MEDICAL AID SCHEME

TFG Medical Aid Scheme
2023 Rules

TFG MEDICAL AID SCHEME

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TFG MEDICAL AID SCHEME

RULES

1. NAME

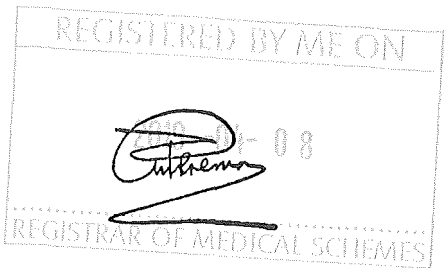
The name of the Scheme is **"TFG Medical Aid Scheme"** (hereinafter referred to as "the Scheme").

2. LEGAL PERSONA/LEGAL PROCEEDINGS

The Scheme is a body corporate who in its own name, is 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, Regulations and these Rules.

3. REGISTERED OFFICE

The Registered Office of the Scheme shall be situated at 1 Discovery Place, Sandhurst, Sandton, 2196, but the Board shall have the right to transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.



4. DEFINITIONS

In these Rules, words and expressions defined in the Medical Schemes Act (Act No. 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context:

(a) a words and expression in the masculine gender includes the feminine and *vice versa*;

(b) a word in the singular number includes the plural and *vice versa*; and

(c) the expressions below have the following meanings:

4.1. **"Act"**, shall mean the Medical Schemes Act (Act No 131 of 1998), as amended and the Regulations framed thereunder.

4.2. **"Acute Medicine"**, shall mean Medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of Medicine Treatment.

4.3. **"Administrators"**, shall mean the person or firm appointed to administer the Scheme in accordance with these Rules.

4.4. **"Admission Date"**, shall mean 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.

4.5. **"Agreed Rate"**, shall mean the rate determined in terms of an agreement between the Scheme and a Service Provider or a group of providers in respect of the payment of Relevant health services.

4.6. **"Algorithms",** shall mean the Treatment guidelines developed by the Council for Medical Schemes for each PMB condition that specify which classes of drugs are appropriate for the Treatment of the PMB conditions and the sequence in which the various classes of drugs should be used.

4.7. **"An Accident",** shall mean an unforeseen event which could not reasonably have been expected to occur and was not planned, caused directly and independently of all other causes, by some external and visible means arising from the said event at an identifiable time and place.

4.8. **"Annual Benefit"**, shall mean the maximum benefits to which a Member and his registered Dependants are entitled in terms of these Rules, and shall be calculated annually to coincide with the Financial year of the Scheme.

4.9. **"Applicable Tariff",** shall mean, in respect of any healthcare service, the tariff inherent in the Member's Benefit Plan, provided that where the cost of any healthcare service is less than the tariff, the Applicable Tariff shall be deemed to be equal to such lower Cost;

4.10. **"Approval",** shall mean prior written or telephonic approval.

4.11. **"Auditor"**, shall mean an Auditor registered under the Public Accountants' and Auditors' Act 1991 (Act No 80 of 1991).

4.12. **"Baskets of Care",** shall mean a list of consultations, investigations and other procedures that pertain to the care of a CDL condition (Chronic Disease List condition as per the Medical Schemes Act and its relevant regulations and amendments for Prescribed Minimum Benefits), over a period of time which may be adaptable to the patient's specific needs through a process of interaction and consultation with the Scheme's contracted managed care entity and/or medical advisors and which will be associated, where applicable, with the drugs as listed in the Council for Medical Schemes' Algorithms for the specific CDL conditions.

4.13. **"Beneficiary"**, shall mean a Member or a person admitted as a Dependant of a Member.

4.14. **"Benefit Plan"**, shall mean the benefits which have been chosen by a Member in terms of these Rules.

4.15. **"Billing Guidelines"**, shall mean the guidelines applied to evaluate individual code submission reported in provider claims, as part of the claims adjudication process.

4.16. **"Board",** shall mean the Board of Trustees constituted to manage the Scheme in terms of the Act and these Rules.

4.17. **"Case management",** shall mean the process whereby Members' specific health care needs are identified and Utilisation management plans or programmes implemented which efficiently utilise health care benefits to achieve optimum patient care in the most cost-effective manner; whether the Scheme prescribes it, or approves it on application by a Beneficiary.

4.18. **"Child",** shall mean 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 who has been placed in the custody of the Member, or his/her Spouse or Partner in terms of an order of court or competent authority and who is not a Beneficiary of any other medical scheme and who is Substantially dependent on the Member.

4.19. "**Chronic Drug Amount (CDA)"**, means the amount up to which chronic Medicine that is not on the Scheme's Medicine List is funded by the Scheme.

4.20. **"Chronic Medication"**, shall mean Medicine prescribed by a person legally entitled to prescribe for an uninterrupted period of at least 3 months and which has been applied for in the manner, and at the frequency, prescribed by the Scheme from time to time, and which application has been accepted by the Scheme.

4.21. **"Commencement"/"Commence"**, shall mean the date on which a person becomes eligible for Membership or, in the case of an Employer, the date on which such an Employer may participate in the Scheme in terms of these Rules.

4.22. **"Condition specific waiting period"**, shall mean a period of twelve consecutive months during which a Beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnoses, care or Treatment was recommended or received within the twelve-month period ending on the date on which an application for Membership was made.

4.23. **"Continuation Member",** shall mean a Member who retains his membership of the Scheme in terms of Rule 6.2 or a Dependant who becomes a Member of the Scheme in terms of Rule 6.3.

4.24. **"Contribution",** in relation to a Member, shall mean the amount, exclusive of interest, paid by or in respect of the Member and his Dependants, if any, as membership fees as set out in Annexure A of these Rules..

4.25. **"Council",** shall mean the Council for Medical Schemes as contemplated in the Act.

4.26. **"Cost",** In relation to a benefit, shall mean the net amount payable in respect of a relevant health service.

4.27. **"Creditable coverage"** means any period in which a Late Joiner was:

4.27.1 a Member or a Dependant of a medical scheme;

4.27.2 a Member or a Dependant of an entity doing the business of a medical scheme which, at the time of his or her membership of such entity, was exempt from the provisions of the Act;

4.27.3 a uniformed Employee of the South African National Defence Force, or

4.27.4 a Dependent of such Employee, who received medical benefits from the South African National Defence Force; or

4.27.5 a Member or a Dependant of the Permanent Force Continuation Fund;

but excluding any period of coverage as a Dependant under the age of 21 years.

4.28. **"Date of Service",** shall mean:

4.28.1 In the event of a consultation, visit or Treatment, the date on which the consultation, visit or Treatment occurred, whether for the same illness or not;

4.28.2 in the event of an operation, procedure or confinement, the date on which each operation, procedure or confinement occurred;

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

4.28.4 in the event of any other service or requirement, the date on which such service was rendered or requirement obtained.

4.29. **"Dependant",** shall mean either:

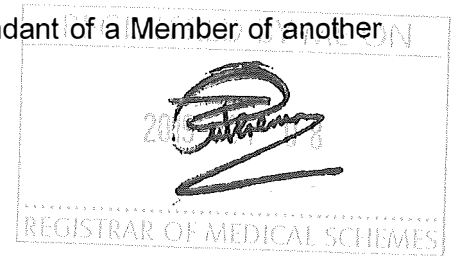
4.29.1 a Member's Spouse or Partner; or

4.29.2 a Member's Dependent Child; or

4.29.3 a Member of the Immediate family of a Member in respect of whom the Member is liable by law for family care and support and who is Substantially dependent on the Member; or

such other persons who are substantially Dependant on the Member and who are recognised by the Board as Dependants for purposes of these Rules;

and who is not a Member or a registered Dependant of a Member of another medical scheme.



4.30. **"Dependent",** in relation to a Child, shall mean:
4.30.1 a Child under the age of 21; or
4.30.2 a Child under the age of 25 years who, due to a mental or physical disability, is dependent upon the Member; or
4.30.3 a Child who is over the age of 21 years, but not over the age of 25 years, who at the Commencement of each academic year provides proof of registration as a student at a University or recognised college for higher education and who is not self supporting.

4.31. **"Designated Service Provider"/"DPA",** means a healthcare provider or group of providers selected by the medical scheme concerned as the Preferred provider or providers to provide to it's Beneficiaries diagnosis, Treatment and care in respect of one or more Prescribed Minimum Benefit conditions or any other relevant health service covered.

4.32. **"Domicilium Citandi Et Executandi",** shall mean the Member's chosen physical address at which notices in terms of Rule 17.9 as well as legal process, or any action arising there from, may be validly delivered and served.

4.33. **"Deductible",** shall mean a specific payment for which a Beneficiary is personally liable, the amount of which is specifically stipulated, in terms of the Rules of the Scheme.

4.34. **"Emergency Medical Condition"/"Emergency",** shall mean 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.

4.35. **"Employee"/"Employee member",** shall mean any person who is in the full time service of the Employer and works at least 109 hours per calendar month.

4.36. **"Employer",** shall mean The Foschini Group (TFG) Limited., and any subsidiary or associated company who has contracted with the Scheme as a participating Employer, for purposes of admission of its Employees as Members of the Scheme.

4.37. **"Financial year"**, shall mean the twelve month period from 1 January to 31 December during which benefits are paid in accordance with defined annual limits and benefit design and covers the twelve month accounting period at the end of which account books are closed and financial reports are prepared for filing.

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

4.39. **"Formulary",** shall mean a list of preferred medicines considered by the Scheme to be those most useful in patient care, rated on the basis of clinical effectiveness, safety and Cost.

4.40. **"Frail care",** shall mean 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.

4.41. **"General waiting period",** shall mean a period in which a Beneficiary is not entitled to claim any benefits, limited to a maximum period of 3 months.

4.42. **"Global fee",** shall mean a fee that covers all relevant medical expenses including, but not limited to, professional, facility, radiology and pathology expenses.

4.43. **"Grandchild",** shall mean a Member's Grandchild, whose natural parent is the Member's Child Dependant under the age of 21, provided that the Child Dependant is Substantially dependent on the Member or a Grandchild whom the Member has legally adopted.

4.44. **"Hospital",** shall mean, any institution established or registered in terms of any law as a private or government Hospital, maternity home, nursing home or similar institution where nursing is practiced, or any other private or governmental institution where surgical or other medical activities are performed, wherein accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy and shall be deemed to include a day clinic, but excluding:

4.44.1 a facility which has as its primary function the provision of remedial, rehabilitative or convalescent care; or

4.44.2 a home for the aged; ;or

4.44.3 a long-term nursing facility; or

4.44.4 a rest home; or

4.44.5 any facility that has not been issued with a registration number by the Board of Healthcare Funders.

4.45. **"Hospital Network Plans",** shall mean and refers in the context of TFG Medical Aid Scheme Benefit Plans the TFG Health Plan.

4.46. **"Immediate family"**, shall mean biological parents, siblings or children of the principal Member, but not further removed.

4.47. **"Income",** for the purposes of calculating Contributions in respect of:

4.47.1. a Member who is an Employee - gross monthly salary;

4.47.2. a Member who registers a Spouse or Partner as a Dependant — the higher of Member or Spouse's or Partner's salary or earnings;

4.47.3. a Continuation Member - gross monthly earnings.

