by affinity or consanguinity, of a member;

4.6.4. the second spouse of a member under a customary union according to indigenous Black Law or Custom or under a union recognised as a marriage under the tenets of any religion;

4.6.5. a person with whom the member enjoys a relationship similar to the relationship of legally married spouses.

4.7. **“Approval”**

prior written or telephonic approval.

4.8. **“Auditor”**

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

4.9. **“Beneficiary”**

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

4.10. **“Benefit plan”**

the benefits which have been chosen by a member in terms of these Rules.

4.11. **“Billing Guidelines / Rules”**

the guidelines applied to evaluate individual code submission reported in provider claims, as part of the claims adjudication process.

4.12 **“Board”**

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

4.13 **“Child”**

a member’s natural child, or a stepchild or legally adopted child or a child who has been placed in the custody of the member or his spouse or partner in terms of an order of court or competent authority.

4.14. **“Child dependant”**

the child of a member, registered as a child dependant in terms of these Rules.

4.15. **“Classic Direct Rate”**

the rate that the Scheme will pay a Classic Direct Rate provider in accordance with the undertaking referred to in clause 4.16. pursuant to which such provider’s in-hospital procedures and consultations will be paid by the Scheme in full and beneficiaries will not be required to make any further payments to him save in instances of depleted benefits.

4.16. **“Classic Direct Provider”**

a dental specialist or medical specialist who has undertaken *inter alia*, to bill beneficiaries of the Executive Plan and Classic Plans at the Classic Direct Rate for procedures and consultations in accordance with the relevant in-hospital procedure codes and consultation codes in return for direct payment by the Scheme of benefits to which beneficiaries are entitled.

4.17. **“Condition specific waiting period”**

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

4.18. **“Continuation member”**

a member who retains his membership of the Scheme in terms of rule 6.2 or a dependant who becomes a member of the Scheme in terms of rule 6.3.

4.19. **“Contribution”**

in relation to a member, the amount, exclusive of interest, paid by or in respect of the member and his registered dependants if any, as membership fees.

4.20. **“Cost”**

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

4.21. **“Council”**

the Council for Medical Schemes as contemplated in the Act.

4.22. **“Creditable coverage”**

any period during which a late joiner was:

4.22.1. a member or a dependant of a medical scheme;

4.22.2. 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;

4.22.3. a uniformed employee of the South African National Defence Force, or a dependent of such employee, who received medical benefits from the South African National Defence Force; or

4.22.4. 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.

4.23. **“Deductible”**

a specific payment for which a beneficiary is personally liable, the amount of which is specifically stipulated, in terms of the Rules of the Scheme.

4.24. **“Delta Range”**

referred herein as the network restrictions elected by members for the purposes of attaining a discounted premium on the Essential Core, Essential Saver, Classic Core, Classic Saver, Essential Comprehensive and Classic Comprehensive Plans.

4.25. **“Dependant”**

- 4.25.1. a member’s spouse or partner who is not a member or a registered dependant of a member of another medical scheme;
- 4.25.2. a member’s child who is not a member or a registered dependant of a member of another medical scheme;
- 4.25.3. an adult dependant as defined in 4.6.
- 4.25.4. the immediate family of a member in respect of whom the member is liable in law for family care and support
- 4.25.5. such other persons who are recognised by the Board as dependants for purposes of these Rules.

4.26. **“Designated Service Provider”**

a healthcare provider or group of providers selected by the Scheme as preferred provider/s to provide to the beneficiaries, diagnosis, Treatment and care in respect of one or more Prescribed Minimum Benefit conditions or any other relevant health service covered by the Scheme.

4.27. **“Discovery Health Medication Rate”**

the single exit price plus the appropriate professional fee as determined by Discovery Health.

4.28. **“Discovery Health Rate” / “DH Rate”**

Either:

- 4.28.1 the fee/rate in respect of the payment of relevant health services as prescribed in the Discovery Health Guide to Fees; or
- 4.28.2 the fee/rate as determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services.

4.29. **“Discovery network GP”**

a general practitioner who has contracted with Discovery Health (Pty) Limited and / or Discovery Health Medical Scheme to be part of the Discovery GP network.

4.30. **“Emergency Medical Condition” / “Emergency”**

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.

4.31. **“Employee” / “Employee member”**

a person in the employment of an employer.

4.32. **“Employer”**

a participating employer who has contracted with the Scheme for purposes of admission of its employees as members of the Scheme.

4.33. **“Financial year”**

the financial year of the Scheme as described in rule 22 and as defined in the Act.

4.34. **“Fixed fee”**

a fee that covers all costs incurred by the facility for a specified procedure, including, but not limited to ward, theatre and drug costs unless otherwise specifically agreed to.

4.35. **“Frail care”**

the assistance required by persons who, due to physical or mental ailment, are wholly or partially incapable of carrying out activities associated with daily living, which activities may include attention to personal hygiene, feeding, dressing, reasonable and due attendance to personal safety and the safety of others.

4.36. **“General waiting period”**

a period in which a beneficiary is not entitled to claim any benefits for a maximum of three months.

4.37. **“Global Fee”**

a fee that covers all relevant medical expenses including, but not limited to, professional, facility, radiology and pathology expenses.

4.38. **“Hospital Network Plans”**

refers to the following Benefit plans: KeyCare Core, KeyCare Plus, Coastal Core, Coastal Saver, and Essential Core, Essential Saver, Classic Core, Classic Saver, Essential Comprehensive and Classic Comprehensive Plans where members have elected network restrictions regarded as the Delta Range.

4.39. **“Income”**

means any amount received by or accrued to or deemed to have been received by or accrued to a Member or Member’s immediate family by way of, including and without limitation;

4.39.1. Average twelve months earnings, commission or rewards arising from employment, which shall include; self-employment and employment in the informal sector as well as from being an independent contractor;

4.39.2. interest, including capitalised interest from active and passive investments;

4.39.3. income from leasing of assets and / or property;

4.39.4. any distributions received from a trust, discretionary or vested, where the Member or Member’s immediate family is a beneficiary or otherwise.

4.40. **“KeyCare DPA Specialist”**

a specialist medical practitioner who has entered into an agreement contemplated in 4.28.2. in respect of beneficiaries on the KeyCare Core and KeyCare Plus options.

4.41. **“Medically necessary”**

the evaluation of healthcare services by a health professional or a multi-disciplinary committee or panel appointed by the Scheme to determine if the healthcare services or level of care is medically appropriate and necessary to meet the healthcare needs of the patient, consistent with the diagnosis or condition; rendered in a cost effective manner and type of setting appropriate to the supply of the service required for the purposes other than comfort or convenience; and consistent in type, frequency and duration of Treatment with scientifically based guidelines of medical practice and of demonstrated medical value.

