ENGEN MEDICAL BENEFIT FUND
RULES

(WITH EFFECT FROM 1 January 2018)

1. NAME

The name of the scheme is **"ENGEN MEDICAL BENEFIT FUND"** hereinafter referred to as the "Scheme".

2. LEGAL PERSONA

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

3. REGISTERED ADDRESS

The registered address of the Scheme is located at Engen Court, Thibault Square, Cape Town but the Board may change such address to any other location within the Republic of South Africa should circumstances so dictate.

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4. DEFINITIONS

In these Rules words and expressions defined in the Medical Schemes Act, 1998 (Act 131 of 1998) bear the meanings thus assigned to them and, unless inconsistent with the context: -

a) all words and expressions purporting the masculine gender shall include the feminine;

b) words signifying the singular number shall include the plural and vice versa; and

c) the following expressions shall have the meanings assigned to them:

4.1 **"Act"** - the Medical Schemes Act, 1998 (Act No. 131 of 1998) as amended, and the regulations framed there under;

4.2 **"Administrator"** - any duly accredited person or body appointed to administer the Scheme in terms of Rule 20.4;

4.3 **"admission date"** - the date on which a person becomes a member, or in respect of a dependant, the date on which such dependant is admitted as a dependant in terms of these Rules and in the case of an employer, the date on which such employer participates in the Scheme in terms of these Rules;

4.4 **"annual limit"** - the maximum benefits to which a member and the member's registered dependants are entitled in terms of these Rules, and shall be calculated annually to coincide with the benefit year of the Scheme;

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4.5 **"Applicant "** - a person who applies for membership for himself and/or for the registration of his dependants;

4.6 **"Application "** – a completed application form, for membership and/or for registration of a dependant for approval by the Scheme;

4.7 **"approval"** - prior written approval or it's authorised representative;

4.8 **"auditor"** - an auditor registered in terms of the Public Accountants' and Auditors' Act, 1991 (Act No 80 of 1991);

4.9 **"beneficiary" - each** individual Member and/or Dependant;

4.10 **"benefit year"** - the period commencing 1 January each year until 31 December;

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

4.12 **"BHF"** – the Board of Healthcare Funders of Southern Africa;

4.13 **"Case Management"** - the process whereby a beneficiary's specific health care needs are identified and management plans or programmes are implemented to achieve optimum patient care in the most cost- effective way;

4.14 **"child"** - a member's natural child, or grandchild placed in the legal custody of the member or his/her spouse or a step-child or legally adopted child or a child in the process of being legally adopted or a child in the process of being placed in foster care, or a child for whom the member has a legal duty of support, or a child who has been placed in the legal custody of the member

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or his/her spouse and who is not a beneficiary of any other medical scheme;

4.15 **"Company"** - Engen Limited;

4.16 **"condition-specific waiting period"** – a period in which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnoses, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made;

4.17 **"continuation member"** - a member or dependant, as the case may be, who continues as a member in terms of Rules 6.2 or 6.3;

4.18 **"Contracted fee "** – the fee determined in terms of an agreement between the scheme and a service provider or group of providers in respect of the payment of relevant health services;

4.19 **contribution"** - in relation to a member, the amount, exclusive of interest, payable by or on behalf of the member and his registered dependants if any, as membership fees;

4.20 **cost"** - in relation to a benefit the net or final amount payable in respect of a relevant health service;

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4.21 **"Creditable coverage"** – any period during which a late joiner was –

4.21.1 a member or a dependent of a medical scheme;

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

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

4.21.4 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 years.

4.22 **"Council "** – the Council for Medical Schemes as contemplated in the Act;

4.23 **"date of service"**: -

4.23.1 in the event of a consultation, visit or treatment, the date on which each consultation, visit or treatment took place, whether for the same illness or not;

4.23.2 in the event of an operation, procedure or confinement, the date on which such operation or procedure was performed or confinement occurred;

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4.23.3 in the event of hospitalisation, the date of each discharge from a hospital or nursing home, or date of cessation of membership, whichever date occurs first;

4.23.4 in the event of any other service or requirement, the date on which such service was rendered or requirement obtained or received;

4.24 **"Dependant":** -

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

4.24.2 a member's dependent child who is not a member or a registered dependant of a member of a medical scheme;

4.24.3 a parent, brother and sister of a member in respect of whom the member is liable for family care and support and who is not a member or a registered dependant of a member of a medical scheme.

4.24.4 For the purposes of determining contributions:

4.24.4.1 a child under the age of 21

4.24.4.2 "child dependant "in respect of a members child who is dependent on the member, under the age of 25 years, and is attending an educational institution full time/part time; or is mentally or physically disabled

4.24.4.3 a special dependant referred to in 4.24.3 above who is under the age of 21.

4.24.4.4 " adult dependant" in respect of all other dependants.

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4.25 **"Dependent":** - in relation to a child:

4.25.1 a child under the age of 21; or

4.25.2 a child who, due to a mental or physical disability, is dependent upon the member; or

4.25.3 a child under the age of 25 years and is attending an educational institution full time/part time;

4.26 **"Designated Service Provider"**

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

4.27 **"Domicilium citandi et executandi"**

the member's chosen physical address at which notices in terms of rules 11 and 13, as well as legal process, or any action arising there from, may be validly delivered and served;

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

4.29 **"employee"** - a person in the full-time employ of an employer;

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4.30 **"employer"** - the Company or any associated company, which has been admitted to participation in the Scheme in terms of Rule 6.1.1;

4.31 **Engen Medical Benefit Fund Tariff (EMBFT) "** – the tariff published by the scheme (from time to time) for reimbursement of claims in the absence of any other agreed or contracted tariff with any service provider;

4.32 **"general waiting period"** - a period in which a beneficiary is not entitled to claim any benefits;

4.33 **"income"** shall mean:

for the purposes of calculating contributions in respect of -

a) employee members;

- the gross monthly benefit base excluding bonus, if applicable; or

b) **continuation members**;

- two thirds of the gross monthly benefit base in the last month prior to retirement date, escalated by the applicable pension increase per annum, excluding any other increases that may arise due to exceptional circumstances.

4.34 **"late joiner"** – an applicant or the dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years 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 consecutive months since 1 April 2001;

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4.35 **"Medical necessity"** shall mean the evaluation of health care services to determine if they are medically necessary and appropriate to meet the health care needs of the patient, consistent with the diagnosis or condition; rendered in a cost effective manner and type of setting appropriate to the supply of the service required for purposes other than comfort or convenience; and consistent in type, frequency and duration of treatment with scientifically based guidelines of medical practice and of demonstrated medical value;

4.36 **"member"** - any person who is eligible to be a member of the scheme in terms of Rule 6 of these Rules, and who is registered as such by the scheme. A reference to a/the Member in these rules shall be a reference to the principal member of the scheme.

4.37 **member family"** - the member and all the member's registered dependants;

4.38 **"Prescribed Minimum Benefits"** - the benefits contemplated in section 29(1)(o) of the Act which consists of the provision of the diagnosis, treatment and care costs of –

(a) the conditions listed in Annexure A of the regulations specified therein ;and

(b) any emergency medical condition.

4.39 **"Prescribed Minimum Benefit condition"** - a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the regulations or any emergency medical condition;

4.40 **"Partner"** - a person with whom the member has a committed and serious relationship akin to a marriage based on objective criteria

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of mutual dependency and a shared and common household, irrespective of the gender of either party;

4.41 **"Pre-authorisation"** - shall mean authorisation in advance, of the medical necessity, efficiency and or appropriateness of health care services and treatment plans for specified services;

4.42 "**Pre-existing sickness condition**" - means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for admission as a beneficiary was made;

4.43 **"Principal Officer**" - the person appointed by the Board as the Principal Officer in terms of the Rules;

4.44 **"Registrar**" - the Registrar or Deputy Registrar of Medical Schemes appointed under section 18 of the Act;

4.45 **"retiree"** - a member who retires (as an employee in terms of the rules of the pension or provident fund of which the employee, or, if the employee is not a member of a pension or provident fund, in terms of any written contract of service with the employer's employee) or withdraws, as the case may be, from the service of the employer on or after normal retirement date or on such earlier date prior to the member's normal retirement date as may be agreed between the employee and employer;

4.46 **"Rules"** - the Rules governing the Scheme inclusive of annexures and any other provisions relating to the benefits which may be granted, the contributions which are payable and the members rights and obligations;

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4.47 **"service / relevant health service"** - any health care treatment of a person by a person registered in terms of any law, which treatment has as its object:

a) the physical or mental examination of that person;

b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;

c) the giving of advice in relation to any such defect, illness or deficiency;

d) the giving of advice in relation to or treatment of any condition arising out of pregnancy;

e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency, or a pregnancy;

f) nursing or midwifery; and includes 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 practiced, or any other institution where surgical or other medical activities are performed; provided such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;

4.48 **"Spouse"** - the spouse of a member to whom the member is married in terms of any law or custom;

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5. **OBJECTS: (Definition: "business of a medical scheme")**

The objects of the Scheme are to undertake liability in respect of its members and their dependants, in return for a contribution or premium, and thereby to make provision for;

5.1 the obtaining of any relevant health service;

5.2 the granting of assistance to members in defraying expenditure incurred by them and their dependants in connection with health care treatment as provided for and in accordance with the Rules of the Scheme; and/or

5.3 the rendering of a relevant health service, contemplated in these Rules, to members and their dependants, either by the Scheme itself or by any supplier, or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with the Scheme.

6. **PARTICIPATION BY AN EMPLOYER AND MEMBERSHIP**

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6.1 **Eligibility**

6.1.1 **Employer participation**

The Board may, in its entire discretion, on application by any company subsidiary to or associated with the Company admit such company as an employer and extend participation in the Scheme to the employees of such company on the same terms and conditions as apply to the employees of existing employers participating in the Scheme;

6.1.2 **Employee**

6.1.2.1 Membership of the Scheme is restricted to employment or former employment by the employer and shall be compulsory for all employees of the Company and any other participating employer in respect of whom membership is a condition of employment.

Provided that where an employee whose spouse is a member of another medical scheme and the employee elects to be registered as a dependant on the spouse's employer-sponsored medical scheme, the employee shall, not be obliged to join the Scheme, but may at some future date, be admitted to membership subject to the waiting periods contemplated in Rule 8.;

6.2 **Retiree**

6.2.1 A member is eligible to, retain membership of the scheme with registered dependants, if any, in the event of retiring from the service of the employer or whose service is terminated by the member's employer on account of age, ill-health or other disability.

6.2.2 The Scheme shall inform the member of the right to continue membership of the Scheme and of the contribution payable from the date of retirement or termination of employment. Unless such member informs the Board in writing of the desire to terminate membership, the member shall continue as a member. Should a member elect to terminate membership of the Scheme, he will not be eligible to rejoin the Scheme at a later date.

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6.3 **Dependants of deceased members**

6.3.1 If a member of the Scheme dies, the spouse of the member, if he or she is registered as a dependant of the member at the time of his or her death, shall forthwith be entitled to become a member of the Scheme and no waiting period, not in effect at the time of the death of the deceased, will apply to such new member. Any other person registered as a dependant of the member at the time of his or her death, shall be entitled to be registered as dependants of such newly admitted member and no waiting period, not in effect at the time of the death of the deceased, will apply to such dependant.

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

6.3.3 Where a child dependant/s has been orphaned, the eldest child may be deemed to be the member, and any younger siblings, the child dependant/s

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

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7.1 Registration of Dependants

7.1.1 Application for registration

At a member's admission date or at any other time thereafter the member may apply to the Scheme for registration of the member's eligible dependants, subject to Rule 8.

