BESTMED RULES

(Adopted by the Board of Trustees on 22 September 2021)

1. NAME

The name of the Scheme is Bestmed Medical Scheme, hereinafter referred to as the "Scheme". The abbreviated name is Bestmed.

2. LEGAL PERSONA

The Scheme is a body corporate, capable in its own name 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, 1998, the Regulations there under and these Rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, 0081, 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 word or expression in the masculine gender includes the feminine and vice versa; and
- A word in the singular number includes the plural, and vice versa; and
- The following expressions have the following meanings:

4.1 “**Administrator**” means any person who has been accredited by the Council in terms of section 58, and shall, where any obligation has been placed on the Scheme in terms of the Act, also mean a medical scheme;

4.2 **"Approval"** means prior written approval;

4.3 **"Auditor"** means an auditor registered in terms of the Public Accountants' and Auditors' Act, 1991, (Act No. 80 of 1991);

4.4 **“Beneficiary”** means a Member or a person admitted as a Dependant of a Member;

4.5 **“Benefits”** mean the benefits to which a Member is entitled as set out in Rule 16 and in terms of the schedule of the Scheme option in which he participates, subject to the restrictions imposed by these Rules;

4.6 **“Biological and other high cost medicine”** means:

4.6.1 **Biological medicine** - any substance made from a living organism or its products and used in the prevention, diagnosis or treatment of acute and chronic diseases; and

4.6.2 **High cost medicine** - any costly medicine that the Scheme has classified as such and is only covered under this benefit, except where this treatment is PMB level of care;

4.7 **"Board"** means the Board of Trustees constituted in terms of Rule 18 to govern the Scheme in terms of the Act and these Rules;

4.8 “**Board of Trustees**” means the board of trustees charged with the governance of the affairs of this Scheme, and which has been elected or appointed under these Rules;

4.9 “**Broker”** means a person whose business, or part thereof, entails providing broker services, but does not include:

4.9.1 An employer or employer representative who provides service or advice exclusively to the employees of that employer;

4.9.2 A trade union or trade union representative who provides service or advice exclusively to Members of that trade union; or

4.9.3 A person who provides service or advice exclusively for the purposes of performing his or her normal functions as a trustee, principal officer, employee or administrator of the Scheme, unless a person referred to in this paragraph elects to be accredited as a broker, or actively markets or canvasses for membership of this Scheme;

4.10 "**Broker Services**" means:

4.10.1 The provision of services or advice in respect of the introduction or admission of Members to this Scheme; or

4.10.2 The on-going provision of service or advice in respect of access to, or benefits or services offered by, this Scheme;

4.11 "**Business of a Medical Scheme**" means the business of undertaking, in return for a premium or contribution, the liability associated with one or more of the following activities:

4.11.1 Providing for the obtaining of any relevant health service;

4.11.2 Granting assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; or

4.11.3 Rendering 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;

4.12 **"Child"** means a Member's natural child, or a stepchild or legally adopted child or a child who has in accordance with the law been placed in the custody of the Member or his spouse or partner;

4.13 "**Chronic Disease List (CDL)**" means a list of chronic conditions where the Scheme will provide and pay for medication and the treatment of the chronic condition as listed in the Act;

4.14 **"Claim"** means an itemised statement of services and costs from a health care provider or facility submitted to the Scheme for payment where the Member and or his beneficiary(ies) applies for benefit pay out for relevant health service(s) utilised or the amount which a Member demands of the Scheme in respect of expenditure incurred by him in connection with a relevant health service in respect of which he and/or his Dependants are entitled to in terms of Rule 16 and Annexure B of these Rules, in the benefit option which he participates in;

4.15 **"Condition-specific Waiting Period"** means a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made;

4.16 **"Continuation/Retired/Widowed/Orphaned Member"** means:

4.16.1 An employee of a participating employer who retains his membership of the Scheme upon retirement; or

4.16.2 Due to death of a Member, his registered Dependant(s) become(s) a Member of the Scheme in terms of Rule 6.3;

4.17 **"Contracted Fee"** means the fee determined in terms of an agreement between the Scheme and a service provider or group of service providers in respect of the payment for relevant health services;

4.18 **"Complaint"** means a complaint against any person required to be registered or accredited in terms of the Act or any person whose professional activities are regulated by the Act and these Rules, and alleging that such person has:

4.18.1 Acted, or failed to act, in contravention of this Act and these Rules; or

4.18.2 Acted improperly in relation of any matter which falls within the jurisdiction of the Council;

4.19 "**Co-Payment**" means that portion of a claim or medical expense that is paid by the Member to the service provider or, on request that, with the exception of PMB claims, may be paid from the available funds in the Member's medical savings account or vested medical savings account, as provided on the selected benefit option;

4.20 **"Cost"** means, in relation to a benefit, the net amount charged in respect of a relevant health service;

4.21 **"Council"** means the Council for Medical Schemes established by section 3 of the Act;

4.22 **"Creditable Coverage"** means 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 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 Dependant of such employee, who received medical benefits for the South African National Defence force; or

4.22.4 A Member or a dependent of the Permanent Force Continuation Fund, but excluding any period of coverage as a Dependant under the age of 21 (twenty-one) years;

4.23 **"Date of Service"** means

4.23.1 In the case of consultations, visits or treatments by a health practitioner, the date on which each consultation, visit or treatment took place, whether it was for the same illness or not;

4.23.2 In the case of operations, procedures or confinements, the date on which the operation, procedure or confinement took place;

4.23.3 In the case of hospitalisation, the date of each discharge from a hospital or nursing home alternatively the date on which membership is terminated, whichever date is the earlier;

4.23.4 In the case of any other benefit, the date on which the service was rendered or the benefit or item was obtained; and

4.23.5 In the case of an accident, event or injury referred to in Rule 15.5, the date of final ruling;

4.24 **"Dependant"** means

4.24.1 A Member's spouse or partner who is not a member or a registered dependant of a member of another scheme;

4.24.2 A Member's dependent child who is under the age of 24 (twenty-four) years and not a member or a registered dependant of a member of another Scheme;

4.24.3 A parent, brother or sister of a Member in respect of whom the Member is liable for family care and support, and for whom adult Dependants

contributions shall be payable, if such Dependant is older than 24 (twenty-four) years of age;

4.24.4 A Member's child who is 24 (twenty-four) years or older, registered as a student at a school or other educational institution recognised and accepted as such by the Board, and has not reached the age of 26 (twenty-six) years for whom child Dependants contributions shall be payable: Provided that;

4.24.4.1 Proof acceptable to the Board is submitted to the effect that the child is a registered student at the institution in question; and

4.24.4.2 The child is not enrolled as a member or a dependant of a member of another scheme.

4.24.5 A Member's child who is 24 (twenty-four) years or older in respect of whom the Member is liable for family care and support, or because of a mental/ physical handicap or for any similar reason is dependent on the Member and adult Dependant's contribution shall be payable;

4.24.6 Any other person who is recognised by the Board as a Dependant for purposes of these Rules.

4.25 **"Designated Service Provider"** means a health care provider or group of providers selected by the Scheme as the preferred provider or providers to provide to the Members diagnosis, treatment and care in respect of one or more prescribed minimum benefit condition at a contract fee rate;

4.26 "**Dispensing Fee**" means the fee a pharmacist charges for dispensing medicine;

4.27 **"Electronic Communications"** as derived from the Electronic Communications Act 36 of 2005 it means the emission, transmission or reception of information, including without limitation, voice, sound, data, text, video, virtual general meetings, animation, visual images, moving images and pictures, signals or a combination thereof by means of magnetism, radio or other electromagnetic

waves, optical, electromagnetic systems or any agency of a like nature, whether with or without the aid of tangible conduct, but does not include content service;

4.28 **“Emergency Medical Condition”** means 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;

4.29 **"Employee"** means a person in the employ of a participating employer;

4.30 **"Employer”** means a participating employer who has contracted with the Scheme for purposes of admission of its employees or part thereof as Members of the Scheme;

4.31 “**Endoscopic Investigation**” means looking inside the body for medical reasons using an instrument called an endoscope, to examine the interior of a hollow organ or cavity of the body;

4.32 **“Financial Year”** means a period from the 1st (first) day of January to the 31st (thirty-first) day of December of that year, both days included;

4.33 **“Fit and Proper”** means with regard to persons' fitness and propriety for office:

4.33.1 A person will not be regarded to be a fit and proper person for membership of a board of trustees or for appointment in or incumbency of the office of chief executive officer of a medical scheme or the chief executive of any entity accredited under the Act or seeking such accreditation, where the person–

4.33.1.1 is a professional who is disqualified under any law from carrying on his or her profession;

4.33.1.2 is not permanently resident in the Republic;

4.33.1.3 has been convicted–

4.33.1.3.1 of any offence by a competent court of law in the Republic in respect of which he or she was sentenced to a term of imprisonment without the option of a fine; or

4.33.1.3.2 by a competent court of law in any other country of an offence which is also an offence in the Republic, and sentenced in respect thereof to a term of imprisonment without the option of a fine;

4.33.1.4 in any civil matter–

4.33.1.4.1 has had any judgment of a competent court of law in the Republic or elsewhere entered against him or her in which a finding of fraud, misrepresentation or dishonesty was made against the person.

4.33.1.4.2 has accepted civil liability for fraud or misrepresentation under the law of the Republic or of any other country;

4.33.1.5 has provided false or misleading information to the Council or the Registrar;

4.33.1.6 is an un-rehabilitated insolvent; or

4.33.1.7 at any time has been removed from a position of trust in terms of this Act, any other law or in terms of rules of any medical scheme.