4.42. **“Member”**

a person who is admitted as a member in terms of these Rules but does not include a dependant.

4.43. **“Member family”**

the member and all the member’s registered beneficiaries.

4.44. **“Network Hospital”**

a hospital contracted to or nominated by the Scheme for purposes of a Hospital Network Plan.

4.46. **“Non-Network Hospital”**

a hospital not contracted to nor nominated by the Scheme for purposes of a Hospital Network Plan.

4.47. **“Officer”**

any member of the board, the principal officer and any employee or other agent of the Scheme, but does not include the auditor.

4.48. **“Partner”**

a person with whom the member has a committed and serious relationship akin to a marriage or recognised as a union or partnership by law, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

4.49. **“Per Diem”**

a Fee based on a set rate per day.

4.50. **“Planned Procedures”**

those medical procedures that are non-life threatening that develop over time, are not of sudden onset and where the timing of the procedure is generally discretionary and/or elective.

4.51. **“Pre-existing sickness condition”**

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.

4.52. **“Preferred Provider”**

a healthcare provider or group of providers, selected by the Scheme in terms of an agreement in which the fee/rate is determined in respect of the payment of relevant health services.

4.53. **“Premier Rate”**

the rate that the Scheme will pay a Premier Rate provider in accordance with the undertaking referred to in clause 4.53. pursuant to which such provider's procedures and consultations will be paid by the Scheme in full and beneficiaries will not be required to make any further payments to him save in instances of depleted benefits.

4.54. **“Premier Rate provider”**

a dental specialist or medical specialist who has undertaken *inter alia*, to bill beneficiaries at the Premier Rate for procedures and consultations in accordance with the relevant procedure codes and consultation codes in return

for direct payment by the Scheme of benefits to which beneficiaries are entitled.

4.55. **“Prescribed Minimum Benefits” / “PMBs”**

the benefits contemplated in section 29(1)(o) of the Act and consist of the provision of the diagnosis Treatment and care costs of the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations to the Act, subject to any limitations specified therein.

4.56. **“Registrar”**

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

4.57. **“Related Account”**

is any account related to an approved in-hospital admission other than the hospital account.

4.58. **“Relevant health services”**

a service as defined in the Act which is provided for in a benefit plan.

4.59. **“Rules”**

these Rules of the Scheme, including the benefit plan schedule and Annexures.

4.60. **“Second Opinion”**

means an opinion of a health professional appointed by the Scheme. Such opinion will be based on:

4.60.1 a clinical examination of the patient/beneficiary by such healthcare professional and/or;

4.60.2 a clinical report submitted by the Scheme to the healthcare professional.

4.61. **“Social pension”**

the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (Act No. 59 of 1992).

4.62. **“Spouse”**

the spouse of a member to whom the member is married or in a union recognised in accordance with any law or custom.

4.63. **“Termination date”**

the effective date of termination of a member’s membership, dependant’s registration or an employer’s participation in terms of these Rules.

4.64. **“Treatment”**

Provision of healthcare services which would include, but is not limited to hospitalisation or non-hospitalisation benefits and subject to 4.41.

4.65. **“TTO”**

medication that member is required to take at home but is prescribed to the member whilst in hospital.

5. OBJECTS

The objects of the Scheme are:

- 5.1. to undertake liability, in respect of its members and their dependants, in return for a contribution or premium;
- 5.2. to make provision for the obtaining of any relevant health service;
- 5.3. to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/ or
- 5.4. to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme.

6. MEMBERSHIP

6.1. Eligibility

Subject to rule 8, membership is open to any person or group of persons, and shall be compulsory in respect of an employee member who in terms of his conditions of employment, is required to become a member.

6.2. Retirees

- 6.2.1. A member shall retain his membership of the Scheme with his registered dependants, if any, in the event of his retiring from the service of his employer or his employment being terminated by his employer on account of age, ill health or other disability.
- 6.2.2. The Scheme shall inform the member of his right to continue his membership and of the contribution payable from the date of retirement or termination of his employment.

6.3. Dependants of deceased members

- 6.3.1. The dependants of a deceased member, who are registered with the Scheme as his dependants at the time of such member's death, shall be entitled to membership of the Scheme without any new restrictions, limitations or waiting periods.
- 6.3.2. The Scheme shall inform the dependant of his right to membership and of the contributions payable in respect thereof. Unless such person informs the Board in writing of his intention not to become a member, he shall be admitted as a member of the Scheme.
- 6.3.3. Such a member's membership terminates if he becomes a member or a dependant of a member of another medical scheme.
- 6.3.4. 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.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1. Registration of Dependants

- 7.1.1. A member may apply for the registration of his dependants at the time that he applies for membership in terms of Rule 8.
- 7.1.2. If a member applies to register a newborn or newly adopted child within 90 days of the date of birth or adoption of the child, such child shall at the member's request be registered by the Scheme as a dependant from date of birth or adoption. Increased contributions shall then be

due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption.

7.1.3. Should a member at any time acquire an eligible dependant whether by 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; 8.5.3 and 8.6, be entitled to impose, upon later registration as a dependant, a waiting period of three months and/or a 12 month pre-existing condition exclusion during which period no benefit shall accrue to such dependant, but subscriptions shall be paid to the Scheme.

7.1.4. If a member, who marries subsequent to joining the Scheme, applies within 90 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 be due as from the first day of the month of commencement of membership and benefits will accrue as from the date of commencement of membership.

7.1.5. 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*.

7.1.6. **Special Provisions relating to Foster Children**

7.1.6.1. On application by a member, the Scheme shall permit the member to register as a dependant, a foster child upon submission of proof of dependency. The Scheme may request proof of ongoing dependency at anytime. Increased contributions shall be due as from the first day of the month of commencement of membership. Such dependant shall be entitled to benefits from the date of commencement of membership.