4.48. **"KeyCare Acute Medicine Formulary and Protocols,** means Medicine used for diseases or conditions for members registered on the TFG Health Benefit Plan that have a rapid onset, severe symptoms, and that require a short course of Medicine Treatment, for which a list of preferred medicines considered by the

Scheme to be those most useful in patient care, rated on the basis of clinical effectiveness, safety and Cost, are available, within a set of guidelines in relation to the optimal sequence of diagnostic testing and Treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard Treatment guidelines, disease management guidelines, Treatment Algorithms and clinical pathways.

4.49. **"KeyCare Direct Payment Arrangement"**, means a healthcare provider or group of providers selected by the medical scheme concerned as the Preferred provider or providers to provide to its Beneficiaries diagnosis, Treatment and care in respect of one or more Prescribed Minimum Benefit conditions or any other relevant health service covered.

4.50. **"KeyCare Health DPA Specialist",** shall mean a specialist medical practitioner who has entered into an agreement contemplated in Rule 4.85 in respect of Beneficiaries on the TFG Health Benefit Plan.

4.51. **"KeyCare Network GP"**, shall mean a General Practitioner who has contracted with Discovery Health (Pty) Limited and/or TFG Medical Aid Scheme to be part of a GP network on the TFG Health Benefit Plan.

4.52. **"KeyCare Network Hospital"**, shall mean a Hospital contracted to or nominated by the medical scheme for purposes of a Hospital Network Plan established for the TFG Health Benefit Plan.

4.53. **"Late Joiner",** means an applicant or the adult Dependant of an applicant who, at the date of application for membership or admission as a Dependant, as the case may be, is 35 years of age or older, but excludes any Beneficiary who enjoyed coverage with one or more Medical Scheme/s as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001

4.54. **"Managed Health Care",** shall mean clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and Cost effectiveness of Relevant health services within the constraints of what is affordable, through the use of Rules-based and clinical management-based programmes.

4.55. **"Managed Healthcare Organisations",** shall mean a person who has contracted with the Scheme in terms of regulation 15A to provide a managed healthcare service.

4.56. **"Medically necessary",** shall mean the services, care or supplies which are appropriate and necessary and evidence-based for evaluating or determining the symptoms, diagnosis and/or clinical management of a medical condition

and/or is provided for the direct care and/or Treatment of a medical condition provided that the level of service, care or supply-

4.51.1 meets the standard of good clinical practice amongst relevant medical practitioners practicing in the community within which the Member resides:
4.51.2 is not primarily for the convenience or comfort of the Member, the medical scheme and/or the provider; and
4.51.3 is deemed to be appropriate and necessary (relevant to and consistent with the Member's diagnosis or condition) to meet the healthcare needs of the Member, as may be determined by the Scheme or a health professional, multi-disciplinary committee or panel of experts appointed by the medical scheme to make such a determination.

4.57. **"Medicine",** shall mean a substance registered under the Medicines and Related Substances Control Act, 1965, as amended or replaced from time to time.

4.58. **"Member",** shall mean any eligible person who is admitted as Member in terms of these Rules and does not include a Dependant and in respect of whom Contributions are paid to the Scheme in order to obtain benefits in terms of these Rules.

4.59. **"Member Family",** shall mean the Member and all his registered Dependants.

4.60. **"Motion",** shall mean a written proposal formally submitted to a general meeting of Members for discussion and possible ~~a~~ and plan as a resolution.

4.61. **"Non-Network Hospital",** shall mean a Hospital not contracted with the Scheme.

4.62. **"Officer",** shall mean any Member of the Board, Independent Board Committee Member, the Principal Officer or any other agent of the medical scheme authorised by the Board of Trustees to act on behalf of the Scheme, but does not include the Auditor.

4.63. **"Participating Health Care Provider",** shall mean a health care provider who, by means of a contract directly between the provider and the Scheme in terms of regulation 15A, or pursuant to an arrangement with a Managed Health Care organisation which has contracted with the Scheme in terms of regulation 15A, undertakes to provide a relevant health service to the beneficiaries of the Scheme concerned.

4.64. **"Partner",** shall mean 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.

4.65. **"Payment in Full",** shall mean in relation to a Prescribed Minimum Benefit, means payment according to the Service Provider's invoice (i.e. Cost) for relevant healthcare services rendered, subject to the use of Protocols, Designated Service Providers (DSPs), formularies, Pre-authorisation or such other managed care initiatives in place and provider for in these Rules.

4.66. **"Per Diem",** shall mean a fee based on a set rate per day.

4.67. **"Planned/Elective Procedures",** shall mean those medical procedures that are non-life threatening that develop over time, are not of sudden onset and where the timing of the procedures is generally discretionary.

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

4.69. **"Pre-existing sickness condition"**, shall mean 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 was made.

4.70. **"Premier Plus GP",** shall mean a General Practitioner who has contracted with Discovery Health (Pty) Limited and/or TFG Medical Aid Scheme to be part of the Discovery Premier Plus network Service Providers.

4.71. **"Preferred provider",** shall mean 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.

4.72. **"Premier Rate",** shall mean the rate that the Scheme will pay a Premier Rate provider in accordance with the undertaking referred to in Rule 4.71 and Rule 4.73, as may be applicable, and such provider's procedures and consultations will be paid by the Scheme in full and Beneficiaries will not be required to make any further payments to him save in instances of depleted benefits.

4.73. **"Premier Rate provider",** shall mean a dental specialist or medical specialist who had undertaken *inter alia*, to bill Beneficiaries at the Premier Rate for

procedures and consultations in accordance with the relevant procedure codes and consultation codes in return for direct payment by the Scheme of benefits to which Beneficiaries are entitled.

4.74. **"Prescribed Minimum Benefits"/"PMB",** shall mean the benefits contemplated in section 29(1)(o) of the Act and consist of the provision of the diagnosis, Treatment and care costs of –

4.69.1 the Diagnosis and Treatment Pairs listed in Annexure A of the regulations, subject to any limitations specified therein; and
4.69.2 any Emergency Medical Condition.

4.75. **"Prescribed Minimum Benefit Condition",** shall mean a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any Emergency Medical Condition.

4.76. **"Prescription or repeat prescriptions",** shall mean all Medicine prescribed at the same time by a person legally entitled to prescribe for one person for the condition under Treatment.

4.77. **"Principal Officer",** shall mean the person appointed in accordance with the Rules.

4.78. **"Protocol",** shall mean a set of guidelines in relation to the optimal sequence of diagnostic testing and Treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard Treatment guidelines, disease management guidelines, Treatment Algorithms and clinical pathways.

4.79. **"Proxy",** shall mean a Member authorised in terms of the Rules to act on behalf of another Member in circumstances where the Member is unable to attend a meeting.

4.80. **"Registrar",** shall mean the Registrar or Deputy Registrar of Medical Schemes appointed under Section 18 of the Act.

4.81. **"Relevant health services",** shall mean a service as defined in the Act which is provided for in a Benefit Plan.

4.82. **"Rules",** shall mean the Rules of the Scheme and shall include the Benefit Plan schedules, Annexures and any other provisions relating to the benefits which may be granted or the Contributions which may become payable in terms of a resolution adopted in general meeting or by the Board.

4.83. "**Scheme Medication Rate**", shall mean the single exit price plus the appropriate professional fee.

4.84. **"Second Opinion",** shall mean an opinion of a health professional appointed by the Scheme. Such opinion will be based on: a clinical examination of the patient/Beneficiary by such healthcare professional and/or; a clinical report submitted by the Scheme to the healthcare professional

4.85. **"Scheme Rate",** shall mean the fee/ rate 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.

4.86. **"Service Provider",** shall mean a medical practitioner, dentist, pharmacist, Hospital, nurse or any other person or entity who is duly registered or licensed as such with a statutory Council or relevant state department – or if practicing in a territory outside South Africa, registered or licensed as such with a similar body in that territory.

4.87. **"Specialised Medicine",** shall mean those benefits as set out in Rule 34.

4.88. **"Spouse",** shall mean the person to whom the Member is married in terms of any law or customs.

4.89. **"Southern Africa",** shall mean the territory of the Republic of South Africa and other territories within the Rand Monetary Area.

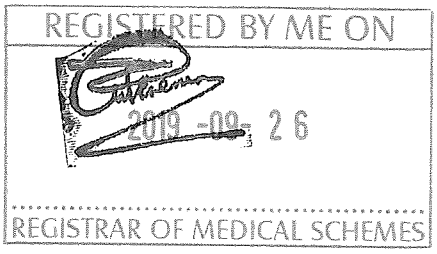
4.90. **"Substantially dependent",** shall mean any Dependant, whether Child or otherwise, who is dependent upon the principal Member for family care and support.

4.91. **"Uniform Patient Fee Schedule (UPFS),"** shall mean the schedule of rates charged by the state/public facilities.

4.92. **"Utilisation management",** shall mean a plan or programme of managed care implemented by the Scheme and administered by or on behalf of the Scheme by means of Case management principles, which is that of direct involvement with individual Members, their Dependants and Service Providers before services are provided and while services are being provided.

4.93. **"Trauma",** subject to Annexures D and D1 and without derogating from Annexures B4 and C2, the following sudden, serious physical injuries of the body caused by an act of violence or An Accident –

4.91.1 injuries at work
4.91.2 burns
4.91.3 injuries sustained as a victim of crime
4.91.4 sexual assault
4.91.5 injuries as a result of a car accident
4.91.6 injuries from a fall
4.91.7 the loss of an arm, hand, leg or foot
4.91.8 near drowning
4.91.9 head injuries
4.91.10 poisoning or an anaphylactic reaction



4.94. **"Treatment",** shall mean the provision of healthcare services which would include, but is not limited to hospitalisation or non-hospitalisation benefits and is subject to the provisions of Rule 4.56.

4.95. **"TTO"/"To Take Out"**, shall mean the medication that a Beneficiary is required to take at home but is prescribed to the Beneficiary whilst in Hospital.

5. BUSINESS OF A MEDICAL SCHEME

The business of the Scheme is:

5.1 to undertake liability, in respect of its Members and their Dependants, in return for a Contribution or premium;

5.2 to make provision for the obtaining of any relevant health service;

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

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

6. MEMBERSHIP

6.1. Eligibility

6.1.1. Subject to Rule 8 membership of the Scheme is restricted to employment or former employment by the Employer.

6.1.2. Membership of the Scheme shall be voluntary or compulsory in respect of every Employee in the service of the Employer, depending on the Employee's conditions of employment.

6.1.3. An Employee who ceases to be a registered Dependant of this or any other Medical Scheme may become a Member subject to the provisions of Rule 8.

6.2. Continuation Members

6.2.1. With effect from 1 September 2016, a Member shall, retain his membership of the Scheme as a Continuation Member in the event of his:

6.2.1.1. retiring from the service of the Employer; or

6.2.1.2. employment being terminated by the Employer on account of age, ill-health or other disability; or

6.2.1.3. employment being terminated through resigning from the service of the Employer within five years of his minimum retirement age and having not less than ten years continuous membership of the Scheme; or

6.2.1.4. employment being terminated by the Employer through retrenchment within five years of his minimum retirement age and having not less than ten years continuous membership of the Scheme.

Provided that where such Member is not permanently resident in Southern Africa, services will be restricted to those rendered in Southern Africa.

6.2.2. The Scheme shall inform the Member of his right to continue his membership and of the Contribution payable from the date of retirement or termination of his employment. 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 Member

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

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

6.3.3. Such a Member's membership terminates if he becomes a Member or a Dependant of a Member of another Medical Scheme.