4.34 "**Formulary**" means a list of medicines that the Scheme will pay for to treat the acute and chronic conditions as per the benefit option the Member selected;

4.35 **"General Waiting Period"** means a period in which a beneficiary is not entitled to claim any benefits;

4.36 **"Income"** means for the purposes of calculating contributions in respect of —

4.36.1 A Member who is an employee of a participating employer – basic salary;

4.36.2 An individual Member - gross monthly income;

4.36.3 A Member who registers a spouse or partner as a Dependant — the higher of the Member's or spouse's gross monthly income; and

4.36.4 A continuation Member - gross monthly income;

4.37 **"Health Practitioner"** means any person, including a student, registered with the Council in a profession registrable in terms of the Health Professions Act, No. 56 Of 1974;

4.38 **"Individual Member"** means a Member that obtained membership of the Scheme by joining on his/her own and not through a participating employer organisation.

4.39 **"Late Joiner"** means an applicant or the adult Dependant of an applicant who, at the date of application for membership or admission as a Dependant, as the case may be, is 35 (thirty-five) years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical Schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 (three) consecutive months since 1 April 2001;

4.40 "**Late Joiner Penalty**" means a penalty payable for a late joiner that will be added to the Member's monthly contribution. The penalty is applied only to the portion of the contribution related to the Member or adult Dependant who qualifies for late joiner penalties and as such is calculated on the bands as prescribed by the Act;

4.41 **"Managed Health Care"** means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rule-based and clinical management-based programmes;

4.42 "**Maxillofacial Surgery**" means surgery to the jaw or face;

4.43 “**Maximum Benefits”** means the total benefits which may accrue to a Member and his Dependants in terms of these Rules for the financial year;

4.44 “**Medical Savings Account**” means a benefit account established in the name of the Member concerned into which an amount that may not exceed 25% (twenty-five percent) of the total gross contribution made in respect of the Member during the financial year concerned is payable as indicated by the specific benefit option chosen by the Member. Funds deposited in a Member’s personal medical savings account, where applicable, shall be available for the exclusive benefit of the Member and his or her Dependants and will not be used to offset the Member’s contributions, provided that the Scheme may use funds in a Member’s personal medical savings account to offset debt owed by the Member to the Scheme following that Member’s termination of membership of the Scheme. Any interest earned shall be accrued to the medical savings account balance. No cross subsidisation applies to the medical savings account;

4.45 **“Medical Scheme”** means any medical scheme registered under section 24 of the Act.

4.46 “**Mediscor Reference Price (MRP)**” means a reference list of generic medicines that cost less than original brand name medicines. The MRP sets a maximum reimbursement price for each generic product. A change in the MRP, as and when it is received from Mediscor, will affect the co-payment amount payable by the Member if he elects to receive the original brand medicines;

4.47 **"Member"** means a person who has been enrolled or admitted as a Member of the Scheme in terms of these Rules;

4.48 “**Network Option Services**” means an arrangement entered into between the Scheme and an accredited managed care organisation whereby the Scheme pays to such an accredited managed care organisation a prenegotiated fixed fee in return for the delivery or arrangement of the delivery of specified benefits to some or all of the Members of the Scheme;

4.49 **"Non-CDL Condition"** means other chronic conditions which do not form part of the Chronic Disease List. Payment shall depend on non-CDL benefits specified per benefit option, as determined by the Scheme, at its sole, discretion, in accordance with each individual benefit option;

4.50 **"Officer"** means any member of the Board of Trustees, any manager, the Principal Officer, treasurer, clerk or other employee of the Scheme, but does not include the auditor of the Scheme;

4.51 **"Partner"** means a person with whom the Member has a sustained committed, serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party;

4.52 **"Practice Number"** means the number allocated to a supplier of services as a practice number by registered authorities;

4.53 **"Pre-Authorisation"** means the formal approval by the Scheme for payment of a requested procedure before it occurs;

4.54 **"Pre-Existing Sickness Condition"** means a sickness condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 (twelve) month period ending on the date on which an application for membership was made;

4.55 **"Preferred Provider Network"** means a health care provider or group of providers selected by the Scheme as the preferred provider or providers to provide to the Members of the Scheme diagnosis, treatments and care in respect of one or more conditions at a prenegotiated rate;

4.56 **"Prescribed Minimum Benefits"** means the benefits contemplated in section 29 (1) (o) of the Act and consist of the provision of the diagnosis, treatment and care costs of:

4.56.1 The Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, as amended from time to time, subject to any limitations specified therein; and

4.56.2 Any emergency medical condition.

4.57 **"Prescribed Minimum Condition"** means a condition contemplated in the Diagnosis and Treatment Pairs or any emergency medical condition in terms of Annexure A of the Regulations, as amended from time to time;

4.58 **"Prescribed"** means prescribed by regulation;

4.59 "**Preventative Care**" means pro-actively identifying a health risk or the management thereof, aimed at preventing disease, payable by the Scheme for specifically defined benefits;

4.60 **"Principal Officer"** means the principal officer appointed in terms of section 57 (4) (a) of the Act;

4.61 "**Prosthesis**" means an artificial part supplied to remedy a deficiency;

4.62 "**Protocols**" means clinical guidelines, compiled by experts in the field of a specific medical condition, which specify how a condition should be treated, based on best practice principles;

4.63 **"Registrar**" means the Registrar or Deputy Registrar(s) of Medical Schemes appointed in terms of section 18 of the Act;

4.64 **"Relevant Health Service"** means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object:

4.64.1 The physical or mental examination of that person;

4.64.2 The diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;

4.64.3 The giving of advice in relation to any such defect, illness or deficiency;

4.64.4 The giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;

4.64.5 The prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or

4.64.6 Nursing or midwifery,

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;

4.65 **“Rules”** means the Rules of a medical scheme and include:

4.65.1 The provisions of the law, charter, deed of settlement, memorandum of association or other document by which the Scheme is constituted;

4.65.2 The articles of association or other Rules for the conduct of the business of the Scheme; and

4.65.3 The provisions relating to the benefits which may be granted by and the contributions which may become payable to the Scheme;

4.66 **"Scheme Tariff"** means the negotiated rate for hospitals and designated or preferred service providers. For all other service providers, 100% of the National Health Reference Price List (NHRPL) for health care services published in 2006 plus 155.33% in accordance with the provisions of Rule 16.6;

4.67 **Self-payment gap”** refers to a temporary gap in day-to-day benefits, resulting from over-the-counter medicine purchases, when the funds in the annual PMSA has

been depleted and the threshold has not yet been reached. During the time of the self-payment gap the Member and/or Dependants will be liable for day-to-day claims;

4.68 "**Single Exit Price**" means a single exit price included in a transparent pricing system contemplated in section 22G(2)(a) of the Medicines And Related Substances Act No. 101 Of 1965, which is published as prescribed, and such price shall be the only price at which manufacturers shall sell medicines and scheduled substances to any person other than the State;

4.69 **"Spouse"** means the person to whom the Member is married in terms of any law or custom recognised by Law;

4.70 **"Subscription /Contribution/ Premium"** means, in relation to a Member, the gross amount, including amounts for his savings account, paid by or in respect of the Member and his registered Dependents, if any, as membership fees;

4.71 **"the Act"** means the Medical Schemes Act (ACT 131 OF 1998) and includes the Regulations and sections referred to herein.

4.72 "**Vested Medical Savings Account**" means an account to which unused medical savings are transferred after a period of 4 (four) calendar months or at the beginning of the financial year, according to the benefit option, and that could be used for out-of-hospital expenses. Any interest earned shall accrue to the Vested Medical Savings Account balance. No cross subsidisation applies to the Vested Medical Savings Account;

5. MISSION AND BUSINESS OF THE SCHEME

5.1 Mission

The mission of the Scheme is to operate a medical scheme in terms of the Act in a financially responsible manner for the defrayal of its Members' healthcare expenses by means of:

5.1.1 The optimal appropriation of Members' contributions and other income;

5.1.2 The operation and administration of the Scheme and/or its benefit option(s);

5.1.3 The striving for balanced growth in membership;

5.1.4 The rendering of relevant health services; and

5.1.5 Negotiations with providers of relevant health services for the supply of quality and cost effective services.

5.2 Business of the Scheme

The business of the Scheme is undertaking, in return for a premium or contribution, the liability associated with one or more of the following activities:

5.2.1 Providing for the obtaining of any relevant health service;

5.2.2 Granting assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; or

5.2.3 Rendering a relevant health service, either by the medical scheme itself, or by any supplier or group or suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.

6. MEMBERSHIP

6.1 Individual Members

6.1.1 Any person who is self-employed or financially independent and who is neither an Employee nor a continuation Member of a Participating Employer may apply to become a Member of the Scheme.

6.1.2 The provisions of Rules 6.2 and 6.3 are mutatis mutandis (the necessary changes having been made) applicable to Individual Members who retire as well as the Dependants of deceased individual Members.

6.2 Retirees

6.2.1 A Member shall retain his/her membership of the Scheme as a Continuation Member together with his registered Dependants, if any, in the event of his retiring on pension from the service of his employer or his employment being terminated by his employer on account of age, ill-health or other physical or mental disability, and will remain on his current benefit option until the end of that financial year, where after he may elect to change from benefit option in accordance with the registered Rules.