7.2. **De-registration of Dependants**

- 7.2.1. A member shall inform the Scheme within 30 days of the occurrence of any event, which results in any one of his dependants no longer satisfying the conditions in terms of which he may be a dependant.
- 7.2.2. When a dependant ceases to be eligible to be a dependant, he 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 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. of 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 or a dependant of a member.
- 8.3. Prospective members shall, prior to admission, complete and submit to the Scheme the application forms required by the Scheme. The Scheme may require satisfactory evidence of age, income, state of his health, dependency on the main member and the health of his dependants and of any medical advice, diagnosis, care or Treatment recommended or obtained within a period of 12 months immediately prior to the date on which application to the Scheme was made.
 - 8.3.1 for the purposes of calculating contributions in respect of the KeyCare Plans, Income shall be based on the higher of the total annual Income of the Member Family which shall be determined by regular audits and verification and/or any other third party information to verify Income;
 - 8.3.2 where Income is provided by way of an employer confirmation, the

Scheme has the discretion to utilize such confirmation as an accurate proxy of Income;

- 8.3.3 Proof of any prior membership of any other medical scheme must also be submitted. The costs of any medical tests, reports or examinations that are required at the behest of the Scheme will be paid for by the Scheme. The Scheme may 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 days preceding the date of application:

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

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

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

8.4.2.1. a condition-specific waiting period of up to 12 months, except in respect of any Treatment or diagnostic procedures covered within the Prescribed Minimum Benefits;

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

- 8.4.4. Where the former medical scheme had imposed a general or condition-specific waiting period in respect of persons referred to in this rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.
- 8.5. No waiting periods may be imposed on –
- 8.5.1. a person in respect of whom application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of:
- 8.5.1.1. change of employment; or
- 8.5.1.2. an employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the Scheme's financial year, or reasonable notice must have been furnished to the Scheme by no later than 30 September to which an application is made for such transfer to occur at the beginning of the financial year.
- 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 and registered in accordance with 7.1.2.
- 8.6. Any dependant of a member shall be entitled to the same benefits as the member, provided that:
- 8.6.1. if the Scheme excluded the member from a benefit in respect of a particular illness, disorder or disability which existed at the time of admission, or has limited such benefit, such exclusion or limitation

shall not extend to any registered dependant; and

- 8.6.2. if the Scheme has excluded a dependant from a benefit in respect of a particular illness, disorder or disability which existed at the time of admission or has limited such benefit, such exclusion or limitation shall not extend to the member or any other registered dependant.
- 8.7. Every member will, on request, 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.
- 8.8. A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a member is entitled under these Rules, or any right in respect of such benefit or payment of such benefit to such member, if a member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.
- 8.9. The Scheme shall in no circumstances be obliged to re-establish membership of a member whose membership has been terminated in terms of Rules 11.4 (unless full rehabilitation can be demonstrated) or 11.5.
- 8.10. Payment by a member or his employer or by any third party in respect of any contribution to the Scheme on behalf of the member shall constitute the member's acknowledgement that he is bound by these Rules and by any amendment hereto.

9. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

- 9.1. Every member shall be furnished with a membership card, containing such particulars as may be prescribed. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership or destroyed.
- 9.2. The utilisation of a membership card by any person other than the member or his registered dependants is not permitted and may be construed as an abuse of the privileges of membership of the Scheme.

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

10. CHANGE OF ADDRESS OF MEMBER

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

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. Except with the approval of the Scheme, where a member ceases to reside in the Republic of South Africa, his membership shall terminate.
- 11.1.3. A member of a Scheme who resigns from the service of his/her employer shall, on the date of such termination, be eligible to continue as an individual member without re-applying or the imposition of any new restrictions that did not exist at the time of his/her resignation.

11.2. Voluntary termination of membership

- 11.2.1. A member, who is not required in terms of his conditions of employment to be a member, may terminate his membership of the Scheme on giving 30 days written notice. All rights to benefits cease after the last day of membership.
- 11.2.2. Such notice period shall be waived in substantiated cases where membership of another medical scheme is compulsory as a result of a condition of employment.

11.2.3. A participating employer may terminate his participation with the Scheme on giving 30 days written notice.

11.3. Death

Membership of a beneficiary terminates on his death.

11.4. Failure to pay amounts due to the Scheme

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

11.5. Abuse of privileges, false claims, misrepresentation and non-disclosure of factual information

11.5.1. The Board may exclude from benefits or terminate the membership of a member or dependant who is found to be abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information.

12. CONTRIBUTIONS

12.1. The total monthly contributions payable to the Scheme by a member or in respect of a Member Family are as stipulated in Annexure A.

12.2. The contributions payable in respect of a Member Family from time to time shall be calculated by the Scheme on the basis of:

12.2.1. The Principal member;

12.2.2. the number of Adult dependants or Spouse or Partner of a member;

- 12.2.3. the number of Child dependants of a member;
 - 12.2.4. income as defined herein under 4.39;
 - 12.2.5. where members have elected network restrictions for the purposes for attaining discounted premiums.
- 12.3. Contributions shall be due monthly in advance or in arrears and in the manner as determined by the Scheme from time to time. Where contributions or any other debt owing to the Scheme, have not been paid within 3 days of the due date, the Scheme shall have the right to suspend all benefit payments which have accrued to such member irrespective of when the claim for such benefit arose, and to give the member and/or employer notice that if contributions or such other debts are not paid up to date within 14 days, membership may be cancelled.
- 12.4. In the event that payments are brought up to date, benefits shall be reinstated subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest 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 may be recovered by the Scheme.
- 12.5. 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.
- 12.6. The balance standing to the credit of a member in terms of any option which provides for personal medical savings accounts shall, at all time remain the property of the member.
- 12.7. Subject to 11.5, no refund of any contribution or any portion of a contribution shall be made on termination of membership.
- 12.8. In the case of a member who selects an option on which medical savings account benefits are available, there shall be added to his monthly

contributions an amount equivalent to 15% or 25% of the total medical scheme contribution (as defined in Annexure A).

- 12.9. For all payments made other than debit orders, the member must ensure that payment is allocated by the Scheme.

13. LIABILITIES OF EMPLOYER AND MEMBER

- 13.1. 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 and/or any agreement between the employer and the member.
- 13.2. The liability of a member to the Scheme is limited to the amount of his unpaid contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants, which has not been repaid to the Scheme.
- 13.3. 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 on cancellation of the membership or when called upon by the Scheme to do so.