6.3.4. Where a Child Dependant has been orphaned, the eldest Child may be deemed to be the Member, and any younger siblings, the Child Dependant/s.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of Dependants

7.1.1 A Member may apply to the Scheme for registration of his Dependants in terms of Rule 8 at the time that he applies for membership or at any other time. In addition to the terms of Rule 8, the Scheme may require proof to its satisfaction that the Member is indeed liable for support in respect of the person for whom the application is made.

7.1.2 Birth of infants and adoption of children

A Member who wishes to register a new born or newly adopted Child as his Dependant, shall notify the Scheme within 30 days of the birth or adoption of a Child, and shall apply to the Scheme to register such Child as a Dependant. Increased Contributions shall apply as from the first day of the month following birth or adoption. Benefits will accrue as from the date of birth or adoption.

7.1.3 Change in marital status

A Member whose marital status changes subsequent to joining the Scheme is required to notify the Scheme within 30 days thereof.

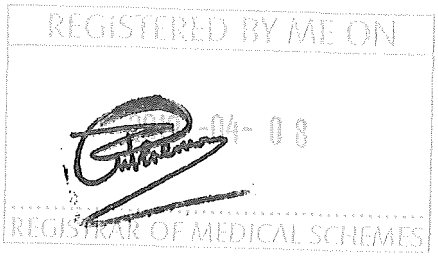
Should a newly married Member wish to register his Dependants, increased Contributions shall apply from the first day of the month following the change in his marital status. Benefits will be adjusted from the date of such change in status.

Should a Member divorce, his former Spouse is no longer eligible for membership and will be withdrawn from the Scheme. Reduced Contributions shall apply from the first day of the month following the withdrawal of the former Spouse.

7.2 Deregistration of Dependants

7.2.1. A Member shall inform the Scheme within 30 days of the occurrence of any event which results in any one of his Dependants no longer satisfying the conditions in terms of which he may be a Dependant.

7.2.2. From the time the Dependant ceases to be eligible to be a Dependant, he shall no longer 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 person under the age of sixteen years may not become a Member without the consent of his parent or guardian.

8.2. No person shall be a Member of more than one registered Medical Scheme or a Dependant:

8.2.1. of more than one Member of a particular Medical Scheme; or

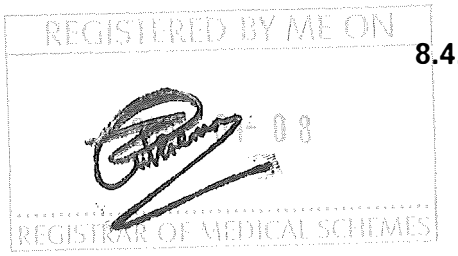
8.2.2. of Members of different Medical Schemes or;

8.2.3. claim or accept benefits in respect of himself or any of his Dependants from any Medical Scheme in relation to which he is not a Member or a Dependant of a Member.

8.3. Prospective Members shall, prior to Admission Date, complete and submit the application forms required by the Scheme, together with satisfactory evidence of age, Income, state of his health and the health of his Dependants and of any medical advice, diagnosis, care or Treatment recommended or obtained within a period of 12 months immediately prior to the date on which application to the Scheme was made. Proof of any prior membership of any other Medical Scheme must also be submitted. The Costs of any medical tests or examinations required, to provide such a medical report, will be paid for by the Scheme. The Scheme may however designate a provider to conduct such tests or examinations.

8.4. Waiting periods

8.4.1. On admission the Scheme may impose upon a person in respect of whom an application is made for membership or for registration as a Dependant and who was not a Beneficiary of a Medical Scheme for a period of at least 90 days preceding the date of application –



8.4.1.1. a General waiting period of three months, during which period no insured benefits whatsoever shall accrue, but Contributions shall be paid to the Scheme in full;

8.4.1.2. a Condition specific waiting period of up to 12 months in respect of any condition contemplated in Rule 8.3. If both a General waiting period and a condition-specific waiting period are imposed, they will run concurrently, but the provisions of the General waiting period shall predominate. No insured benefits shall accrue for services in respect of a condition for which a waiting period has been imposed, but Contributions shall be paid to the Scheme in full.

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

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

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

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

8.5. No waiting periods may be imposed on

8.5.1. a person in respect of whom application is made for membership or admission as a Dependant, and who was previously a Beneficiary of a Medical Scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of –

8.5.1.1. change of employment; or

8.5.1.2. an Employer changing or terminating the Medical Scheme of its Employees, in which case such transfer

shall occur at the beginning of the Financial year, or reasonable notice must have been furnished to the scheme to which an application is made for such transfer to occur at the beginning of the Financial year.

Where the former Medical Scheme had imposed a general or Condition specific waiting period in respect of persons referred to in this rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former Medical Scheme.

8.5.2. a Beneficiary who changes from one benefit Plan to another within the Scheme unless that Beneficiary is subject to a waiting period on the current benefit Plan in which case the remaining period may be applied;

8.5.3. a Child Dependant born during the period of membership

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

8.7. Every Member will, on admission to membership, receive a detailed summary of these Rules, which shall include Contributions, benefits, limitations, the Beneficiary's rights and obligations. Members and their Dependants, and any person who claims any benefit under these Rules or whose claim is derived

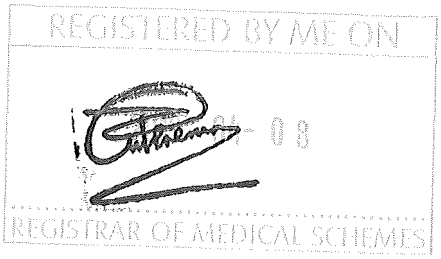
from a person so claiming are bound by these Rules as amended from time to time.

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

8.9. Nothing in these Rules shall be construed as altering in any way the Employer's right to either terminate the service of an Employee who is a Member of the Scheme or to terminate or amend any agreement between the Employer and the Employee in regard to conditions of service.

9. TRANSFER OF COMPANY GROUPS FROM ANOTHER SCHEME

9.1 If the Members of a scheme who are Members of that scheme by virtue of their employment by a particular company, terminate their membership of the said scheme with the object of obtaining membership of the Scheme, the Board shall admit as a Member, without a waiting period or the imposition of new restrictions on account of the state of his health or the health of any of his Dependants, any Member or a Dependant of such first-mentioned scheme who:



9.1.1. is a Member;

9.1.2. is a Continuation Member;

9.1.3. is a Continuation Member's surviving Spouse or Partner, or surviving Dependant.

10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

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

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 shall be construed as an abuse of the benefits of the Scheme and subject to penalties in Rule 12.5.

10.3 On termination of membership or on de-registration of a Dependant, the Scheme must within 30 days of such termination, or at any time on request, furnish such person or any Medical Scheme to which the former Member or Dependant subsequently applies for membership with a certificate of membership and cover, containing such particulars as may be prescribed.

11. CHANGE OF ADDRESS OF MEMBERS

A Member shall notify the Scheme within 30 days of any change of address including his/her Domicilium Citandi Et Executandi. The Scheme shall not be held liable if a Beneficiary's rights are prejudiced or forfeited as a result of neglecting to comply with the requirements of this Rule.

12. TERMINATION OF MEMBERSHIP

12.1 Termination

Subject to Rule 6.2 a Member shall cease to be a Member on ceasing to be an Employee or his Employer ceasing to be an Employer. On so ceasing to be a Member he shall have no claim on the Scheme or on its funds, except in respect of services rendered prior thereto.

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 by giving 30 days written notice if proof is provided of joining another registered Scheme. Where a Member, in terms of his conditions of employment, is required to be a Member of the Scheme, he may not terminate his membership while he remains an Employee without the prior written consent of the Employer. The provision of Rule 8 will apply on re-admission to membership. All rights to benefits cease after the last day of membership.

12.2.2 Such notice period shall be waived in substantiated cases where membership of another Medical Scheme is compulsory as a result of a condition of employment.

12.2.3 A participating Employer may terminate his participation with the Scheme on giving three (3) months written notice.

12.3 Death

Membership of a Member terminates on his death.

12.4 Failure to pay amounts due to the Scheme

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

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

Subject to the provisions of Rule 28 the Board may suspend the benefits or terminate the membership of a Member or the registration as a 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 the non-disclosure of factual information required in terms of the Act. In such event he shall be required by the Board to refund to the Scheme any sum which, but for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf.

13. CONTRIBUTIONS

13.1 The monthly Contributions payable to the Scheme by or in respect of a Member shall be as indicated in Schedule 1 and 2 of Annexure A. It shall be the responsibility of the Member to notify the Scheme of changes in Income that may necessitate a change in Contribution in terms of Annexure A hereto.

13.2 Contributions shall be due monthly in arrears and be payable by not later than the 3rd day of each month. Where Contributions or any other debt owing to the scheme, have not been paid within thirty (30) days of the due date, the Scheme shall have the right –

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

13.2.2 to give the Member at his/her Domicilium Citandi Et Executandi and/or Employer written notice that if Contributions or such other debts are not paid up to date within fourteen (14) days of posting such written notice, membership may be cancelled.

A notice sent by prepaid registered post to the Member at his/her Domicilium Citandi Et Executandi shall be deemed to have been received by the Member on the 7th day after the date of posting. In the event that, as per Rule 11, the Member has not notified the Scheme of a change in address, or in the event that the Member fails to nominate a Domicilium Citandi Et Executandi, the Member's postal or residential address on his/her application form shall be deemed to be his/her Domicilium Citandi Et Executandi.

13.3 In the event that payments are brought up to date, and provided membership has not been cancelled in accordance with Rule 13.2.2, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest on the arrear amount at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the Member from the date of default and any such benefit paid may be recovered by the Scheme.

13.4 Contributions are calculated on the basis of:

13.4.1 the Income of a Member or his Spouse as defined in the Rules; provided that Contributions will be calculated according to the higher of the Member or his Spouse's Income. Where a Spouse is self employed, an owner of a business, a director, a farmer, a senior executive, or a Member of a Partnership or close corporation the Contribution will be the maximum Contributions according to the family group, unless documentary proof of a lower Income can be submitted to the Board

13.4.2 the number of Dependants of the Member,

13.5 Beneficiaries who are Late Joiners are subject to penalties set out in Annexure A. Those penalties also apply to Beneficiaries who were subject to similar penalties at previous Medical Schemes of which they had been Members or adult Dependants of Members. However, any years of Creditable coverage, which can be demonstrated, by the Member or Dependant of the Member will be taken into account in determining the applicable penalty.

13.6 No portion of a Contribution shall be refunded where a Member's membership or that of any of his Dependants terminate.

13.7 Adjustment of Contributions as a result of increases or decreases of Income shall be effective from the first of the month during which, such increase or decrease becomes effective.

13.8 All Contributions in respect of new Members shall be payable from the first day of the month during which employment Commences, except when the date on which employment Commences is the 15th of the month, or thereafter, in which case the Contributions shall be payable from the first day of the month following. Benefits shall Commence from the date on which employment Commences.

13.9 When a Member's employment is terminated on the 15th or later of a month, Contributions for the full month shall be paid. In cases where termination takes place up to and including the 14th of the month, no Contribution is payable for that month.

13.10 The Contribution payable by a Continuation Member shall be paid monthly in arrears. If payment of the Contribution is not made within thirty days of the date when it is due and no satisfactory explanation is submitted to the Board, the provisions of rule 13.2 will apply.

14. LIABILITY OF EMPLOYER AND MEMBER

14.1 **Liability of Employer** - The liability of the Employer shall be limited to payment of Contributions in respect of Employees in terms of an agreement between the Scheme and the Employer.

14.2 **Liability of Members** - The liability of a Member shall be limited to the amount of his unpaid Contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his Dependants, which has not been repaid by him 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.