6.2.2 The Scheme shall inform the Member of his right to continue his membership and of the contribution payable by himself or on his behalf from the date of retirement or termination of his employment within a reasonable time. Unless such Member informs the Scheme in writing of his desire to terminate his membership, he shall continue to be a Member of the Scheme, and the Scheme will be entitled to collect all contributions in terms of his Membership in terms of his current benefit option until the end of that financial year, where after he may elect to change from benefit option in accordance with the registered Rules.

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 retain membership of the Scheme as Continuation Members 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 within a reasonable time.

Unless such person informs the Scheme in writing of his intention not to become a Member within 30 (thirty) days from the date of the deceased Member's death, he shall be admitted as a Member of the Scheme and the Scheme will be entitled to collect all contributions in terms of his membership.

6.3.3 Such a Member's membership shall automatically terminate if he becomes a member or a dependant of a member of another medical scheme. The Scheme must be informed in writing of another membership before the beginning of any calendar month, failing which the Member shall be held liable for that specific month's contribution.

6.3.4 Where a child Dependant has been orphaned, any child may be deemed to be the Member, and the sibling as a child Dependant.

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 new-born or newly adopted child or a stepchild within 30 (thirty) days of the date of birth or adoption or it becoming a stepchild of the Member, such child shall be registered by the Scheme as a Dependant: Provided that contributions in respect of such a child shall be due as from the first day of the month following the month of birth or adoption or becoming a stepchild of the Member, and benefits will accrue as from the date of birth or adoption or the date of the child becoming a stepchild.

7.1.3 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 following the month of marriage and benefits will accrue as from the date of marriage: Provided that the Spouse shall not qualify for benefits until such time as the Member himself qualifies for benefits.

7.1.4 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 7.1.3, 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 (the necessary changes having been made).

7.1.5 The provisions of Rule 8.6 in respect of subscriptions and accrual of benefits apply in all cases not specifically provided for above.

7.2 De-registration of Dependants

7.2.1 A Member shall inform the Scheme and his Employer where applicable in writing within 30 (thirty) 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 considered to be a Dependant. A Member who fails to inform the Scheme shall not be entitled to a refund of contributions or subscriptions received by the Scheme as from the date 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 considered to be a Dependant, until the aforesaid Dependant(s) has been de-registered by the Scheme as the Member's 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 be entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise: Notwithstanding anything to the contrary, and subject to the provisions of the Act, the Scheme may claim reimbursement from the Member for benefits paid on behalf of such Dependant and costs incurred after he ceased to be a Dependant in terms of these Rules.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 Minors

A minor may become a Member with the written consent of his parent or guardian.

8.2 Membership of one Scheme only

No person shall:

8.2.1 Be a Member of more than one medical scheme;

8.2.2 Be admitted as a Dependant of –

8.2.2.1 of more than one Member of a particular medical scheme; or

8.2.2.2 Members of different medical schemes; or

8.2.3 Claim or accept benefits in respect of himself or any of his Dependants from any scheme other than the scheme of which he is a Member.

8.3 Application form and information required

8.3.1 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 Dependants, of age, income, state of health and of any prior membership or admission as a Dependant of a Member of any other medical scheme.

8.3.2 The Scheme may require an applicant to provide the Scheme with a medical report in respect of him or of his proposed beneficiary (ies) in

respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12- (twelve-) month period ending on the date on which an application for membership was made. The cost of medical tests or examinations required and requested by the Scheme will be paid for by the Scheme. The Scheme may, however, at its sole discretion, appoint a Preferred Service Provider to perform such tests or examinations.

8.3.3 The non-disclosure of material information shall result in the action of cancelation or suspension of membership of the Member or that of any of his Dependents.

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;
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; or

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.

8.4.3 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 Non-applicability of waiting periods

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 (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 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; 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.

8.5.2 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 Payment of subscriptions and accrual of benefits

Subject to the provisions of Rules 7.1.2 and 7.1.3 subscriptions become due in respect of and benefits accrue to Members and their Dependants on the 1st (first) day of the month following acceptance of their applications for membership, or, in exceptional circumstances on such other day as the Scheme may decide, in its sole discretion. Failure to pay in full the membership fees required in the Rules, within the time allowed in these Rules, will result in cancelation or suspension of membership of the Member or that of any of his Dependants.

8.7 Re-establishment of membership

The Scheme may, after reasonable consideration and upon the Member being satisfactorily rehabilitated, re-establish membership of a Member whose membership has been terminated in terms of Rule 12.7.

8.8 Dependants in same option as Member

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

8.9 Binding force of these Rules

Members 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.

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 Scheme 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 past employment by the particular employer and admit any person who has been a registered dependant of such member, as a Dependant.

10. MEMBERSHIP CARD AND MEMBERSHIP CERTIFICATE

10.1 Every Member will, on admission to membership, receive a detailed summary of these Rules, specifying the Member's rights and obligations, which shall include contributions, benefits and limitations. The Scheme, our 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.

10.2 Every Member shall be furnished with a membership card containing such particulars as may be prescribed by the Act. This card must be exhibited to the supplier of a relevant health service on request. The old membership card must be destroyed upon receiving a new one from the Scheme or on termination of membership.

10.3 The utilisation of a membership card by any person other than the Member or his registered Dependants, with the knowledge or consent of the Member or his Dependants, is not permitted and shall constitute a breach of the Rules of the Scheme in terms of Rule 12.7.

10.4 On termination of membership or on de-registration of a Dependant, the Scheme shall, 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 prescribed by the Act.

11. CHANGE OF ADDRESS AND MEMBER STATUS

11.1 A Member shall notify the Scheme, and his employer, where applicable, in writing within 30 (thirty) days on the required forms of any change of address, contact details as well as any change in the circumstances that may bring about an amendment in the subscriptions payable or the membership status.

11.2 The Scheme shall not be held liable if a Member's rights are prejudiced or forfeited as a result of the Member's failure to comply with this Rule.

12. TERMINATION OF MEMBERSHIP

12.1 Resignation from service of participating employer

A Member who resigns from the service of the Employer (Participating Employer) shall, on the date of such resignation, be eligible for individual membership of the Scheme if he so chooses without the imposition of any new restrictions that did not exist at the time of his resignation.

12.2 Voluntary termination of membership

12.2.1 A Member may terminate his membership of the Scheme by furnishing 1 (one) month's written notice starting on the first day of any calendar month. All rights to benefits shall cease following the last day of membership.

12.2.2 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,

where after such consent must accompany the Member's written notice of membership termination in terms of Rule 12.2.1.

12.2.3 An Employer (participating employer) or such part of the Employer as communicated to the Scheme, may terminate its participation with the Scheme by giving 2 (two) calendar months' written notice to that effect, stating if the Employer as a whole or partly terminates its relationship with the Scheme, starting on the first day of any calendar month. All rights to benefits cease following the last day of membership. The Employer shall be responsible to provide notice of the termination to his Employees, Continuation, Retired, Widowed, and Orphaned Members who obtained membership of the Scheme by virtue of their current and/or past employment or relationship with the Employer. The Employer shall provide, on request by the Scheme, proof of notification to the stated Employees, Continuation, Retired, Widowed, and Orphaned Members, which notice must contain the date on which the aforesaid membership will terminate.

12.2.4 The Scheme's entitlement to the notice period referred to in Rules 12.2.1 and 12.2.3 may be waived in substantiated cases where membership of another medical scheme becomes compulsory for the Members as a result of a condition of employment.

12.3 Membership whilst abroad

A Member who proceeds on leave outside the Republic of South Africa or is required to temporarily leave the Republic of South Africa on official duty, may either apply to have his membership suspended during such period of absence, subject to the Scheme's approval or may elect to continue to receive the benefits in accordance with the benefit option of his choice: Provided further that contributions are paid by or on behalf of such Member and that the benefits thus received shall not exceed the amount that would have applied in the Republic of South Africa.

12.4 Death

Membership shall terminate upon the death of that Member: Provided that the surviving spouse and Dependants of a deceased Member may continue to be Members subject to the terms and conditions contained in Rule 6.3.

12.5 Cessation of benefits

The right to benefits of the Member and of any Dependants of a Member, whose membership has been terminated, shall cease after the last day of membership.

12.6 Failure to pay amounts due to the Scheme

If a Member and/or his Employer, as the case may be, fails and/or refuses and/or neglects to pay any amount, and/or any debt, due to the Scheme as set out in the Rules:

12.6.1 The Member and/or his Employer, where applicable, must be informed that the Member is in default.

12.6.2 If payments are not brought up to date, within a stipulated time period the Scheme may, at its sole discretion:

12.6.2.1 Suspend all benefit payments which have accrued to such Member and his Dependants, irrespective of when the claim for such benefits arose; and/or

12.6.2.2 Pay to or on behalf of the Member any benefits less the relevant amount owed by or in respect of the Member to the Scheme; and/or

12.6.2.3 Deduct from any moneys owing to the Member by the Scheme, any relevant outstanding amount; and/or

12.6.2.4 Terminate the Member's membership and institute any action to recover any losses and outstanding amounts as well as all legal costs incurred on attorney and own client scale.

12.7 Contravention of the Rules of the Scheme

12.7.1 The Scheme may exclude from benefits, suspend or terminate the membership of a Member or a Dependant who –

12.7.1.1 Contravenes any provision of these Rules or fails to comply therewith;

12.7.1.2 Submits fraudulent claims:- submits or causes to be submitted any claim for the payment of any benefit allegedly due in terms of these Rules, knowing such claim to be false;

12.7.1.3 Commits any fraudulent act:- knowingly makes or causes to be made a false representation of any material fact to the Scheme, for use in determining any right to any benefit allegedly due in terms of the Rules of the Scheme;

12.7.1.4 Fails to disclose material information:- having knowledge of any fact or the occurrence of any event affecting his right to receive any benefit in terms of these Rules, and who fails to disclose such fact or event to the Scheme with the intent to obtain a benefit to which he is not entitled or a larger benefit than that to which he is entitled.