14. CLAIMS PROCEDURE

- 14.1. 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 itemized account or statement as prescribed. In order to ensure consistent and correct claims adjudication, the Scheme shall make use of practitioner-specific Billing Guidelines to ensure proper adjudication for services rendered.
- 14.2. If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme must, in addition to the payment contemplated in Section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars:
- 14.2.1. the name and the membership number of the member;
 - 14.2.2. the name of the supplier of service;
 - 14.2.3. the date of service rendered by the supplier of service on the account or statement which is covered for the service concerned;
 - 14.2.4. the relevant code as required by the Scheme;

- 14.2.5. the total amount charged for the service concerned; and
 - 14.2.6. the amount of the benefit awarded for such service.
- 14.3. In order to qualify for benefits, any claim must, unless otherwise arranged:
- 14.3.1. be signed and certified as correct and must be submitted to the Scheme no later than the fourth month following the date in which the service was rendered. The Scheme will have the discretion to extend the four month period to a maximum of six months; or,
 - 14.3.2. where the claim must be resubmitted for correction, be resubmitted within 60 days following the date during which such claim was requested to be corrected.
- 14.4. Where a member has paid an account, he shall, in support of his claim, submit a proof of payment.
- 14.5. 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.
- 14.6. Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, for any reason whatsoever including that the Treatment rendered is not medically necessary, the Scheme shall notify the member or the healthcare provider, whichever is applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member or provider the opportunity to reply or to return such corrected claim to the Scheme within 60 days.
- 14.7. The Scheme may at its discretion and based on justifiable reason, stop all payments to a provider where it can be shown on probable cause that such provider has placed the Scheme, or any other schemes, at risk.
- 14.7.1. The Scheme shall notify the provider in writing of such decision and the reasons thereof and the provider will be entitled to dispute the decision.
 - 14.7.2. Any financial prejudice unwittingly incurred by a member as a result of the decision, the member may notify the Scheme for a possible

payment consideration.

- 14.8. In any dispute as to whether a claim was properly submitted, the member shall bear the onus of proving that the claim was submitted in accordance with these Rules.
- 14.9. In any dispute as to the manner of payment of the account, the healthcare provider or member must submit notice within 120 days from date of claims payment.
- 14.10. If any amount which the Scheme is liable to pay in terms of these Rules is not paid timeously, then any claim which a member may have as a result shall be a claim for specific performance against the Scheme.

15. BENEFITS

- 15.1. Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the member to his registered dependants. A member must, on admission, elect to participate in any one of the available options, detailed in Annexure B.
- 15.2. A member is entitled to change from one to another benefit option subject to the following conditions:
 - 15.2.1. the change may be made with effect from 01 January of any financial year provided that the Board may, in its absolute discretion, permit a member to change from one to another benefit option on any other date; and
 - 15.2.2. application for such a change must be in writing and lodged with the principal officer by not later than 30 September prior to the year upon which it is intended that the change will take place: provided that the member has had at least 30 days prior notification of any intended changes in benefits or contributions for the next year;
 - 15.2.3. The Scheme shall provide its members with prior notification of any intended changes in benefits or contributions at least 30 days before such change is affected.
- 15.3. The Scheme shall, where an account has been rendered, pay any benefit

due to a member, either to that member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.

15.4. The Scheme may, in respect of the financial year in which a member joins the Scheme, reduce the annual benefits *pro rata* to the period of membership in the financial year concerned, and calculated from the admission date to the end of the financial year concerned.

15.5. If, for any reason whatsoever, the Scheme pays an amount in excess of the amount which it is liable to pay in respect of a claim in terms of these Rules, then such amount shall be a loan repayable to the Scheme.

15.6. In the event that a 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 Republic of South Africa, the member or dependant shall:

15.6.1. be obliged to take all steps which are necessary to timeously submit to the Road Accident Fund ("RAF") established in terms Act 56 of 1996, a claim for compensation for the costs of any healthcare services performed and which in the future may be necessitated in connection with such injury; and

15.6.2. advise and keep the Scheme advised of the progress in relation to such claim for compensation; on admission of such claim by the RAF, advise the Scheme of the terms 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 healthcare services for which the RAF has undertaken to make payment.

15.7. In the event that a 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:

15.7.1. be obliged to take all steps which are necessary to timeously submit a claim for compensation to the Compensation

Commissioner (“the Commissioner”) as provided for in terms of the Compensation for Occupational Injuries and Diseases Act 130 of 1993, a claim for compensation for the costs of any healthcare services performed and which in the future may be necessitated in connection with such injury or disease and;

- 15.7.2. advise and keep the Scheme advised of the progress in relation to such claim for compensation; on submission of such claim to the Commissioner, advise the Scheme of the terms of such submission, including any terms relating to any undertaking by the Commissioner to make payment of the costs of any future medical expenses, in which event the Scheme shall be absolved from liability to make payment of any benefit in respect of healthcare services for which the Commissioner has undertaken to make payment.
- 15.8. The Scheme shall be entitled to withhold payment of any benefits otherwise due to a Member Family whose contribution, or any part thereof, is unpaid. The Scheme shall be entitled to recover from the member any payment made to or on behalf of a member whose contribution is unpaid, in part or in whole.
- 15.9. Any benefit option offered in Annexure B covers the Prescribed Minimum Benefits in accordance with Annexure 7.
- 15.10. The Scheme may exclude services from benefits as set out in Annexure C and Annexure 4.
- 15.11. The Scheme will be entitled to apply clinical policy and managed care protocols to determine members’ entitlement to benefits and to determine the application of limits and sub-limits.
- 15.12. **Exclusion**

The Scheme shall not pay for benefits from Health Care Cover if:

- 15.12.1. in the reasonable opinion of a medical officer appointed for this purpose by the Scheme, taking into account generally accepted medical practice, the service/s

- 15.12.1.1. could have been reasonably rendered in the consulting rooms of a medical practitioner; or
- 15.12.1.2. could have been reasonably rendered at a lower level of care; or
- 15.12.1.3. are not Medically Necessary; or
- 15.12.1.4. were rendered to the member or his dependant as out-patients of the hospital concerned; or
- 15.12.1.5. comprise a general exclusion to the Scheme as reflected in Annexure C and Annexure 4 to these Rules; or
- 15.12.1.6. were rendered to the member and his dependants in emergency rooms of the hospital, except for PMB conditions; or
- 15.12.1.7. do not meet the protocols and clinical guidelines of the Scheme or the cover provided by the member's Benefit Plan; or
- 15.12.1.8. is such that the quantum of the service comprises a Deductible.