15. CLAIMS PROCEDURE

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

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 must, in addition to the payment contemplated in Section 59(2) of the Act, dispatch to the Member a statement containing at least the following particulars:

15.2.1 the name and the membership number of the Member;

15.2.2 the name and practice number of the supplier of service;

15.2.3 the Date of Service rendered by the supplier of service, on the account or statement, which is covered for the service concerned;

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 received from a Member or Dependant must, unless otherwise arranged:

15.3.1 Be signed and certified as correct and shall be submitted to the Scheme no later than the last day of the fourth month following the month in which the service was rendered.

15.4 Where a Member has paid an account, he shall, in support of his claim, submit a proof of payment.

15.5 Accounts for Treatment of injuries or expenses recoverable from third parties, shall be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained. The Scheme may claim the Costs of whatsoever nature incurred for Treatment arising out of an injury sustained by a Member or a Dependant and for which the Member received a refund from any other party who may be liable from the Member. The Member is required to lodge a claim in respect of the said expenses incurred by the Member or Dependant against the other party concerned and to pursue it with due diligence, with the Scheme being kept fully informed. Should the Member or Dependant not pursue the claim against such other party to the satisfaction of the Board, it may require the Member to cede or procure the cession of such claim to the Scheme, in which event the Member or Dependant shall provide the Scheme with all such assistance and co-operation as it may reasonably require in pursing such claim. The Member shall be obliged to pay to the Scheme so much of the damage actually recovered by him or his Dependant as relates to the service in respect of which he or his Dependant has received or benefited from such advances from the Scheme.

15.6 Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, for any reason, whatsoever including that the Treatment rendered is not Medically necessary, the Scheme shall notify the Member or the healthcare provider, whichever is applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such Member and provider the opportunity to return such corrected claim to the Scheme within 60 days.

15.7 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.

15.8 If any amount which the Scheme is liable to pay in terms of these Rules is not paid as required in terms of the Act and these Rules, then any claim which a Member may have as a result shall be a claim for specific performance against the Scheme.

15.9 The Scheme may at its discretion and based on justifiable reason, stop all payments to a provider where it can be shown on probable cause, that such provider has placed the Scheme, or any other Schemes, at risk.

15.10 The Scheme shall notify the provider in writing of such decision and reasons thereof and the provider will be entitled to dispute the decision.

15.11 The Member may notify the Scheme for possible payment consideration should they unwittingly be financially prejudiced as a result of the decision.

15.12 Members receiving services outside South Africa shall in the first instance, pay all medical accounts and thereafter, in order to verify the validity of the claim, submit the detailed accounts, together with receipts, proof of travel documents (including copies of flight tickets and passports) to the Scheme for refund, in accordance with the Scheme Rate, according to the benefits laid down in Annexures B and C.

16. BENEFITS

16.1 Unless membership is suspended as set out in Rule 12 or a waiting period is placed in terms of Rule 8.4, Members are entitled to benefits during a Financial year, as per Annexure B, and such benefits extend through the Member to his registered Dependants. A Member must, on admission, elect to participate in any one of the available options, detailed in Annexures B and C.

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

15.4.1. Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the health care provider, whichever is applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such member and provider the opportunity to return such corrected claim to the Scheme within 60 days of the notice.

15.5. The Scheme may at its discretion and based on justifiable reason, stop all payments to a provider where it can be shown on probable cause, that such provider has placed the Scheme, or any other Schemes, at risk.

15.5.1. The Scheme shall notify the provider in writing of such decision and reasons thereof and the provider will be entitled to dispute the decision.

15.5.2. The member may notify the Scheme for possible payment consideration should they unwittingly be financially prejudiced as a result of the decision.

15.6. Members receiving services outside South Africa shall in the first instance, pay all medical accounts and thereafter, in order to verify the validity of the claim, submit the detailed accounts, together with receipts, proof of travel documents (including copies of flight tickets and passports) to the Scheme for refund, in accordance with the Scheme Rate, according to the benefits laid down in Annexure B.

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. A member must, on admission, elect to participate in any one of the available options, detailed in Annexure B:

REGISTERED BY ME ON

2016-04-13

REGISTRAR OF MEDICAL SCHEMES

16.2.1 The change may be made with effect from 1 January of any Financial year, provided that the Board may, in its absolute discretion, permit a Member to change from one to another benefit Plan on any other date.

16.2.2 Application to change from one benefit Plan to another must be in writing and lodged with the Scheme within the period notified by the Scheme provided that the Member has had at least 30 days prior notification of any intended changes in benefits or Contributions for the next year;

16.2.3 The Scheme shall, where an account has been rendered, pay any benefit due to a Member, either to that Member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.

16.3 The Scheme shall, 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.

If, for any reason whatsoever, the Scheme pays an amount in excess of the amount which it is liable to pay in respect of a claim in terms of these Rules, then the Member will become liable to the Scheme for the amount overpaid in line with the Scheme's debt management policy in effect at the time payment falls due.

16.4 The Scheme shall be entitled to withhold payment of any benefits otherwise due to a Member Family whose Contribution, or any part thereof, is unpaid. The Scheme shall be entitled to recover from the Member any payment made in respect of claims processed on behalf of the Member, in the event that any Contribution or part of a Contribution remains unpaid.

16.5 The Scheme may exclude services from benefits as set out in Annexures D and D1.

16.6 Any Benefit Plan offered in Annexures B and C covers the Prescribed Minimum Benefits in accordance with Annexures B4 and C2.

16.7 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.

16.8 Specific Exclusions

The Scheme shall not pay for benefits if:

16.8.1 in the reasonable opinion of a medical Officer appointed for this purpose by the Scheme, taking into account generally accepted medical practices, the service/s

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

16.8.1.2 comprise a general exclusion to the Scheme as reflected in Annexures D and D1 to these Rules; or

16.8.1.3 is such that the quantum of the service comprises a Deductible.

16.9 Review

If hospitalisation or certain non-hospitalisation benefits ("Treatment") is recommended for a Member or a Dependant then, subject to Rules 16.11 and 16.13 below, the following provisions shall apply:

16.9.1 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;

16.9.2 the Members shall give notice to the Scheme within such reasonable period as will allow the provisions of this Rule 16.9 to be complied with; but in any event, notice of not less than 48 hours prior to the Treatment;

16.9.3 upon receiving such notice, the Scheme shall be entitled to require the Member or his Dependant (as the case may be) to obtain a Second Opinion from a medical practitioner approved by the Scheme as to whether the recommended Treatment is necessary. The charges levied by such medical practitioner in respect of the Second Opinion shall be borne by the Scheme;

16.9.4 immediately upon obtaining such Second Opinion, the Member shall furnish the Scheme with a copy thereof; and

16.9.5 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 exclusions stipulated in Rule 16.8 are present;

16.9.6 if the Member or Dependant (as the case may be) undergoes Treatment without the Member obtaining authorisation from the Scheme in accordance with this Rule 16.9 the Scheme's liability in respect of the Treatment of the Members or Dependant shall be subject to what is stated in Rules 16.8 to 16.13 and will further be limited as set out in the Benefit Schedules and Benefit Annexures which the Board of Trustees would have approved and as may be applicable.

16.10 The provisions of Rule 16.9.2 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 Rule 16.10, Treatment shall be deemed to have been required as a matter of urgency if the Member could not have been expected to comply with the provision of Rule 16.9.2 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.

16.11 The onus shall be upon the Member to prove that:

16.11.1 he gave notice in accordance with Rule 16.9.1;

16.11.2 such notice was given within the time period referred to in Rule 16.9.2;

16.11.3 a copy of the written Second Opinion was given to the Scheme in accordance with Rule 16.9.4;

16.11.4 Treatment was required as a matter of urgency in terms of Rule 16.10 if a dispute in respect of any such matter arises.

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

16.12.1 The Member will ensure that either the Member Family or the Hospital calls the Scheme to pre-authorise the admission.

16.12.2 All admissions are subject to Pre-authorisation.

16.12.3 Where the Scheme receives a Hospital claim that has not been preauthorised payment will be limited in accordance with Rule 16.9.6.

16.12.4 The Member is obliged to make full disclosure during or after Pre-authorisation of all healthcare services even if they are subject to a general scheme exclusion. Failure to do so may lead to the entire claim being declined and may be regarded as a misrepresentation.

16.12.5 A Pre-authorisation is not a guarantee nor a confirmation of the Scheme's obligation to make payment of a claim.

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

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

16.13.2 Should the Beneficiary be admitted to a Non-Network Hospital for reasons other than an emergency and involuntariness in respect of a Prescribed Minimum Benefit, such admission will be covered up to a maximum of 80% of the benefit available to the Beneficiary on the particular Hospital Network Plan or with a Deductible applied as may be applicable as set out in the Annexures to these Rules.

16.13.3 Admissions of Beneficiaries on the TFG Health plan for non-emergency reasons or involuntariness to Non-Network Hospitals will not be covered save in accordance with Annexures B4 and C2.

16.14 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 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.

16.15 Funding only for Medically necessary healthcare services:

16.15.1 The Scheme shall only fund healthcare services provided to a Member if the service in question is Medically necessary.

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

16.15.3 The Scheme may require a Member to be medically examined for purposes of establishing whether the healthcare service is Medically necessary. Should the Member and/or the Member's family decline consent for such an examination, the Scheme may then, in keeping with generally accepted clinically practice and with the clinical

information at hand, withdraw or reduce clinical funding to the recommended level of care as contemplated in Rule 4.51.

17. PAYMENT OF ACCOUNTS

17.1 Payment of accounts or reimbursement of claims is restricted to the net amount payable in respect of such benefit and maximum amount of the benefit which the member is entitled to as set out in the Annexures of the Plan elected.

17.2 Subject to Rule 15.6, the Scheme may, whether or not by mutual agreement, and in respect of 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: South African Medical Association (SAMA), 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.

17.6 If a supplier of service renders an account, which is not in accordance with the Scheme Rate, the benefit to which the Member is entitled, shall be based on the Scheme Rate and will be paid to the Member, who is personally liable for the settlement of such accounts.

17.7 The Board of Trustees may at its sole discretion, make *ex gratia* payments to or for the benefit of a Beneficiary.

17.8 Addresses

17.9.1 Postal address

17.9.1.1. Any notice in connection with these Rules may be addressed to a Member or an Employer at his address stated in the application form.

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

17.9.1.2.1 7 days after posting to the address in Rule 17.9.1.1 if posted by prepaid registered post;

17.9.1.2.2 on delivery, if delivered;

17.9.1.2.3 on transmission, if successfully transmitted to the party's telefax number.

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

17.9.1.3 Any Member or Employer shall notify the Scheme within 30 days of any change of address, by notice in writing.

17.9.2 Address for service of legal documents

17.9.2.1 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.

17.9.2.2 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.

18. GOVERNANCE

18.1 The affairs of the Scheme must be managed according to these Rules by a Board of fit and proper persons (i.e. persons with the requisite character, integrity, skill, competence, financial soundness and ability to exercise a fiduciary duty) of at least 8 persons.

18.2 The following persons are not eligible to serve as Members of the Board:

18.2.1 a person under the age of 21 years;

18.2.2 an Employee, Partner, director, Officer, consultant, or contractor of the Administrator or the Scheme or of the holding company, subsidiary, joint venture or associate of that Administrator or any other medical scheme Administrator or provider of Managed Health Care services to

a medical scheme;

18.2.3 a broker;

18.2.4 a person, including a legal person, associated with the Administrator and/or the provider of Managed Health Care services to the Scheme;

18.2.5 the Principal Officer of the Scheme;

18.2.6 the Auditor of the Scheme.

