ANGLOVAAL
GROUP MEDICAL SCHEME

RULES OF THE ANGLOVAAL GROUP MEDICAL SCHEME

2023

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ANGLOVAAL GROUP MEDICAL SCHEME RULES

1. NAME

The name of the Scheme is the Anglovaal Group Medical Scheme, hereinafter referred to as the "Scheme".

2. LEGAL PERSONA

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

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 2 Harries Road, Illovo, Sandton. The Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

4. DEFINITIONS

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

4.1 a word in the singular number includes the plural, and vice versa; and a word or expression in the masculine gender includes the feminine, and vice versa;

4.2 the following expressions have the following meanings:

4.2.1 "Act", the Medical Schemes Act (Act 131 of 1998), and the Regulations framed there under.

4.2.2 "Actuary", an actuary who is a fellow of an institute, faculty, society or chapter of actuaries approved by the Minister of Finance.

4.2.3 "Administrator", the duly accredited body appointed by the Scheme, on such terms and conditions as it may determine, for the proper execution of the business of the Scheme;

4.2.4 "Admission date", the date upon which a person becomes a member or, in respect of a dependant, the date upon which such dependant is registered

as a dependant in terms of these Rules or, in the case of an employer, the date on which such employer may participate in the Scheme in terms of these Rules.

4.2.5 "Annual Limit", the maximum benefits which a member and his registered dependants are entitled to as determined by the Board and provided for in the Rules from time to time. Such limits shall be calculated annually to coincide with the financial year of the Scheme and the limits shall be adjusted on a pro-rated basis for members who join the Scheme during a financial year.

4.2.6 "Approval", prior written or telephonic approval.

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

4.2.8 "Beneficiary", a member or a person admitted as a dependant of a member.

4.2.9 "Billing Guidelines/Billing Rules", the guidelines and/or rules applied to evaluate individual code submissions reported in provider claims, as part of the claims adjudication process.

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

4.2.11 "Child", a member's natural child, or a stepchild 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 duty of support or a child who has been placed in the custody of the member or his/her spouse or partner and who is not a beneficiary of any other medical scheme.

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

4.2.13 "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.

4.2.14 "Continuation member", a member who retains his membership of the Scheme in terms of Rule 6.2 or a dependant who becomes a member of the Scheme in terms of Rules 6.3 and 6.4.

4.2.15 "Contribution", in relation to a member, the amount, exclusive of interest, paid by or in respect of the member and his registered dependants if any, as membership fees and shall include contributions to personal medical savings accounts.

4.2.16 "Council", the Council for Medical Schemes as contemplated in the Act.

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

4.2.18 "Creditable coverage", any period during which a late joiner was:

4.2.18.1 A member or a dependant of a medical scheme;

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

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

4.2.18.4 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 (twenty-one) years.

4.2.19 "Dependant", the registered dependants of a member and may include the following:

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

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

4.2.19.3 The immediate family of a member in respect of whom the member is liable for family care and support;

4.2.19.4 Any other person who is recognized by the Board as a dependant for purposes of these Rules.

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

4.2.21 "Discovery Health GP Network", a general practitioner who is contracted with Discovery Health (Pty) Ltd to be part of the Discovery GP Network.

4.2.22 "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.

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

4.2.24 "Employee", a person in the employment of an employer who in terms of his or her conditions of employment is eligible for membership of the Scheme.

4.2.25 "Employer", the participating employers are listed in Annexure D.

4.2.26 "Ex gratia payments", gratuitous payments made by the scheme to members without obligation.

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

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

4.2.29 "General waiting period", a period during which a beneficiary is not entitled to claim any benefits.

personal hygiene, feeding, dressing, reasonable and due attendance to personal safety and the safety of others.

4.2.29 "General waiting period", a period during which a beneficiary is not entitled to claim any benefits.

4.2.30 "Income", any amount received by or accrued to or deemed to have been received by or accrued to a member or member's immediate family by way of, including and without limitation:

4.2.30.1 an average of 12 (twelve) months earnings, commission or other rewards arising from employment, which shall include self-employment and employment in the informal sector as well as an independent contractor;

4.2.30.2 interest, including capitalised interest from active and passive investments;

4.2.30.3 income from leasing of assets and / or property;

4.2.30.4 any distributions received from a trust, discretionary or vested, where the member or member's immediate family is a beneficiary or otherwise.

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

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

4.2.33 "Member, Main Member or Principal Member "a person who is admitted as a member in terms of these Rules and if the context so warrants or indicates, may include –

4.2.33.1 his/her dependant(s) of whatever type;

4.2.33.2 persons who apply for membership or admission as a dependant; and/or

4.2.33.3 persons whose membership or status as a dependant has terminated.

4.2.34 "Member family", the member and all his registered dependants.

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

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

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

4.2.36.2 any emergency medical condition.

4.2.37 "Partner", a person with whom the member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

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

4.2.39 "Pre-existing sickness condition", a sickness condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership of the Scheme was made.

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

4.2.41 "Premier rate provider", a dental specialist or medical specialist who has undertaken to bill beneficiaries at the Premier Rate for procedures and consultations in accordance with the relevant procedure codes and consultation codes in return for direct payment by the Scheme of benefits to which beneficiaries are entitled.

4.2.42 "Premier Rate", the rate that the scheme will pay a Premier rate provider in accordance with the undertaking referred to in clause 4.2.41 pursuant to which such provider's procedures and consultations will be paid by the Scheme in full and beneficiaries will not be required to make any further co-payments to him save in instances of depleted benefits

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

4.2.44 "Related account", any account related to an approved in-hospital admission other than the hospital account.

4.2.45 "Scheme", the Anglovaal Group Medical Scheme.

4.2.46 "Scheme rate", the rate as determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services or the rate in respect of the payment of relevant health services as prescribed in the Discovery Health Guide to Fees.

4.2.47 "Scheme medication rate", the single exit price plus the appropriate professional fee as determined by the Scheme.

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

4.2.49 "Second opinion", an opinion of a health professional appointed by the Scheme. Such opinion will be based on:

4.2.49.1 a clinical examination of the patient/beneficiary, by such healthcare professional, which examination may include such tests or other investigations as are deemed necessary by the healthcare professional, and/or;

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

4.2.50 "Spouse", the spouse of a member to whom the member is married in terms of any law or custom.

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

4.2.52 "Treatment", provision of healthcare services which would include, but is not limited to hospitalisation or non-hospitalisation benefits and subject to 4.2.32.

5. OBJECTS

The objects of the Scheme are to undertake liability, in respect of its members and their dependants, in return for a contribution premium to:

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

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

5.3 render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme.

6. MEMBERSHIP

6.1 Eligibility -

6.1.1 Subject to Rule 8, membership of the Scheme is restricted to:

6.1.1.1 persons in the employ or former employ of an employer who, in terms of his/her conditions of employment, is entitled to become a member of the Scheme; and

6.1.1.2 persons who qualify for membership in terms of Rules 6.2, 6.3, 6.4 and 9.