15.13. **Review**

If hospitalisation or certain non hospitalisation benefits ("Treatment") is recommended for a member or a dependant then, subject to 15.15 and 15.17 below, the following provisions shall apply:

- 15.13.1. the member shall give the Scheme written or verbal notice advising that such Treatment has been recommended, giving full details including the name(s) of the medical practitioner(s) who has/have made such recommendation and obtain the required authorisation from the Scheme that it will pay for the Treatment;
- 15.13.2. the members shall give notice to the Scheme within such reasonable period as will allow the provisions of this 15.13 to be complied with; but in any event, notice of not less than 48 hours prior to the Treatment;

- 15.13.3. upon receiving such notice, the Scheme shall be entitled to require the member or his dependant (as the case may be) to obtain a Second Opinion from a medical practitioner approved by the Scheme as to whether the recommended Treatment is necessary. The charges levied by such medical practitioner in respect of the Second Opinion shall be borne by the Scheme;
 - 15.13.4. immediately upon obtaining such Second Opinion, the member shall furnish the Scheme with a copy thereof; and
 - 15.13.5. the Scheme shall, on good cause shown, be entitled to reject a request for authorisation, notwithstanding that a second opinion may have been furnished, if in its opinion any of the criteria stipulated in clause 15.12 are present;
 - 15.13.6. if the member or dependant (as the case may be) undergoes Treatment without the member obtaining authorisation from the Scheme in accordance with this 15.13 the Scheme's liability in respect of the Treatment of the members or dependant shall be subject to what is stated in clauses 15.12 to 15.17 and will further be limited to 70% of the amount for which the Scheme would have approved in terms of the relevant section of Table "A".
- 15.14. The provisions of 15.13.2 insofar as they pertain to the 48 (forty eight) hour notification period shall not apply where Treatment is required by a member or by a dependant as a matter of urgency. For the purposes of this paragraph 15.14, Treatment shall be deemed to have been required as a matter of urgency if the member could not have been expected to comply with the provision of 15.13.2 without his health or that of his dependant being placed in jeopardy. Notwithstanding this, the Member will be required to give the Scheme notification of the Treatment as soon as he is able.
- 15.15. The onus shall be upon the member to prove that:
- 15.15.1. he gave notice in accordance with 15.13.1;
 - 15.15.2. such notice was given within the time period referred to in

15.13.2;

15.15.3. a copy of the written second opinion was given to the Scheme in accordance with 15.13.4;

15.15.4. Treatment was required as a matter of urgency in terms of 15.14

if a dispute in respect of any such matter arises.

15.16. Pre-authorisation for Beneficiaries will take place on the following basis:

15.16.1. The member will ensure that either the Member Family or the hospital calls the Scheme to pre-authorise the admission.

15.16.2. All admissions are subject to pre-authorisation.

15.16.3. Where the Scheme receives a hospital claim that has not been preauthorised payment will be limited in accordance with 15.13.6.

15.16.4. The member is obliged to make full disclosure during or after pre-authorisation of all healthcare services even if they relate to a General Scheme exclusion.

15.16.4.1. Failure to do so may lead to the entire event being declined and may be regarded as a misrepresentation.

15.17. Admission for Beneficiaries on the Hospital Network Plans will take place in accordance with the following:-

15.17.1. Should the Beneficiary be admitted to a Non-Network Hospital in the event of an emergency, the Beneficiary may be transferred to a Network Hospital as soon as the patient is stabilised.

15.17.2. Should the Beneficiary be admitted to a Non-Network Hospital for reasons other than an emergency and involuntariness in respect of a Prescribed Minimum Benefit, such admission will be covered up to a maximum of 80% of the benefit available to the Beneficiary on the particular Hospital Network Plan.

15.17.3. Should the Beneficiary of a Classic Core, Classic Saver, Essential Core, Essential Saver, Essential Comprehensive or

Classic Comprehensive elect network restrictions (as defined in Annexure B) and be admitted to a Non-Network Hospital for reasons other than an emergency, such admission will be subject to a Deductible.

- 15.17.4. Admissions of Beneficiaries on the KeyCare Core and KeyCare Plus plans for non-emergency reasons to Non-Network Hospitals will not be covered save in accordance with Annexure 7.
- 15.17.5. Admissions of Beneficiaries on the Coastal Core and Coastal Saver plans for non-emergency reasons to Non-Network Hospitals will be covered up to a maximum of 70% of the benefit available to the Beneficiary on the particular Hospital Network Plan.
- 15.18. The Scheme shall only be required to fund medical technologies and Treatments not previously funded, or existing Treatments for new clinical indications, and/or unregistered medicines from Health Care Cover if such medical Treatments meet the Scheme's protocols, where they exist, which shall be developed on the basis of evidence-based medicine and cost effectiveness criteria.
- 15.19. Funding only for Medically Necessary healthcare services
 - 15.19.1. The Scheme shall only fund healthcare service provided to a member if the service in question is Medically Necessary.
 - 15.19.2. If the Scheme reasonably determines that the healthcare service and/or level of care is not Medically Necessary, the Scheme may fund such service at the appropriate or cost-effective level of care.
 - 15.19.3. The Scheme may require a member to be medically examined for purposes of establishing whether the healthcare service is medically necessary. Should the member and/or the member's family decline consent for such an examination, the Scheme may then, in keeping with generally accepted clinical practice and with the clinical information at hand, withdraw or reduce funding to the recommended level of care as contemplated in

4.41.

15.20. Specified devices

15.20.1. In respect of a claim for a specified device, the Scheme may require a member to submit a quote for the device to enable the Scheme to verify the cost thereof and/or take steps to reduce its cost.

15.20.2. If the claim is in respect of an upgrade or replacement of an existing specified device, the Scheme may –

15.20.2.1. Recommend to the member that s(h)e procure a sale, trade-in, discount or refund in respect of the existing specified device or may itself take such steps.

15.20.2.2. When determining the amount payable for the claim, deduct the proceeds of any sale or the value of any trade-in, discount or refund procured in respect of the existing specified device.

15.20.2.3. Recover from the member the proceeds of any sale or the value of any trade-in, discount or refund procured in respect of the existing specified device but not disclosed by the member at the time of making the claim or procured by the member subsequent to the claim being paid.

15.20.2.4. Not decline a claim for reason only that a member did not take the steps recommended in terms of 15.20.2.1.

15.20.2.5. For purposes of this Rule, 'specified device' means an external medical item as defined in Annexure 6 and any of the following devices including, but not limited to items such as cochlear implants, hearing aids and pacemakers.

16. PAYMENT OF ACCOUNTS

- 16.1. Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected.
- 16.2. 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 who rendered the service.
- 16.3. Billing Rules are the prerogative of the Scheme and this includes but is not limited to: Discovery Health Guide, SAMA, international practice and consultation with professional groups.
- 16.4. Where the Scheme has paid an account or portion of an account or any benefit to which a member is not entitled, whether payment is made to the member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme.
- 16.5. Notwithstanding the provisions of this rule, the Scheme has the right to pay any benefit directly to the member concerned.
- 16.6. The Scheme may, in its discretion, make *ex gratia* payments to or for the benefit of a beneficiary.