18.3 The Board shall be composed of 8 persons of which 4 must be –

18.3.1 elected from amongst Members and shall be known as "elected representatives"; and the balance

18.3.2 must be appointed by the Employer and shall be known as "appointed representatives". Appointed representatives chosen by the Employer could be independent of or employed by the Employer.

18.4 A Board Member shall serve a term of 5 years and shall be eligible for re-election or re-appointment. Retiring Board Members are eligible for re-election or re-appointment and shall not serve more than 3 terms during his/her lifetime; provided that he/she may not hold office for more than 2 terms consecutively and provided that there is at least a 2 year interval between the end of the second consecutive term and the commencement of the third term.

18.5 The Board may co-opt a person with the requisite skills and expertise (an Independent co-opted Member) to assist it in its deliberations. The Board may at any time withdraw such co-option. An independent co-opted Member shall not serve on the Board beyond the next Annual General Meeting, but shall be eligible for subsequent co-option. An Independent co-opted Member shall not have a vote at Board meetings.

18.6 Nominations to fill vacancies on the Board, must be signed by the nominator and nominee in good standing, signifying the nominee's consent to stand for election and that he/she is not disqualified to serve on the Board for the reasons set out in Rule 18.2 above and must be submitted to the Scheme by no later than 14 days prior to the Annual General Meeting. The Board may appoint an electoral officer to assess all nominees against the eligibility criteria described in Rule 18.2 above. The Board may appoint an independent third party service provider for purposes of carrying out this function. The election must be conducted amongst the Members present in person or virtually at the Annual General Meeting of the Scheme.

18.7 The remaining Members of the Board may temporarily fill, by appointment any casual vacancy which occurs on the Board during its term of office, within 40 days of such vacancy arising. The period of such appointment will not be deemed to be tenure of office for purposes of Rule 18.4. A person so appointed, shall retire at the first ensuing Annual General Meeting and that meeting shall elect a candidate to fill the vacancy.

18.8 Persons so elected/appointed to the Board must disclose at his/her first meeting of the Board and then annually all interests they have in relation to the Scheme.

18.9 The Board must elect from its number the chairperson and vice-chairperson at the first meeting of the Board following an AGM. The chairperson and vice-chairperson shall serve for one year and shall be eligible for re-election each year.

18.10 In the absence of the chairperson and vice-chairperson, the Board Members present must elect one of their numbers to preside.

18.11 A quorum at meetings of the Board shall be 5 Members provided that 2 Members shall be from among each of the elected and appointed representatives respectively. If a quorum cannot be confirmed at any meeting of the Board within fifteen minutes after the time set for its commencement, the meeting shall stand adjourned.

18.12 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson has a casting vote in addition to his deliberative vote.

18.13 If the chairperson presiding at a meeting is of the opinion that an important matter of principle is involved and that no prior notice or that insufficient notice has been given that such matter of principle would require consideration, the discussion of the matter shall stand over and the matter shall be considered either at a special meeting or at the next ordinary meeting as the Board shall determine.

18.14 A Board Member may resign at any time by giving written notice to the Board. Such vacancy will be filled in terms of Rule 18.7.

18.15 A Board Member shall be obliged to vacate office, or failing which, may be removed from office by a simple majority decision of the Board if he/she -

18.15.1 becomes mentally ill or incapable of managing his/her affairs;

18.15.2 is declared insolvent or has surrendered his estate for the benefit of his/her creditors;

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

18.15.4 is removed from office if he is found to have acted in a manner seriously prejudicial to the interest of the Scheme, subject to the procedure set out in Rule 18.16.

18.15.5 is removed by the court from any office of trust on account of

misconduct;

18.15.6 is disqualified under any law from carrying on his profession;

18.15.7 if elected by Members of the Scheme, ceases to be a Member of the Scheme;

18.15.8 absents himself from 3 consecutive meetings of the Board without the permission of the chairperson; or

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

18.16 A Member of the Board who acts in a manner which is seriously prejudicial to the interests of the beneficiaries of the Scheme may be removed by the Board, provided that:

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

18.16.2 the resolution to remove the Member is taken by at least two thirds of the Members of the Board;

18.16.3 the Member shall have recourse to disputes procedures of the Scheme or complaints and appeal procedures provided for in the Act.

18.17 The Board must meet at least once every 3 months or at such intervals as it may deem necessary.

18.18 The Board may, discuss and resolve matters and adopt resolutions by telephone, video or electronic conferencing means, provided that the participants in such discussions are sufficient to constitute a quorum in the normal course.

18.19 The chairperson may convene a special meeting of the Board should the necessity arise. Any two Board Members may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

18.20 Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as Board Members.

18.21 The Board shall perform a self-assessment and a review of the performance of the Chairperson on an annual basis.

18.22 The Board may establish committees of the Board to enable it to carry out its functions. A committee may be comprised of Board Members and/or independent persons with requisite expertise (Independent Board Committee Member). An Independent Board Committee Member shall serve a term of 5 years and shall be eligible for re-appointment. Retiring Independent Board Members are eligible for re-appointment and shall not serve more than 3 terms during his/her lifetime; provided that he/she may not serve for more than 2 terms consecutively and provided that there is at least a 2 year interval between the end of the second consecutive term and the commencement of the third term. Independent Board Committee members are appointed by the Board and may at any time be removed from the committee by the Board. Independent Board Committee Members shall have a vote at their respective committee meetings. Persons so appointed to a committee must disclose at his/her first meeting of the committee then annually all interests they have in relation to the Scheme.

18.23 The provisions of Rules 18.15 and to 18.16 apply *mutatis mutandis* to the Principal Officer.

19. FIDUCIARY DUTIES OF THE BOARD OF TRUSTEES

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

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

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

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

19.5. The Board shall appoint a Principal Officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the Principal Officer and of any person employed by the Scheme:

Provided that the following persons are not eligible to be a Principal Officer-

19.5.1 An Employee, director, Officer, consultant or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;

19.5.2 A broker

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

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

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

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

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

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

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

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

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

19.15. The Board must cause revenue and expenditure accounts to be prepared and submitted to the Board and the payments reflected therein shall be confirmed.

The Board shall approve all disbursements, provided that such authority may be delegated to the Administrators.

19.16. The Board must cause any mortgage bond, title deed or other security belonging to or held by the Scheme to, except when in the temporary custody of another person for the purpose of the Scheme, 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.

19.17. 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.

19.18. The Board must disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme as prescribed.

20. POWERS OF BOARD

The Board shall have the power to carry out the objects and purposes of the Scheme in accordance with the Rules and without detracting in any way from the generality of this provision shall have the following powers:

20.1 to cause the termination of the services of any Employee of the Scheme;

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

20.3 to delegate any of its powers to the Principal Officer or to a Committee consisting of such of its Members as it may nominate, provided that a Committee so nominated shall in the exercise of its powers conform to any Rules or instructions that may be imposed on or issued to it by the Board;

20.4 to appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme.

The terms and conditions of such appointment shall be contained in a written contract, which complies with the requirements of the Act and the regulations.

20.5 to institute, conduct, defend, compound or abandon any legal proceedings by or against the Scheme;

20.6 to contract with Managed Health Care organisations subject to the provisions of the Act and its regulations;

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

20.8 to let or hire movable or immovable property;

20.9 to contribute towards any fund of any kind whatsoever which is conducted for the benefit of the Employees of the Scheme and To Take Out and pay for insurance policies on the lives of Employees of the Scheme for the benefit of such Employees or their Dependants;

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

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

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

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

20.14 to authorise payment for services provided for in these Rules but may, in its absolute discretion, in respect of the benefits provided increase the amount payable in terms of these Rules as an *ex-gratia* award.

20.15 to reinsure obligations in terms of the benefits provided for in these Rules;

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

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

20.18 to extend, on application, the age limit of 25 years imposed on full-time students in the definition of "Dependant", subject to such terms and conditions as it may determine; and

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

21. DUTIES OF PRINCIPAL OFFICER AND STAFF EMPLOYED

21.1 The staff of the Scheme must ensure the confidentiality of all information regarding its beneficiaries.

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

21.2.1 he acts in the best interests of the Members of the scheme at all times;

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

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

21.2.4 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;

21.2.5 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;

21.2.6 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.

21.2.7 The Principal Officer shall cause minutes of the proceedings of all meetings to be recorded, and the minutes of such meetings shall be laid before the first succeeding respective meeting, provided that the minutes of every Special General Meeting shall, (as the Board may decide), be laid before the first succeeding Special General Meeting or the Annual General Meeting. If the minutes of any such meeting are accepted as correct, they shall be signed by the Chairman as a true record of the proceedings.

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

21.4 The Principal Officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Scheme and 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 of the Scheme.

21.5 The Principal Officer shall be responsible for the supervision of the staff employed by the Scheme.

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

21.7 The Principal Officer shall in respect of every Financial Year cause to be prepared annual financial statements and shall within four months after the end of a Financial Year, furnish a copy of the audited statements concerned, together with the annual report and all statutory returns to the Registrar.

22. INDEMNIFICATIONS AND FIDELITY GUARANTEE

22.1 The Board and any officer of the Scheme is indemnified by the Scheme against all proceedings, Costs and expenses incurred by reason of any claim against/by the Scheme, not arising from their negligence, dishonesty or fraud.

22.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its Officers.

23. FINANCIAL YEAR OF THE SCHEME

The Financial year of the Scheme shall extend from the first day of January to the 31st day of December of that year.

24. BANKING ACCOUNT

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

25. AUDITORS AND AUDIT COMMITTEE

25.1 An Auditor approved in terms of section 36 of the Act shall be appointed by resolution at each Annual General Meeting, to hold office from the conclusion of that meeting, until the conclusion of the next Annual General Meeting.

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

25.2.1. a Member of the Board;

25.2.2. an Employee, Officer or contractor of the Scheme;

25.2.3. an Employee, director, Officer or contractor of the Scheme's administrator, or of the holding company, subsidiary, joint venture or associate of the administrator;

25.2.4. a person not engaged in public practise as an Auditor;

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

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

25.4 Where at an Annual General Meeting no Auditors are appointed or re-appointed, the Board shall within 30 days as from the date of the meeting appoint a person to fill the vacancy and if it fails to do so, the Registrar may at any time do so.

25.5 The Auditor of the Scheme shall have a right of access at all times to the books and accounts and vouchers of the Scheme, and shall be entitled to require from the Board and the other Officers of the Scheme such information and explanations as he thinks necessary for the performance of his duties.

25.6 The Auditor shall make a report to the Members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in General Meeting. A copy of such report shall be sent to the Company, who will exhibit it for the information of Members, and furthermore, a copy shall be available for inspection by Members at the offices of the Scheme.

25.7 The Board must appoint an Audit Committee in the prescribed manner.

26. GENERAL MEETINGS

At a General Meeting of Members the Chairman of the Board or in his absence the Vice-Chairman of the Board shall be Chairman of the meeting. In the absence of the

Chairman or the Vice-Chairman the Members present shall choose one of their numbers to be Chairman of the meeting.