6.2 Retirees -

6.2.1 A member shall retain his membership of the Scheme with his registered dependants, if any, in the event of his retiring from the service of his

6.2 Retirees -

6.2.1 A member shall retain his membership of the Scheme with his registered dependants, if any, in the event of his retiring from the service of his employer or his employment being terminated by his employer on account of age, ill health or other disability.

6.2.2 The Scheme shall inform the member of his right to continue his membership and of the contribution payable from the date of retirement or termination of employment. Unless such member informs the Board in writing of his desire to terminate his membership, he shall continue to be a member.

6.3 Dependants of Deceased Members -

6.3.1 The dependants of a deceased member who are registered with the Scheme as his dependants at the time of such member's death shall be entitled to membership of the Scheme without any new restrictions, limitations or waiting periods.

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

6.3.3 Such a member's membership terminates if he becomes a member or a dependant of a member of another medical scheme.

6.4 Where a child dependant/s has been orphaned, the eldest child shall be deemed to be the member, and any younger siblings, the child dependants.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of Dependants -

7.1.1 A member may apply for the registration of his dependants at the time of his application for membership in terms of Rule 6 or at any other time.

7.1.2 A member who wishes to register a new-born, adopted or foster child as his dependant, shall notify the Scheme within 90 (ninety) days of the birth, fostering or adoption of a child, and shall apply to the Scheme to register such child as a dependant. Increased contributions shall be due from the

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

7.1.3 If a member, who marries subsequent to joining the Scheme, applies within 90 (ninety) days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the date of registration and benefits will accrue as from that date.

7.1.4 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the member may apply to the Scheme for the registration of such person as a dependant, whereupon the provisions of Rule 8 shall apply mutatis mutandis.

7.2 De-registration of Dependants -

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

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

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

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

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

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

8.2.2 of members of different medical schemes.

8.3 No person may claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member or a dependant of a member.

8.4 Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in

respect of himself and his dependants, of age, income, state of health and of any prior membership or admission as dependant of any other medical scheme. The Scheme may require an applicant to provide the Scheme with a medical report in respect of any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership 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.

8.5 Waiting periods -

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

8.5.1.1 a general waiting period of up to three months; and

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

8.5.2 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application, a condition-specific waiting period of up to 12 (twelve) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits; and

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

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

8.5.5 No waiting periods may be imposed:

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

8.5.5.1.1. change of employment; or

8.5.5.1.2. an employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the scheme to which an application is made for such transfer to occur at the beginning of the financial year;

8.5.5.2 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, but the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme;

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

8.5.5.4 on a child dependant born during the period of membership and registered in accordance with 7.1.2.

8.6 The registered dependants of a member are entitled to the same benefits as the member, provided that:

8.6.1 if the Scheme excluded the member from a benefit in respect of a particular illness, disorder or disability which existed at the time of admission, or has limited such benefit, such exclusion or limitation shall not extend to any registered dependant; and

8.6.2 if the Scheme has excluded a dependant from a benefit in respect of a particular illness, disorder or disability which existed at the time of admission or has limited such benefit, such exclusion or limitation shall not extend to the member or any other registered dependant.

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

8.8 A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a member is entitled under these Rules or any right in respect of such benefit or payment of such benefit to such member, if a member attempts to assign or transfer, or otherwise cede or pledge or hypothecate such benefit.

9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

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

10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

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

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

10.3 On termination of membership or on de-registration of a dependant, the Scheme must, within 30 (thirty) days of such termination or at any time on request, furnish

such person with a certificate of membership and cover, containing such particulars as may be prescribed.

11. CHANGE OF ADDRESS

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

12. TERMINATION OF MEMBERSHIP

12.1 Resignation -

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

12.1.2 A member whose employment with a participating employer is terminated shall, on the date of such termination, cease to be a member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto regardless of whether the Scheme has been notified of such termination of employment or not.

12.2 Voluntary Termination of Membership -

12.2.1 A member, who is not required in terms of his conditions of employment to be a member, may terminate his membership of the Scheme on one month's written notice. All rights to benefits cease after the last day of membership except for claims in respect of services rendered prior thereto.

12.2.2 The notice period referred to in 12.2.1 shall be waived in substantiated cases where membership of another medical scheme is compulsory as a result of a condition of employment.

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

12.3 Death -

12.3.1 Membership of a member terminates on his death.

12.4 Failure to Pay Amounts due to the Scheme -

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

12.5 Abuse of Privileges, False Claims, Misrepresentation and Non-disclosure of Factual Information -

12.5.1 The Board may exclude from benefits or terminate the membership of a member of dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information. In such case he will be required to refund to the Scheme all false claims paid or claims paid as the direct result of a material misrepresentation or non-disclosure of factual information. In the event that the member is required to refund all claims paid then the Scheme must refund to the member all contributions paid by the member.

13. CONTRIBUTIONS

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

13.2 Contributions shall be due monthly in arrears and payable within 3 (three) days of month end. Where contributions or any other debt owing to the Scheme have not been paid within 14 (fourteen) days of the due date, the Scheme shall have the right to suspend all benefit payments which have accrued to such member irrespective of when the claim for such benefit arose, and to give the member and/or employer written notice that if contributions or such other debts are not paid up to date within 14 (fourteen) days of such notice, membership may be cancelled.

13.3 In the event that payments are brought up to date, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest 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.

13.4 No refund of any assets of the Scheme or any portion of a contribution, other than in respect of Personal Medical Savings Accounts as provided for in Rule 2.4 of

Annexure "B", shall be paid to any person where such member's membership or cover in respect of any dependant terminates during the course of the month.

13.5 The balance standing to the credit of a member in terms of his Personal Medical Savings Account shall, at all times remain the property of the member.

14. LIABILITIES OF EMPLOYER AND MEMBER

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

14.2 The liability of a member to the Scheme is limited to the amount of his unpaid contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants to which they were not entitled in terms of the Rules of the Scheme and which has not been repaid to the Scheme.

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

15. CLAIMS PROCEDURE

15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement. In order to ensure consistent and correct claims adjudication, the Scheme shall make use of practitioner-specific Billing Guidelines to ensure proper adjudication for services rendered.

15.2 If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme shall, in addition to the payment contemplated in Section 59 (2) of the Act, dispatch to the member a statement containing the following particulars:-

15.2.1 The name and the membership number of the member;

15.2.2 The name of the supplier of the service;

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

15.2.4 The relevant code as required by the Scheme;

15.2.5 The total amount charged for the service concerned; and

15.2.6 The amount of the benefit awarded for such service.

15.3 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct by the member and must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered; or where the claim must be resubmitted for correction, be resubmitted within 60 (sixty) days following the date on which such claim was requested to be corrected. The Scheme will have the discretion, on good cause shown, to extend the 4 (four) month period to a maximum of 6 (six) months.

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

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

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

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

15.5.1 be obliged to take all steps which are necessary to timeously submit a claim for compensation to the Compensation Commissioner ("the Commissioner") as provided for in terms of the Compensation for Occupational Injuries and Diseases Act 130 of 1993, for the costs of any healthcare services performed and which in the future may be necessitated in connection with such injury or disease and;

15.5.2 advise and keep the Scheme advised of the progress in relation to such claim for compensation; and on admission of such claim by the

Commissioner, advise the Scheme of the terms of such admission, including any terms relating to any undertaking by the Commissioner to make payment of the costs of any future medical expenses, in which event the Scheme shall be entitled to recover payment of any benefit in respect of healthcare services for which the Commissioner has undertaken to make payment.