16.7. **Addresses**

16.7.1. Postal address

- 16.7.1.1. Any notice in connection with these Rules may be addressed to a member or an employer at his address stated in his application form.

16.7.2. The notice shall be deemed to have been duly given at such address:

- (a) 7 days after posting to the address in 16.7.1.1. if posted by prepaid registered post;
- (b) on delivery, if delivered;
- (c) on transmission, if successfully transmitted to the party's telefax number.

- (d) by e-mail if successfully sent to the party's e-mail address

16.7.3. Any member or employer shall notify the Scheme within 30 days of any change of address, by notice in writing.

16.8. Address for service of legal documents

16.8.1. Each employer and member chooses the physical address stated in his application form as the address at which documents in legal proceedings may be served.

16.8.2. Any employer or member may change his address for this purpose to another physical address in the Republic of South Africa, by notice in writing subject to Rule 10.

17. GOVERNANCE

17.1. The affairs of the Scheme must be managed according to these Rules by a Board of fit and proper persons of at least five but no more than eight persons. Subject to clause 17.7, a trustee shall serve a term of three years and shall be eligible for re-election. Such trustees shall not serve more than two consecutive terms.

17.2. At least half of such trustees must be elected by members from amongst members.

17.3. The balance of the trustees may be elected by members from amongst participating employers, or appointed by incumbent member elected trustees: provided that the trustees appointed in terms hereof by the incumbent trustees shall be subject to clause 17.7;

17.3.1. at any given time not exceed 25 % of the total number of trustees;
and;

17.3.2. have their appointment presented for confirmation by members at the first annual general meeting following their appointment.

- 17.4. The following persons are not eligible to serve as members of the Board:
- 17.4.1. a person under the age of 21 years;
 - 17.4.2 an employee, director, officer, consultant, or contractor of the administrator or the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator or any other medical scheme administrator or provider of managed care services to a medical scheme;
 - 17.4.3 a broker;
 - 17.4.4 a person, including a legal person, associated with the administrator and/or the provider of managed care services to the Scheme;
 - 17.4.5 the principal officer of the Scheme; and
 - 17.4.6 the auditor of the Scheme;
 - 17.4.7 the legal advisors of the Scheme and of the administrator of the Scheme;
 - 17.4.8 an employee, director, officer, consultant or contractor of, or any person associated with, a community pharmacy, a wholesale pharmacy, a group of pharmacies, a manufacturer of medicines and/or complimentary medicines, a manufacturer of medical devices and/or medical consumables, distributor and/or wholesaler of medicines, complimentary medicines, medical devices or medical consumables;
 - 17.4.9 an employee, director, officer, consultant or contractor of a private hospital or hospital owning or operating group or a pathology laboratory or pathology owning or operating group;
 - 17.4.10 an employee, director, officer, consultant, contractor or person associated with a supplier of goods or services (including a relevant health service), to the Scheme or its administrator or to the holding company, subsidiary, joint venture or associate of its administrator, where the supply of such services and goods forms a significant percentage of the supplier's business (in excess of 25% of gross

revenue shall be deemed to be “a significant percentage” of the supplier’s business);

- 17.4.11 a person holding a trusteeship of any other medical scheme or schemes; and
- 17.4.12 a person who by virtue of holding public or other office is in a position of actual or potential conflict of interest with the Scheme.
- 17.5. Retiring members of the Board are eligible for re-election, provided that no person shall serve more than two consecutive terms. Notwithstanding this however, a person will be entitled to serve more than two terms in his lifetime.
- 17.6. Nominations to fill vacancies, signed by the nominee and the candidate signifying his consent to stand for election, must be submitted to the Scheme at least 30 days before the date of the annual general meeting of the Scheme. The Scheme may appoint a nomination committee to assess all nominees against the eligibility criteria described in rule 17.4 above. The election must be carried out by the members present at the annual general meeting of the Scheme.
- 17.7. The Board may fill by appointment by the remaining members of the Board, any casual vacancy, which occurs during its term of office within 40 days. 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.
- 17.8. The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.
- 17.9. Half of the members of the Board plus one, is a quorum at meetings of the Board.
- 17.10. The Board must elect from its number the chairperson and vice-chairperson.
- 17.11. In the absence of the chairperson and vice-chairperson, the Board members present must elect one of their numbers to preside.
- 17.12. Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson has a casting vote in

addition to his deliberative vote.

- 17.13. A member of the Board may resign at any time by giving written notice to the Board. Such vacancy will be filled in terms of rule 17.7.
- 17.14. A member of the Board ceases to hold office if:
- 17.14.1. he becomes mentally ill or incapable of managing his affairs;
 - 17.14.2. he is declared insolvent or has surrendered his estate for the benefit of his creditors;
 - 17.14.3. he is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;
 - 17.14.4. he is removed by the court from any office of trust on account of misconduct;
 - 17.14.5. he is disqualified under any law from carrying on his profession;
 - 17.14.6. he ceases to be an appointee by a participating employer, or being a Board member elected by members of the Scheme, he ceases to be a member of the Scheme;
 - 17.14.7. he absents himself from three consecutive meetings of the Board without the permission of the Chairperson; or
 - 17.14.8. he is removed from office by the Council in terms of Section 46 of the Act.
- 17.15. The Board must meet at least once every two months or at such intervals as it may deem necessary, but not less than six times in any financial year.
- 17.16. The chairperson may convene a special meeting should the necessity arise. Any two members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.
- 17.17. Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as trustees.

- 17.18. Members of the Board are entitled to remuneration, an honorarium or any other fee in respect of services rendered in their capacity as members of the Board as determined and recommended by the Board's Remuneration Committee which will be reviewed on an annual basis.
- 17.19. The Board shall perform a self assessment and a review of the performance of the Chairperson on an annual basis.

18. DUTIES OF BOARD OF TRUSTEES

- 18.1. The Board is responsible for the proper and sound management of the Scheme, in terms of these Rules.
- 18.2. The Board must act with due care, diligence, skill and in good faith.
- 18.3. 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.
- 18.4. The Board must apply sound business principles and ensure the financial soundness of the Scheme.
- 18.5. The Board shall appoint a principal officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the principal officer and of any person employed by the Scheme;
- 18.6. The chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.
- 18.7. The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.
- 18.8. The Board must ensure that proper control systems are employed by and on behalf of the Scheme.
- 18.9. The Board must ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the Rules.
- 18.10. The Board must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and the Rules.