7.1.2 **Birth of infants and adoption of children**

7.1.2.1 A member who wishes to register a new-born or adopted child as the member's registered dependant shall notify the Scheme within **30 days** of the birth or adoption of a child, and shall apply to the Scheme to register the child as a dependant. Increased contributions shall be due as from the first day of the month following the birth or adoption. Benefits however shall be adjusted as from the date of birth or adoption;

7.1.2.2 A member who fails to take action under Rule 7.1.2.1 will be subject to rule 8.5.1.3 and will be liable to forfeiture of all benefits in respect of the newly-born infant or adopted child until the member has given the required notification and paid the applicable contribution.

7.1.3 **Change in marital status**

7.1.3.1 A member whose marital status changes subsequent to joining the Scheme and who elects to register or withdraw dependants is required to notify the Scheme within **30 days** thereof, and to subscribe at the applicable contribution rate from the first day of the month following the change in the marital status. Benefits will however be adjusted from the date of such change in status.

7.1.3.2 A member who fails to notify the Scheme in terms of Rule 7.1.3.1 shall forfeit all benefits in respect of the new dependant until the member has given the required notification and paid the applicable contribution.

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

7.2 **Deregistration of Dependants**

7.2.1 The member shall inform the Scheme within 30 days of the occurrence of any event which results in any registered dependant no longer satisfying the conditions in terms of which the dependant may be registered as a dependant

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

7.3 **Application for cancellation of registration**

A member may on one month's written notice cancel the registration of a dependant.

Benefits will however not be adjusted based on the period of membership, following the resignation of a dependant.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 **Minimum age for admission**

A person who has not attained the age of 16 years may not become a member without the assistance of the applicant's parent or guardian.

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8.2 **Membership of more than one medical scheme prohibited**

No person shall be a member or dependant of a member of more than one medical scheme

8.3 Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence of age, income, state of their health and the health of their dependants to be registered as such. The Scheme may require of an applicant to provide it with a medical report in respect of himself and or any of his dependants to be registered as such, in respect of a condition for which any medical advice, diagnosis, care or treatment recommended or obtained within a period of 12 months immediately prior to the date on which application to the Scheme was made. The cost of any medical tests or examinations required to provide such medical report will be paid for by the Scheme. The Scheme may however designate a provider to conduct such tests or examinations. Proof of any prior membership or registration, as a dependant with any other medical scheme must also be submitted.

8.4 Waiting Periods

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

8.4.1.1 a general waiting period of three months; and

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8.4.1.2 a condition-specific waiting period of 9 months on existing pregnancies in respect of all pregnancy-related services; and

8.4.1.3 a condition-specific waiting period of up to 12 months in respect of any condition contemplated in rule 8.3.

8.4.1.4 If both a general waiting period and a condition-specific waiting period are imposed, they will run concurrently, but the provisions of the general waiting period shall predominate. No insured benefits shall accrue for services in respect of a condition for which a waiting period has been imposed, but contributions shall be paid to the Scheme in full.

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

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

8.4.2.2 where a waiting period imposed by a former previous medical scheme had not expired at the time of termination, the Scheme has the right to apply the remainder of, a general or condition-specific waiting period for the unexpired duration of such a waiting period.

8.4.3 a general waiting period of up to 3 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

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8.5 No waiting periods may be imposed on:

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

8.5.1.1 change of employment; or

8.5.1.2 an employer changing or terminating the medical scheme of its employees.

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 subject to the provisions of rule 8.4.2.2.

8.5.1.3 A child dependant born during the period of membership.

8.6 Every member will, on admission to membership, receive a summary of the rules, which shall include annexures as well as other provisions relating to the benefits, which may be granted, the contributions payable and the member's rights and obligations. Members or any other person who claims a benefit under these Rules are bound by these rules as amended from time to time.

8.7 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

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benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a member is entitled under these rules, or any right in respect of such benefit or payment of such benefit to such member, if a member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.

8.8 **Conditions of employment not affected by the Rules**

Nothing in these Rules shall be construed as altering in any way an employer's right to terminate the service of an employee who is a member of the Scheme or any agreement between the employer and the employee in regard to conditions of service.

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, who qualifies as an employer in terms of definition 4.31, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Board may 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.

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10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

10.1 Membership card

Every member shall be issued with a membership card containing such particulars as prescribed by the Act. This card shall be exhibited to the supplier of a service on request. It remains the property of the Scheme and shall be returned to the Scheme on termination of membership.

10.2 Misuse of membership card

The utilisation of a membership card by any person other than the member or the member's registered dependants with the knowledge or consent of the member or the member's dependants is not permitted and shall be construed as an abuse of the privileges of the Scheme.

10.3 Certificate of membership

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

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11. CHANGE OF ADDRESS

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

12. TERMINATION OF MEMBERSHIP

12.1 Termination of employment

12.1.1 Subject to any provisions of Rule 6.2.1, a member whose service as an employee is terminated, shall be entitled to have benefits till the end of the termination month.

12.1.2 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.

12.2 Voluntary Resignation

12.2.1 A member for whom membership is a condition of employment shall not, except with the prior approval of the Board and the consent of the member's employer, be permitted to resign from the Scheme whilst the member remains an employee.

A member who is permitted to resign from the Scheme in order to be, and is, registered as a dependant of the member's spouse on another medical scheme will, subject to the provisions of Rule 8 be permitted to rejoin the Scheme at a later date.

12.2.2 A continuation member in terms of Rules 6.2 or 6.3 may, on one month's written notice, be permitted to resign from the Scheme. A member who elects to resign from the Scheme in terms of this Rule will not again be admitted to membership of the Scheme.

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12.2.3 A participating employer may terminate its participation with the scheme on giving three months written notice.

12.3 **Death**

Membership of a member terminates on his death.

12.4 **Termination by default**

12.4.1 The Board shall have the right to suspend or terminate the membership, of a member whose contributions are more than three months in arrears or where the member fails to pay to the Scheme any amount due by the member to the Scheme in terms of these Rules.

On payment of the amount due to the Scheme after a period of more than 3 months break in membership, reinstatement will be subject to rule 8.4.1 and the waiting periods contemplated in rule 8.

12.4.2 **Failure to pay any other amounts due to the Scheme**;

If a member fails to pay amounts due to the Scheme, his/her membership may be terminated in terms of these rules.

12.5 **Abuse of privileges, false claims, mis-representations and non-disclosure of factual information**

Subject to Rule 28 the Board may exclude from benefits or terminate the membership of a beneficiary whom the Board finds guilty of abusing the benefits and privileges of the Scheme by

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presenting false claims, or false representations or non-disclosure of factual information.

The Board shall inform the member in writing of the reason for this decision. In such event the member may be required by the Board to refund to the Scheme any sum which, but for his or his dependant's abuse of the benefits or privileges of the Scheme, would not have been disbursed on the beneficiary's behalf.

12.6 **Effect of termination of membership**

On termination of membership of the Scheme in terms of any of Rules 12. 1 to 12.4 all rights and benefits shall thereupon cease on the date of termination, except for claims in respect of service rendered up to and including the date of termination.

13. **CONTRIBUTIONS**

13.1 **Basis of calculation**

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

13.2 **Date of payment of contributions and authority to deduct from remuneration.**

Contributions shall be due monthly in arrears and be payable by not later than the 3rd day of each month. Where contributions or any other debt owing to the scheme, have not been paid within one month of the due date, the Scheme shall have the right

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

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

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

13.3 **Interest on late payment of contributions**

The Board at their discretion shall be entitled to charge interest on any contributions which may not have been received by due date. Interest shall be charged at the ruling prime overdraft rate as charged by the Scheme's bankers from time to time as proved by a certificate from any authorised official of the bank. In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with rule 13.2,2 benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expense associated with the default and to recover interest on the arrear amount at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the member from the date of default and any such benefit paid may be recovered by the Scheme.

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13.4 **Refund of contributions**

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

13.5 **Contribution payment and benefit entitlement on admission**

(Subject to Rule 8. - Terms and conditions applicable to membership):

13.5.1 **New Members**

All contributions shall be calculated as from the first day of the month in which member was employed. Admission date and benefit entitlement shall be from employment date.

13.5.2 **Application for an additional dependent (excluding newborns)**

All contributions shall be calculated as from the first day of the month of application for membership. Admission date and benefit entitlement shall be from application date.

13.5.3 In instances where a member specifies the admission date of an dependant, all contributions shall be calculated as from the first of the month and benefit entitlement would be from the date specified.

All new applications/employments that commenced during a month, where applicants still have cover on previous medical aid;

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admissions dates, benefit entitlement and contributions shall be calculated from the first day of the month following termination on previous medical aid.

13.5.4 **Newborns**

No contribution is required for the month in which the baby is born. First contribution shall be calculated as from the first day of the month, following birth date. Benefit entitlement shall be from date of birth.

13.6 **Contribution payment benefit entitlement on termination**

When a member's or dependant's employment/membership is terminated, contributions shall be paid for the full month and benefit entitlement shall be till the end of the termination month, provided he/she is not a member of another medical scheme.

14. LIABILITY OF EMPLOYERS AND MEMBERS

14.1 Liability of Employer

Subject to the provisions of Rule 14.2 the liability of an employer shall be limited to the amount of the employer's unpaid contributions or subsidy in terms of any agreement between the employer and the Scheme.

14.2 Liability of Member

Where a member is required by the member's employer to pay any portion of the member's contribution the liability of such member

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shall be limited to the amount of the member's unpaid contributions together with any sum disbursed by the Scheme on the member's behalf or on behalf of the member's dependants, which has not been repaid to the Scheme.

Any amount owing by a member to the Scheme in respect of the member or the member's registered dependants may be recouped out of the member's remuneration from the member's employer by arrangement with such member.

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

14.4 **Collection costs in recovery of amounts owing the Scheme**

In the event of the Scheme instructing an attorney to collect any amount owing by a member to the Scheme in respect of the member or the member's dependants, then and in such event, the member shall be liable to pay all and any costs incurred by the Scheme, which costs shall, without limiting the generality of the afore going, include the costs of a letter of demand, collection charges, tracing charges as well as all party to party and attorney and client charges.

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14.5 **Jurisdiction of Courts**

In terms of Section 45 of the Magistrates Court Act, 1944 (No. 32 of 1944), the Magistrates Court shall have jurisdiction to determine any action or proceedings which may arise under or in connection

with the Rules of the Scheme, without prejudice to the rights of either the Scheme or the member to bring proceedings in the High Court where such proceedings would fall outside the jurisdiction of the Magistrates Court.

15. CLAIMS PROCEDURE

15.1 Details required when submitting claims

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 and shall contain the following particulars:

15.1.1 the surname and initials of the member;

15.1.2 the surname and first name and other initials (if any) 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 as issued by BHF (if applicable) of the supplier of the service, and in the case of a group practice, the name of the practitioner who provided the service;

15.1.6 the date on which each service was rendered;

15.1.7 the nature and cost of each service rendered, including the item code number (Tariff code and ICD10 diagnosis code) that relates to such service (if applicable), and where the supplier of service

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supplied medicine to the member concerned or to a dependant of that member, the name, quantity, dosage and net amount payable in respect of the medicine;

15.1.8 where the account is a photocopy of the original, certification by the supplier of service by way of a rubber stamp or signature on such photocopy;

15.1.9 where a pharmacist supplies medicine according to a prescription to a member or a dependant of a member a certified copy of such prescription, if so required by the Board;

15.1.10 the name and the practice code number as issued by BHF of the referring medical practitioner or dentist;

15.1.11 in the case where such account or statement refers to the use of an operating theatre where an operation was performed on the member or the dependant of that member –

i) the name or names and the practice code number as issued by BHF of the medical practitioner or dentist who performed that operation;

ii) the name or names and the practice code number as issued by BHF of every medical practitioner or dentist who assisted at such operation; and

iii) all procedures carried out; and

15.1.12 in the case of a first account or statement in respect of orthodontic treatment, a treatment plan indicating –

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i) the expected total amount the orthodontist will charge for the treatment;

ii) the expected duration of the treatment;

iii) the initial amount the member has to pay; and

iv) the monthly amount the member has to pay.