13. SUBSCRIPTIONS

13.1 Total monthly subscriptions

The total monthly subscriptions payable to the Scheme by or in respect of a Member are as stipulated in Annexure A of these Rules, as amended from time to time: Provided that subscriptions shall be determined on the basis of income or

the number of Dependants or both income and number of Dependants: Provided further that contribution penalties for persons joining late in life may be applied in accordance with the provisions of the Act.

13.2 Due date for subscriptions

13.2.1 Subscriptions shall be due monthly in advance, or in arrears as shall be determined and approved by the Scheme, on the following dates:

13.2.1.1 On the 20th (twentieth); or

13.2.1.2 On the 25th (twenty-fifth); or

13.2.1.3 On the 1st (first); or

13.2.1.4 As agreed upon between the Scheme and an Employer,

and be payable by not later than the 3rd (third) day after each respective due date of each month.

13.2.2 Where subscriptions owing to the Scheme have not been paid on or before the due date as indicated in 13.2.1 respectively, the Scheme shall notify the Member and Employer, where applicable, and suspend the membership due to non-payment or partial payment of subscriptions, with effect from the 1st (first) day of the month for which subscriptions are due and not received. A written confirmation of suspension will be issued to the Members involved.

13.2.3 If payments are not brought up to date within three (3) months from the date the amount was due, the Scheme shall terminate the membership, with retrospective effect.

13.3 Reinstatement of membership and benefits

The membership and benefits shall be reinstated without any break in continuity only–

13.3.1 In the event that payments are brought up to date subsequent to the Scheme's decision in terms of Rules 12.6 and/or 12.7, as the case may be;

13.3.2 If a Member applies for reinstatement within three (3) months of the date of termination, all outstanding debt has been paid in full, should that be the reason for termination, and provided that such application shall be accompanied by a declaration of health to determine underwriting for the Member and his Dependants;

13.3.3 If a Member requests to be reinstated after the three (3) months period, the Member shall reapply for new membership by completing an application form, after which underwriting will apply.

Reinstatement is subject to the right of the Scheme to recover reasonable expenses associated with the default.

13.4 No refund of subscriptions

Unless specifically provided for in these Rules in respect of savings accounts, no refund of any assets of the Scheme or any portion of a subscription 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 or where the Member has failed to notify the Scheme of a change in membership status in accordance with Rule 11.

13.5 Balance of savings account

The balance standing to the credit of a Member in terms of any option which provides for personal medical savings accounts shall be for the exclusive benefit of the Member and his Dependants: Provided that such savings account:

13.5.1 May not be used to offset contributions: Provided that the Scheme may use such funds to offset debt owed by the Member to the Scheme following the Member's termination of membership;

13.5.2 Shall be transferred to another medical Scheme or benefit option with a savings account when such Member changes medical schemes or benefit options within 5 (five) months calculated from the date following the last day of membership or last date of the Member's previous benefit option, as the case may be;

13.5.3 Must be taken as a cash benefit, subject to applicable taxation laws, when the Member terminates his membership and does not join another medical scheme or an option with a savings account; and

13.5.4 Shall not be used to pay for the costs of prescribed minimum benefits.

14. LIABILITIES OF EMPLOYER AND MEMBER (RESPECTIVELY)

14.1 Liability of Employer

The liability of an Employer towards the Scheme is limited to any amounts payable in terms of any agreement between the Employer and the Scheme. An employer shall be held liable for and pay the monthly subscription of each Member in his employ and continuation Members to the Scheme on the basis agreed upon.

14.2 Liability of Member to Scheme

The liability of a Member to the Scheme is limited to the amount of his unpaid subscriptions 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. If a Member fails to refund within 30 (thirty) days from the due date, any amounts owing by him to the Scheme in respect of himself or his Dependants, the Scheme may act in accordance with Rule 12.6.

14.3 Amounts owing on cessation of membership

In the event of a Member ceasing to be a Member, any amount still owing by such Member shall be a debt due to the Scheme and recoverable by the Scheme.

14.4 Recovery of amounts owed to the Scheme

The Scheme is competent to deduct from any moneys owing to the Member by the Scheme, any amount outstanding on a loan to the Member and/or the Member's share of any account for which the Member is responsible in terms of these Rules; or to request a Member's Employer to recover from a Member, any amount owing to the Scheme, by the Member, from any moneys payable to the Member.

15. CLAIMS PROCEDURE

15.1 Information on accounts

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. An account for relevant health services rendered must contain the following:

15.1.1 The surname and initials of the Member;

15.1.2 The surname, first name and other initials, if any and the date of birth of the patient;

15.1.3 The name of the Scheme;

15.1.4 The membership number of the Member;

15.1.5 The practice code number, group practice number and individual provider registration number issued by the registering authorities for

providers, if and where applicable, and name and address of the provider of the relevant health service;

15.1.6 The date on which each relevant health service was rendered;

15.1.7 The relevant diagnostic (ICD 10 code) and such other item code numbers, as stipulated by the Department of Health or required by law from time to time, that relate to such health services;

15.1.8 The nature and cost of each relevant health service rendered, including the supply of medicine to the Member concerned or to a Dependant of that Member; and the name, NAPPI code, quantity and dosage of and net amount charged by the provider of the relevant health service in respect of the medicine and payable by the Member;

15.1.9 Where a pharmacist supplies medicine according to a prescription to a Member or to a Dependant of a Member of the Scheme, a copy of the original prescription or a certified copy of such prescription, if the Scheme requires or requests it;

15.1.10 If the account is a photocopy of the original, certification on the photocopy by the supplier by means of a rubber stamp or signature, declaring same to be a true reflection of the original;

15.1.11 A statement whether the account is in accordance with the Scheme tariff, or any other applicable tariff;

15.1.12 The name of the referring medical practitioner or dentist, where applicable; and

15.1.13 The signature of the Member or of the patient where the Member himself submits the claim.

15.1.14 Where mention is made in such account or statement of the use of a theatre:

15.1.14.1 The name and relevant practice number and provider number contemplated in Rule 15.1.5 of the medical practitioner or dentist who performed the operation;

15.1.14.2 The name or names and the relevant practice number and provider number contemplated in Rule 15.1.5 of every medical practitioner or dentist who assisted in the performance of the operation; and

15.1.14.3 All procedures carried out together with the relevant item code number contemplated in paragraph 15.1.7;

15.1.15 In the case of a first account or statement in respect of orthodontic treatment or other advanced or specialised dentistry, a treatment plan Indicating:

15.1.15.1 The expected total amount in respect of the treatment;
15.1.15.2 The expected duration of the treatment;
15.1.15.3 The initial amount payable; and
15.1.15.4 The monthly amount payable.

15.2 Confirmation of payment by Scheme

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 shall, in addition to the payment contemplated in Section 59 (2) of the Act, despatch to the Member a statement containing at least the following particulars -

15.2.1 The name and the membership number of the Member;
15.2.2 The name of the supplier of relevant health service;
15.2.3 The final date of service rendered by the supplier of the relevant health service on the account or statement which is covered by the payment;

15.2.4 The total amount charged for the service concerned; and

15.2.5 The amount of the benefit awarded for such relevant health service.

15.3 Claims to be submitted within 4 (four) months

15.3.1 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct by a Member and must be submitted to the Scheme not later than the last day of the 4th (fourth) month following the month in which the relevant health service was rendered.

15.3.2 It remains the Member's responsibility to submit claims timeously. If a Member is unable to obtain an account for services rendered or where he has in fact received an account but because of special circumstances beyond his control is unable to lodge the account within 4 (four) months as required, the Scheme may in its sole discretion extend this period, on condition that a written application for extension is received by the Principal Officer before the expiration of the period named in Rule 15.3.1.

15.3.3 All accounts of Members whose membership has been terminated in terms of Rule 12.6 and 12.7 respectively shall, together with the Member's contribution, reach the Scheme in terms of the provisions of Rule 15.3.1 and failure to comply with this requirement shall relieve the Scheme of any obligation for the payment of its contribution in terms of the Schedule of the Scheme option in which the Member participates: Provided that where the membership of a Member is terminated by his death, the executor in his estate may, in the discretion of the Scheme, be granted additional time to submit to the Principal Officer the accounts as well as written proof that all outstanding amounts inclusive of any outstanding contributions owing by the deceased Member to the Scheme, has been settled in full..

15.3.4 Accounts paid by Members

Where a Member has paid an account, he shall, in support of his claim, submit a receipt of the net amount paid after any discount.

15.4 Erroneous and unacceptable accounts

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 healthcare service provider accordingly, within 30 (thirty) days after receipt thereof. The Scheme shall state the reasons why such account, statement or claim is regarded as erroneous or unacceptable and afford such Member and provider the opportunity to correct and resubmit such account, statement or claim to the Scheme within 60 (sixty) days following the date from which the aforesaid account was returned for correction.