26.1 Annual General Meeting

26.1.1. The Board shall convene an Annual General Meeting of Members within six months following the last day of December, on a date to be determined by the Board

26.1.2. The order of business at the Annual General Meeting shall be as follows:

26.1.2.1. Notice convening the meeting

26.1.2.2. Minutes of the previous meeting and business arising there from;

26.1.2.3. Report of the Auditor;

26.1.2.4. Report of the Board and Statement of Accounts;

26.1.2.5. The appointment of an Auditor for the ensuing year;

26.1.2.6. Any general business of which due notice has been given.

26.1.3. The number of Members of the Scheme present in person or virtually (subject to the Scheme's operational requirements on virtual participation in any given year) who shall constitute a quorum at an Annual General Meeting of Members shall exceed at least twice the number of Members of the Board.

26.1.4. If within thirty (30) minutes of the time appointed for the meeting there is no quorum, the meeting shall stand adjourned for seven days and Members then present will form a quorum: **provided** that if the day so determined is a public holiday then the adjourned meeting shall be held on the first day thereafter which is not a Sunday or a public holiday.

26.1.5. The adjourned meeting shall be held at the same hour and place set down for the meeting originally convened.

26.1.6. The notice convening the Annual General Meeting shall be sent, at least 14 days before the date of the meeting, to all Members and to each Company stating the day, place and hour at which the Annual General Meeting of Members is to be held, the notice shall contain the Agenda, Highlights of the Annual Financial Statements and advise the Members how the Annual Financial Statements, Auditor's and Annual report may be obtained. The non-receipt of such notice by a Member does not invalidate the proceedings at such a meeting.

26.2 Special General Meeting

26.2.1. The Board may, of its own volition, convene a Special General Meeting of Members if it is deemed necessary.

26.2.2. On the requisition of at least 50 Members of the Scheme, the Board shall cause a Special General Meeting to be called within 21 days of the requisition. The requisition shall state the objects of the meeting and shall be signed by all the requisitionets and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting shall be discussed.

26.2.3. The notice convening the special general meeting, containing the agenda, must be furnished to Members at least 14 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.

26.2.4. At least 50 Members present in person or virtually (subject to the Scheme's operational requirements on virtual participation in any given year) constitute a quorum. If a quorum is not present at a special general meeting after the lapse of thirty (30) minutes from the time fixed for the Commencement of the meeting, the meeting is regarded as cancelled.

27. VOTING AT GENERAL MEETINGS

27.1 Every Member of the Scheme present in person or virtually (subject to the Scheme's operational requirements on virtual participation in any given year) and in respect of whom, Contributions are not in arrears shall have one vote and the decision of the majority shall be binding. In the event of an equality of

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votes the Chairman of the meeting shall, if he is a Member, have a casting vote in addition to his deliberative vote. Voting shall be done by show of hands in person or virtually. A resolution so adopted shall be binding on all the Members.

27.2 Any Member who is entitled to attend and vote at a General Meeting of the Scheme shall have the right to appoint a Proxy, who must also be a Member, to attend and vote in his stead.

28. SETTLEMENT OF COMPLAINTS AND DISPUTES

28.1 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.

28.2 A "complaint" means a complaint defined in the Act, and for purposes of these Rules, a "complaint" and a "dispute" bears the same meaning.

28.3 Members may lodge their complaints, in writing (whether by post, email or telefax), to the Scheme. A complaint may also be lodged verbally by telephone but must be followed up in writing. The Scheme or its Administrators shall provide a dedicated telephone number, which may be used for dealing with telephonic complaints.

28.4 A Member lodging a complaint must do so within 2 years of alleged service failure that gave rise to the complaint; failing which the Member's right to lodge such complaint shall prescribe.

28.5 A Member lodging a complaint in respect of Prescribed Minimum Benefits must do so within 3 years of alleged service failure that gave rise to the complaint; failing which the Member's right to lodge such complaint shall prescribe.

28.6 The Scheme shall endeavour to respond to all complaints received in writing within 30 days of receipt thereof, failing which, within a reasonable time.

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

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28.8 If dissatisfied with the finding on the complaint the complainant may -

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

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

28.9 A Disputes Committee of three persons, who may not be Members or Employees of the administrator of the Scheme or Officers of the Scheme, must be appointed by the Board annually. At least one of such Members shall be a person with legal expertise. Such person shall preside over the Dispute Committee meeting.

28.10 On receipt of a dispute in terms of Rule 28.9, the Principal Officer shall convene a meeting of the Disputes Committee by giving not less than 14 days notice in writing to the complainant, Members of the Board and all Members of the Disputes Committee specifying::

28.10.1 the date of the meeting which must not be less than 21 days from the date of submitting the notice or such earlier date as the Principal Officer and Member may agree to;

28.10.2 the Commencement time and venue for the meeting

28.10.3 who will comprise the Disputes Committee

28.10.4 the particulars of the complaint; and

28.10.5 the procedures and 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.

28.11 The parties to any dispute shall have the right to be heard before such Committee either in person or through a representative. The decision of the

said Committee shall, subject to Rule 28.8, be final and binding unless overturned by the Council for Medical Schemes appeal process.

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

28.13 The operation of any decision, which is the subject of an appeal under rule 28.8, shall be suspended pending the decision of the Council on such appeal.

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

29. TERMINATION OR DISSOLUTION

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

29.2 Members in general meeting may decide that the Scheme shall be dissolved in which event the Board shall arrange for Members to decide by ballot whether the Scheme shall be liquidated. Unless the majority of Members decide that the Scheme shall continue, the Scheme shall be liquidated in terms of Section 64 of the Act.

29.3 In the case of a ballot the Principal Officer shall dispatch to every Member by registered post 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:

Provided that the memorandum and ballot paper shall before dispatch be forwarded to the Registrar for comment. Every Member shall be requested to return his ballot paper duly completed before a set date. If at least 50 per cent of the Members return their ballot papers duly completed and if the majority thereof are in favour of the dissolution of the Scheme, the Board shall take a formal decision that the Scheme shall be dissolved with effect from a set date from which date no further Contributions shall be payable to the Scheme. If a

decision to dissolve the Scheme has been taken, the dissolution shall be affected in accordance with the memorandum and as provided for in the Act and for this purpose the Scheme shall, with the approval of the Registrar, appoint a competent person as liquidator.

30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1. If the Employer transfers its business to or amalgamates with any other business, company or organization, the Employer may elect to:

30.1.1. withdraw wholly from the Scheme, or

30.1.2. continue to contribute to the Scheme in respect of existing Members, in which event, the Scheme shall not be affected except that Employer shall then mean the new business, company or organisation.

30.2. The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with or transfer its assets and liabilities to or take transfer of the assets and liabilities of any other registered Medical Scheme or person. Before such event the Board must arrange for Members to decide by ballot whether the proposed amalgamation/transfer should be proceeded with or not.

30.3. If at least 50 per cent of the Members return their ballot papers duly completed and if the majority thereof is in favour of the amalgamation or transfer then, subject to section 63 of the Act, the amalgamation or transfer may be concluded. The Registrar may, on good cause shown, ratify a lower percentage of votes.

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 The Scheme shall furnish the Member with a Member's guide, including the summary of these Rules as contemplated in Rule 8.10, on admission.

31.2 Any Beneficiary shall on request be supplied by the Scheme free of charge with the following documents:

31.2.1 a copy of the Rules of the Scheme;

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31.2.2 a copy of the latest audited revenue and expenditure account and balance sheet together with the agenda for the Annual General Meeting, Auditors Report and Trustees Report; and

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

31.3 Additional copies of the documents mentioned in Rule 31.2 shall be supplied by the Scheme on application and on payment of R10.00 per copy.

31.4 A Beneficiary shall be entitled to inspect free of charge at the Registered Office of the Scheme any document referred to in rule 31.2 and to make copies thereof.

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

32. AMENDMENT OF RULES

32.1 The Board shall be entitled to alter or rescind any Rule or Annexure or to make any additional Rule or Annexure. No alteration, rescission or addition which affects the objects of the Scheme or which increases the rates of Contribution or decreases the extent of benefits of the Scheme or of any particular benefit Plan by more than twenty five percent during any Financial year, is valid unless it has been approved by a majority of Members present in a general meeting or a special meeting or by ballot.

32.2 Members must be furnished with a copy of such amendment within 14 days after registration thereof. Should a Member's rights, obligations, Contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.

32.3 The Board shall, on request and to the satisfaction of the Registrar, amend any Rule that may be inconsistent with the requirements of the Act or any amendment thereto.

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

MEDICAL AID SCHEME

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES

Resolution 1 of 2023

Certified as having been adopted in terms of the rules, this serves to confirm the contribution and benefit changes to take effect 1 January 2023. The changes were discussed and agreed at a **Board of Trustees** meeting of the TFG Medical Aid Scheme ("the Scheme" or "TFGMAS") held on **15 September 2022**.

The changes agreed are:

1. Limits of the TFG Health and TFG Health Plus benefit plans are increased in line with the assumed tariff increase assumptions on general risk claims of the benefit plan. The application of these limits does not apply to PMB benefits, as these are paid for as set out in the registered benefit rules and are not subject to limits. The enclosed limit sheets detail the percentage increase of limits per benefit limit and per benefit plan.
2. Contribution increases of:
   - 2.1 TFG Health – Average increase of 7.25%
   - 2.2 TFG Health Plus – Average increase of 5.5%
   - 2.3 Overall average increase 6.375%
   - 2.4 A contribution holiday approved upon application sent to the Council for Medical Schemes ("CMS") for the month of January 2023 was confirmed by the trustees to be applied.
   - 2.5 New contribution tables as set out in Annexure A to the Rules adopted to take effect 1 January 2023. No changes to the income category values.

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3. Benefit changes and managed healthcare initiatives approved for TFG Health and TFG Health Plus are as per the below summarised table and are also set out in the actuarial reports enclosed:

Item nr	Description of change	TFG Health	TFG Health Plus	Summary of Rules impacted and Reasons if no Rule amendments incorporated
1	REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES 2022 Spinal Care Programme co-payment	N/a	✓	To effect the introduction of a co-payment of 20% from 2023 as approved by the Board of Trustees, should members registered on this benefit plan obtain services outside of the 2022 approved spinal surgery network, current benefit rule 34.1.23 (revised benefit rule 34.1.24) to be amended to make provision for payments to be limited to 80% of the Scheme Rate at non-network facilities or providers outside of the spinal surgery network.
2	Day Surgery Network: Deductibles on TFG Health Plus	N/a	✓	To effect the increase in deductibles, as approved by the Board of Trustees, to be applied where members of TFG Health Plus obtain day surgery procedures outside of the day surgery network, current Annexure B3 of TFG Health Plus to be amended by deleting the current reference of R1 500.00 and the value to be replaced with the industry aligned value of R6 300.00.
3	Oncology Pharmacy DSP introduction: TFG Health Plus	✓ (In existence)	✓ (Intro: 2023)	**TFG Health: Benefit rule 33.1.16** To clarify the existing requirement to obtain medicine related to oncology from the defined list of oncology pharmacies, the Basis of Cover

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	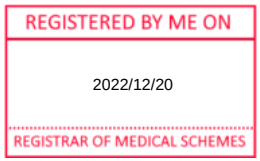			was amended through the insertion of the provisions set out in Annexure B4 of the benefit rules. **TFG Health Plus: Benefit rule 34.1.14** No change effected as the introduction of the defined list of oncology pharmacies were approved by the trustees, but without the introduction of a co-payment if members obtain their medicine related to oncology from a non-DSP oncology pharmacy. **Both benefit plans:** A sentence was introduced in the preamble of both benefit rules 33 and 34 to clarify the addition of the oncology pharmacies to other pharmacies where members obtain their acute and chronic medicines from.
5	Diabetes Nurse Educators ("DNE") for Chronic Illness Benefit ("CIB")	✓	✓	Members registered on the Chronic Illness Benefit ("CIB") for diabetes is enrolled onto the Diabetes Care programme by their nominated Premier Plus GP. To give effect to the approval obtained from the trustees to fund for coaching sessions with Diabetes Nurse Educators, the basket of care as referenced in the benefit rules are adjusted and there are no benefit rule amendments to be submitted for registration.
6	Diabetes-Cardiometabolic Population Health Management	✓	✓	Diabetes management is already contracted with Discovery Health ("DH") and the

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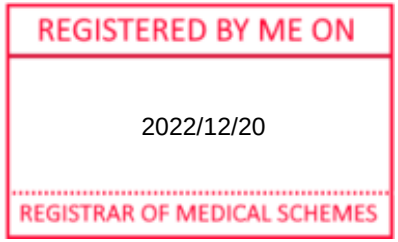
	by Discovery Care Maintenance Organisation ("CMO") 			enhancements of the programme, as approved by the trustees, requires clarification with the introduction of a new benefit rule 33.1.19 on the **TFG Health** benefit plan and a new benefit rule 34.1.18 on the **TFG Health Plus** benefit plan. Prescribed Minimum Benefit funding and Chronic Disease List ("CDL") diagnoses are referenced in Annexures B 4 and C2.
7	International clinical review service	✓	✓	**Both benefit plans:** Rules 33.1.32 and 34.1.30 (2023) to be amended to increase the percentage funding for services related to this benefit as approved by the trustees.