15.6 Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member or the health care provider, whichever is applicable, accordingly within 30 (thirty) days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member or provider the opportunity to return such corrected claim to the Scheme within 4 (four) months of the notice.

15.7 Where the Scheme believes on good cause that a provider has placed the Scheme at risk through unprofessional, illegal or unethical conduct, the Scheme may, after consideration of the facts by the Board, refuse payment of all future claims in respect of services obtained from such provider (subject to the provisions of clause 15.8), in which event the Scheme must notify the provider in writing of such decision and the reasons therefor. The provider is entitled to dispute the decision. The provisions of Rule 29.8 and 29.9 shall apply to the resolution of such disputes.

15.8 In respect of all providers who have received a notice in terms of Rule 15.7, the Scheme shall: –

15.8.1 inform its members thereof by publishing the names of all such providers on its website; and

15.8.2 in writing or by recorded telephone conversation, inform all members who received services from such providers in the 12 (twelve) month period preceding such notice, of its decision to stop payment.

15.9 The Scheme shall not be obliged to pay claims made in respect of services received from such providers more than 30 (thirty) days after dispatch of written notice to members or from the day following the recorded telephone conversation referred to in clause 15.8.2.

15.10 In the event of any financial prejudice unwittingly incurred by a member as a result of a Rule 15.7 decision, the member may apply to the Scheme for consideration of a possible reimbursement.

15.11 The Scheme may at its discretion, at any time remove or suspend a notice issued in terms of Rule 15.7.

15.12 In any dispute as to whether a claim was properly submitted, the member shall bear the onus of proving that the claim was submitted in accordance with these Rules.

15.13 In any dispute as to the manner of payment of the account, the healthcare provider or member must submit notice of dispute within 120 (one hundred and twenty) days from date of claims payment.

15.14 If any amount which the Scheme is liable to pay in terms of these Rules is not paid timeously then any claim which a member may have as a result thereof shall be a claim for specific performance against the Scheme.

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

16. BENEFITS

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the member to his registered dependants.

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

16.3 Any benefit in Annexure B covers the cost of services rendered in respect of the Prescribed Minimum Benefits, in accordance with Appendix 2.

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

16.5 The Scheme may exclude services from benefits as set out in Annexure C.

16.6 The Board shall not authorise payment for services other than those provided for in these Rules but may, in its absolute discretion and on such terms and conditions as it may determine, make ex-gratia payments.

16.7 The Scheme shall only be required to fund medical technologies and Treatments not previously funded, or existing Treatments for new clinical indications, and/or unregistered medicines, from Health Care Cover if such medical Treatments meet

the Scheme's protocols, where they exist, which shall be developed on the basis of evidence-based medicine and cost effectiveness criteria.

16.8 The Scheme will be entitled to apply clinical policy and managed care protocols to determine members' entitlement to benefits and to determine the application of limits and sub-limits.

16.9 Exclusions –

16.9.1 The Scheme shall not pay for benefits from Major Medical Expenses (as set out in clause 3 of Annexure B hereto) if:

16.9.1.1 in the reasonable opinion of a medical officer appointed for this purpose by the Scheme, taking into account generally accepted medical practice, the service/s could have been reasonably rendered in the consulting rooms of a medical practitioner; or

16.9.1.2 could have been reasonably rendered at a lower level of care; or

16.9.1.3 are not Medically Necessary; or

16.9.1.4 were rendered to the member or his dependant as out-patients of the hospital concerned; or

16.9.1.5 comprise a general exclusion to the Scheme as reflected in Annexure C to these Rules; or

16.9.1.6 were rendered to the member and his dependants in the emergency rooms of the hospital, except for PMB conditions; or

16.9.1.7 do not meet the protocols and clinical guidelines of the Scheme.

16.10 Pre-authorisation -

16.10.1 If Treatments are recommended for a member or a dependant then, subject to 16.12 and 16.15 below, the following provisions shall apply:

16.10.1.1 the member shall give the Scheme written or verbal notice advising that such Treatment has been recommended, giving full details including the name(s) of the medical practitioner(s)

who has/have made such recommendation and obtain the required authorisation from the Scheme that it will pay for the Treatment;

16.10.1.2 the members shall give notice to the Scheme within such reasonable period as will allow the provisions of this clause 16.10.1 to be complied with; but in any event, notice of not less than 48 (forty-eight) hours prior to the Treatment;

16.10.1.3 on receiving such notice, the Scheme shall be entitled to require the member or his dependant (as the case may be) to obtain a second opinion from a medical practitioner approved by the Scheme as to whether the recommended Treatment is necessary. The charges levied by such medical practitioner in respect of the second opinion shall be borne by the Scheme;

16.10.1.4 immediately upon obtaining such second opinion, the member shall furnish the Scheme with a copy thereof; and

16.10.1.5 the Scheme shall, on good cause shown, be entitled to reject a request for authorisation, notwithstanding that a second opinion may have been furnished, if in its opinion any of the criteria stipulated in clause 16.9 are present.;

16.11 The provisions of 16.10.1.2, insofar as they pertain to the 48 (forty eight) hour notification period, shall not apply where Treatment is required by a member or by a dependant as a matter of urgency. For the purposes of this paragraph 16.11, Treatment shall be deemed to have been required as a matter of urgency if the member could not have been expected to comply with the provisions of 16.10.1.2 without his health or that of his dependant being placed in jeopardy. Notwithstanding this, the member will be required to give the Scheme notification of the Treatment as soon as he is able to.

16.12 If a dispute arises in respect of any matter addressed in this clause 16.10, the onus shall be upon the member to prove that -:

16.12.1 he gave notice in accordance with 16.10.1.1;

16.12.2 such notice was given within the time period referred to in 16.10.1.2 or 16.11, as the case may be;

16.12.3 a copy of the written second opinion was given to the Scheme in accordance with 16.10.1.4; or;

16.12.4 Treatment was required as a matter of urgency in terms of 16.11.

16.13 Where the Scheme receives a hospital claim that has not been pre-authorised payment will be limited in accordance with Annexure B.

16.14 The member is obliged to make full disclosure during or after pre-authorisation of all proposed healthcare services even if they relate to a General Scheme exclusion and failure to do so may lead to the entire event being declined and may be regarded as a misrepresentation.

16.15 The Scheme shall only be required to fund medical technologies and Treatments not previously funded, or existing Treatments for new clinical indications, and/or unregistered medicines from Health Care Cover if such medical Treatments meet the Scheme's protocols, where they exist, which shall be developed on the basis of evidence-based medicine and cost effectiveness criteria.

16.16 Funding only for Medically Necessary healthcare services -

16.16.1 The Scheme shall only fund healthcare service provided to a member if the service in question is Medically Necessary.