15.2 **Submissions of claims**

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

15.2.2 Where a claim is received by the Schemes within the period specified in Rule 15.2.1 and the Scheme is of the opinion that the claim is incorrect or unacceptable for payment the Scheme shall notify the member or healthcare provider, whichever is applicable, accordingly within 30 days after receipt thereof.

The Scheme shall state the reasons why such a claim is incorrect or unacceptable. The member or provider shall thereupon return, for adjudication, such corrected claim within **60 days** of the date of notification by the Scheme that the claim is incorrect or unacceptable.

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15.3 **Claims to be supported by receipt**

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

15.4 **Claims in respect of injuries**

Account for treatment of injuries or expenses recoverable from third parties shall be supported by a statement setting out particulars of the circumstances in which the injury was sustained, as and when required by the Board.

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

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

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16. BENEFITS

16.1 Entitlement to benefits

The minimum and maximum benefits to which a member is entitled are set down in Annexure B and covers the cost of services rendered in respect of prescribed minimums benefits, in accordance with Annexure D. Subject to the limitations set out in the preamble to Annexure B and (unless otherwise agreed by the Board) the exclusions set out in Annexure C, and subject further to the provisions of Rule 12.4 beneficiaries shall be entitled to benefits as set out in Annexure B, and such benefits shall extend through the member to the member's dependants; provided that such benefits shall only accrue from the admission date of the member or dependant as the case may be.

16.2 Benefits when contributions are in arrears

The Board shall have the right to withhold or refuse payment of benefits to members whose contributions are more than one month in arrears, or at any time should an employer notify the Scheme that, arising out of industrial action, contributions due or about to become due to the Scheme in respect of the member concerned will not be paid on due date.

16.3 Benefits on termination of membership arising from default or abuse of privileges

Where a member's membership is terminated in terms of Rule 12.4 or 12.5 benefits shall only be payable in respect of all services rendered up to the month for which contributions have been paid.

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16.4 **Suspension of benefits when members' portions owing**

Where the Scheme has paid any account for services rendered to a member or dependant of a member in terms of the Rules which has resulted in an amount owing by a member for the excess portion payable by that member to the Scheme, and the member fails to pay such outstanding amount within 30 days of having been notified of the amount due and the aggregate of any amounts owing by the member in respect of such outstanding accounts exceeds 50 percent of the member's monthly contribution, the Board shall have the right to withhold or refuse payment of further benefits to the member until such time as the outstanding amounts due to the Scheme have been paid. When the member concerned has settled the member's indebtedness to the Scheme the member shall be entitled to such benefits for services rendered during the period of suspension.

16.5 **Date of payment of benefits**

The Scheme shall pay any benefit due to a member within 30 days of the receipt of the claim pertaining to such benefit.

16.6 **Benefits for services outside the Republic**

The benefit for any claim accepted by the Scheme in terms of these Rules in respect of services provided outside the Republic of South Africa will be determined in accordance with the Recommended Scale of Benefits or at the cost of services whichever is the lower and payment will be made in terms of Rule 17.5.

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16.7 **Minimum Benefits- Subject to Annexure D**

Subject to the limitations imposed by these rules, the benefits payable by the Scheme in respect of claims by any member or his dependants are those set out in Annexure B, appended to these rules. Notwithstanding anything to the contrary in these rules contained, any benefit option or plan offered by the Scheme covers in full, in the public hospital system in South Africa, the cost of the minimum benefits as may be prescribed from time to time: Provided that if cover for a prescribed minimum benefit is exhausted in terms of a schedule of benefits annexed to these rules and the member or his registered dependant still requires diagnoses, care or treatment for that prescribed minimum benefit, he may be transferred to the public hospital system or the provisions of paragraph 3 of Annexure D will apply. In those instances where the public hospital service is not reasonably available the Scheme will provide that patient with the cover prescribed in the most cost effective provider or provider network. The Scheme will accept liability for all costs incurred in that network, which may be a lower cost provider or provider network.

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

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

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17. PAYMENT OF ACCOUNTS

17.1 Agreements with suppliers of services

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

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

17.1.3 The Scheme may, by agreement or not, pay the benefit to which the member is entitled, directly to the supplier (or group of suppliers) who rendered the service.

17.2 Party to whom claim will be paid

Where a supplier of service has rendered an account that is in excess of an agreement entered into in terms of Rule 17.1 the account shall not be paid by the Scheme direct to the supplier of service but the benefit due to the member shall be paid direct to the member concerned.

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17.3 Refund of claims paid in error

Where the Scheme has paid an account or portion of an account to which a beneficiary is not entitled whether payment is made to the

member or to the supplier of service, the amount of any such overpayment shall be recoverable by the Scheme from the party concerned.

17.4 **Recovery of claims paid when contributions are in arrears**

Where the Scheme has paid an account or portion of an account in respect of a beneficiary whose contributions are more than three months in arrears whether payment is made to the member or to the supplier of service, the amount of any such payment shall be recoverable by the Scheme from the member concerned.

17.5 **Currency of payment**

Any claim accepted by the Scheme in terms of these Rules in respect of services provided outside the Republic of South Africa will be paid in the currency of the Republic of South Africa.

17.6 **Ex-Gratia Payments**

The Board shall not authorise payment for services other than those provided for in these Rules but may, in its absolute discretion, in respect of the benefits provided, increase the amount payable in terms of these Rules as an ex *gratia* award provided it is satisfied that undue hardship would otherwise be imposed upon a member.

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18. MANAGEMENT

18.1 Constitution of Board

The affairs of the Scheme shall be managed according to these Rules by a Board consisting of 10 persons, who are fit and proper to be trustees and who shall be members of the Scheme, of whom:

5 shall be elected by members in terms of Rule 18.4 (hereinafter referred to as "member representatives"), and;

5 shall be nominated by the Company (hereinafter referred to as "employer representatives");

18.2 Term of office

18.2.1 An employer representative shall serve a term of office of 3 years. An employer representative may be re-appointed by the Company.

18.2.2 Each member representative shall serve a term of office of 3 years, terminating on the date of the annual general meeting. A member representative may be eligible for re-election.

18.2.3 A member representative may resign at any time by giving written notice to the Board of the member's intention not to remain a member of the Board.

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18.3 **Alternate Board members**

18.3.1 The Company shall have the right to appoint one person to act as alternate employer representative and to withdraw such appointment. Such alternate shall be subject to the same conditions as a trustee and shall have a vote when one or more employer representatives are unable to attend a Board meeting.

18.3.2 One person acting as alternate for member representatives, who will be the person obtaining the next highest number of votes in the most recent election. Such alternate shall be subject to the same conditions as a trustee and shall have a vote when one or more member representatives are unable to attend a Board meeting.

18.3.3 Each alternate member representative shall serve a term of office of 3 years, to be ratified at the annual general meeting following the alternate member's election.

18.4 **Election of member representatives**

The names of candidates for election or re-election as Board members, shall be submitted (signed by proposers and endorsed with the candidate's agreement to stand for election) to reach the Principal Officer at least 30 (thirty) days before the annual general meeting of the Fund.

The candidates shall, if there be more than the required number of Trustee positions falling vacant by majority vote of all the members voting by ballot under arrangements made by the Board.

The names of the candidates elected shall be announced at the annual general meeting.

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

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Board:

18.5.1 A person under the age of 21 years;

18.5.2 a director, employee, partner, representative, officer, consultant, contractor or agent of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;

18.5.3 a broker;

18.5.4 the principal officer of the Scheme; and

18.5.5 the auditor of the Scheme.

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

18.7 **Casual vacancies**

The Board shall have the right to fill any casual vacancy amongst the member representatives that may occur during their terms of office. A person so appointed shall retire at the first ensuing annual general meeting and that meeting shall fill the vacancy for the un-expired period of office of the vacating member of the Board.

18.8 The Board may co-opt up to two knowledgeable persons who need not be members of the Scheme. A co-opted person's participation may be terminated by the Board at any time. A co-opted person

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may participate in the deliberations of the Board but shall have no vote.

18.9 **Quorum for meetings**

Half of the members of the Board physically present plus one shall constitute a quorum for a meeting of the Board. Members of the Board will, for the purposes of constituting a quorum, not include suspended Board members.

18.10 **Election of office bearers**

The Board shall, at its first meeting after each annual general meeting, elect from its number a chairperson and vice-chairperson of the Scheme.

18.11 Should the chairperson or vice-chairperson resign or cease to be a member of the Board or be removed from office on a vote of no confidence by the Board, the Board shall fill the vacancy thus created for the remaining period for which the previous incumbent was elected.

18.12 **Chairperson at meetings**

The chairperson, or in the absence of the chairperson the vice-chairperson, shall preside at each meeting of the Board. In the absence of the chairperson and the vice-chairperson at a meeting of the Board, the Board members present shall elect one of their number to preside at that meeting.

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18.13 **Voting at Board meetings**

Matters before the Board shall be decided by a majority vote and in the event of an equality of votes, the chairperson of the meeting shall have a casting vote in addition to the chairperson's deliberative vote;

Provided that, subject to Rule 32.1, all decisions of the Board relating to the rates of contribution or the benefits payable or any other matter with financial implications shall be valid only if taken by 70% of the Board members present at the meeting when the decision is taken.

18.14 **Inquorate meeting**

Notwithstanding any vacancy on the Board, the continuing members thereof may act on its behalf;

Provided that if and so long as their number is reduced below that fixed for a quorum by these Rules such members may act only for the purpose of increasing the number of members to that number or for summoning a general meeting of the Scheme, but for no other purpose.

18.15 **Cessation of office**

A member of the Board shall cease to hold office if the member:

18.15.1 is certified mentally ill or is incapable of managing the member's affairs; or

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18.15.2 is declared insolvent or the member's estate has been surrendered for the benefit of the member's creditors; or

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

18.15.4 is removed by the Court from any office of trust on account of misconduct; or

18.15.5 is disqualified under any law from carrying on his profession; or

18.15.6 ceases to be an appointee by the Company, or he ceases to be a member of the Scheme; or

18.15.7 is absent from three consecutive meetings of the Board without the prior permission of the chairperson; or

18.15.8 is removed from office by the Council in terms of Section 46 of the Act.

18.15.9 The provisions of rules 18.15.1 – 18.15.5 apply *mutatis mutandis* to the principal officer.

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18.16 **Meetings of Board**

The Board shall meet at least once in every three months or at such intervals, as it may deem necessary.

Seven clear day's notice of a Board meeting, unless otherwise agreed by the Board, shall be given to each member of the Board

and such notice shall, as far as possible, contain a statement of the business to be transacted at the meeting. The non-receipt of any notice shall not invalidate the proceedings of any meeting of the Board.

18.17 **Special meetings of Board**

The Chairperson may convene a special meeting should the necessity arise. Any three members of the Board may request the chairperson to convene a special meeting of the Board provided the matters to be discussed at the meeting are clearly stated in the request.

Upon receipt of the request the chairperson shall within seven days thereafter convene a special meeting of the Board to deal with the matters stated therein for which notice shall be given in terms of Rule 18.16.

18.18 **Remuneration of Board members**

Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as trustees. Such reimbursement must be disclosed to the members in the Annual General Meeting.

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

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18.20 **Round-robin resolution**

A resolution in writing signed by Board members or, if a Board member be not available, by the Board member's alternate being not less than are sufficient to constitute a quorum, shall be as valid and effectual as if it had been passed at a meeting of the Board duly called and constituted;

Provided that one of the signatories shall be the chairperson, or in the chairperson's absence the vice-chairperson.

Any such resolution may consist of several documents in like form, each signed by one or more of the signatories contemplated in this Rule.