Enclosed with this Resolution are:

1. A revised Annexure A that contains the revised Contribution tables to take effect 1 January 2023. A tracked change document is enclosed for ease of reference to identify these changes, together with the required Appendices.
2. A revised Annexure B and B4, which contains the TFG Health Benefit Plan revised benefit information applicable for 2023. Tracked change documents are enclosed for ease of reference to identify these changes. Annexure B1 and B2 remains in terms of content unchanged and is not submitted for re-registration.
3. A revised Annexure B3 which contains the Day Surgery Cases and related information applicable to both TFG Health and TFG Health Plus Benefit Plans. A tracked change document is enclosed for ease of reference to identify the changes incorporated into this Annexure.
4. A revised Annexure C, C1 and C2, which contains the TFG Health Plus Benefit Plan revised benefit information applicable for 2022. A tracked change document is enclosed for ease of reference to identify these changes.
5. Annexures D and D1 remains in terms of content unchanged and is not submitted for re-registration.

Note: In all Annexures spelling and grammar corrections and/or typo corrections, where necessary, were made. Duplications in benefit rules and where benefit rules were deemed to require further clarification were incorporated to ensure the benefit rules align with the benefits provided by the Scheme as approved by the trustees in 2022 and prior.

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The benefit changes incorporated into Annexures B to C2, are referenced below per CMS requirements for review and registration purposes:

Annexure B

Rule number	Change	Reason for change
Rule 33 in its entirety	Limits were increased as per enclosed limit sheet in Excel format	As approved by the Board of Trustees to be increased at inflationary rates.
Preamble	Insertion or a sentence to read: "- A defined list of oncology pharmacies to obtain medicine related to oncology treatment"	To make provision for the existence of an oncology pharmacy network where members diagnosed with cancer is to obtain their medicine related to oncology treatment.
Deletion of Benefit Rule 33.1.9.2 with benefit description: Point-of-care medical devices REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	The deletion of the entire benefit rule that reads under the "Basis of Cover.." column: "Up to a maximum of 75% of the Scheme Rate paid from Health Care Cover. The device must be approved by the Scheme, subject to the Scheme's protocols and clinical and benefit entry criteria." With the deletion of the following under the "Annual Limits" column: "One device per family"	These devices are funded from the "home-monitoring" devices benefit referenced under current benefit rule 33.1.9.1 and this additional benefit rule introduced in 2022 is therefore to be deleted.
Benefit Rule 33.1.16 with benefit description: Chemotherapy, Radiotherapy and Oncological treatment	The addition of the following under the "Basis of Cover.." column: "Medication to be scripted and dispensed in accordance with the oncology preferred product list. Where a non-preferred product is used, funding will be approved up to a maximum of 80% of Scheme Rate, the balance will be for the members own pocket. Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Scheme Rate and	To clarify funding in the benefit rule with the addition of information referenced in Annexure B4.

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	the balance will be for the member's own pocket. Annexure B4 is applicable."	
New Benefit Rule 33.1.19 with benefit description: "Disease Management for cardio-metabolic risk syndrome for members registered on the Scheme's Disease Management Programme"	The insertion of the following under the "Basis of Cover.." column: "Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols." And the insertion of the following under the "Annual Limits" column: "Basket of care as set by the Scheme."	To clarify the changes to the disease management programme and the funding of diabetes as approved by the Board of Trustees.
Benefit Rule 33.1.27 with benefit description: "MRI and CT Scans" REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	The insertion of the following under the "Basis of Cover.." column: "..for in-hospital scans performed in respect of treatment related to an authorised admission" at the end of current sentence that reads: "Up to a maximum of 100% of the Scheme Rate." And the insertion of the words "up to a maximum of 100% of the Scheme Rate" in the second sentence after the words "Where MRI and CT scan is unrelated to the admission it will be covered"…	To clarify that funding up to 100% of Scheme Rate with no benefit limit applicable relates to "in-hospital" scans. Out of Hospital funding is funded up to the benefit limit of R5 000 (2023 limit) up to 100% of the Scheme Rate. This is not a benefit change but merely for clarification purposes updated.
Benefit Rule 33.1.32 with benefit description: "International clinical review service"	The deletion of "50" and replacement with "75" in the "Basis of Cover.." column.	To give effect to the higher percentage of funding for services of this nature.
Benefit Rule 33.1.40 with benefit description: "Preventative Benefit - Pneumococcal vaccination"	The deletion of the following sentence under the Annual Limits" column: "One vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons over the age of 65" And the insertion of the following sentence instead:	To update the benefit rule per the amended clinical protocol as approved by the Board of Trustees.

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	"Up to 2 pneumococcal vaccine doses per person per lifetime."	
New Benefit Rule 33.1.42 with benefit description: "Additional screening benefit for: - Primary healthcare screening services for visual, hearing, dental and skin conditions - Physical well-being screening at a dietician, biokinetisist and/or physiotherapist - Women and men's screening and prevention healthcare services - Screening and prevention healthcare services for children - Cover for a defined list of registered screening and health monitoring devices"	The insertion of the following sentences under the "Basis of Cover.." column to read: "Up to a maximum of 100% of the Scheme Rate, subject to completion of the group of tests as set out in Screening Benefit A and Screening Benefit C, as applicable and stipulated in this benefit table. The benefit is available for a maximum of 2 years. For any beneficiary joining the Scheme, the benefit is available in the year of joining and the year thereafter. Subject to the Scheme's clinical entry criteria, treatment guidelines and protocols." And the insertion of the following sentences and limits under the "Annual Limit" column: "Basket of care as set by the Scheme limited to: R2 500 per adult beneficiary once per lifetime; R1 250 per child beneficiary once per lifetime; up to a maximum of R10 000 per family"	To create a new benefit as approved by the trustees for purposes of allowing members additional screening benefits for a maximum period of 2 years up to approved benefit limits introduced. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES
Deletion of Benefit Rule 33.2.6 with description that reads: "Coronary Artery Disease care for members (CADCare)"	The deletion of the following under the "Basis of Cover.." column: "Basis of cover is contained in Annexure **B4**. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care." And the deletion of the following under the "Annual Limits" column: "Baskets of Care as set by the Scheme"	Funding for coronary artery surgery is already referenced in benefit rule 33.1.10 and this benefit rule is deleted as it was not necessary to add a new benefit rule in 2022 to the benefit rules.
Benefit Rule 33.2.6 is re-numbered to Benefit Rule 33.2.7 and the description is amended by deleting the words:	The insertion of the following under the "Annual Limits" column:	To correctly cross reference funding to the home-monitoring device benefit rule 33.1.9.1.

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"Bluetooth enabled" from the description to read: "Blood glucose monitoring device"	"..limited to the home-monitoring device limit as stipulated in Rule 33.1.9.1" after the words "1 per beneficiary per year.."	This is not a new benefit and is amended for clarification purposes.
Deletion of Benefit Rule 33.3.1.1 with description that reads: "GP Virtual House Call" REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES	The deletion of the following under the "Basis of Cover.." column: "Up to a maximum of 100% of the Scheme Rate, subject to selected consultation and procedure codes, as well as out-of-hospital consultation codes for virtual visits to meet the digital platform criteria. Member has to be registered for Chronic Illness Benefits ("CIB") have selected a KeyCare Network GP that is part of the Scheme's selected network on joining the Benefit Plan." And the deletion of the following under the "Annual Limits" column: "Baskets of Care as set by the Scheme"	Provision for these consultations are funded from the existing consultation benefits and the "WHO recognised disease(s)" as set out in Benefit Rule 33.3.15 and the addition of this benefit rule in 2022 was not necessary.
Benefit Rule 33.3.2 with description that reads: "Specialists"	The insertion of the following under the "Basis of Cover.." column: The word "chosen" after the words "Member must be referred by.." and the addition of a sentence to read: "Subject to authorisation and/or approval and treatment meeting the Scheme's treatment guidelines and entry criteria."	For clarification purposes
Benefit Rule 33.3.13 with description that starts with: "Over and above the DTPMB entitlement, this benefit also covers certain out-of-hospital healthcare services arising from an emergency, trauma-related event resulting in the following PMB conditions:…"	The insertion of the following under the "Basis of Cover.." column: "Healthcare services related to counselling is applicable to all registered beneficiaries."	For clarification purposes
Revision of Benefit Rule 33.3.15 with description that starts with:	The deletion of the following sentence under the "Basis of Cover.." column:	To update the funding for COVID-19 as required by the Prescribed Minimum

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"Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks: Out-of-hospital healthcare services related to COVID-19:.." The description is amended with the insertion of the word "specific" before the words ".. global World Health Organisation.." and the rest of the description that reads as follows are deleted: "Out-of-hospital healthcare services related to COVID-19: - Vaccine and administration of the vaccine - Screening consultation with a nurse or GP - Defined basket of pathology - Defined basket of x-rays and scans - Consultations with a nurse or GP - Supportive treatment - Contact tracing - Home-based care in lieu of hospitalisation Treatment of complications and rehabilitation for Long Covid." The description are amended with the insertion of the words "COVID-19" and "Monkeypox" instead.	Cover for testing is subject to referral. And the deletion of the following sentences under the "Annual Column": "Out-of-hospital healthcare services related to COVID19: - Screening consultation with a nurse or GP: unlimited - Defined basket of pathology: 2 tests per person per year and up to 4 tests per person per year for registered healthcare providers except where covered as PMB - Unlimited home-based care in lieu of hospitalisation Activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider" With the insertion of the following in the "Annual Limits" column instead: "PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail." And the addition of the words "per condition" at the end of the sentence that reads: "Basket of care as set by the Scheme."	Benefits (PMB) requirements and per the guidelines received from CMS. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES pb

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Annexure B3

Footer and hear updates were done.