16.16.2 If the Scheme reasonably determines that the healthcare service and/or level of care are not Medically Necessary, the Scheme may choose not to fund or fund such service at the appropriate or cost-effective level of care.

16.16.3 The Scheme may, at its own cost, require a member to be medically examined for purposes of establishing whether the healthcare service is Medically Necessary. Should the member and/or the member's family decline consent for such an examination, the Scheme may then, in keeping with generally accepted clinical practice and with the clinical information at hand, withdraw or reduce funding to the recommended level of care as contemplated in Annexure B.

17. PAYMENT OF ACCOUNTS

17.1 Payment of accounts is restricted to the maximum amount of the benefit entitlement.

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

17.3 Billing Rules are the prerogative of the Scheme and this includes but is not limited to the: Discovery Health Guide, SAMA guidelines, international practice and consultation with professional groups.

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

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

18. DOMICILIUM CITANDI ET EXECUTANDI

18.1 Postal address -

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

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

18.1.2.1 7 (seven) days after posting to the address in 18.5.1.1. if posted by prepaid registered post;

18.1.2.2 on delivery, if delivered;

18.1.2.3 on transmission, if successfully transmitted to the party's telefax number;

18.1.2.4 by e-mail if successfully sent to the party's e-mail address.

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

18.3 Address for service of legal documents -

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

18.3.2 Any employer or member may change his address for this purpose to another physical address in the Republic of South Africa, by notice in writing subject to Rule 11.11.

19. GOVERNANCE

19.1 The affairs of the Scheme shall be managed according to these rules by a Board consisting of at least 8 (eight) members who in equal numbers are member-elected and employer-appointed trustees. The Board shall be appointed at alternate annual general meetings to serve terms of office of 2 (two) years each provided that retiring trustees shall be eligible for re-election.

19.2 The Chairperson shall be elected by the Board from its number.

19.3 Every participating employer shall be entitled to nominate 1 (one) trustee to the Board and the employee and continuation members of an associated employer shall be entitled to elect 1 (one) trustee to the Board.

19.4 Nominations for member-elected trustees, signed by the candidate signifying his consent to stand for election, shall be submitted to the Scheme by 28 February of the year in which the Board's term of office expires and the Principal Officer shall arrange postal ballots for the elected representatives by no later than 30 (thirty) days before the date of the annual general meeting referred to in Rule 27.1.1. The latest membership register shall serve as a voters' roll for each group of members and the result will be decided on simple majority of duly completed and returned ballot papers.

19.5 The Board shall be entitled to appoint an eligible person to fill a casual vacancy in the number of member-elected Board members until the end of its term of office. A person so appointed must retire at the first ensuing annual general meeting and that meeting must fill the vacancy for the unexpired period of office of the vacating member of the Board.

19.6 A majority of members of the Board shall form a quorum.

19.7 In the absence of the Chairperson, the Board members shall elect one of their number to preside.

19.8 Matters serving before the Board shall be decided by a majority vote. In the event of an equality of votes, the Chairperson shall have the casting vote in addition to his deliberate vote.

19.9 The Board may co-opt knowledgeable persons to assist it in its deliberations provided that such persons shall not have a vote at any meeting of the Board.

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

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

19.11.1 a person under the age of 21 (twenty-one) years;

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

19.11.3 a broker;

19.11.4 the Principal Officer of the Scheme; or

19.11.5 the auditor of the Scheme.

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

19.12.1 he becomes mentally ill or incapable of managing his affairs.

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

19.12.3 he is removed by a court from any office of trust on account of misconduct;

19.12.4 he is removed from office by the Council in terms of Section 46 of the Act;

19.12.5 he absents himself from three consecutive meetings of the Board without prior permission of the Chairperson;

19.12.6 he is disqualified under any law from carrying on his profession;

19.12.7 in the case of an employer-appointed trustee, he is removed from office by the participating employer giving the Scheme written notice of such withdrawal; or

19.12.8 in the case of a member-elected trustee, he ceases to be a member of the Scheme.

19.13 The Board shall meet at least once every 3 (three) months provided that the Chairperson may convene a special meeting should the necessity arise.

19.14 Any 4 (four) members of the Board may request the Chairman to convene a special meeting provided the matters to be discussed at the meeting are clearly stated in the request, and the Chairperson shall, within 7 (seven) days, convene a special meeting of the Board to deal with the matters stated therein.

19.15 Members of the Board shall only be remunerated as determined from time to time at the annual general meeting.

19.16 A member of the Board who acts in a manner which is seriously prejudicial to the interests of beneficiaries of the medical scheme may be removed by the Board, provided that:

19.16.1 before a decision is taken to remove the member of the Board, the Board shall furnish the member with full details of evidence which the Board has at its disposal regarding the conduct complained of, and allow such member a period of not less than 30 (thirty) days in which to respond to the allegations;

19.16.2 the resolution to remove the member is taken by at least 2/3 (two-thirds) of the members of the Board;

19.16.3 the member shall have recourse to disputes procedures of the scheme or complaints and appeal procedures provided for in the Act.

20. DUTIES OF BOARD OF TRUSTEES

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

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

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

20.4 The Board must apply sound business principles and ensure the long term financial soundness of the Scheme.

20.5 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.

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

20.7 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.

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

20.9 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.

20.10 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.

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

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

20.13 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.

20.14 The Board must take all reasonable steps to protect the confidentiality of medical information concerning any member or dependant's state of health.

20.15 The Board must approve all disbursements.

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

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

20.18 The Board must act with impartiality in respect of all members.

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

21. POWERS OF BOARD

21.1 The Board has the power to:

21.2 terminate the services of any employee of the Scheme;

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

21.4 appoint a committee consisting of such Board members and/or other experts as it may deem appropriate;

21.5 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;

21.6 appoint, compensate and determine the level of services of any accredited broker for the introduction or admission of a member to the Scheme;

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

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

21.9 let or hire movable or immovable property;

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

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

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

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

21.14 grant repayable loans to members or to make ex gratia payments on behalf of members in order to assist such members to meet commitments in regard to any matter specified in Rule 5;

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

21.16 re-insure obligations in terms of the benefits provided for in these rules;

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

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

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

22. DUTIES OF PRINCIPAL OFFICER AND STAFF

22.1 The staff of the Scheme must ensure the confidentiality of all information regarding its members.

22.2 The principal officer is the executive officer of the Scheme and as such shall ensure that:

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

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

22.2.3 he keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in Section 57(4) of the Act;

22.2.4 he keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of section 57(6) of the Act; and

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

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

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

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

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

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

22.8 If the Principal Officer is absent from the Republic of South Africa for a period exceeding 30 (thirty) days, or for any other reason unable to discharge any duty imposed on him by the provisions of the Act, the Scheme shall, for the duration of such absence or inability, appoint another officer in his stead.

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

22.9.1 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.

22.9.2 A broker.

22.10 The provisions of rules 19.12.1 to 19.12.6 apply mutatis mutandis to the Principal Officer.

23. INDEMNIFICATION & FIDELITY GUARANTEE

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

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

24. FINANCIAL YEAR OF THE SCHEME

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

25. BANKING ACCOUNT

The Scheme must maintain a banking account with a registered commercial bank. All moneys received must be deposited to the credit of such account and all payments must be made either by electronic transfer, tape exchange or by cheque under the joint signature of not less than 2 (two) persons duly authorised by the Board.