18.21 **Record of proceedings of meetings**

The Board shall cause the proceedings of all annual, special general and Board meetings to be properly minuted and the minutes of such meetings shall be laid before the first succeeding respective meeting;

Provided that the minutes of every special general meeting shall, as the Board may decide, be laid before the first succeeding special general meeting or the annual general meeting.

If the minutes of any such meetings are accepted and confirmed as correct they shall be signed by the chairperson.

18.22 **Evidence of minutes**

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Every minute signed by the chairperson of the meeting to which such minutes relate or signed by the chairperson of the meeting subsequent to the meeting to which such minutes relate shall be sufficient evidence of the facts stated therein.

19. DUTIES OF THE BOARD OF TRUSTEES

19.1 The Board shall be responsible for the proper and sound management of the Scheme in terms of these rules.

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

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

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

19.5 The Board shall appoint a principal officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the principal officer and of any person employed by the Scheme; Provided that the following persons are not eligible to be a principal officer –

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

19.5.2 A broker.

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19.6 The duties of the Chairperson shall be to preside and to preserve due and proper conduct at meetings.

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

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

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

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

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

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

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

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

19.15 **Authority for payments**

All disbursements shall be approved by the Board;

Provided that such authority may be delegated to the Principal Officer or to such other person as the Board may approve.

19.16 **Liability for expenses**

The whole of the expenses in connection with or incidental to the management and administration of the Scheme shall be borne by the Scheme.

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

19.18 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.

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

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20. POWERS OF THE BOARD

The Board shall have power:

20.1 to employ staff for the execution of the business of the Scheme and to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfillment of the Scheme's obligations under such appointments;

20.2 to cause the termination of the services of any employee of the Scheme;

20.3 **Appointment of Committees**

The Board shall have the power to appoint a committee consisting of such Board members and experts, as it deems necessary and to delegate any of its powers to such committee;

Provided that a committee so appointed shall in the exercise of its powers conform to any rules or instructions that may be imposed or issued to it by the Board;

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

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

20.7 to let or hire movable or immovable property;

20.8 to institute or defend any legal action for or on behalf of the scheme;

20.9 in respect of any moneys not required to meet current charges upon the Scheme and subject to the provisions of the Act, to lend, invest or otherwise to deal with such moneys upon such security and in such manner as the Board may from time to time decide and to realise, vary re-invest or otherwise deal with such moneys and investments in such manner as it may from time to time determine;

20.10 to borrow money for the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

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

20.12 to make donations to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interest of all or any of its members;

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20.13 to grant repayable loans to or make *ex-gratia* payments on behalf of members of the Scheme in order to assist such members to meet commitments in regard to the obtaining of a health care service;

20.14 to contribute to any association or fund conducted for benefit of the employees of the Scheme;

20.15 to reinsure obligations in terms of the benefits provided for in these rules in the prescribed manner;

20.16 to authorise such officers of the Scheme or Board members or such other persons as it may decide from time to time, and upon such terms and conditions as the Board may decide, 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;

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

20.18 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 THE PRINCIPAL OFFICER AND STAFF

21.1 The Principal Officer is the executive of the Scheme and as such shall ensure the following:

21.1.1 the officers of the Scheme retains the confidentiality of any information regarding its members

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21.1.2 will at all times act in the best interests of the members of the Scheme

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

21.1.4 ensure there is proper and appropriate communication between the Scheme and those parties affected by the decisions and instructions of the Board;

21.1.5 keep the Board sufficiently and timeously informed of the affairs of the Scheme concerning any matter relating to the duties of the Board as stated in section 57(4) of the Act;

21.1.6 does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and at all times observe the authority of the Board in its governance of the Scheme

21.1.7 ensure that all duties required for the proper execution of the business of the Scheme, and Board directives are carried out.

21.1.8 Shall attend all meetings of the Board, and any other duly appointed committee where his/her attendance may be required, and ensure proper recording of the proceedings of all meetings.

21.1.9 shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

21.2 The Principal Officer shall be the accounting officer of the Scheme and will be responsible for the following:

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21.2.1 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.

21.2.2 shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

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

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

21.3.2 A broker.

21.4 The provision of rules 18.15.1-18.15.5 apply *mutatis mutandis* to the Principal Officer

22. INDEMNIFICATIONS AND FIDELITY GUARANTEE

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

22.2 No indulgence, which the Scheme may show to any member or employer, shall in any way prejudice the Scheme's rights or be construed as a waiver of the scheme's rights or a novation of any party's rights.

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22.3 The Board shall ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers 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 extend from the 1st day of January to the 31st day of December of that year.

24. BANK ACCOUNT

The Scheme shall maintain a banking account in the name of the Scheme and under its direct control with a registered commercial bank. All moneys received shall be deposited to the credit of such account and all payments shall be made either by electronic transfer 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) must be appointed by resolution at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.

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

25.2.1 a member of the Board;

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25.2.2 an employee, officer or contractor of the Scheme;

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

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

25.2.5 a person who is disqualified from acting as an auditor in terms of the Companies Act, 1973.

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 must within 30 days appoint another auditor to fill the vacancy for the unexpired period.

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

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

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

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25.7 The Board must appoint an audit committee of at least five members of whom at least two must be members of the Board.

25.8 **Auditor's right to attend meetings and make statements**

The auditor of the Scheme shall be entitled to attend any general meeting of the Scheme and to receive all notices of and other communications relating to any general meeting which any member of the Scheme is entitled to receive and to make at such meetings any statement that the auditor desires to make in relation to any return, account or balance sheet examined by the auditor or report made by the auditor.

26. GENERAL MEETINGS

26.1 Annual general meeting

26.1.1 Time for holding and business to be transacted

The annual general meeting of members shall be held not later than 30 June of each year on a date, which may be shown to permit reasonable attendance by members at such time and place as the Board, shall determine for the purpose of:

i) receiving and adopting the annual financial statements together with the auditor's report and the report of the Principal Officer as required by the Act.;

ii) the election of member representatives to the Board;

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iii) the appointment or re-appointment of the auditor;

iv) the election of the disputes committee;

v) any other business of which due notice has been given;

26.1.2 **Notice**

The notice convening the meeting containing the agenda, and advising how the annual financial statements the annual report and the auditor's report may be obtained, must be furnished to all members at least 21 days before the date of the meeting.

The non-receipt of such notice by a member shall not invalidate the proceedings of the meeting provided that the notice procedure followed by the Board was reasonable.

26.1.3 **Quorum**

Fifteen members of the Scheme present in person shall constitute a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting shall be adjourned to the same day and time of the next week and members then present shall constitute a quorum;

Provided that if the same day of the next week is a public holiday meeting shall be adjourned to the first working day following the public holiday.

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26.1.4 **Tabling of financial statements**

The financial statements and reports specified in Rule 26.1.1 shall be laid before the meeting.

26.1.5 **Notices of motion**

Notice of motions to be placed before the annual general meeting must reach the Principal Officer not later than seven days prior to the date of the meeting.

26.2 **Special General Meetings**

26.2.1 **Convening of meeting by the Board**

A special general meeting of all members may be called at any time by the Board if deemed necessary. In such event the provisions of rule 26.1.3 shall *mutatis mutandis* apply.

26.2.2 On the requisition of at least 50 members of the Scheme, the Board must cause a special general meeting to be called within 30 days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitionists and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

26.2.3 **Notice**

The notice convening a special general meeting containing the agenda shall, be dispatched to all members at least 14 days before the date of the meeting. Such notice shall be sent to the last address of members known to the Scheme.

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The non-receipt of such notice by a member shall not invalidate the proceedings of the meeting provided that the notice procedure followed by the Board was reasonable.

26.2.4 At least 50 members present in person constitute a quorum at a meeting called at the request of members in terms of rule 26.2.2. If a quorum is not present at a special general meeting after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled.

26.3 **Representation at general meetings**

26.3.1 Every member who is entitled to be present at a general meeting of the Scheme and whose contributions are not in arrears, shall be entitled to appoint, subject to the provisions of Rule 26.3.2, another person, who shall be a member, as the member's proxy to attend, speak and vote in the member's stead.

26.3.2 The instrument appointing the proxy shall be in writing, in a form determined by the Board and shall be signed by the member. The proxy form shall be deposited not later than 48 hours before the time for holding the meeting at the registered office of the Scheme or such other place or places as the Board shall decide and of which notice has been given in the notice of the meeting.

26.3.3 In default of complying with the provisions of Rule 26.3.2 the instrument of proxy will be deemed invalid.

26.3.4 A member may withdraw the authority given in terms of Rule 26.3.1 at any time and in the case of a meeting adjourned to not less than seven days after the original date set down for the meeting the

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member may substitute a new instrument in place of the previous one.

27. VOTING AT MEETINGS

27.1 Every member who is present in person or by proxy at a general meeting of the Scheme and whose contributions are not in arrears shall have the right to vote at the meeting.

27.2 Save as is otherwise expressly provided by the Act or by these Rules all questions, matters and resolutions arising at or submitted to any general meeting shall be decided by a majority of votes cast and shall, in the first instance be decided by a show of hands unless a poll is demanded (before or on the result of a show of hands) by:

a) the chairperson of the meeting, or

b) not less than five members having the right to vote at the meeting, or

c) a member or members representing by proxy not less than one-tenth of all members having the right to vote at the meeting;

provided that where members are called upon to vote on any matter which affects the rates of contribution or the extent of benefits, the voting shall be by ballot.

In the case of an equality of votes the chairperson of the meeting shall, if he is a member, on both a show of hands and a poll, have a casting vote in addition the chairperson's deliberative vote. A declaration by the chairperson of the meeting that a resolution has,

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on a show of hands, been carried unanimously, or carried by a particular majority, or lost, or not carried by a particular majority, shall be final and binding on all members.

27.3 If a poll is demanded as aforesaid it shall be taken in such a manner and at such place and time as the chairperson of the meeting directs, and either immediately or after an interval or adjournment. The demand for a poll may be withdrawn.

Two scrutineers shall be elected to count the votes and to declare the result of the poll and their declaration, which shall be announced by the chairperson of the meeting, shall be deemed to be the resolution of the meeting at which the poll was demanded. In the case of any dispute as to the admission or rejection of a vote, the chairperson of the meeting shall determine the same, and the determination of the chairperson made in good faith shall be final and conclusive.

27.4 The demand for a poll shall not prevent the continuance of a meeting for the transaction of any business other than the question on which a poll has been demanded.

27.5 **Adjournment of meetings**

Subject to the provisions of Rule 27.3 the chairperson of a general meeting at which a quorum is present may, with the consent of the meeting (and shall if so directed by the meeting), adjourn the meeting to a date not earlier than seven nor later than 21 days after the date set down for the meeting, and the Board shall within three days give notice of the adjournment stating.

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a) the date, time and place to which the meeting has been adjourned;

b) the matter before the meeting when it was adjourned; and

c) the grounds for the adjournment.

No business shall be transacted at any adjourned meeting other than the business left unfinished at the meeting at which the adjournment took place.

27.6 **Chairperson at meetings**

The chairperson of the Board or in the chairperson's absence the vice-chairperson appointed in terms of Rule 18.11 shall preside at any general meeting of the Scheme. In the absence of both the chairperson and vice-chairperson the members present shall elect one of their number to preside at that meeting.

28. COMPLAINTS AND DISPUTES

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

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

28.3 A disputes committee of three persons, who may not be members of the Board, employees or officers of the Scheme or the administrator, must be appointed by the Board to serve a term of

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office of 3 years. At least one of such persons shall be a person with legal expertise.

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

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

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

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

28.8 An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than three months after the date on which the decision concerned was made. .

28.9 A member may appeal to the Council against a decision of a review panel established in terms of Chapter 5 of the regulations to the Act.