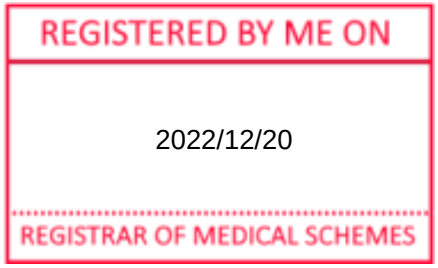
The amount of R1 500.00 as referenced in this Annexure is replaced with the revised amount of R6 300.00 to give effect to the decision of the trustees to align the deductible amount that members will be liable for with industry standards, if procedures to be obtained at day surgery facilities is received in an acute hospital instead, by choice.

Annexure B4

Footer and year updates were done.

The following change in the remainder of the document as set out in the below table:

Column header	Change	Reason for change
Preamble	Insertion or a sentence to read: "- A defined list of oncology pharmacies to obtain medicine related to oncology treatment"	To make provision for the existence of an oncology pharmacy network where members diagnosed with cancer is to obtain their medicine related to oncology treatment.



Annexure C

Footer and year updates were done.

The detailed changes in the remainder of the document are set out in the below table:

Rule number	Change	Reason for change
Rule 34 in its entirety	Limits were increased as per enclosed limit sheet in Excel format	As approved by the Board of Trustees to be increased at inflationary rates.
Preamble	Insertion or a sentence to read: "- A defined list of oncology pharmacies to obtain medicine related to oncology treatment"	To make provision for the existence of an oncology pharmacy network where members diagnosed with cancer is to obtain their medicine related to oncology treatment.
Deletion of Benefit Rule 34.1.6.2 with benefit description:	The deletion of the entire benefit rule that reads under the "Basis of Cover.." column:	These devices are funded from the "home-monitoring" devices benefit

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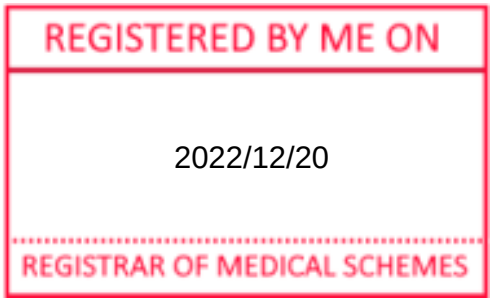
Point-of-care medical devices	"Up to a maximum of 75% of the Scheme Rate paid from Health Care Cover. The device must be approved by the Scheme, subject to the Scheme's protocols and clinical and benefit entry criteria." With the deletion of the following under the "Annual Limits" column: "One device per family"	referenced under current benefit rule 34.1.6.1 and this additional benefit rule introduced in 2022 is therefore to be deleted.
Benefit Rule 34.1.7 with benefit description: Pre-operative assessment for the following list of major surgeries: Colorectal surgery is amended by the insertion of the words: "Arthroplasty,.., coronary artery bypass graft, radical prostectomy and mastectomy" before and after the words : "colorectal surgery"	As set out in the "Rule number" column. 	To correctly reflect the benefit rule description to include all pre-operative assessments approved by the Board of Trustees in the 2022 benefit year.
New Benefit Rule 34.1.18 with benefit description: "Disease Management for cardio-metabolic risk syndrome for members registered on the Scheme's Disease Management Programme"	The insertion of the following under the "Basis of Cover.." column: "Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols." And the insertion of the following under the "Annual Limits" column: "Basket of care as set by the Scheme."	To clarify the changes to the disease management programme and the funding of diabetes as approved by the Board of Trustees.
Benefit Rule 34.1.23 now Rule 34.1.24 with benefit description:	The insertion of the following under the "Basis of Cover.." column: "..and related specialist and healthcare service provider costs if obtained" before the words "at a network" and the deletion	To make provision for a co-payment of 20% to be applied where members obtain services and treatment related to spinal surgery at non-network facilities.

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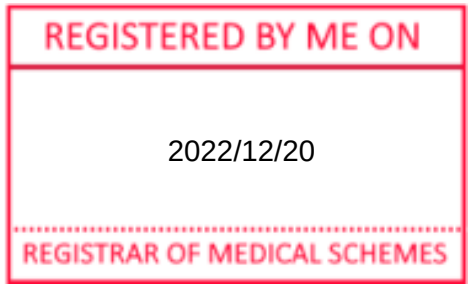
"Internal prostheses, including spinal care and surgery, as well as conservative back pain management"	of the words "or a non-network" prior to the word "facility", as well as the addition of the following words: ".. and if obtained through a provider in the spinal surgery network. Funding will be limited to up to 80% of the Scheme Rate at a non-network facility and if services obtained from providers outside the spinal surgery network" at the end of the sentence that currently reads: "Up to a maximum of 100% of the Scheme Rate for the hospital account.."	
Benefit Rule 34.1.25 now Benefit Rule 34.1.26 with benefit description: "MRI and CT Scans"	The insertion of the following under the "Basis of Cover.." column: "..for in-hospital scans performed in respect of treatment" at the end of current sentence that reads: "Up to a maximum of 100% of the negotiated or Scheme Rate." And the insertion of the words "up to a maximum of 100% of the Scheme Rate" in the second sentence after the words "Where MRI and CT scan is unrelated to the admission it will be covered"…	To clarify that funding up to 100% of Scheme Rate with no benefit limit applicable relates to "in-hospital" scans. Out of Hospital funding is funded up to the radiology and pathology benefit limit and up to 100% of the Scheme Rate. This is not a benefit change but merely for clarification purposes updated.
Benefit Rule 34.1.29 now Benefit Rule 34.1.30 with benefit description: "International clinical review service"	The deletion of "50" and replacement with "75" in the "Basis of Cover.." column.	To give effect to the higher percentage of funding for services of this nature.
Benefit Rule 34.1.37 now Benefit Rule 34.1.38 with benefit description: "Preventative Benefit - Pneumococcal vaccination"	The deletion of the following sentence under the Annual Limits" column: "One vaccine per person every 5 years for persons under the age of 65 and one vaccine per person per lifetime for persons over the age of 65" And the insertion of the following sentence instead: "Up to 2 pneumococcal vaccine doses per person per lifetime."	To update the benefit rule per the amended clinical protocol as approved by the Board of Trustees.
New Benefit Rule 34.1.42 with benefit description: "Additional screening benefit for:	The insertion of the following sentences under the "Basis of Cover.." column to read:	To create a new benefit as approved by the trustees for purposes of allowing members additional screening benefits for

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- Primary healthcare screening services for visual, hearing, dental and skin conditions - Physical well-being screening at a dietician, biokinetisist and/or physiotherapist - Women and men's screening and prevention healthcare services - Screening and prevention healthcare services for children - Cover for a defined list of registered screening and health monitoring devices"	"Up to a maximum of 100% of the Scheme Rate, subject to completion of the group of tests as set out in Screening Benefit A and Screening Benefit C, as applicable and stipulated in this benefit table. The benefit is available for a maximum of 2 years. For any beneficiary joining the Scheme, the benefit is available in the year of joining and the year thereafter. Subject to the Scheme's clinical entry criteria, treatment guidelines and protocols." And the insertion of the following sentences and limits under the "Annual Limit" column: "Basket of care as set by the Scheme limited to: R2 500 per adult beneficiary once per lifetime; R1 250 per child beneficiary once per lifetime; up to a maximum of R10 000 per family"	a maximum period of 2 years up to approved benefit limits introduced. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES
Deletion of Benefit Rule 34.2.6 with description that reads: "Coronary Artery Disease care for members (CADCare)"	The deletion of the following under the "Basis of Cover.." column: "Basis of cover is contained in Annexure B4. Up to 100% of the Scheme Rate for services covered in the Scheme's Baskets of Care." And the deletion of the following under the "Annual Limits" column: "Baskets of Care as set by the Scheme"	Funding for coronary artery surgery is already referenced in benefit rule 33.1.10 and this benefit rule is deleted as it was not necessary to add a new benefit rule in 2022 to the benefit rules.
Deletion of Benefit Rule 34.3.1.1 with description that reads: "GP Virtual House Call"	The deletion of the following under the "Basis of Cover.." column: "Up to a maximum of 100% of the Scheme Rate, subject to selected consultation and procedure codes, as well as out-of-hospital consultation codes for virtual visits to meet the digital platform criteria.	Provision for these consultations are funded from the existing consultation benefits and the "WHO recognised disease(s)" as set out in Benefit Rule 33.3.15 and the addition of this benefit rule in 2022 was not necessary.

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	Member has to be registered for Chronic Illness Benefits ("CIB") have selected a KeyCare Network GP that is part of the Scheme's selected network on joining the Benefit Plan." And the deletion of the following under the "Annual Limits" column: "Baskets of Care as set by the Scheme"	
Revision of Benefit Rule 34.3.13 with description that starts with: "Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks: Out-of-hospital healthcare services related to COVID-19:.." The description is amended with the insertion of the word "specific" before the words ".. global World Health Organisation.." and the rest of the description that reads as follows are deleted: "Out-of-hospital healthcare services related to COVID-19: - Vaccine and administration of the vaccine - Screening consultation with a nurse or GP - Defined basket of pathology - Defined basket of x-rays and scans - Consultations with a nurse or GP - Supportive treatment - Contact tracing - Home-based care in lieu of hospitalisation	The deletion of the following sentence under the "Basis of Cover.." column: Cover for testing is subject to referral. And the deletion of the following sentences under the "Annual Column": "Out-of-hospital healthcare services related to COVID19: - Screening consultation with a nurse or GP: unlimited - Defined basket of pathology: 2 tests per person per year and up to 4 tests per person per year for registered healthcare providers except where covered as PMB - Unlimited home-based care in lieu of hospitalisation Activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider" With the insertion of the following in the "Annual Limits" column instead: "PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail." And the addition of the words "per condition" at the end of the sentence that reads:	To update the funding for COVID-19 as required by the Prescribed Minimum Benefits (PMB) requirements and per the guidelines received from CMS. REGISTERED BY ME ON 2022/12/20 REGISTRAR OF MEDICAL SCHEMES

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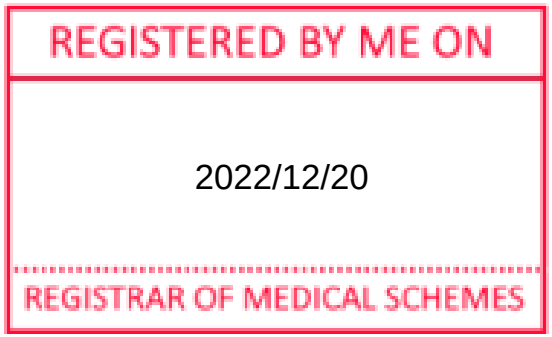
Treatment of complications and rehabilitation for Long Covid." The description are amended with the insertion of the words "COVID-19" and "Monkeypox" instead.	"Basket of care as set by the Scheme."	

Annexure C1

Footer and year updates were done and the words "Effective 1 January 2023" was inserted under the header.

Values were updated in line with the limit sheets enclosed.



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Annexure C2

Footer and year updates were done.

The following change in the remainder of the document as set out in the below table:

Column header	Change	Reason for change
Preamble	Insertion or a sentence to read: "- A defined list of oncology pharmacies to obtain medicine related to oncology treatment"	To make provision for the existence of an oncology pharmacy network where members diagnosed with cancer is to obtain their medicine related to oncology treatment.

Note: In all instances Header and Footers of all Annexures were amended to read "2023" instead of "2022" where necessary.

Chairperson M Wilson _____ (Mr M Wilson)

Trustee _____ (Mr Paul Barnard)

Principal Officer _____ (Ms C Harris)

Date: 26 September 2022

REGISTERED BY ME ON

2022/12/20

REGISTRAR OF MEDICAL SCHEMES