15.5 Personal injury claims against third parties

In the event of the Scheme paying benefits to or on behalf of a Member or Dependant in respect of personal injuries suffered by the Member or Dependant in consequence of an accident, incident or event caused by a third party, under circumstances which give rise to a legally enforceable claim by the Member or Dependant against such third party, then the Member shall be obliged to:

15.5.1 Take all reasonable steps in order to timeously lodge a claim and/or institute an action for the recovery of compensation in respect of the aforesaid personal injuries (including past and future medical, hospital and allied expenses) against the third party concerned before the claim prescribes or becomes unenforceable;

15.5.2 Diligently and reasonably prosecute such claim to its final conclusion or settlement;

15.5.3 Pay, or cause to be paid, to the Scheme the amount or amounts awarded or received by the Member or Dependant in respect of the benefits paid by the Scheme, including amounts received under a written undertaking

furnished by the Road Accident Fund or Compensation Commissioner to the Member or Dependant.

15.6 Evaluation of claims for medical applicability

The Scheme reserves the right to evaluate or have evaluated any claim for benefits for relevant health services to determine the clinical applicability, cost effectiveness and quality of the services. After consulting its clinical advisers, the Scheme may intervene to revise or adjust the use of such services on a future, simultaneous or retrospective basis.

15.7 Prolonged indisposition and/or hospitalisation

15.7.1 In the case of a prolonged indisposition of a Member or a registered Dependant of a Member, the Scheme may require such Member or Dependant to consult a particular preferred provider forming part of the Scheme's Preferred Provider Network nominated by the Scheme after consulting the treating doctor, and if the advice of the preferred provider(s) is not followed, the Scheme may decide not to grant any further benefits for the indisposition in question.

15.7.2 In cases of prolonged hospitalisation for any medical condition of a Member or a registered Dependant of a Member, the Scheme may require such Member or Dependant to consult a preferred provider forming part of the Scheme's Preferred Provider Network nominated by the Scheme to obtain a second opinion regarding the clinical prognosis, management and level of care of such Member or Dependant. If in the light of the opinion(s) expressed by the nominated preferred provider(s), it is clear that the Member or a Dependant suffers from a terminal condition which is not a PMB, and furthermore, the financial impact of granting further benefits for such hospitalisation would constitute a substantial threat to the continued financial viability of the option selected by the Member, then the Board of Trustees of the Scheme may decide, after having duly considered the relevant facts, to grant benefits for such hospitalisation to

an appropriate level of care given the clinical circumstances of the Member or Dependant. The Scheme remains liable for all costs where a decision taken by the Board of Trustees requires that a beneficiary be transferred to another provider considered affordable.

15.8 Consultation of specialists without referral

Whenever a specialist, except an ophthalmologist, is consulted without being referred by a general practitioner, the benefit granted by the Scheme may be restricted to the amount that would have been paid to a general practitioner for the same service.

15.9 Disease management programmes

Where the Scheme provides additional benefits by means of disease management programmes, the Member and/or his Dependants shall be obliged to register on such programme and provide the Scheme with any relevant information requested: Provided that beneficiaries will only qualify for benefits in respect of services provided for in the programme if the Scheme's requirements are complied with.

15.10 Designated Service Provider

15.10.1 The Scheme has selected, and as such contracted with various health care providers, pharmacists and hospitals to provide diagnosis, treatment and/or care in respect of one or more Prescribed Minimum Benefit condition(s) at an agreed rate.

15.10.2 Prescribed minimum benefits (PMBs) are defined by law. They are the minimum level of diagnosis, treatment, and care that the Scheme will cover from the risk pool in full.

15.10.3 The Scheme will pay in full for the diagnosis, treatment and care costs of a prescribed minimum benefit condition if those services are obtained from the selected designated service provider in respect of that condition.

A full list of all the Scheme's contracted DSP's are available from the Scheme's website or through the Scheme's Call Centre, who will provide full details on request.

15.10.4 Members making voluntary use of providers outside of the designated service provider network will be liable for the co-payment equal to the difference between the actual cost incurred and the Scheme tariff or contracted DSP rate, whichever is less. Provided that no co-payment or deductible is payable by a Member if the service was involuntarily obtained from a provider other than a designated service provider.

15.10.5 For the purposes of clarification to 15.10.4, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider; if

15.10.5.1 The service was not available from the designated service provider or would not be provided without unreasonable delay;

15.10.5.2 Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

15.10.5.3 There was no designated service provider within a 50 (fifty) kilometre radius to the beneficiary's ordinary place of business or personal residence.

16. BENEFITS

16.1 Choice of benefits and options

Members are entitled to benefits during a Financial Year, as per Annexure B of these Rules, and such benefits extend through the Member to his registered Dependants. A Member shall, on admission as a Member elect in writing to

participate in any one of the available options, detailed in Annexure B of these Rules.

16.2 Change from one option to another

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

16.2.1 The change may be made only with effect from 1 January of any financial year. The Scheme may, in its absolute discretion, permit a Member to change from one benefit option to another benefit option on any other date.

16.2.2 Application to change from one benefit option to another must be in writing and lodged with the Scheme by not later than 31 December prior to the year upon which it is intended that the change will take place.

16.2.3 A Member may, within 3 (three) months of joining, exercise his final choice of one of the possible benefit options in writing, including the accompanying correction in membership and benefits accrued where applicable. If the Member does not notify the Scheme in writing of his final choice on or before the last day on which the period of 3 (three) months expires, such a Member shall remain on the benefit option originally chosen, after which a change of benefit options will be exercised in accordance with the provisions on Rules 16.2.1 and 16.2.2 respectively.

16.3 Payment to Member or supplier

Subject to the respective provisions of Rules 12.7, 17.2 and 17.4, the Scheme shall, where an account has been correctly rendered, pay any benefit that is 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 after the date of receipt of the claim pertaining to such benefit.

16.4 Transfer of claims and rights

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.

16.5 Payment for prescribed minimum benefits

All benefit options offered in Annexure B of these Rules, cover in full the cost of Prescribed Minimum Benefits subject to the provisions of Rule 15.10 read with Annexure D.1 of these Rules: Provided that the funds in a Member's medical savings account shall not be used to pay for the costs of a Prescribed Minimum Benefit.

16.6 Scheme tariff

16.6.1 The Scheme tariff shall be approved annually by the Board of Trustees.

16.6.2 All benefits shall be paid according to the Scheme tariff or contracted fees, as the case may be.

16.7 Exclusion of services from benefits

The Scheme may exclude services from benefits as set out in Annexure C of these Rules.

16.8 Guidelines or protocols for services

Where the Scheme has funding guidelines or protocols in respect of any covered services or supplies, beneficiaries will only qualify for benefits in respect of those services and supplies if the guidelines or protocols have been complied with.

16.9 Requirements for benefits without protocols

Where the Scheme does not have funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme acknowledges them as medically necessary. “Medically necessary” refers to services or supplies that meet all the following requirements:

16.9.1 It is required to restore function of an affected limb, organ, or system;

16.9.2 No alternative exists that has a better outcome, is more cost-effective, and has a lower risk;

16.9.3 It is accepted by the relevant service-provider group as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;

16.9.4 It is not rendered for the convenience of the relevant beneficiary or service provider;

16.9.5 For which outcome studies are available and acceptable to the Scheme; and

16.9.6 Evidence based medicine as published in peer review journals.

16.10 Clinical data required for recognition of new medicine, technology, procedures and interventions

No benefits are payable in respect of any new technology, investigational procedures/interventions, and service or supply, including newly registered medicine, until such time that the Scheme has been satisfied through the submission of clinical data of the acceptability of all of the following aspects relating to that service or supply:

16.10.1 Therapeutic role in clinical medicine;

16.10.2 Cost-efficiency;

16.10.3 Value relative to existing services or supplies;

16.10.4 Local indications, application, and outcome studies; and

16.10.5 A Funding Guideline or Protocol has been drawn up. The Scheme may, at its discretion structure projects with specific providers around new technology, in order to gauge results and/or finalise its funding guidelines.

16.11 Exclusion of service or supply due to lack of clinical data

16.11.1 If the Scheme is not satisfied in respect of a particular new service or supply as contemplated in Rule 16.10, the Scheme may exclude or limit that service or supply from benefits until sufficient clinical data has been submitted, alternatively submitted clinical data has been properly reviewed and accepted by the Scheme.

16.11.2 An exclusion of one or more years may be required by the Scheme, at its sole discretion, to assess the local indications, application and outcome data on all new medicines/technology/procedures or any instance where evidence is lacking or still under review before it can be considered for benefits.

16.12 Foreign claims

Benefits for foreign claims shall be based on the Scheme tariffs or other tariffs applicable to similar services/items in the Republic of South Africa: Provided that

16.12.1 Medical claims incurred in foreign countries must be paid in full by the Member and proof of payment must accompany the claim;

16.12.2 Fully specified accounts must be submitted to the Scheme within the prescribed period of four months under cover of the Scheme's special claim form for foreign claims;

16.12.3 Accounts must be translated into English if rendered in a foreign language; and

16.12.4 Benefits for elective and planned surgery or procedures abroad shall be subject to pre-authorisation, Scheme protocols and Scheme tariff. Each case shall be evaluated individually, on the clinical information available.

16.13 Medicine supply

Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to 1 (one) month's supply for every prescription or repeat thereof.

16.14 Interest on Personal Medical Savings Account (PMSA)/ Vested Medical Savings Account

16.14.1 Any balance in the PMSA/ Vested Medical Savings Account at the end of a financial year remains the property of the Member and accumulates to his credit until such time comes that savings funds are paid to the Guardians Fund. No cross subsidisation applies to the PMSA/ Vested Medical Savings Account.

16.14.2 Any funds standing to the credit of the PMSA/ Vested Medical Savings Account shall be invested within 7 (seven) days of receipt thereof in a Savings trust account according to specifications of item 1a of Annexure B to the Medical Schemes Act. These trust accounts held by the Scheme are current and money market accounts.