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29. TERMINATION OF EMPLOYER PARTICIPATION AND DISSOLUTION

29.1 Termination of employer participation

29.1.1 The employer may, on giving three months written notice to the Board, terminate its participation in the Scheme;
Provided that in its absolute discretion the Board may accept a shorter period of notice.

29.1.2 Should an employer cease to be a subsidiary or to be an associated company as contemplated in Rule 6.1 such employer shall on the date of such cessation terminate its participation in the Scheme.

29.2 Dissolution of Scheme

29.2.1 The Company may, on giving three months' written notice to the Board, reduce, suspend or terminate its contributions to the Scheme. The Board shall thereupon arrange for members to decide by ballot whether the Scheme shall continue business without the Company's contributions or with its reduced contributions, or whether the Scheme shall be liquidated. Unless a majority of members decide that the Scheme shall continue, the Scheme shall be liquidated in accordance with the provisions of Rule 29.2.3.

29.2.2 Should the Board propose or should members in general meeting propose and the motion is passed by not less than a two-thirds majority, that the Scheme should be dissolved the Board shall arrange for members to decide by ballot whether the Scheme shall be liquidated. Unless the majority of members decide that the

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Scheme shall continue, the Scheme shall be liquidated in accordance with the provisions of Rule 29.2.3.

29.2.3 Pursuant to a decision by members taken in terms of Rule 29.2.2 the Principal Officer shall dispatch to every member by registered post or deliver by hand a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of a winding up, together with a ballot paper; provided that the memorandum and ballot paper shall, before dispatch, be forwarded to the Registrar for comment.

Every member shall be requested to return the ballot paper duly completed before a set date. If at least 50 percent of the members return their ballot papers duly completed and if the majority thereof are in favour of the dissolution of the Scheme, the Board shall take a formal decision that the Scheme shall be dissolved with effect from a set date from which date no further contributions shall be payable to the Scheme. If a decision to dissolve the Scheme has been taken, the dissolution shall be effected in accordance with the memorandum and as provided in section 64 of the Act and in terms of Rule 29.2.4. For that purpose the Board shall, with the approval of the Registrar, appoint a competent person as liquidator.

29.2.4 The person appointed as liquidator shall liquidate and distribute the assets of the Scheme in the following order:

29.2.4.1 for the payment of debts other than claims of members under these Rules;

29.2.4.2 for the payment of the expenses of dissolution of the Scheme;

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29.2.4.3 for the payment of claims of members under these Rules in respect of expenses incurred prior to the resolution to discontinue the Scheme.

Members will decide by ballot the basis upon which any remaining reserves are distributed. Save as aforementioned no member shall have the right to claim any benefit from the Scheme in respect of expenses incurred after the date of dissolution of the Scheme.

30. AMALGAMATION WITH OR TRANSFER TO ANOTHER MEDICAL SCHEME

Of the Scheme with or to another medical scheme

30.1 Notwithstanding the provision of Rule 29.2 the Scheme may, subject to the provisions of section 63 of the Act, amalgamate with, or transfer its assets and liabilities to, or take transfer of assets and liabilities from any other medical scheme or person. Before such event the Board must arrange for members to decide by ballot whether the proposed amalgamation should be proceeded with or not.

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

Of the Company's business to or amalgamation with any other business, company or organisation

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30.3 If the Company transfers its business to or amalgamates with any other business, company or organisation, the company may elect to:

30.3.1 withdraw wholly from the Scheme in which event the future of the Scheme shall be determined in accordance with Rule 29.2.3; or

30.3.2 continue to contribute to the Scheme in respect of the existing employees in which event the Scheme shall not be affected except that "Company" shall then mean the new business, company or organisation.

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any beneficiary must on request and on payment of a fee of R4 per A4 page, be supplied by the Scheme with the copy of the following documents:

31.1.1 the rules of the Scheme;

31.1.2 the latest audited annual financial statements, returns, Trustees Reports and

31.1.3 the latest auditor's report; and

31.1.4 the accompanying management accounts in respect of the Scheme and all its benefit options.

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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 therefrom.

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

32. AMENDMENT OF RULES

32.1 Board's right to amend Rules

The Board shall be entitled to alter or rescind any Rule or annexure or to make any additional rule or annexure;

Provided that no alteration, rescission or addition which affects the objects of the Scheme, shall be valid unless it has been approved by a majority of members present in general meeting or by ballot and no alteration, rescission or addition which increases the overall rates of contribution or decreases the overall extent of benefits of the Scheme by more than 25 percent during any financial year shall be valid unless a majority of members approve such alteration, addition or rescission in general meeting or by ballot.

32.2 Amendment not valid until registered

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

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32.3 **Members to be furnished with copy of amendments**

Members shall be furnished with a copy of the amendments within 14 days after registration thereof. Should a member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.

32.4 **Registrar's right to require amendments**

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

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ENGEN MEDICAL BENEFIT FUND

ANNEXURE A

PART 1 – CONTRIBUTIONS

1.1 Liability for contributions

The total monthly contribution, based on the member's income as defined and the number of the registered dependants, is payable by or in respect of the member and the registered dependants in accordance with the table below.

1.2 Contributions of the period 1 July 2017 to 30 June 2018

Including contributions in respect of a member's Medical Savings Account.

Income Category R	Principal Member	Adult Dependant	Child Dependant
0 – 4 800	1 925	1 700	586
4 801 to 5 850	2 491	1 814	768
5 8501 to 8 400	2 997	2 355	834
8 401 to 10 500	3 075	2 412	848
10 501 to 12 500	3 188	2 570	864
12 501 to 14 700	3 304	2 730	910
14 701 to 15 350	3 307	2 778	924
15 351 to 16 850	3 493	2 888	968
16 851 to 21 700	3 650	3 017	1 008
21 701+	3 716	3 072	1 030

Contributions for children are limited to a maximum of four children, without limiting the number of child dependants that may be registered.

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1.3 Contributions of the period 1 July 2018 to 31 December 2019

Including contributions in respect of a member's individual account.

Income Category R	Principal Member	Adult Dependant	Child Dependant
0 – 4 800	2 070	1 827	630
4 801 to 5 850	2 678	1 951	826
5 8501 to 8 400	3 222	2 532	896
8 401 to 10 500	3 306	2 593	912
10 501 to 12 500	3 427	2 763	928
12 501 to 14 700	3 552	2 935	978
14 701 to 15 350	3 623	2 986	993
15 351 to 16 850	3 755	3 105	1 041
16 851 to 21 700	3 924	3 243	1 084
21 701+	3 995	3 303	1 107

Contributions for children are limited to a maximum of four children, without limiting the number of child dependants that may be registered.

1.3 Time for payment of contributions

Contributions are due monthly in arrears and shall be payable to the Fund by mot later than the 3rd day of the month following that to which the contribution applies.

PART 2 - CONTRIBUTION PENALTIES FOR PERSONS JOINING LATE IN LIFE

2.1 Contribution penalties may be applied to a late joiner. Such penalties shall be applied only to that portion of the contribution relative to the late joiner and shall not exceed the following bands:

Penalty Bands **Maximum Penalty**

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1 - 4 years	@ 0.05 multiplied by the relevant contribution in 1 above
5 - 14 years	@ 0.25 multiplied by the relevant contribution in 1 above
15 - 24 years	@ 0.5 multiplied by the relevant contribution in 1 above
25+ years	@ 0.75 multiplied by the relevant contribution in 1 above

2.2 Should a late joiner penalty already have been imposed and evidence of creditable coverage is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the time that such evidence was provided.

2.3 If an applicant is unable to obtain documentary proof to substantiate periods of creditable coverage, he/she shall be entitled to produce a sworn affidavit declaring such detailed information and that reasonable efforts to obtain documentary evidence of such periods of creditable coverage were unsuccessful.

"Creditable coverage" – for the purpose hereof, means any period during which a late joiner was –

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

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

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

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

"late joiner" – for the purpose hereof, 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 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 consecutive months since 1 April 2001.

PART 3 – INDIVIDUAL ACCOUNT (WITH EFFECT FROM 01 JANUARY 2014)

3.1 On admission to the Scheme, an individual savings account (hereinafter called the individual account) held by the Scheme shall be established in the name of a member. Contribution(s) to the individual account is (are) payable by or in respect of a member and his registered dependants monthly in arrears at the same time as the contribution contemplated in paragraph 1.3 above.

3.2 The money available in the member's individual account may be used to defray expenditure incurred by him or his dependants in connection with health care services received, as stated in Annexure B.

3.3 The money available in a member's individual account may also be used to reimburse such member for costs incurred by him in respect of hospitalisation and related benefits where pre-authorisation has been declined, but members nonetheless wish to receive the relevant health

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service. In which case, reimbursement to the member will be on the basis of the submission of receipted accounts as detailed in the claims procedures in terms of rule 15.

3.4 At the commencement of the financial year, the Scheme shall make an advance payment equal to 10% of the total contribution shown in paragraph 1.2 above, into a member's individual account (hereinafter called the advance credit). A member shall therefore have access to the equivalent of his full annual individual account contribution on 1 January each year.

3.4.1 Members joining during the year shall, on joining, have access to the equivalent of a pro-rated portion of the total advance credit. Pro-rating shall be based on full months available until the end of the financial year of joining inclusive of the change of number of dependants.

3.4.2 Members resigning during the year shall, on termination of membership be entitled to the equivalent of a pro-rata portion of the advance credit. Such pro-rating shall be based on full months of membership in that financial year. Any amount that such member has utilised from the advance credit to which he is not entitled in terms of this sub-rule, shall be a debt due to the Scheme and recoverable by it.

3.4.3 Changes in the number of dependants shall likewise result in the benefits that are subject to the individual account being appropriately pro-rated.

3.4.4 An advance credit contemplated in this rule shall be available to a member, interest free.

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3.5 For all benefits that are funded out of a member's individual account, such member and his dependants may use any provider duly registered of their choice.

3.6 All disbursements from an individual account shall be limited to the amount available in the account and shall be made only on the submission of the relevant claims in terms of rule 15.

Any balance in a member's individual account at the end of a financial year remains the property of the member and accumulates in his name. Such balance shall be rolled over to the following financial year.

3.8 Upon the death of the member, the balance due to the member will be transferred to the dependants who continue membership of the Scheme or paid into the estate in the absence of such dependants.

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

3.10 Should a member be admitted to membership of another medical scheme, which provides for a similar account, the balance due to the member must be transferred to such scheme within 5 months after termination of membership.

3.11 Any negative balance in a member's individual account shall be recoverable from the member by the Scheme upon the termination of membership, or in the event of his/her death, from the estate.

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3.12 The funds in the member's individual (savings) account may not be used to pay for the costs of a prescribed minimum benefit or to offset contributions.

3.13 interest accrued on any positive balance shall be paid to the member at the rate earned by the Scheme, after deduction of bank charges and investment management fees directly related to the management of the Savings account.

3.14 On termination of membership, funds in the member's individual (savings) account may be used to offset any debt owed by the member, including outstanding contributions.

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ANNEXURE B

Fund Schedule of Benefits 2019

PREAMBLE

1. Subject to limitations and exclusions set out in Annexure C, the Statutory Prescribed Minimum Benefits and the provisions of the Rules of the Fund, members and their dependants are entitled to the benefits set out in this Annexure in respect of treatment received from the first day of membership. Prolonged treatment may be subject to review.
2. Members admitted during the course of a financial year shall be entitled to the benefits set out herein with the maximum benefits being adjusted in proportion to the period of membership during that financial year, calculated from the admission date to the end of that financial year.
3. No member shall be entitled to assign, transfer, pledge, hypothecate or cede his benefits, or rights to benefits, in or from the Fund.
4. All claims must be submitted in accordance with Rule 15.
5. Benefits are not transferable from one benefit period to another or from one category to another.
6. The Fund shall enter into, or cause to be entered into, such arrangements or contracts with private hospitals or hospital groups, including, but not limited to, Alternative Reimbursement agreements, as may be considered appropriate. Benefit entitlements shall be at the agreed rate according to the arrangement, agreement or contract if services are provided by these providers.