26. AUDITOR & AUDIT COMMITTEE

26.1 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.

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

26.2.1 a member of the Board;

26.2.2 an employee, officer or contractor of the Scheme;

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

26.2.4 a person not engaged in public practice as an auditor;

26.2.5 a person who is disqualified from acting as an auditor in terms of the Companies Act, 2008.

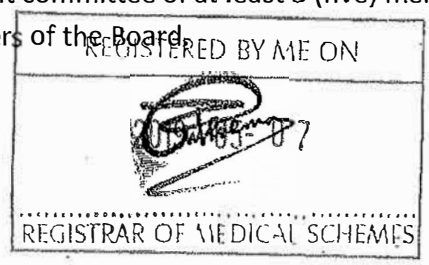
26.3 Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board must within 30 (thirty) days appoint another auditor to fill the vacancy for the unexpired period.

26.4 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 (thirty) days make such appointment, and if it fails to do so, the Registrar may at any time do so.

26.5 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 other officers of the Scheme such information and explanations as he deems necessary for the performance of his duties.

26.6 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 meetings.

26.7 The Board must appoint an audit committee of at least 5 (five) members of whom at least 2 (two) must be members of the Board.



27. **GENERAL MEETINGS**

27.1 Annual General Meeting -

27.1.1 The annual general meeting of members must be held not later than 30 June of each year.

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

27.1.3 At least 15 (fifteen) members of the Scheme present in person (in respect of which the term "present in person" shall include being present by may be held by means of such electronic or other communication facility or media as permits all persons participating in the meeting to communicate with each other simultaneously and instantaneously and persons so participating shall be deemed to be present at such meeting) shall constitute a quorum. If a quorum is not present after the lapse of 30 (thirty) minutes from the time fixed for

the commencement of the meeting, the meeting must be postponed to a date determined by the Board, and members then present constitute a quorum.

27.1.4 The financial statements and reports specified in Rule 27.1.2 must be laid before the meeting.

27.1.5 Notices of motions to be placed before the annual general meeting must reach the principal officer not later than seven days prior to the date of the meeting.

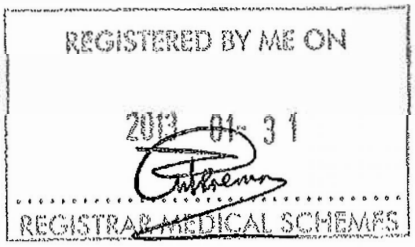
27.2 Special General Meeting -

27.2.1 The Board may call a special general meeting of members if it is deemed necessary.

27.2.2 On the requisition of at least 20 (twenty) members of the Scheme, the Board must cause a special general meeting to be called within 30 (thirty) days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitioners and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

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

27.2.4 Twenty members present in person shall form a quorum. If a quorum is not present at a special general meeting called by the Board after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting shall be postponed until the same day and time of the next week and the members then present shall form a quorum provided that if the same day of the next week is a public holiday the meeting will be postponed until the first working day following the public holiday. If a quorum is not present at a special general meeting convened on the request of members after the lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.



28. VOTING AT MEETINGS

28.1 Every member who is present at a general meeting of the Scheme and whose contributions are not in arrears, has the right to vote, or may, subject to this rule, appoint another member of the Scheme as proxy to attend, speak and vote in his stead.

28.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the member and the person appointed as the proxy. The proxy form shall be deposited not later than 2 (two) days before the time for holding the meeting at the registered office of the Scheme or at such other place or places as the Board shall decide and of which notice has been given in the notice of the meeting.

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

29. COMPLAINTS AND DISPUTES

29.1 Any member may lodge a complaint to the Scheme in terms of these Rules or in terms of the Act to the Registrar. These Rules deal with complaints lodged to the Scheme.

29.2 A 'complaint' means a complaint as defined in the Act and for purposes of these Rules, a 'complaint' and a 'dispute' bear the same meaning.

29.3 A complaint may be lodged in writing (whether by post, e-mail or telefax). A complaint may also be lodged verbally by telephone.

29.4 A member lodging a complaint must do so within 3 (three) years of alleged service failure that gave rise to the complaint; failing which, the member's right to lodge such complaint shall prescribe.

29.5 The Scheme shall use its best endeavours to cause all complaints to be processed within 60 (sixty) days of receipt thereof, failing which, within a reasonable time.

29.6 If the Scheme, in its opinion, finds that there is no merit in the complaint, it must notify the complainant in writing of its finding and the reasons for the finding.

29.7 If dissatisfied with the finding on the complaint, the complainant may

29.7.1 within 60 (sixty) days of receiving the relevant notice, refer the complaint in writing (by completing the appropriate Dispute Form) for consideration by the Scheme's Dispute Committee; or

29.7.2 refer the complaint to the Registrar for consideration in terms of the Act.

29.8 Upon receipt of the referral in terms of Rule 29.7.1, the Scheme must convene a Dispute Committee meeting by giving notice to the complaint specifying -

29.8.1 the date of the meeting which may not be less than 21 (twenty-one) days from the date of submitting the notice or such earlier date as the Scheme and member may agree to;

29.8.2 the commencement time and venue for the meeting;

29.8.3 who will comprise the Dispute Committee;

29.8.4 the particulars of the complaint; and

29.8.5 the procedures and the Rules to be applied when considering the dispute which must include the right of the complainant to be heard in person or through a representative at the Dispute Committee meeting.

29.9 The Dispute Committee of three members, who may not be members of the Board, employees of the administrator of the Scheme or officers of the Scheme, must be appointed by the Board to serve a term of 2 (two) years. At least 1 (one) of such member shall be a person with legal expertise.

29.10 A member of the Scheme has the right to appeal in terms of the Act to the Council against the decision of the Disputes Committee. The Act requires such appeal to be in the form of an affidavit directed to the Council to be furnished not later than 3 (three) months after the date on which the Dispute Committee decision was made.

29.11 The decision of the Dispute Committee shall be final and binding unless overturned by the Council appeal process.

30. TERMINATION OR DISSOLUTION

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

30.2 The Board, or members in general meeting, may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by ballot

whether the Scheme must be liquidated. Unless the majority of members decide that the Scheme must continue, the Scheme must be liquidated in terms of Section 64 of the Act.

30.3 Pursuant to a decision by the Board or members taken in terms of Rule 30.2, the Principal Officer must, in consultation with the Registrar, furnish to every member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper. Every member must be requested to return his ballot paper duly completed before a set date. If at least 50% (fifty percent) of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

31. AMALGAMATION AND TRANSFER OF BUSINESS

31.1 The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person. Before such event the Board must arrange for members to decide in general meeting or by ballot whether the proposed transfer or amalgamation should be proceeded with or not.

31.2 If a ballot is held and at least 50% (fifty percent) 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.

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

32. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

32.1 Any member must on request and on payment of a fee of R25.00 (Twenty Five Rand) per copy be supplied by the Scheme with a copy of the following documents:-

32.1.1 The Rules of the Scheme.

32.1.2 The latest audited annual financial statements, statutory returns, trustees' reports and auditor's report of the Scheme.