- 18.11. The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.
- 18.12. The Board must obtain expert advice on legal, accounting, actuarial and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.
- 18.13. The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.
- 18.14. The Board shall ensure that the Scheme complies with applicable laws and considers adherence to non binding Rules, codes and standards.
- 18.15. The Board must take all reasonable steps to protect the confidentiality of medical records concerning any member or dependant's state of health.
- 18.16. The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme.
- 18.17. The Board must make such provision, as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.
- 18.18. The Board shall disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme.
- 18.19. The Board shall ensure that the Scheme is and is seen to be a responsible corporate citizen.

19. POWERS OF BOARD

The Board has the power:

- 19.1. To appoint any employee required for the proper execution of the business of the Scheme, determine the terms of such appointment and where necessary to cause the termination of the services of any employee of the

Scheme;

- 19.2. To take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfillment of the Scheme's obligations under such appointments;
- 19.3. To appoint and delegate authority to a committee consisting of such Board members and other experts as it may deem necessary. This committee will be responsible to provide feedback to the Board.
- 19.4. 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;
- 19.5. To appoint, compensate (in accordance with Annexure D) and determine the levels of service of any accredited broker for the introduction or admission of a member to the Scheme;
- 19.6. To contract with managed healthcare organisations subject to the provisions of the Act and its regulations;
- 19.7. To purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it;
- 19.8. To let or hire movable or immovable property;
- 19.9. In respect of any monies not immediately required to meet current charges upon the Scheme and in the manner determined by the Board and in accordance with section 35(5) of the Act and section 30 of the regulations to the Act, to invest or otherwise deal with such monies upon security and to realise, re-invest or otherwise deal with such monies and investments;
- 19.10. 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;
- 19.11. 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;

- 19.12. 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 members;
- 19.13. To make *ex gratia* payments on behalf of members;
- 19.14. To contribute to any fund conducted for the benefit of employees of the Scheme;
- 19.15. To apply risk management tools in terms of the benefits provided for in these Rules;
- 19.16. 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;
- 19.17. To contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes; and
- 19.18. In general, to do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.

20. DUTIES OF PRINCIPAL OFFICER AND STAFF

- 20.1. The staff of the Scheme must ensure the confidentiality of all information regarding its members.
- 20.2. The provisions of Rules 17.14.1 – 17.14.5 apply *mutatis mutandis* to the principal officer.
- 20.3. The principal officer is the executive officer of the Scheme and as such shall ensure that:
 - 20.3.1. the decisions and instructions of the Board are executed without unnecessary delay;
 - 20.3.2. where necessary, there is proper and appropriate communication between the Scheme and those parties, affected

by the decisions and instructions of the Board;

- 20.3.3. he keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;
 - 20.3.4. he 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;
 - 20.3.5. he does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.
- 20.4. The principal officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all monies received and payments authorised by and made on behalf of the Scheme.
- 20.5. The principal officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Board, and any other duly appointed subcommittee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.
- 20.6. The principal officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.
- 20.7. The principal officer shall keep full and proper records of all monies received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.
- 20.8. The principal officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.
- 20.9. If the principal officer is, for a period exceeding 30 days, absent from the Republic of South Africa, or for any other reason unable to discharge any duty imposed on him by the provisions of the Act, the Scheme shall, for the duration of such absence or inability, appoint another officer in his stead.
- 20.10. The following persons are not eligible to be a principal officer:

- 20.10.1. 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; and
- 20.10.2. a broker.

20.11. Any person, who, immediately prior to commencement of the Medical Schemes Amendment Act, was a principal officer of a medical scheme in contravention of section 57(7) of this Act, will be deemed to comply with that section for the period terminating on 01 January 2004.

21. INDEMNIFICATION AND FIDELITY GUARANTEE

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

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

22. FINANCIAL YEAR OF THE SCHEME

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

23. BANKING ACCOUNT

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

24. AUDITOR AND AUDIT COMMITTEE

24.1. 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.

- 24.2. The following persons are not eligible to serve as auditor of the Scheme:
- 24.2.1. A member of the Board;
 - 24.2.2. An employee, officer or contractor of the Scheme;
 - 24.2.3. An employee, director, officer or contractor of the Scheme's administrator, or of the holding company, subsidiary joint venture or associate of the administrator;
 - 24.2.4. A person not engaged in public practice as an auditor; and
 - 24.2.5. A person who is disqualified from acting as an auditor in terms of the Companies Act, 1973.
- 24.3. Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board must within 30 days appoint another auditor to fill the vacancy for the unexpired period.
- 24.4. If the members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this rule, the Board must within 30 days make such appointment, and if it fails to do so, the Registrar may at any time do so.
- 24.5. The auditor of the Scheme at all times has a right of access to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from the Board and the officers of the Scheme such information and explanations as he deems necessary for the performance of his duties.
- 24.6. The auditor must report to the members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in general meeting.
- 24.7. The Board must appoint an audit committee of at least five members of whom at least two must be members of the Board.

25. GENERAL MEETINGS

25.1. Annual general meeting

- 25.1.1. The annual general meeting of members must be held not later than 30th June of each year.
- 25.1.2. The notice convening the annual general meeting, containing the agenda and advising how the annual financial statements, auditor's report and annual report may be obtained, must be furnished to members at least 21 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such meeting.
- 25.1.3. At least 15 members of the Scheme present in person constitute a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting must be postponed to a date determined by the Board, and members then present constitute a quorum.
- 25.1.4. The financial statements and reports specified in 25.1.2 must be laid before the meeting.
- 25.1.5. Notices of motions to be placed before the annual general meeting must reach the principal officer not later than seven days prior to the date of the meeting.

Special general meeting

- 25.1.6. The Board may by written notice convene a special general meeting of members –
 - 25.1.6.1. at its discretion, if it deems it necessary; or
 - 25.1.6.2. upon receipt of a written request for such meeting signed by at least 100 (one hundred) members of the Scheme of which no more than 10 (ten) members who are signatories to the requisition may be employed by the same company or group of companies.

25.1.7. The written request contemplated in Rule 25.1.6.2 must be delivered to the Registered Office of the Scheme, either by hand or electronic mail, addressed to the Principal Officer, containing the following:

- the proposed agenda for the meeting,
- the signatures and membership numbers of the members that have requested the meeting.

25.1.8. The date for a special general meeting requested by members must be set by the Board within 30 (thirty) days of receiving the written meeting request as contemplated in Rule 25.1.7 and subject to Rule 25.1.9, such a meeting must be convened within 60 (sixty) days of receiving the written meeting request.