	SERVICE	BENEFIT (Subject to annual limits)	ANNUAL LIMITS	CONDITIONS / REMARKS
1	STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER ANNEXURE D			
		1. Services to be provided by Designated Service Providers (DSP) 2. For purposes of the Prescribed Minimum Benefits, DSPs are: 2.1 ER24 for Ambulance Services 2.2 The Discovery Health GP Network, the Premier Plus GP network for the management of Diabetes, Cardiovascular Diseases, Major Depression and HIV/AIDS; 2.3 The Discovery Health Premier A and Premier B Specialist Networks		
1.1	Benefits contemplated in Section 29(1)(o) of the Act as per Annexure D	100% of the cost, subject to the use of relevant DSPs	No limit	1. Subject pre-authorisation clinical criteria and hospital case management. 2. If non-DSP services are used voluntarily, claims paid up to the Fund Rate only
1.2	General and Specialist Practitioner services (consultations in hospital)	Up to 100% of the agreed rate at DSP or up to 100% of the Fund Rate with non-DSP	Unlimited	1. Excludes radiology and pathology (refer to 1.4 below) 2. Subject to preauthorization, clinical criteria and hospital case management

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1.3	General and Specialist Practitioner services (consultations out of hospital)	Up to 100% of the agreed rate at DSP or up to 100% of the Fund Rate with non-DSP	Subject to baskets of care for each of the CDL conditions	1. Subject to authorisation of benefits as contemplated in 1.5 below and DTPMB 2. Applicable basket of care benefits is automatically available once benefits are authorised under 1.5 below 3. Benefits subject to clinical criteria
1.4	Radiology and Pathology	100% of the agreed rate from DSP or up to 100% of the Fund Rate for non-DSP	Subject to baskets of care for each of the CDL conditions	1. Subject to authorisation of benefits as contemplated in 1.5 below and DTPMB 2. Applicable basket of care benefits is automatically available once benefits are authorised under 1.5 below 3. Benefits subject to clinical criteria
1.5	Chronic Medication	100% of MMAP	Limited to PMB CDL conditions	1. Subject to chronic application and authorisation according to the Fund's PMB formulary 2. If a co-payment is applied to the medicine dispensed by a pharmacy, the member will be personally liable for settling the amount directly with the pharmacy
2	**HOSPITALISATION AND RELATED BENEFITS**			
	Preamble 1. Preauthorisation must be obtained at least 48 hours before admission to hospital for non-emergency hospitalization, surgical procedures, and before CT or MRI scans are performed. In the case of an emergency, or after hours' admission, the Fund shall be notified within 24 hours or on the first working day following the admission of such an emergency or treatment having been initiated, failing which the provision of paragraph 2.3 of this preamble will apply. Notwithstanding anything to the contrary, the Fund shall not refuse such authorisation or preauthorisation for a Prescribed Benefit 2. In respect of benefits set out in this Annexure, the following principles will apply in all cases where preauthorisation is required: 2.1 If preauthorisation is obtained, but the authorisation is exceeded, benefits will accrue for the authorized treatment only; 2.2 The cost in excess of the authorisation, will be payable by the member. Application may be made retrospectively for review in respect of treatment in excess of that initially authorised. 2.3 If treatment is undergone without preauthorisation having been obtained, application may be made retrospectively for an authorisation. Should such authorisation be granted (except in an emergency) the benefit will be subject to a penalty of R1 000. If authorisation is declined, no benefits will accrue, subject to Prescribed Minimum benefits that will be covered in full, as provided for in Rule 16. 3. Benefits paid under this section of the Rules shall not be charged to the Medical Savings Account benefits			
2.1	Accommodation: *General ward, high care, intensive care or labour ward; use of the recovery room, theatre fees and anaesthetics administered in the theatre*	100% of the Fund Rate	Unlimited	1. Subject to preauthorisation 2. No benefit shall be paid for non-registered unattached theatres
2.2	Medicines, materials and hospital equipment	100% of the Fund Rate	Unlimited	Subject to preauthorisation

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	Includes costs of ward and theatre drugs, dressings, materials consumed and equipment used in hospital			
2.3	To Take Out (TTO) medicines (on discharge)	100% of the cost	7 days' supply per beneficiary per admission	Subject to preauthorisation of the admission
2.4	In hospital operations, surgical procedures and consultations *Includes in hospital GP, Specialists and ante-natal consultations, the cost of anaesthesia and of assistants at surgical procedures, operations or confinements*	100% of the Fund Rate	Unlimited	1. Subject to preauthorisation 2. A co-payment of R1 200 applies to all elective endoscopies: Colonoscopy / Sigmoidoscopy / Proctoscopy / Gastroscopy/ Cystoscopy / Arthroscopy / Laparoscopy or Hysteroscopy)
2.5	Step-down, recuperation and rehabilitation facilities *For services in lieu of hospitalisation*	100% of the Fund Rate	Unlimited	1. Subject to preauthorisation, 2. The facility must be registered with the Department of Health 3. Private nursing / frail care / hospice paid from the Primary Care (day to day) Benefit
2.6	Post-operative or rehabilitation care *Post-operative physio-, occupational- or speech therapy;* *Surgical appliances*	100% of the Fund Rate 100% of the cost	Limited to a 6 week period	Benefit availability limited to a period of 6-weeks from date of discharge for the same condition for which the patient was hospitalised initially
2.7	Maxillo-facial or oral surgery	100% of the Fund Rate	Unlimited	Subject to preauthorisation and PMB
2.8	Internal prostheses	100% of the Fund Rate	Multiple external or internal prostheses subject to a joint limit of R86 000 per beneficiary per year	1. Subject to prior approval 2. Defined as appliances when placed in the body as an internal adjuvant during an operation, or as the replacement of artificial eyes and limbs 3. Dental implants of any nature are not included in the definition of internal prostheses 4. Several sub-limits apply: <u>Hip replacements:</u> Bilateral hip replacement R70 000 Total hip replacement R40 000 Partial hip replacement R22 500 Revision hip replacement R76 000 <u>Knee Replacements</u>: Without patella R44 500 With patella R50 000 Bilateral knee replacement R89 000 Revision knee replacement R77 000

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				Shoulder replacements: Total shoulder replacement R53 000 Bilateral shoulder replacement R67 000 Spinal fusion: Level 1 (without cage) R24 000 Level 1 (with cage) R46 000 Level 2 (without cage) R32 000 Level 2 (with1 cage) R51 000 Level 2 (with 2 cages) R75 000 Artificial limbs: Below the knee R23 000 Above the knee R38 500 Artificial eyes R23 000 Finger joint prostheses R 5 700 Pacemakers: With leads R48 000 Bi-ventricular R79 000 Intra cardiac device R265 000 Cardiac valves (each) R36 500 Cardiac stents (max 3 pa) (each) With delivery system R26 000 Drug eluting R32 500 Aortic aneurism repair grafts R152 500
2.9	Oncology *Including chemotherapy, medicines and materials used, radiation in- and out of hospital and PET Scans*	PMB claims paid at cost Non-PMB claims paid up to 100% of the Fund Rate	Unlimited A threshold pf R210 000 applies per beneficiary per year	1. Subject to preauthorisation and the treatment meeting the Fund's clinical criteria 2. All claims accumulate to the threshold 3. Once the threshold is reached, non-PMB claims paid at 80% of the Fund Rate
2.10	Chronic appliances *Includes oxygen products, cylinders and ventilation expenses, and stoma products*	100% of cost	Limited to R25 500 per family per year	1. Subject to authorisation. 2. Subject to the use of the Fund's DSP for oxygen products. 3. If the services of the DSP are not used, claims paid up to the Fund Rate only
2.11	Organ transplants	PMB claims paid at cost	Limited to R430 000 per	1. Subject to preauthorisation

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	Includes hospitalisation, organ and patient preparation, medication in- and out-of-hospital, harvesting and transportation of the organ	Non-PMB claims paid up to 100% of the Fund Rate	family per year for non-PMB treatment	2. No benefits for travelling and accommodation
2.12	Renal dialysis *Includes procedure, treatment, associated medicines and drugs*	100% of the Fund Rate	Unlimited	1. Subject to ongoing case management, preauthorisation
2.13	Mental health *Subject to PMB only*	100% of the cost for PMB	Limited to 21 days in hospital and 15 psychotherapy sessions	1. Subject to preauthorisation, 2. Members may have access to the Major Depression Management Programme, if registered by a Premier Plus GP
2.14	Drug or Alcohol rehabilitation Subject to PMB only Detox treatment	100% of the cost for PMB	Limited to 21 days Limited to 3 days	1. Subject to preauthorisation 2. In hospital treatment only
2.15	Ambulance services *Includes emergency ambulance transport services to the nearest hospital, or inter-hospital transfers*	100% of the agreed rate	Unlimited	1. All non-emergency ambulance transport subject to authorisation by the DSP 2. If ambulance transport is not authorised, claims paid up to the Fund rate only, subject to PMB
2.16	MRI or CT Scans	100% of the Fund Rate	Limited to 2 scans per beneficiary per year	1. Subject to authorisation 2. Subsequent scans subject to clinical motivation and approval
2.17	Surgical procedures performed in doctors' rooms *In lieu of hospitalisation*	100% of the Fund Rate	Unlimited	1. Subject to authorisation 2. Minor procedures performed by GPs paid subject to 5.2
2.18	Radiology or Pathology *Includes radiology, x-rays, pathology and endoscopic procedures done in a doctor's rooms*	100% of the Fund Rate	Unlimited	No authorisation required
2.19	Clinical and medical technologists *Includes services rendered, materials and apparatus supplied*	100% of the Fund Rate	Unlimited	No authorisation required
2.20	Blood transfusions	100% of the Fund Rate	Unlimited	No authorisation required
2.21	Medical and surgical appliances	100% of the cost	Limited to R25 500 per family per year	1. Excludes prostheses provided for in 2.8 above

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	Including first hearing aid and wheelchairs Second hearing aid		Limited to R12 500 per family per year	2. Includes conditions not covered under the post-operative / rehabilitation appliance benefit or the chronic appliances benefit 3. Includes 100% of the net cost after discount for the supply and fitment of hearing aids, and hearing aid repairs Subject to clinical criteria, motivation and approval
2.21	HIV /AIDS and related illnesses Medicines	100% of the agreed rate at DSP 100% of MMAP	Unlimited	1. Subject to preauthorisation and the services being rendered by DSP providers 2. Subject to enrollment on the HIV or AIDS Management Programme
3	**CHRONIC AND SPECIALISED MEDICINE**			
3.1	Non-PMB chronic medicine *Includes approved medicine or injection material* for any condition requiring ongoing treatment for three months or longer	100% of the Fund Medicine Rate	Limited to R13 250 for a Single Member; R26 000 for a family	1. Excludes cover for PMB conditions and the medicine or injection material supplied, or administered in a hospital or nursing home 2. If a co-payment is applied, the member must settle the amount due directly with the dispensing pharmacy
3.2	Specialised medicine benefit	100% of the Fund Rate	Limited to R152 500 per family per year	1. This benefit relates to a defined list of specialised medicine 2. Subject to clinical motivation and authorisation
4	**MATERNITY**			
4.1	Ante-natal ultrasound examinations	100% of the Fund Rate	Limited to 2 examinations per pregnancy	All ultrasound scans, including 3D and 4D scans, paid at the rate for 2D scans only
4.2	Post-natal care by a midwife	100% of the Fund Rate		1. Subject to authorisation 2. Requires referral by the patient's GP
4.3	Ante-natal classes (in- and out of hospital) *Includes exercise classes and/or visits*	100% of the Fund Rate	Limited to R950 per confinement	Subject to authorisation
5	**PREVENTATIVE SCREENING**			
5.1	Faecal occult blood test	100% of the Fund Rate	Limited to R1 100 per beneficiary per year	1. Used as a screening method for male prostate cancer 2. Screening tests available to male members who are 50 years or older
5.2	Cervical cytology	100% of the Fund Rate	Limited to R1 100 per	1. Used as a screening method to detect potentially pre-cancerous