16.14.3 Should a Member terminate membership of the Scheme and not be admitted as a member of another medical scheme or be admitted to membership of another medical scheme which does not provide for an PMSA/ Vested Medical Savings Account, the balance due to the Member, including interest earned, must be refunded to the Member five (5) months after termination of membership, and subject to applicable laws.

16.14.4 Interest income to the PMSA/ Vested Medical Savings Account balance shall be allocated on credit balances on the month-end savings balance on a pro-rata basis at month-end and shall accrue to the PMSA/ Vested Medical Savings Account balance of all active and resigned Members. The interest allocated is netto interest income minus bank charges on the trust accounts.

16.14.5 Unclaimed balances, where the Member cannot be traced within 5 (five) years after termination of membership and after all reasonable attempts at tracing the Member have been pursued, the unclaimed savings balance of the particular Member will be paid to the Guardians Fund. Interest will not be accrued once the savings balance was paid over to the Guardians Fund.

17. PAYMENT OF ACCOUNTS

17.1 Payment restricted to maximum of benefit option

Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected.

17.2 Suppliers may be paid directly

Notwithstanding Rule 16.3, the Scheme may, whether by agreement or not with any supplier or group of suppliers of a relevant health service, pay the benefit to which the Member is entitled, directly to the supplier who rendered the service.

17.3 Recovery of overpayments

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 in terms of Section 59(3) of the Act.

17.4 Scheme may pay Members directly

Notwithstanding the provisions of these Rules, the Scheme shall be entitled within its absolute discretion to pay any benefit directly to the Member concerned.

17.5 Claims from outside South Africa

A claim from a Member on official duty outside the Republic of South Africa will be dealt with on its merits by the Board as contemplated in Rule 16.10 and benefits shall not exceed the amount that would have applied for the service in the Republic of South Africa.

18. GOVERNANCE

18.1 Constitution of the Board of Trustees

The affairs of the Scheme shall be managed according to these Rules and the applicable legislation by a Board of Trustees consisting of not more than 10 (ten) persons, who are fit and proper to be trustees and who shall be constituted as follows:

18.1.1 Member representatives

18.1.1.1 A maximum of 2 (two) Employee Members of the Scheme who are nominated for election by the Employee Members and thereafter elected by all Members of the Scheme;

18.1.1.2 A maximum of 2 (two) Individual Members of the Scheme who are nominated for election by the individual Members and thereafter elected by all Members of the Scheme;

18.1.1.3 1 (one) Continuation/Retired/Widowed Member of the Scheme who is nominated for election by Continuation/Retired/Widowed Members and thereafter elected by all Members of the Scheme;

18.1.2 Appointed trustees

5 (five) persons, who need not be Members of the Scheme, appointed by the Board;

18.1.3 Vetting of candidates

18.1.3.1 No person shall serve on the Board unless such person has participated in a vetting process prescribed by the Scheme and has in consequence thereof been declared fit and proper to be a Trustee.

18.1.3.2 Any existing Trustee who has not complied with the requirements set out in Rule 18.1.3.1 shall be afforded a period of 30 (thirty) days from the date upon which this rule comes into effect to subject him or herself to the vetting process, and in the event of failing or neglecting to do so the term of office such Trustee shall automatically be deemed to have terminated on the last day of the aforesaid period.

18.2 Eligibility of candidates to serve on the Board

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

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

18.2.1.2 If that person is or becomes an employee, director, officer, consultant or contractor of any person contracted by the Scheme to provide administrative, marketing, or managed health care services, or of the holding company, subsidiary, joint venture or associate of such person;

18.2.1.3 If that person is or becomes a broker or an employee, director or officer of a person that provides broker services;

18.2.1.4 If that person has a material relationship with any person contracted by the Scheme to provide administrative, marketing, broker, managed health care or other services, or with its holding company, subsidiary, associate or joint venture partner;

18.2.1.5 The Principal Officer of the Scheme;

18.2.1.6 The auditor of the Scheme;

18.2.1.7 Any person that is or becomes a trustee of any other registered medical scheme; and

18.2.1.8 A person who fails to satisfy the requirements of Rule 18.1.3.

18.2.2 A person who has served as an employee or a related party to an employee shall not be eligible to serve as a Board member within 5 (five) years of having left the employ of Bestmed.

18.2.3 Retiring members of the Board are eligible for re-election and re-appointment, subject to a maximum of 2 (two) terms from date of appointment or election.

18.2.4 Not more than 1 (one) representative within each group referred to in Rule 18.1.1 or Rule 18.1.2 may be an Employee of the same Employer. Should there be more than 1 (one) representative, such representative shall be disqualified and replaced by candidates from that particular membership group who are not such employees who received the next most votes.

18.3 Election of Member representatives

18.3.1 Not later than 1 November of the year before a vacancy is due to occur the Scheme's Principal Officer shall request each Member in each different membership group referred to in Rule 18.1.1 to nominate not more than 1 (one) candidate from that group, on the relevant nomination form approved by the Board, for election to the Board. These nominations should reach the Principal Officer on or before 31 January of the following year.

18.3.2 Each nomination must be seconded by another Member of the particular membership category and the nominee must accept the nomination in writing for a nomination to be valid: Provided that an independent nomination of the same nominee by another Member shall be regarded as a secondment of the nominee.

18.3.3 If only the numbers of candidates for whom there are vacancies are so nominated, they shall be declared duly elected at the annual general meeting, subject to the provisions of Rule 18.2.4.

18.3.4 If more candidates than the number for which there are vacancies in a membership category are so nominated, the Principal Officer shall provide all the Members of the Scheme on or before 20 April of the year in which the election takes place with ballot papers approved by the Board for this purpose, containing the names of all the nominated candidates in each membership category. All the Members of the Scheme shall then elect, by means of such ballot papers, the number of candidates for which there are vacancies. Completed ballot papers shall reach the principal officer on or before 28 May of such year.

18.3.5 The number of candidates for which there are vacancies in each membership category and who receive the majority vote in this manner shall be declared duly elected at the annual general meeting subject to the provisions of Rules 18.1.3 and 18.2.4: Provided that in the event of an equal number of votes for candidates in the same group, a rerun of the election for that particular vacancy shall be take place.

18.3.6 If fewer candidates than the number for which there are vacancies in the membership category are so nominated, additional members shall be nominated by all the Members present at the annual general meeting and be subject to Rules 18.1.1; 18.1.4 and 18.2.4.

18.3.7 The term of office of elected Member representatives is 4 (four) years and shall commence on the date of the annual general meeting in the year of election, subject to a maximum of 2 (two) terms from date of election.

18.3.8 Should any Member dispute the outcome of the election such a dispute must be referred to the Principal Officer within 5 (five) days following the formal announcement of the outcome. The Principal Officer, after consultation with the Board, shall advise the Member, of the Scheme's decision, within 7 (seven) days following the dispute.

18.4 Appointment of Trustees referred to in Rule 18.1.2

18.4.1 At the last scheduled Board meeting before the annual general meeting in which a vacancy is due to occur, a maximum of 5 (five) persons referred to in Rule 18.1.2, who need not be Members of the Scheme, shall be appointed by the other members of the Board as Trustees. The names of the members appointed shall be made known at the annual general meeting.

18.4.2 The term shall commence on the date of the annual general meeting and shall be for a period of 4 (four) years, subject to a maximum of 2 (two) terms from date of appointment.

18.5 Co-option of additional members

18.5.1 The Board may co-opt 1 (one) or more knowledgeable person(s) who are Members of the Scheme to assist with its deliberations**:** Provided that such person shall not have a vote at meetings of the Board.

18.5.2 Where such co-opted member is appointed or elected to any committee, he shall have the right to vote in such committee.

18.5.3 The term of office of co-opted members shall be 1 (one) year.

18.6 Filling of vacancies of the Board

18.6.1 When a member of the Board resigns, is disqualified from service or dies, the Board may, by majority vote of the remaining members of the Board and for the unexpired period of the term, either appoint or facilitate an election process depending on whether the member was elected or appointed. If the member was appointed, then the Board shall ensure that it embarks on a transparent and fair process for the filling of such a vacancy. Should the vacancy emanate from an elected member, the Board shall either utilise the nominated candidate(s) with the next most number of votes from the most recent election or hold a new election.

18.6.2 Should the Board be dissolved or fail to meet the prescribed minimum number of members, the nominated candidates(s) with the next most number of votes from the most recent election shall then fill the remaining vacancies for elected members within 60 (sixty) days from the date of the Board's dissolution.

18.6.3 Within 30 (thirty) days following the filling of the elected member vacancies, the elected members shall facilitate the appointment process of the remaining members of the Board.

18.6.4 Notwithstanding the Board's decision to fill the vacancy or vacancies, the appointment of the new member shall be subject to the vetting process prescribed in terms of Rule 18.1.3.

18.6.5 Following the establishment of such a Board and the appointment of a new Chairperson, the Board shall be required to call a special general

meeting in accordance with Rule 26.2.1 in order to confirm the constitution of the new Board.

18.6.6 The term for of office for a Board constituted following a dissolution of a Board shall be for a 4 (four) year term, as per Rules 18.3.7 and 18.4.2.