32.1.3 The most recent management accounts of the Scheme.

32.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 32.1 and to make extracts there from at his own cost.

32.3 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.

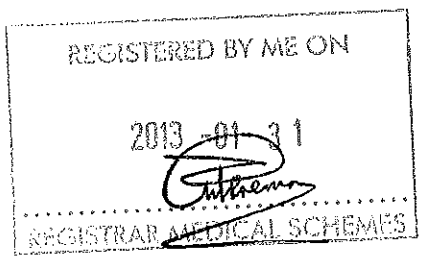
33. AMENDMENT OF RULES

33.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure, provided that no such amendment rescission or addition shall be valid until it has been registered by the Registrar in terms of the Act.

33.2 Should a member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 (thirty) days advance notice of such change.

33.3 Notwithstanding the provisions of Rule 33.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.

33.4 If there is any conflict between these Rules and any brochure, pamphlet, explanatory document or marketing material in respect of the Scheme, the provisions of these Rules shall apply.



1. ANGLOVAAL GROUP MEDICAL SCHEME RULES

ANNEXURE A

1. CONTRIBUTIONS FROM 1/1/2023

INSURED CONTRIBUTIONS			
INCOME BANDS	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
Below R4 600	R2 133	R2 133	R659
R4 601 – R9 100	R2 496	R2 496	R757
R9 101 – R13 600	R2 713	R2 713	R831
R13 601 – R18 100	R2 875	R2 875	R877
Above R18 101	R2 946	R2 946	R891

MSA CONTRIBUTIONS @ 25% OF TOTAL CONTRIBUTION			
INCOME BANDS	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
Below R4 600	R532	R532	R165
R4 601 – R9 100	R623	R623	R188
R9 101 – R13 600	R678	R678	R207
R13 601 – R18 100	R720	R720	R219
Above R18 101	R736	R736	R221

TOTAL CONTRIBUTIONS			
INCOME BANDS	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
Below R4 600	R2 665	R2 665	R824
R4 601 – R9 100	R3 119	R3 119	R945
R9 101 – R13 600	R3 391	R3 391	R1 038

R13 601 – R18 100	R3 595	R3 595	R1 096
Above R18 100	R3 682	R3 682	R1 112

For purposes of the contribution table "Adult Dependent" means the member's spouse or partner and any other dependent who is over the age of 21 years irrespective of the person's relationship to the member.

2. **PREMIUM PENALTIES FOR PERSON JOINING LATE IN LIFE**

2.1 Premium 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
1-4 years	0.05 x contribution
5-14 years	0.25 x contribution
15-24 years	0.5 x contribution
25+ years	0.75 x contribution

The following formula shall be applied to determine the applicable penalty band:

A= B minus (35 + C) where:

A= number of years to determine appropriate penalty band

B= age of the late joiner at time of the application

C= number of years of creditable coverage which can be demonstrated

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.

ANGLOVAAL GROUP MEDICAL SCHEME RULES

ANNEXURE B
BENEFITS AND LIMITATIONS

Members and their registered dependents shall, subject to the provisions of Annexure C and other limitations imposed by the Rules of the Scheme, be entitled to the following benefits in 2023:

1. PRESCRIBED MINIMUM BENEFITS (PMB'S)

1.1. 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:

- The Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and
- Any emergency medical condition.

"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.

1.2. Designation of Service Providers

The medical scheme designates the following service provider(s) for the delivery of prescribed minimum benefits to its beneficiaries:

Category	Designated Service Provider
General Practitioner	Any GP participating in the Discovery Health GP Network
Specialist	All Premier Rate providers who are part of the Direct Payment Arrangement and/or working in a state hospital contracted to the Scheme

Medication	Any dispensing provider or pharmacy that has contracted with the Scheme
Radiology	Any provider that has contracted with the Scheme
Pathology	Any provider that has contracted with the Scheme
Hospital	Any hospital contracted with the Scheme
Mental Illness	Drug Abuse – any SANCA facility contracted to the Scheme Other – any hospital with psychiatric ward facilities that is contracted to the Scheme
Terminal Care	Hospice
Renal Dialysis	Any provider contracted with the Scheme
HIV/AIDS	OptiPharm; or any provider contracted with the Scheme

The above service provider(s) shall for the purposes of this Appendix be referred to as "designated service providers".

1.3. Prescribed Minimum Benefits Obtained from Designated Service Providers

100% of the cost in respect of diagnosis, treatment and care costs of prescribed minimum benefits.

1.4. Prescribed Minimum Benefits Voluntarily Obtained from Other Providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to a co-payment equal to the difference between the actual cost incurred and the Scheme Rate.

1.5. Prescribed Minimum Benefits Involuntarily Obtained from Other Providers

1.5.1 If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the medical scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions.

1.5.2 For the purposes of paragraph 1.5.1, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if:

- The service was not available from the designated service providers or would not be provided without unreasonable delay;
- Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
- There was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

1.5.3 Except in the case of an emergency medical condition, preauthorization shall be obtained by a member prior to involuntarily obtaining a service from a provider other than the designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in Rule 1.5.2 of Annexure B are applicable.

1.6. Medication

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

- The medication is included on the applicable formulary in use by the Scheme; or
- The formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

1.6.2 Where a prescribed minimum benefit includes medication and that medication is voluntarily obtained from a provider other than a designated service provider, a co-payment equal to the difference between the cost of the drug and the Scheme Medicine Rate of the formulary drug will apply.

1.7. Prescribed Minimum Benefits Obtained from Public Hospitals

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.

1.8. 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.

1.9. Co-Payments

Co-payments in respect of the costs for PMB's obtained from providers other than designated service providers may not be paid out of medical savings accounts.

1.10. Chronic Conditions

The Scheme covers the full cost for services rendered in respect of the prescribed minimum benefits which includes 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.

1.11 Insofar as the terms of any other clause in this Annexure B may conflict with the provisions of this clause 1, the terms of this Clause 1 shall prevail.

2. PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)

2.1 On admission to the Scheme, a PMSA, held by the Scheme, shall be established in the name of the member concerned into which the contributions allocated by the Scheme in respect of the PMSA shall be credited and benefits in respect thereof, shall be debited.

Although the full annual (or pro-rated) PMSA allocation shall be available for the payment of claims at any time during the year, the monthly balance in a member's PMSA shall be calculated on the basis of contributions actually received, less any expenditure incurred.

Interest does not accrue to positive PMSA balances.

2.2 The amount allocated to the PMSA by the Scheme for the benefit of the member will be set at 20% of the total gross contributions in respect of the member during the financial year concerned.

2.3 Subject to sufficient funds being available at the date on which the claim is processed, members shall be entitled to claim for all health care services from the PMSA at 100% of the cost.

2.4 Funds allocated to the members' PMSA shall be available for the exclusive benefit of the member and his/her dependents. Any credit balance in the PMSA at the end of the financial year accumulates for the benefit of the member.