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			beneficiary per year	and cancerous processes in the cervix 2. Screening tests available to female members between the ages of 21 and 65 years
5.3	HPV Screening	100% of the Fund Rate	Limited to R560 per beneficiary per year	1. Used as a screening test for female members who receive abnormal results after a cervical cystology screening test (abnormal PAP test)
5.4	Mammography	100% of the Fund Rate	Limited to R2 225 per beneficiary per year	1. Breast imaging that uses low doses x-rays to detect cancer early 2. Available to female members who are 40 years or older
5.5	Health Risk Assessment	100% of the Fund Rate		1. Includes blood pressure, blood glucose and total serum cholesterol tests
6	***PRIMARY CARE (DAY-TO-DAY) BENEFITS*** ***Subject to payment from Medical Savings Account***			
	Preamble Primary care (day-to-day) benefits are first paid at 100% of the Fund Rate from the Medical Savings Account (MSA) (which comprises 10% of the total annual medical contribution) until the advance credit has been fully utilised in any one financial year. Once the MSA is exhausted, the Primary Care benefits are paid as described in 5.1 to 5.22 below			
6.1	Acute, homeopathic or naturopathic medicine *Includes medicine, material for injections and vaccinations prescribed by a person legally entitled to prescribe;* *Includes medicine dispensed to outpatients* Pneumococcal Vaccinations Implanon (contraceptive device)	100% of the Fund Rate	Limited to: M R5 200 M+1 R7 800 M+2 R9 000 M+3 R10 250 M+4+ R11 500 per year Limited to one vaccination per beneficiary	1. Do not include medicines and materials for injections supplied or administered in hospital or a nursing home 2. If a co-payment is applied to the medicine dispensed by the pharmacy, the member must settle the amount due directly with the dispensing pharmacy Pneumococcal vaccinations paid from Insured benefits for beneficiaries older than 65 Paid from available Medical Savings only
6.2	General Practitioner, Medical Specialists, Homeopaths, Naturopaths and registered Private Nurse practitioner consultations and non-surgical procedures *Includes the cost of vaccinations and injection material, e.g. of mumps,*	100% of agreed DSP rate or up to the Fund Rate	Limited: M R2 700 M+1 R4 450 M+2 R5 200 M+3 R5 700 M+4+ R6 600 per year	1. PMB or DTPMB-related treatment and in hospital visits and care not included in this benefit 2. If services of non-DSPs are used, paid up to the Fund Rate only 3. Includes services and fees charged for outpatient consultation services

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	measles and rubella (MMR) vaccinations by registered nurses			
6.3	Self-medication (Over the Counter (OTC)) medicine	100% of cost	Limited to R250 per script per beneficiary per day	1. Limited to medicine which a pharmacist is entitled to prescribe 2. Paid from the Medical Savings Account
	PARAMEDICAL AND ASSOCIATED SERVICES			
6.4	Acupuncture	80% of the Fund Rate	Limited to R1 725 per family per year	
6.5	Chiropractic treatment	80% of the Fund Rate	Limited to R3 150 per family per year	1. Includes the cost of the treatment and x-rays 2. The benefit shall not exceed the Fund Rate for a consultation with a General Practitioner
6.6	Dietetics	80% of the Fund Rate	Limited to R1 050 per family per year	
6.7	Non-surgical prostheses	80% of the cost	Limited to R3 150 per family per year	Includes prostheses for which a benefit is not provided elsewhere in these Rules
6.8	Audiology or speech therapy	80% of the Fund Rate	Limited to R3 150 per family per year	
6.9	Occupational therapy	80% of the Fund Rate	Limited to R3 150 per family per year	
6.10	Physiotherapy or Biokinetics	80% of the Fund Rate	Limited to R3 150 per family per year	
6.11	Private nursing and registered private nurse practitioners *Includes private nursing, frail care or hospice treatment prescribed by a medical practitioner*	80% of the Fund Rate	Limited to R26 000 per family per year	1. Subject to preauthorisation 2. Excludes general care 3. Private nurses must be registered with the South African Nursing Council
6.12	Podiatry or Chiropody	80% of the Fund Rate	Limited to R2 100 per family per year	Treatment must be prescribed by a medical practitioner
6.13	Clinical psychology	80% of the Fund Rate	Limited to R8 600 per family per year	

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	DENTISTRY			
6.14	Basic Dentistry	100% of the Fund Rate	Limited to: M R3 750 M+1 R4 00 M+2 R5 900 M+3 R7 200 M+4+ R8 400 per year	Paid from Medical Savings Account and Insured Benefits
6.15	Specialised Dentistry *Includes inlays, crowns, bridges, study models, metal base dentures and the repair thereof, oral medicine, periodontics, orthodontics and prosthodontics and osseo-integrated implantology*	100% of the Fund Rate	Limited to: M R8 500 M+1 R11 750 M+2 R14 750 M+3 R17 250 M+4+ R19 000 per year	1. Paid from Insured Benefits 2. Orthodontics subject to approval 3. Includes payment from this benefit for basic dentistry that is carried out as part of the Special Dentistry procedures
	OPTICAL			
6.16	Eye and tonometry tests	100% of the Fund Rate	1 eye test and one tonometry test per beneficiary per year	1. Paid from the Medical Savings Account and Insured Benefits limit 2. Accrues to the Insured limits even if paid from MSA 3. Eye tests and tonometry must be performed by a registered Optometrist 4. A sub-limit of R1 500 applies per frame in every two year cycle 5. Sunglasses, spectacle cases, solutions and kits for contact lenses are excluded
6.17	Spectacles or contact lenses		The following limits apply in a 2 year cycle: Single Member: R4 750 Family: R9 500	
7	**GENERAL**			
7.1	Acquired immune deficiency syndrome and asymptomatic positivity	100% of the cost in DSP		1. Subject to once-off preauthorisation 2. Subject to PMB 3. Subject to Insured Benefits
7.2	Smoking cessation	100% of the Fund Rate	Limited to R730 per beneficiary per month	1. Subject to the Medical Savings Account 2. Claims paid from the Medical Savings Account may be reimbursed from the Chronic Medication Benefit, subject to a negative nicotine test result

LEGEND

Advance credit	The amount advanced to the member's credit by the Fund and paid into the member's Medical Savings Account
Agreed rate	The rate of payment for services, as negotiated with a DSP
Cost	A fee charged outside the Fund or Agreed Rate as published by the Fund
DSP	Designated Service Provider. The Discovery Network of general practitioners; the Premier Plus GPs for management of the Diabetes, Cardiovascular, Major

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	Depression and HIV/Aids Management Programme benefits and Specialists who agreed to accept the Premier A or Premier B rates provide members with diagnosis, treatment and care for one or more of the PMB conditions at the agreed rates and ER24 for medical emergency transportation
DTPMBs	A list of 270 Diagnosis and Treatment Pairs covered under the PMBs
Fund Rate	The Rate determined from time to time by Engen Medical Benefit Fund for the reimbursement of claims, based on the Discovery Health Rate in the absence of any other agreed or contracted rate with any service provider, or as agreed to between the Fund and the provider. These rates may be based on Alternative Reimbursement Models and be agreed to between the Fund and the provider
ICD-10	International Statistical Classification of Disease and Related Health Problems – version 10: healthcare professionals must provide an ICD-10 diagnosis with every claim submitted to the Fund
PMB formulary	A preferred list of medicines for the treatment of the 26 listed PMB chronic conditions. In creating this list, safety, effectiveness and possible side effects are considered before considering the cost of the medicine. The list meets the requirements of the applicable Regulations
PMB	Prescribed Minimum Benefits

REGISTRAR OF MEDICAL SCHEMES

ENGEN MEDICAL BENEFIT FUND

ANNEXURE C

LIMITATION OF BENEFITS AND BENEFITS EXCLUDED
(Subject to PMB's which will be paid at 100% of the cost for services rendered)

(WITH EFFECT FROM 1 January 2010)

1. **LIMITATION OF BENEFITS**

Unless benefits are to be afforded to members as prescribed minimum benefits or unless benefits are specifically provided for in a Schedule annexed to these rules, no benefits shall be payable, unless the Board decides otherwise.

1.1 The maximum benefits to which a member and his dependants shall be entitled in any financial year shall be limited and subject to such waiting periods as may be determined in the Rules.

1.2 All new members admitted during the course of a benefit year shall be entitled to the benefits set out in the Annexure B with the maximum benefits being adjusted as stipulated in the preamble to the said Annexure B.

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

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1.4 In cases where a specialist, except an ophthalmologist or gynaecologist, is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at the discretion of the Board, be limited to the amount that would have been paid to the general practitioner for the same service.

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

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

2. **SERVICES RENDERED OUTSIDE THE REPUBLIC OF SOUTH AFRICA (OUTSIDE THE RAND MONETARY AREA)**

If in terms of the Rules, a member incurs a cost for services rendered outside the Republic of South Africa for which, in the discretion of the Board, a benefit would have been payable if such service had been rendered within the Republic of South Africa, such service shall be deemed to have been rendered in the Republic of South Africa.

3. **BENEFITS EXCLUDED – With due regard to Prescribed Minimum Benefits (PMB)**

Unless otherwise decided by the Board, expenses incurred in connection with any of the following will not be paid by the Scheme:

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3.1 Reckless Activities: Participation in any extreme activity where, based on an objective test for reasonable behavior, the Beneficiary is deemed to be risking injury recklessly, including, but not limited to, such activities as solo-mountaineering, speed contests other than on recognised race tracks, extreme endurance marathons and the like. Activities such as parachuting, mountaineering, motor racing, bungee jumping, ultra marathons and scuba diving would not be excluded provided they are undertaken within the accepted safety and licensing constraints of the governing bodies of such support. Except for PMBs.

3. 2 All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules, unless otherwise agreed by the Board in terms of Rule 17.6.

3.3 Costs of whatsoever nature incurred for treatment arising out of an injury sustained by a Beneficiary for which any other party is liable. The Fund shall advance to, or on behalf of, the Beneficiary such amounts as would not exceed the benefits to which that Beneficiary is entitled, provided that:

a) The Beneficiary informs the Fund of the potential claim against the other party, and of the relevant health care expenses incurred, in the manner and within the time period applicable to normal claims for benefits under the Fund; provided further that the member provides an irrevocable written undertaking within three days of receiving a request to this effect from the Fund. This undertaking shall be signed by the member and in the event of the member being incapacitated, by anyone of the member's next of kin, and the member warrants that such next of kin is duly authorized to sign the undertaking on the member's behalf and to bind the member to the terms thereof.

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b) A claim in respect of the said expenses is lodged by the Beneficiary against the other party concerned and such claim is pursued with due diligence, with the Fund being kept fully informed. The member shall be obliged to repay to the Fund that portion of the damages actually recovered by him or his dependant from the other party as relates to the costs and service in respect of which he or his dependant has received or benefited from advances contemplated above (the past medical expenses). In the event that it is not specifically indicated how much of the damages or compensation recovered by the member or the dependant is in respect of the past medical expenses, the amount payable by the member to the Fund shall be such percentage of the damages or compensation received, as would be equal to the percentage that the past medical expenses constituted of the total reasonable damages or compensation that was initially claimed from the other party, expressed in Rand;

c) Should the Beneficiary not pursue the claim against such other party to the satisfaction of the Fund, it may require the Beneficiary to cede or procure the cession of such claim to the Fund, in which event the Beneficiary shall provide the Fund with all such assistance and co-operation as it may reasonably require in pursuing such claim. Only the cession of damages in relation to medical costs is permissible. The Beneficiary shall be obliged to pay to the Fund so much of the damages actually recovered by him, or on his behalf, as relates to the service in respect of which he has received or benefited from the advances contemplated above.