18.7 Removal and resignation from the Board

18.7.1 A member of the Board may resign at any time by giving notice in writing to the Board.

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

18.7.2.1 He becomes mentally ill or incapable of managing his affairs;

18.7.2.2 He is declared insolvent or has surrendered his estate for the benefit of his creditors;

18.7.2.3 He is convicted, whether in the Republic of South Africa or elsewhere, of any serious criminal offence;

18.7.2.4 He is removed by a court of law from any office of trust on account of misconduct;

18.7.2.5 He is disqualified under any law from carrying on his profession;

18.7.2.6 Being a Board member elected by Members of the Scheme, he ceases to be a Member of the Scheme;

18.7.2.7 He absents himself from 2 (two) consecutive meetings of the Board without the permission of the Board;

18.7.2.8 He is removed from office by the Council in terms of Section 46 of the Act;

18.7.2.9 He is removed from office by a 2/3 (two-thirds) majority of the Board present at a meeting; or

18.7.2.10 He is removed by the Board for having acted in a manner which is seriously prejudicial to the interest of the Scheme or its Members;

18.7.2.11 Does not meet the requirements to be a director in terms of the Companies Act; or

18.7.2.12 He has failed and/or refused and/or neglected to participate in a vetting process prescribed by the Scheme or he is found to be not fit and proper to occupy the office of Trustee of Bestmed in consequence of such a vetting process.

18.8 Reimbursement of expenses and remuneration of Board

18.8.1 Members of the Board shall in respect of the execution of their official duties be entitled to remuneration as provided for in the Trustee remuneration policy or, where no such provision is made, to a reasonable remuneration which shall be based on an independent source e.g. benchmark survey or similar.

18.8.2 Notwithstanding 18.8.1, Members of the Board are entitled to the following remuneration:

18.8.2.1 Disbursements, including but not limited to:

18.8.2.1.1 Travelling and related expenses;
18.8.2.1.2 Attendance conferences and training events;
18.8.2.1.3 Accommodation and meals; and
18.8.2.1.4 Telephone expenses for business purposes.

18.8.2.2 Fees for attendance of meetings of the board or committees of the board.

18.8.2.3 Fees for attendance of meetings with Bestmed management and/or delegated stakeholders.

18.8.2.4 Fees for attendance and oversight of specific Bestmed activities commissioned by the Board, which will require formal prior approval from the Board.

18.8.2.5 Fees due for holding particular office on the board or committees of the board.

18.9 Procedure at meetings

18.9.1. The Board shall meet at least 4 (four) times per year on such dates as are approved by the Board.

18.9.2 The agenda and accompanying documents for a meeting must reach the members at least 5 (five) days before the scheduled date for a meeting.

18.9.3 Members of the Board wishing to place matters on the agenda should submit them to the Principal Officer at least 15 (fifteen) days before the scheduled date of the meeting: Provided that, with the approval of the meeting, matters of an urgent nature may be submitted at the meeting.

18.9.4 The presence of ½ (half) of the voting members plus 1 (one) during the course of a meeting shall constitute a quorum for that meeting.

18.9.5 Should the required quorum not be obtained during the course of a meeting, such meeting shall be adjourned to a date not less than 3 (three) days from the date on which all members of the Board have been informed of the date to which the meeting has been adjourned: Provided that at such adjourned meeting the voting members of the Board present will constitute a quorum.

18.9.6 The Board must elect from its number a chairperson and a vice-chairperson, who shall also be the chairperson and vice-chairperson of the Board, provided that in the absence of the chairperson the vice-chairperson shall act as chairperson, and in the absence of both the chairperson and the vice-chairperson the meeting shall elect a chairperson for the purposes of that meeting.

18.9.7 Decisions at Board meetings shall be taken 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, subject to Rule 18.9.4.

18.9.8 The Board may, in urgent cases and without holding a meeting, take a decision by postal, telephonic, telegraphic or any other technological means, if the majority [50% plus one vote] of all voting Board members vote in favour of such decision: Provided further that, no decision of the Board shall be invalid because of any vacancy in the membership of the Board.

18.9.9 A member of the Board may appoint another member of the Board as a proxy, such other member to be limited to one proxy per meeting. A proxy shall be in writing and signed by the grantor, and shall:

18.9.9.1 Be in such form as is approved by or acceptable to the Board;

18.9.9.2 Be deposited at the registered office of the Scheme not less than 24 (twenty-four) hours before the scheduled time for the Board meeting;

18.9.9.3 Except insofar as specifically provided otherwise, be deemed to confer the power generally to act at the Board meeting in question, subject to any specific direction contained in the proxy; and

18.9.9.4 Be valid for a specific Board meeting and at every resumption of an adjourned Board meeting to which it relates, unless it has been withdrawn in writing by the grantor not less than 24 (twenty-four) hours before such Board meeting, or the grantor attends such Board meeting himself and acts on his own accord.

18.9.10 The chairperson or in his absence the vice-chairperson may convene a special Board meeting should the need arise and shall convene such Board meeting when any 3 (three) or more voting members of the

Board in writing request the chairperson to convene a special Board meeting, stating the matters to be discussed at such Board meeting.

18.9.11 No matters except those for which the special Board meeting was called may be dealt with at the special Board meeting: Provided that other matters may be dealt with if an unopposed motion to that effect is unanimously adopted by the voting members of the Board present at the Board meeting.

18.9.12 The Board may invite non-Board members to attend a meeting of the Board or part thereof as observers and to participate in the discussions: Provided that such observers shall not have the right to vote on any matter.

19. DUTIES OF BOARD OF TRUSTEES

The duties of the Board of Trustees are as follows:

19.1 The Board shall be responsible for the proper and sound management of the Scheme, in terms of these Rules and in accordance with the Act.

19.2 The Board shall act with due care, diligence, skill and in good faith as is further detailed in the Scheme's Trustee Guidelines.

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

19.4 The Board shall, to the best of its ability, apply sound business principles and endeavour to ensure the financial soundness of the Scheme.

19.5 The Board shall appoint a principal officer who is a fit and proper person to hold such office and shall within 30 (thirty) days of such appointment give notice thereof in writing to the Registrar of the Council for Medical Schemes. The Principal Officer and other staff required for the proper execution of the business of the Scheme

shall be appointed by the Board on such conditions of service as it may determine from time to time;

19.6 The Board shall have the power to take all the steps and to sign and execute all the documents to ensure and secure the due fulfilment of the Scheme's obligations under such appointments.

19.7 The Board shall have the power to cause the termination of the services of any employee of the Scheme in line with labour laws of South Africa: Provided that the termination of the services of the Principal Officer of the Scheme shall be approved by at least 2/3 (two thirds) of the full Board.

19.8 The Board shall take steps to ensure that the interests of beneficiaries are protected, and act with impartiality in respect of all beneficiaries.

19.9 The Board shall keep all minutes, accounts, entries, registers and records that are considered essential for the proper functioning of the Scheme.

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

19.11 The Board shall ensure that adequate and appropriate information be communicated to the Members regarding their rights, benefits, contributions and duties in terms of these Rules.

19.12 The Board shall take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and these Rules.

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

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

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

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

19.17 The Board shall approve all disbursements and exercise financial control over the affairs of the Scheme.

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

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

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

19.21 The Board shall determine through proper evaluation and vetting process that all Trustees who serve on the Board have passed the vetting process prescribed by the Scheme.

20. POWERS OF BOARD

The Board has the power-

20.1 Subject to the provisions of paragraph 19.7, to cause the termination of the services of any employee of the Scheme: Provided in so doing it shall comply fully with all legal requirements;

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

20.3 To appoint 1 (one) or more committees consisting of Board members and other experts as it may deem appropriate and necessary and may invest such committees or an official of the Scheme with all or any of its powers and duties: Provided that any committee so constituted shall comply with all these Rules and instructions of the Board: Provided further that the Board shall not be divested of any power with which it may invest such a committee or official;

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

20.5 To appoint, compensate and contract with any accredited broker for the introduction or admission of a Member to the Scheme;

20.6 To enter into any contract with a managed healthcare organisation or to provide such a service itself, subject to the provisions of the Act;

20.7 To purchase movable and immovable property for the use of the Scheme or otherwise;

20.8 To let or hire movable or immovable property;

20.9 In consideration of section 63 of the Act, to sell movable and/or immovable property of the Scheme subject to sound business practice and fair value principles;

20.10 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 monies and to realise, re-invest or otherwise deal with such monies and investments;

20.11 With the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers for the purpose of bridging a temporary shortage and to the extent necessary, encumber the Scheme's assets as security;

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

20.13 To make a donation to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interest of all or any of the beneficiaries;

20.14 To make *ex gratia* payments on behalf of or to members in order to assist them in meeting commitments in regard to any matter specified in the definition of 'business of a medical scheme' in these Rule;

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

20.16 To reinsure obligations in terms of the benefits provided for in these Rules;

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

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

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

21. DUTIES OF PRINCIPAL OFFICER AND STAFF

21.1 The staff of the Scheme shall ensure the confidentiality of all information regarding its Members subject to disclosure of such information as is reasonable to the Scheme's medical advisers, any managed healthcare organisation, reinsurers, or as consented to by any Member.

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

21.2.1 The decisions and instructions of the Board be executed without unnecessary delay;

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

21.2.3 The Board be sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;

21.2.4 The Board be 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; and

21.2.5 He does not take any major policy 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.

21.3 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.

21.4 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 (unless he is indisposed or prevented by other circumstances beyond his control) attend all meetings of the Board, and any other duly appointed committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.

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

21.6 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.

21.7 The Principal Officer shall prepare annual financial statements or cause such statements to be prepared and shall ensure compliance with all statutory requirements pertaining thereto.