25.1.9. The notice convening a special general meeting must –

25.1.9.1. set out the agenda of the meeting. Only the matters set out in the agenda of the meeting may be discussed at a special general meeting.

25.1.9.2. be furnished to members at least 14 (fourteen) days prior to the date of the meeting. The non-receipt of a notice of a special general meeting by a member does not invalidate the proceedings at such a meeting.

25.1.10. The quorum at a special general meeting convened –

25.1.10.1. at the instance of the Board in terms of Rule 25.1.6.1, shall be 100 (one hundred) members present;

25.1.10.2. at the request of members in terms of Rule 25.1.6.2, shall be 100 (one hundred) members present.

25.1.11. If a quorum is not present at the designated venue for the special general meeting after the lapse of 30 (thirty) minutes from the time the fixed for the meeting, the meeting shall be

regarded as cancelled.

26. VOTING AT MEETINGS

- 26.1. 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 stead.
- 26.2. 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.
- 26.3. The chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson, if he is a member, has a casting vote in addition to his deliberative vote.

27. COMPLAINTS AND DISPUTES

- 27.1. Any member may lodge a complaint to the Scheme in terms of these Rules or in terms of the Act to the Registrar. These Rules deal with complaints lodged to the Scheme.
- 27.2. A 'complaint' means a complaint as defined in the Act and for purposes of these Rules, a 'complaint' and a 'dispute' bears the same meaning.
- 27.3. A complaint may be lodged in writing (whether by post, e-mail or telefax). A complaint may also be lodged verbally by telephone.
- 27.4. A member lodging a complaint must do so within 2 years of alleged service failure that gave rise to the complaint; failing which, the member's right to lodge such complaint shall prescribe.
- 27.5. A member lodging a complaint in respect of Prescribed Minimum Benefits must do so within 3 years of alleged service failure that gave rise to the complaint; failing which, the member's right to lodge such complaint shall prescribe.
- 27.6. The Scheme shall endeavour to cause all complaints to be processed within 30 days of its receipt; failing which, within a reasonable time.

- 27.7. If the Scheme finds that there is no merit in the complaint, it must notify the complainant in writing of its finding and the reasons for the finding.
- 27.8. If dissatisfied with the finding on the complaint, the complainant may –
- 27.8.1. within 60 days of receiving the relevant notice, refer the complaint in writing (by completing the appropriate Dispute Form) to the Principal Officer for consideration by the Scheme’s Dispute Committee; or
 - 27.8.2. refer the complaint to the Registrar for consideration in terms of the Act.
- 27.9. Upon receipt of the referral in terms of Rule 27.8.1, the Principal Officer or any other person designated by him must convene a Dispute Committee meeting by giving notice to the complaint specifying -
- 27.9.1. the date of the meeting which may not be less than 21 days from the date of submitting the notice or such earlier date as the Principal Officer and member may agree to;
 - 27.9.2. the commencement time and venue for the meeting;
 - 27.9.3. who will comprise the Dispute Committee;
 - 27.9.4. the particulars of the complaint; and
 - 27.9.5. the procedures and the Rules to be applied when considering the dispute which must include the right of the complainant to be heard in person or through a representative at the Dispute Committee meeting.
- 27.10. The Dispute Committee shall comprise of 3 persons appointed from the panel established and governed in terms of rule 27.11. At least one of the persons constituting a Dispute Committee must be a person with legal expertise. Such person shall preside over the Dispute Committee meeting.
- 27.11. For purposes of constituting the Dispute Committee, the Scheme shall:

- 27.11.1. annually appoint a panel consisting of up to nine persons (members or non-members), who constitute the pool of persons from amongst whom a Dispute Committee shall be constituted. Of these persons, at least one-third must be persons with legal expertise, no more than one-third may be non-members and none may be a Trustee of the Scheme, a director of the Scheme's administrator or an employee of the Scheme or its administrator;
 - 27.11.2. Designate a person as co-ordinator of the panel. The co -ordinator shall assume responsibility for the constituting the Dispute Committee; and
 - 27.11.3. Determine the remuneration and allowance applicable to persons constituting the Disputes Committee.
- 27.12. A member of the Scheme has the right to appeal in terms of the Act to the Council against the decision of the Disputes Committee. The Act requires such appeal to be in the form of an affidavit directed to the Council to be furnished not later than three months after the date on which the Dispute Committee decision was made.
- 27.13. The decision of the Dispute Committee shall be final and binding unless overturned by the Council appeal process.

28. TERMINATION OR DISSOLUTION

- 28.1. The Scheme may be dissolved by order of a competent court or by voluntary dissolution.
- 28.2. Members in general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by ballot whether the Scheme must be liquidated. Unless the majority of members decide that the Scheme must continue, the Scheme must be liquidated in terms of section 64 of the Act.
- 28.3. Pursuant to a decision by members taken in terms of rule 28.2 the principal officer must, in consultation with the Registrar, furnish to every member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of

winding up, together with a ballot paper.

- 28.4. Every member must be requested to return his ballot paper duly completed before a set date. If at least 50 per cent of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

29. AMALGAMATION AND TRANSFER OF BUSINESS

- 29.1. 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, in which event the Board must arrange for members to decide by ballot whether the proposed amalgamation should be proceeded with or not. The Board may call a Special General Meeting of the Scheme in order for members to decide by ballot, at the meeting, whether the proposed amalgamation should be proceeded with or not.
- 29.2. If at least 50 per cent of the returned ballot papers duly completed are in favour of the amalgamation or transfer, then, subject to section 63 of the Act, the amalgamation or transfer may be concluded.
- 29.3. The Registrar, may on good cause shown, ratify a lower percentage as indicated in 29.2.

30. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

- 30.1. Any beneficiary must on request and on payment of a fee of R50 (fifty Rand) per copy, be supplied by the Scheme with a copy of the following documents:
- 30.1.1. the Rules of the Scheme;
 - 30.1.2. the latest audited annual financial statements, returns, Trustees reports and auditor's report of the Scheme; and
 - 30.1.3. The management accounts in respect of the Scheme and all of its benefit options.
- 30.2. A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in rule 30.1 and to make extracts

there from.

31. AMENDMENT OF RULES

- 31.1. The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure, provided that no such amendment rescission or addition shall be valid until it has been registered by the Registrar in terms of the Act.
- 31.2. Should a member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.
- 31.3. Notwithstanding the provisions of rule 31.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.
- 31.4. If there is any conflict between these Rules and any brochure, pamphlet, explanatory document or marketing material in respect of the Scheme, the provisions of these Rules shall apply.