2.5 Upon the death of the member, the balance due to the member will be transferred to his/her dependents who continue membership of the Scheme or paid into his/her estate in the absence of such dependents.

2.6 On transfer to any other available benefit option of the Scheme, which does not provide for such an account, any balance standing to the credit of the member in the PMSA will be refunded to the member, not later than 4 months after such transfer and subject to applicable taxation laws.

2.7 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 or option which does not provide for a PMSA, the balance due to the member must be refunded to the member not later than 4 months after termination of membership, and subject to applicable taxation laws.

2.8 Should a member transfer to another benefit option or 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 benefit option or scheme not later than 4 months after transfer to the benefit option or termination of membership, as the case may be.

2.9 The funds in the member's medical savings account may not be used to pay costs of a prescribed minimum benefit or to offset contributions.

2.10 Where the Scheme pays a claim or claims, which, in aggregate, exceed/s the aggregate amount of those portions of the member's contributions which have been allocated to the member's PMSA, as at the date of such payment by the scheme, the scheme shall, at its option, be entitled:

20.10.1 to debit the unfunded claim amount against the member's PMSA; or

20.10.2 to recover the unfunded claim from the member.

2.11 On termination of membership, funds in the member's PMSA may be used to offset any debt owed by the member including outstanding contributions.

3. MAJOR MEDICAL EXPENSES (INSURED BENEFITS)

3.1 Hospitalisation

3.1.1 Subject to prior approval for all elective (non-emergency) cases, one hundred percent (100%) of the Scheme rate, while admitted to a private or public hospital, registered unattached operating theatre or day clinic, of:

- Accommodation in a general, high care and intensive care ward;
- Theatre fees;
- Medicines, materials and equipment used in the hospital;
- Consultations, visits and procedures performed by medical and dental practitioners;
- Confinements;
- Internal prosthesis;
- Clinical technologies;
- Radiology excluding CT, MR and radio-isotope scans;
- Physiotherapy;
- Blood transfusions, and
- Pathology.

3.1.2 The Scheme may, as part of the pre-authorisation process, in its sole discretion and after consultation with appropriate experts determine the medical necessity of the proposed hospitalisation and/or procedure.

3.1.3 Where the Scheme has entered into a Preferred Provider Arrangement with a hospital or group of hospitals and/or medical practitioners, members and their dependents will have the option of obtaining services from such providers at no additional cost to themselves.

3.1.4 Where a member or his dependent, who could reasonably have obtained a required service from a preferred provider, chooses to use another provider of his choice, the Scheme's liability for the cost of such services will be limited to that for which it would have been liable in terms of the preferred provider agreement contemplated in Rule 3.1.3 of Annexure B, with the member being liable for any additional costs that are incurred.

3.1.5 In the event of an emergency admission, the Scheme shall be notified of an event within one working day after admission.

3.1.6 The Scheme may refuse to accept liability for any or all of the costs referred to in Rule 3.1.1 if the member fails to obtain prior authorisation or to notify the Scheme as provided for in Rules 3.1.1 and 3.1.5 of this Annexure.

3.1.7 There shall not be an annual limit for in-hospital costs, but the Scheme shall have the right to monitor and manage any such costs and this may, in addition to preferred provider arrangements include prospective, concurrent and retrospective utilisation review and management.

3.1.8 In cases of true medical emergencies where a beneficiary could not reasonably have made use of another provider, the professional fees directly associated with such an emergency will be covered at cost.

3.2. CHRONIC CONDITIONS

3.2.1 The Scheme will cover in full the diagnosis, medical management and medication for the prescribed chronic conditions to the extent that this is provided for by way of a therapeutic algorithm for a special condition, published by the Minister by notice in the Government Gazette.

A member and his/her dependents will also be entitled to medication for other (non-prescribed) chronic conditions as indicated in the following schedule. The cover for non-prescribed chronic conditions does not include the cost of diagnosis or medical management. These costs may be funded from the members' Medical Savings Accounts.

Cover for chronic conditions (prescribed and non-prescribed) will only be provided subject to pre-authorisation, diagnostic and treatment protocols, a formulary and/or reference prices and chronic drug amount as set by the Scheme and the use of designated services providers.

PRESCRIBED CHRONIC CONDITIONS

1.	Addison's Disease	14.	Epilepsy
2.	Asthma	15.	Glaucoma
3.	Bipolar Mood Disease	16.	Haemophilia
4.	Bronchiectasis	17.	Hyperlipidaemia

5.	Cardiac Failure	18.	Hypertension
6.	Cardiomyopathy Disease	19.	Hypothyroidism
7.	Chronic Renal Disease	20.	HIV/AIDS
8.	Coronary Artery Disease	21.	Multiple Sclerosis
9.	Crohn's Disease	22.	Parkinson's Disease
10.	Chronic Obstructive Pulmonary Disorder	23.	Rheumatoid Arthritis
11.	Diabetes Insipidus	24.	Schizophrenia
12.	Diabetes Mellitus Type 1 & 2	25.	Systemic Lupus Erythromatosis
13.	Dysrhythmias	26.	Ulcerative Colitis

OTHER (NON-PRESCRIBED) CHRONIC CONDITIONS COVERED

For the conditions listed in the following table, benefits will be provided above the PMB entitlement, in accordance with the Scheme benefits and managed care protocols.

1.	Allergic Rhinitis	8.	Menopausal symptoms (HRT)
2.	Alzheimer's Disease	9.	Motor Neuron Disease
3.	Ankylosing Spondilitis	10.	Myasthenia Gravis
4.	Cancer Treatment: Side-effects of chemotherapy	11.	Osteoarthritis
		12.	Osteoporosis
5.	Cystic Fibrosis	13.	Paget's Disease of the Bone
6.	Gout	14.	Psoriasis
7.	Major Depressive Disorders		

3.2.2 Benefits under Rule 3.2.1 shall only be paid under the following circumstances and conditions:

3.2.2.1 Suitable motivation, acceptable to the Scheme, must be provided by the member's attending practitioner indicating that the condition is a chronic disorder requiring continuous medicinal treatment.

3.2.2.2 The Scheme shall have the right to authorise, in consultation with the attending practitioner, a suitable generic equivalent or alternative medication for the condition being treated or to include the patient in a disease management programme.

3.2.2.3 The Scheme shall have the right to call for subsequent reports whenever so deemed necessary. Failure to provide such reports within 30 days of such request will cause benefits under this section to cease; and

3.2.2.4 Where the Scheme's formulary or reference price system includes a drug that is clinically appropriate and effective for the treatment of a chronic condition suffered by the beneficiary, and the beneficiary knowingly declines the formulary/reference priced drug and opts to use another drug instead, the Scheme's liability will be limited to that for which it would have been liable in terms of the formulary and/or reference price system. The beneficiary shall be liable for any additional costs.