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3.4 All costs incurred for treatment of any sickness condition sustained by a member or dependant of a member where such sickness condition is directly attributable to failure to carry out the instructions of a medical practitioner.

3.5 Purchase of medicines not included in a prescription from a person legally entitled to prescribe.

3.6 All costs for services rendered by:

3.6.1 Persons not registered as providers of relevant health services with a recognised professional body constituted in terms of an Act of Parliament.

3.6.2 Any place, nursing or similar institution, except a state or provincial hospital, not registered in terms of the applicable legislation as a private hospital, unattached theatre or day clinic and any institution not licensed in terms of the Mental Health Act, 1973.

3.7 Purchase of: -

- medicines not registered with the Medicines Control Council;
- patent medicines and proprietary preparations;
- sun-screening agents and tanning agents;
- non–scheduled soaps, shampoos and other topical applications
- applicators, toiletries and beauty preparations;
- bandages, cotton wool and similar aids;
- patented foods, including baby foods;
- Tonics, slimming preparations and drugs as advertised to the public;
- Household and biochemical remedies.
- Alternative medicines
- Multivitamins

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3.8 Holidays for recuperative purposes.

3.9 Charges for appointments, which a beneficiary fails to keep.

3.10 All costs for use of gold in dentures or the cost of gold as an alternative to non-precious metal in crowns, inlays and bridges.

3.11 All costs in respect of the harvesting of an organ where the recipient / dependant is not a member of the Fund.

3.12 Executive type medical examinations.

3.13 Treatment at State facilities at no charge.

3.14 Accommodation in old age homes or similar institutions catering for the aged;

3.15 Accommodation and/or treatment in headache and stress relief clinics, spas and resorts for health, slimming, recuperative or other similar purposes .For the purposes of this rule, "accommodation "shall include all related expenses and meals, and "treatment "shall include any of the following: examinations, consultations, investigations, diagnosis, test procedures, operations and generally shall include any service or supply by any such enterprise or practice intended to confer a health benefit.

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3.16 Telephone consultations with medical practitioners.

3.17 Examinations for insurance, school camp, visa, employment or similar purposes.

3.18 Replacement batteries for hearing aids.

3.19 Sunglasses, Plano sunglasses and spectacle cases.

3.20 The fee associated with solutions, kits, fittings and adjustments to contact lenses.

3.21 Bleaching of teeth that have not been root canal treated and metal inlays in dentures and front teeth.

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EXCLUSIONS

PAYABLE SUBJECT TO RELEVANT CONDITIONS

A. Examinations, consultations and treatment of obesity; with the exception of:
The authorisation of bariatric surgery from the Insured Benefit at 100% of the EMBFT, subject to sound clinical protocols and pre-authorisation.

B. Examinations, consultations and treatment for cosmetic purposes, at 100% of the EMBFT, subject to motivation, sound clinical protocols and pre-authorisation.

C. Operations, treatment and procedures following willfully self-inflicted injuries subject to the:
- Psychiatric Hospitalisation Benefit Limit
- 100% of the EMBFT
- Maximum of 3 days in lieu of hospitalisation

D. Consultations, investigations, examinations and the treatment of infertility and the artificial insemination of a person as defined in the Human Tissue Act, 1983 (Act 6 5of 1983) unless such costs are incurred in the public health care system, subject to:
- The Insured Benefit at 100% of the EMBFT
- Limited to hospital treatment or investigations as per the PMB list
- Equivalent to benefits as per the State facility.

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E. Consultations and treatment of erectile dysfunction, from Insured benefit at 100% of EMBFT subject to Clinical motivation and pre-authorisation.

ENGEN MEDICAL BENEFIT FUND

ANNEXURE D

PRESCRIBED MINIMUM BENEFITS (PMBs)

(WITH EFFECT FROM 1 January 2014)

DEFINITIONS

"Prescribed minimum benefits"

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

a) the conditions listed in Annexure A of the regulations specified therein; and

b) any emergency medical doctor.

"Prescribed minimum benefit condition"

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

1. **Designation of service providers**

   The Scheme selects ER24 as its Designated Service Provider for Ambulance Services.

   The Scheme selects the Metropolitan Health Pharmacy Network as its Designated Service Provider for medicine benefits.

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The Scheme selects all contracted private hospitals and the Onecare GP and Specialist Network as its Designated Service Provider for all other services.

2. Prescribed minimum benefits obtained from Designated Service Providers

The Scheme shall pay 100% of the Agreed Tariff of diagnosis, treatment and care of the PMB conditions provided that such services are obtained from a Designated Service Provider.

3. Prescribed minimum benefits voluntarily obtained from other providers

Members are entitled to PMB benefits for diseases on the Chronic Diseases List (CDL) and all other PMB conditions from a Designated Service Provider at the Agreed Tariff subject to an authorised Metropolitan Risk Management Care Plan. By providing these Care Plans to the treating practitioners, beneficiaries can ensure that their treatment stays within the protocols prescribed by the Plans and prevent treatment being undertaken that will not be covered under the Insured Benefits.

a) If a Beneficiary voluntarily obtains diagnosis, treatment and care in respect of a PMB condition from a provider other than the Designated Service Provider, the benefit payable in respect of such services will be subject to the Scheme's clinical protocols and would be reimbursed at the Engen Medical Benefit Fund Tariff, only.

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4. Medication

a. Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of that medication if obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider, and

(i) the medication is included on the applicable formulary in use by the Scheme; or

(ii) the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

b. Where a prescribed minimum benefit includes medication, benefit limitations normally applicable in terms of the benefit option chosen by the member will apply if-

(i) that medication is voluntarily obtained from a non-designated service provider or the formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, will result in a co-payment of 30% .

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5. Prescribed minimum benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these rules, the Scheme shall pay 100% of the costs of prescribed minimum benefits obtained in a public hospital, without limitation.

6. Diagnostic tests for an unconfirmed PMB diagnosis

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

7. Co-payments

Co-payments in respect of the costs for PMBs may not be paid out of medical savings accounts.

8. Chronic conditions

The chronic benefit option covers services rendered in respect of the prescribed minimum benefits which includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions.

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REGISTRAR MEDICAL SCHEMES

Preamble

Prescribed Minimum Benefits

Legislated treatment of these chronic illnesses will include "diagnosis, medical management and medication, to the extent that this is provided for by way of a therapeutic algorithm for the specified condition, published by the Minister by notice in the Gazette."

The 26 legislated CDL PMB conditions are as follows: -

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

The Chronic Medication Programme shall be managed by the Scheme's contracted Managed Health Care Organisation.

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CHRONIC CONDITIONS AND ALL OTHER PMB CONDITIONS

1. Metropolitan Health Risk Management Specialists have been appointed on behalf of the Engen Medical Benefit Fund to manage the provision of benefits under the Prescribed Minimum Benefits (PMBs) in terms of a PMB Programme.

2. Members are entitled to treatment for those diseases on the Chronic Diseases List (CDL) according to an authorised Metropolitan Health Risk Management (MHRM) Care Plan. This treatment may be obtained from a DSP at the Agreed Tariff or from a provider of your choice, which may result in a co-payment. In the event that the benefits on the MHRM care plan are exceeded, further benefits from the State service at costs will be reimbursed by the Scheme.

3. The Scheme requires all members to obtain a pre-authorisation for their chronic conditionsto facilitate the identification and correct payment of PMBs. Beneficiaries who have a valid chronic authorisation with the medicine programme (MRM) will be automatically informed of their authorised Care Plan.

4. Once the above has been established and it is confirmed that the beneficiary requires treatment for one of these PMB conditions, a Care Plan based on the published therapeutic algorithm, will be prepared for each beneficiary.

5. Members are entitled to treatment for those diseases on the Chronic Diseases List (CDL). This treatment may be obtained from a DSP at the Agreed Tariff or from a provider of your choice, which may result in a co-payment.

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6. PMB-approved consultations (general practitioner and specialist practitioner services):

   Consultations including the item code number for the specific PMB condition (Tariff code and ICD10 diagnosis code) will be funded directly from the Insured Benefit (PMB).

   The consultation costs related to the diagnosis and management of PMB chronic conditions will be linked to the protocols of the Care Plan. Claims will be settled at the Agreed Tariff from a DSP or at the Engen Medical Benefit Fund Tariff from a provider of your choice.

7. Chronic Medication for PMB related conditions:

   Medication will be funded directly from the Chronic Insured Benefit (PMB). This will be subject to the Fund's medicine formulary, which is a specific list of drugs available to treat each of the 26 CDL PMB conditions.

   All authorised PMB claims received will be settled from the Insured Benefit at 100% of the cost of the approved medicine formulary.

8. Service Providers are requested to comply with treatment protocols, including the registration of patients, following the MHRM Care Plan, and the prescription and dispensing of medicine on the PMB formulary (preferred drug list). When necessary, the submission of motivations for pre-authorisation will be required to ensure that patients' claims are covered under Prescribed Minimum Benefits.

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REGISTRAR MEDICAL SCHEMES

ENGEN MEDICAL BENEFIT FUND **ANNEXURE D**

Subject to the provisions of these rules members and their registered dependants are entitled to the following benefits:

BENEFIT	RATE	CONDITIONS/REMARKS
GENERAL AND SPECIALIST PRACTITIONER SERVICES (Excludes radiology and pathology)		
Consultations in hospital	100% of the Agreed Rate with the DSP. 100% of the Engen Medical Benefit Fund Tariff with a non-DSP	▪ Subject to standard pre-authorised admission and hospital case management ▪ If PMB conditions are confirmed,automatic enrolment on the MHRM Care Plan provided MRM application is completed and authorised
Consultations out of hospital	100% of the Agreed Rate with the DSP. 100% of the Engen Medical Benefit Fund Tariff with a non-DSP	▪ Limited to the number of consultations provided for on the MHRM Care Plan ▪ Subject to MRM application and authorisation ▪ If authorised, automatic enrolment on the MHRM Care Plan

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RADIOLOGY AND PATHOLOGY	100% of COST Insured benefit unlimited	▪ Limited to the number and type of services provided for on the MHRM Care Plan
CHRONIC MEDICATION	100% of the cost of the Fund's approved PMB medicine formulary Insured benefit unlimited	▪ Subject to MRM chronic application and authorisation according to the Fund's PMB formulary. ▪ If PMB formulary (preferred drug list for PMB conditions only) is voluntarily not used, members will be liable for co-payment of 30%. ▪ If a co-payment is applied to the medication dispensed by the Pharmacy, the member will be personally liable for settling the amount due directly with the Pharmacy.

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REGISTRAR MEDICAL SCHEMES

ENGEN MEDICAL BENEFIT FUND **ANNEXURE D**

LEGEND

PMB	:	Prescribed Minimum Benefits
DSP	:	Designated Service Provider
CDL	:	Chronic Disease List as published by the Department of Health
PMB drug formulary	:	This is a preferred list of drugs for treatment of the 26 listed CDL PMB chronic conditions. In creating the list, safety, effectiveness and possible side effects were considered before looking at the cost of the drugs. The list meets the requirements of the regulations.
Engen Medical Benefit Fund Tariff	:	the tariff published by the scheme (from time to time) for reimbursement of claims in the absence of any other agreed or contracted tariff with any service provider;
Agreed Rate	:	the rate as negotiated with the Designated Service Provider
MRM	:	Medicine Risk Management programme via Metropolitan Health Risk Management

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REGISTRAR MEDICAL SCHEMES