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

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

21.8.2 A broker.

22. INDEMNIFICATION AND FIDELITY GUARANTEE

22.1 The Board and any officer of the Scheme shall be indemnified by the Scheme against all legal proceedings, costs and expenses incurred by reason of any claim

against or legal proceedings brought against the Board, any of its Members or such officer in connection with the Scheme, not arising from their negligence, dishonesty or fraud.

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

23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme shall run from 1 January to 31 December of that year.

24. BANK ACCOUNT

The Scheme shall maintain a bank 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.

25. AUDITOR AND AUDIT COMMITTEE

25.1 An auditor (who must be approved in terms of section 36 of the Act) shall 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.

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

25.2.1 A member of the Board;

25.2.2 An employee, officer or contractor of the Scheme;

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

25.2.4 A person not engaged in public practice as an auditor; or

25.2.5 A person who is disqualified from acting as an auditor in terms of the Companies Act, Act 71 of 2008.

25.3 Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board shall within 30 (thirty) days appoint another auditor to fill the vacancy for the unexpired period.

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

25.5 The auditor of the Scheme shall at all times have a right of access to the books, records, accounts, documents and other effects of the Scheme, and shall be entitled to require from the Board and the other officers of the Scheme such information and explanations as he may deem necessary for the due performance of his duties.

25.6 The auditor must report to the Audit Committee on the accounts examined by him and on the financial statements laid before the Scheme in a general meeting.

25.7 The Board must appoint an Audit Committee, with the objectives referred to in section 36(12) of the Act, of at least 5 (five) Members of whom at least 2 (two) must be members of the Board and the majority, including the chairperson of the Audit Committee, may not be officers of the Scheme.

26. GENERAL MEETINGS

26.1 Annual general meeting

The annual general meeting of Members shall be held not later than 30 June of each year, and may be conducted by means of either physical attendance or electronic communication as defined in these Rules, e.g. virtual attendance of Members, or a combination of these, as may be determined by the Scheme.

26.1.1 Notice

The notice convening the annual general meeting, together with the agenda, financial highlights and proposed amendments to these Rules shall be made available electronically or otherwise, to all Members for their information not less than 21 (twenty-one) days before the date of the meeting. A Member who requires a full set of financial statements may apply to the Scheme or may inspect it free of charge and make extracts for a fee from the registered office of the Scheme. The fee(s) shall be indicated in the Scheme's Promotion of Access to Information Act (PAIA) Manual published on the Scheme's website or available on request. Non-receipt of such notice shall not invalidate the proceedings at the meeting.

26.1.2 Reports and statements

The reports and statements referred to in Rule 26.1.1 shall be submitted to the annual general meeting together with any notice of proposal received by the Principal Officer on or before 31 January.

The annual financial statements and trustee remuneration shall be approved by the majority of Members present at the annual general meeting.

26.1.3 Quorum

25 (twenty-five) Members shall constitute a quorum. If a quorum is not present within ½ (half) an hour from the time laid down for the commencement of the meeting, the meeting shall be postponed for a further 30 (thirty) minutes and the Members then present shall constitute a quorum at the annual general meeting.

26.1.4 Motions at annual general meeting

Notices of motions to be placed before the annual general meeting must be provided in writing and reach the Principal Officer not later than 14 (fourteen) days prior to the date of the meeting: Provided that each motion must be seconded by 2 (two) other Members of the Scheme.

26.2 Special general meeting

26.2.1 Meeting called by Board

A special general meeting of Members may be called at any time by the Board, and may be conducted by means of either physical attendance or electronic communication as defined in these Rules, e.g. virtual attendance of Members, or a combination of these, as may be determined by the Scheme.

26.2.2 Meeting called by Members

On receipt of a written request signed by at least 25 (twenty-five) Members of the Scheme the Principal Officer shall call a special general meeting to be held within 30 (thirty) days after receipt of such request. The meeting may be conducted by means of either physical attendance or electronic communication as defined in these Rules, e.g. virtual attendance of Members, or a combination of these, as may be determined by the Scheme. Only matters specified in the request shall be discussed at such a meeting.

26.2.3 Notice

The notice convening the special general meeting together with the agenda and any documents shall be issued to all employers for their information as well as that of their employees who are Members and other Members who are not employer-based, not less than 2 (two) weeks before the date of the meeting. Copies of the said documents shall simultaneously be forwarded to all Members. Non-receipt of such notice shall not invalidate the proceedings of the meeting.

26.2.4 Quorum

25 (twenty-five) Members shall constitute a quorum and Rules 26.1.4, 27.1 and 27.2 shall apply mutatis mutandis (the necessary changes having been made): Provided, however, that if a quorum is not present at the meeting convened at the request of Members after the lapse of ½ (half) an hour from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.

27. VOTING AT MEETINGS

27.1 Only members who are in good standing and are present at the annual general meeting of the Scheme may vote and shall have 1 (one) vote on all matters: Provided that voting shall be by show of hands or by ballot paper if not less than 10 (ten) of the representatives present insist that voting shall be by ballot paper. The Chairperson shall nominate 3 (three) or more representatives to collect, check and count the votes.

27.2 The Chairperson, if he is a Member of the Scheme, shall have a deliberative vote in addition to a casting vote whenever a vote is taken.

28. COMPLAINTS AND DISPUTES BY MEMBERS

28.1 A Member may lodge a complaint, in writing, to the Scheme.

28.2 Any complaints received in writing will be responded to by the Principal Officer of the Scheme in writing within 30 (thirty) days of receipt thereof.

28.3 Should a Member not be satisfied with the outcome and the decision of the Principal Officer, such a Member may have the right to refer the matter to the Disputes Committee of the Scheme. This Committee is only empowered to adjudicate and rule on all complaints relating to the membership status of a Member (e.g. waiting periods, suspensions, terminations and/or contributions)

and/or the medical scheme benefits (e.g. payments to Members or providers, PMBs, data requirements and/or protocols).

28.4 Should a Member wish to lodge a complaint on any matter not provided for in Rule 28.3, then such a Member may approach the Council of Medical Schemes for appropriate relief.

28.5 A Disputes Committee of the Scheme consisting of 3 (three) members, who may not be members of the Board or officers of the Scheme, shall be appointed by the Board to serve a term of office of 3 (three) years, and may be re-appointed for 1 (one) additional term. At least one of such members shall be a person with legal expertise.

28.6 On receipt of the complaint in terms of this Rule 28 by the Member, the Secretariat in consultation with the Chair Person of the Disputes Committee shall within 60 (sixty) days give notice of not less than 21 (twenty-one) days in writing to the complainant and all the Members of the Disputes Committee, stating the date, time, and venue of the meeting and particulars of the dispute.

28.7 The Disputes Committee shall determine the procedure to be followed: Provided that:

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

28.7.2 The parties may question each other on the evidence presented; and

28.7.3 The parties may address the Disputes Committee in respect of all evidence presented.

28.8 The Disputes Committee shall give a ruling within 30 (thirty) days of the meeting and immediately inform the parties in writing thereof.

28.9 An aggrieved party (including the Scheme) has the right to appeal to the Council for Medical Schemes against the decision of the Disputes Committee in accordance with Chapter 10 of the Act.

29. TERMINATION OR DISSOLUTION

29.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution in accordance with the provisions of the Act and any other applicable law.

29.2 Members in general meeting may resolve that the Scheme shall for the reasons stated in such resolution be dissolved, in which event the Board must arrange for all Members to decide by ballot whether the Scheme is to be liquidated. Unless the majority of Members resolve that the Scheme shall continue, the Scheme shall be liquidated in terms of section 64 of the Act.

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

29.4 Every Member must be requested to return his ballot paper duly completed before a set date. If at least 75% (seventy-five percent) of the returned ballots of the Members is in favour of the dissolution of the Scheme, the Board shall ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical Scheme or person.

30.1.1 The Board of Trustees shall investigate and may approve a proposed amalgamation or transfer of up to 15 000 (fifteen thousand) members within a single transaction.

30.1.2 The Board shall arrange for all existing Members to decide by ballot whether a proposed amalgamation or transfer of more than 15 000 (fifteen thousand) members within a single transaction should be proceeded with or not.

30.1.3 If at least 50% (fifty percent) plus 1 (one) of the returned ballots of the Members are in favour of the amalgamation or transfer as indicated in Rule 30.1.2 then, subject to section 63 of the Act, the amalgamation or transfer may be concluded.

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any beneficiary must on request and on payment of a fee that shall be prescribed in the Scheme's Promotion of Access to Information Act (PAIA) Manual, be supplied by the Scheme with a copy of the following documents:

31.1.1 The Rules of the Scheme; or

31.1.2 The latest audited annual financial statements, returns, as the Registrar may require, an annual report of the Board of Trustees to the Registrar and auditor report of the Scheme.

31.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 31.1 and to make extracts there from for a fee in accordance with the Scheme's PAIA Manual that is available on the Scheme's website or on request.

31.3 A beneficiary's right of access to information in terms of the Promotion of Access to Information Act is not limited by the provisions of Rule 31.

32. AMENDMENT OF THESE RULES

32.1 The Board shall be entitled to amend or rescind any Rule or annexure or to make any additional Rule or annexure.

32.2 No alteration, rescission or addition which affects the objects of the Scheme in terms of the Act, shall be valid unless it has been approved by a majority of Members present at a general meeting or a special meeting or by ballot.

32.3 Members shall be furnished with a copy of such amendment within a reasonable time after registration thereof: Provided that should a Member's rights, obligations, contributions or benefits be amended, he shall be given 30 (thirty) days' advance notice of such change.

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

32.5 No alteration, rescission or addition shall be valid unless it has been approved and registered by the Registrar in terms of the Act.