3.3.1 OTHER SERVICES (INSURED PROCEDURE BENEFITS)

One hundred percent (100%) of the cost of the following services in accordance with the Scheme rate, provided that prior approval has been obtained from the Scheme and subject to the annual limits per member family as indicated:

- Emergency evacuation (road or air): R79 547;
- Oncology (including chemotherapy and radiotherapy): R420 378;
- Stoma therapy and hospice: R12 872;
- Audiology including hearing aids: R25 744;
- Ambulance service: R9 760;
- External surgical appliances, artificial limbs and medical apparatus such as glucometers: R9 760;
- CT, MR and radio-isotope scans: R22 632;
- Out-patient surgical and endoscopic procedures (vasectomy, gastroscopy, colonoscopy, cystoscopy, etc.): R19 459;
- Post-hospitalisation home nursing or accommodation in a nursing home or step-down facility: No limit – managed through the Care Coordination Programme;
- Advanced Illness Benefit for oncology patients: unlimited, but subject to the patient meeting clinical entry criteria and the authorization of the treatment plan;
- Screening and Prevention benefit which includes:

- Screening Benefit A: one per year for a group of tests consisting of blood glucose test, blood pressure test, cholesterol test and Body Mass Index (BMI), up to a maximum of the Scheme rate for group of tests at a network provider; and
- Screening Benefit B: one mammogram, one pap smear, one prostate-specific antigen test, and HIV blood tests; and
- one seasonal flu vaccine per year for beneficiaries who are over the age of 65 or are registered one of the following chronic conditions – asthma, bronchiectasis, cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease, chronic renal failure, coronary artery disease, diabetes (type 1 and 2), or HIV; and

- Conservative Dentistry: R731 per beneficiary.
- Mental health management and relapse prevention. Subject to the member meeting the clinical entry criteria and use of the Scheme's designated services providers.
- Continuous Glucose Monitoring devices for Type 1 diabetics.
- Oncology member support, providing a pre-AIB basket of care for early Oncology management.
- Member Care Programme: subject to the member meeting the clinical entry criteria and use of the Scheme's designated services providers.
- Re-admissions benefit for members admitted with specific qualifying conditions
- Conservative spinal care provided within a network and a spinal centre of excellence for the management of spinal surgeries performed by qualifying surgeons
- Hospital at Home, giving members access to home-based healthcare for eligible health conditions
- GP Virtual house call for members registered on the Chronic Illness Benefit (excluding Oncology) – Limit of 1 per annum

Subject to Rule 3.4.1 and 3.4.2 of Annexure B, the Scheme shall not be liable for any expenditure for services obtained without the prior approval of the Scheme.

3.3.2 ENHANCED MATERNITY BENEFIT

Upon registration on the Maternity Program, a defined basket of both pre-and post-natal care will be available, which includes:

Health care services	Basis of cover: Subject to Prescribed Minimum Benefits	Limits
Out-of-hospital healthcare services related to pregnancy and delivery:	Up to 100% of the Scheme rate	Services:
- Antenatal classes and/or postnatal visits with a registered nurse	Paid from Health Care cover: subject to any applicable limits	- Antenatal classes and/or postnatal visits: 5 consultations or classes per pregnancy and/or delivery
- Antenatal consultations with a GP, gynaecologist or midwife	Subject to pre-authorisation and/or registration and treatment meeting the Scheme's clinical entry criteria	- Antenatal consultations: 8 per pregnancy
- Prenatal screening or Non Invasive Prenatal Testing (NIPT)		- Prenatal screening or Non Invasive Prenatal Testing (NIPT): 1 per pregnancy
- Pregnancy scans	3D and 4D scan will be paid up to the cost of a 2D scan	- Pregnancy scans: 2 per pregnancy
- Paediatrician, ENT or GP consultations for infants	Cover for infant consultations up to a maximum of 100% of the Scheme rate, for children under the age of 2 years	- Consultations for infants: 2 per child
- A defined basket of pregnancy blood tests		- Blood tests: 1 routine basket of pregnancy tests per pregnancy
- Postnatal consultation with a GP, gynaecologist or midwife		- Postnatal consultations: 1 per delivery
- Dietician nutrition assessment	Services in excess of the limit paid from MSA	- Dietician nutrition assessment : 1 per delivery
- Postnatal mental health consultation with a GP, psychologist or counsellor	Limits apply for the duration of the pregnancy	- Mental health consultations: 2 per delivery
- Lactation consultation with a registered nurse or lactation specialist		- Lactation consultation: 1 per delivery
- Cover for External Medical Items (EMI)/registered essential devices such as breast pumps or nebulisers		- R6 100 External Medical Items (EMI) benefit subject to a 25% co-payment

- Private ward cover		- Private ward cover: 3 nights for a caesarean section birth and 2 nights for natural deliveries

3.3.3 WORLD HEALTH ORGANIZATION (WHO) GLOBAL OUTBREAK BENEFIT

Basket of care which includes in-hospital and out-of-hospital management and supportive treatment of global World Health Organization recognized disease outbreaks, subject to Prescribed Minimum Benefit guidelines or as otherwise legislated. - COVID-19 - Monkeypox	Up to 100% of the regulated price or a maximum of 100% of the Scheme rate for services within the basket of care. Subject to the Scheme's preferred provider, protocols and clinical entry criteria. Treatment will be funded at 100% of cost at a designated service provider.

3.4. EMERGENCY SERVICES

3.4.1 In the event of a medical emergency, a member or his dependents are entitled to obtain the necessary services from any provider of their choice, subject to the Scheme being notified of any admission to hospital within one working day thereafter. This applies to the Major Medical Expenses and the Prescribed Minimum Benefits.

3.4.2 Following an emergency admission to hospital, the Scheme shall have the right to transfer the patient to another hospital or health care professional, with which it has concluded preferred provider arrangements, as soon as it is deemed practical and medically prudent, by the Scheme, to do so.

3.4.3 The cost of emergency services shall be paid from the appropriate benefit and be subject to the rules and limitations applicable to the respective benefits.

3.5. LIMITATIONS OF BENEFITS

3.5.1 Members admitted during the course of a financial year shall be entitled to the benefits as set out with the maximum benefit (annual limits) being adjusted in

proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

3.5.2 In cases of illness of a protracted nature or proposed treatment with high associated costs, the Board shall have the right to insist upon the member or dependent consulting a medical practitioner nominated by the Board. In such cases, if the medical practitioner's proposed treatment is not acted upon, the Board may disallow all further benefits for that particular illness.

3.5.3 The cost associated with optometric service (including the provision of glasses and contact lenses and refractory eye surgery) will not be paid from the Major Medical Expenses Benefit.

3.5.4 All questions regarding the medical necessity, nature and sufficiency of any relevant health service provided, or to be provided, in terms of the Rules shall, in its sole discretion and after consultation with the Scheme's medical adviser/s and other appropriate experts where deemed necessary, be decided by the Board.

ANGLOVAAL GROUP MEDICAL SCHEME RULES

ANNEXURE D

LIST OF PARTICIPATING EMPLOYERS (effective 01 January 2019)

1. AVI Financial Services (Pty) Ltd
2. National Brands Limited
3. Irvin and Johnson Holding Company (Pty) Ltd
4. Irvin & Johnson Limited
5. Indigo Cosmetics (Pty) Ltd
6. A&D Spitz (Pty) Ltd
7. Green Cross Manufacturers (Pty) Ltd
8. African Rainbow Minerals Limited