BOTSOGO HEALTH PLAN

It's all about wellness

GENERAL RULES

Compiled by Metropolitan Health Botswana, September 2016

GENERAL RULES

1. NAME

The name of the Scheme is **Botsogo Health Plan** (Botswana) (Pty) LTD hereinafter referred to as the "Scheme".

2. LEGAL PERSONA

The Scheme, in its own name, is a private company, 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 these rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at CBD, Zambezi Towers, 1st Floor plot 54352, , Gaborone, but the Board may transfer such office to any other location in Botswana, should circumstances so dictate.

4. DEFINITIONS

In these rules, a word or expression bears the meaning thus assigned to it and, unless inconsistent with the context—

(a) A word or expression in the masculine gender includes the feminine;
(b) A word in the singular number includes the plural, and vice versa; and
(c) A reference to any statute or subordinate legislation or to any provision of any statute or subordinate legislation, includes a reference to any enactment supplementing, amending or substituting that enactment or provision in a context relevant to these Rules from time to time;
(d) Reference to a particular office or function, or to any official or functionary, includes a reference to any substitute or additional office, function, official or functionary;
(e) The following expressions have the following meanings:

4.1. "Approval"

Prior written approval obtained from the Board or its designated authority.

4.2. "Auditor"

An auditor appointed by the Scheme from time to time, registered in terms of the relevant Act.

4.3. "Beneficiary"

A member or a person admitted as a dependant of a member, duly registered and with active membership.

4.4. "Benefit limit"

The maximum amount that can be claimed over the benefit year from the Scheme pertaining to a specific benefit category available on an option.

4.5. "Benefit year"

Benefit year is from 1 June to 31 Mayof the following year. . Benefits will be prorated from commencement date of cover.

4.6. "Board"

The Board of Trustees constituted to manage the affairs of the Scheme.

4.7. "Child"

A member's natural child, or a stepchild or legally adopted child who is not a beneficiary of any other medical scheme.

4.8. "Condition specific waiting period"

A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received.

4.9. "Continuation member"

A member who retains his membership of the Scheme in terms of rule 8.2 or a dependent who becomes a member of the Scheme in terms of rule 8.3.

4.10. "Contracted fee"

The fee determined in terms of an agreement between the scheme and a service provider or group of providers in respect of payment of relevant health services.

4.11. "Contribution"

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

4.12. "Dependant"

A registered dependant described here below of such Member enrolled under and who is entitled to the policy cover of the selected Option:

4.12.1. A Spouse, with who the member is married in terms of any law or custom; or life partner, with who the member is in a committed relationship for more than 24 months akin to marriage, based on objective criteria of mutual dependency and a shared and common household, who is not a Member or Dependant of any other registered Medical Plan.

4.12.2. A child who has not reached the twenty-first (21st) birthday, who is single or unmarried, not, including a step-child, adopted child and a foster child, provided that such child is not self-supporting and is not a Member or Dependant of a Member of any other Medical Plan. In the case of a foster child, the position of such foster child may be required before the Dependant is accepted as such.

4.12.3. A child who has reached the twenty-first (21st) birthday, who is single or unmarried, is not a Member on another Medical Scheme, has not reached the twenty sixth (26th) birthday and who is a full time student at a registered school, College or University as confirmed by certificate from the institution at the beginning of each year provided that such membership is subject to annual review by the company, shall be granted Child dependency status.

4.12.4. A disabled child who has reached the twenty-first (21st) birthday, who due to mental or physical disability is not self-supporting, may on submission of the relevant supporting medical evidence for such condition, be granted Child Dependant status.

4.12.5. Member child who has reached the twenty-sixth (26th) birthday, who is unmarried, and who is a full time student at a registered school, College or University as confirmed by certificate from the institution at the time the child turns 26 shall be seen as an Adult dependant as such, Adult rates will apply in the birth month.

4.12.6. Adult who has reached the twenty-first (21st) birthday, who is unmarried, not self-supporting, is not a Member on another Medical Scheme and who has not been proved a full time student at a registered school, College or University, shall be granted Adult Dependent status.

4.13. "Special Dependant"

The following persons, who have not yet reached the age of 55 years, will be included in the definition of "Special Dependant". The person should be either financially dependent on the principle member or be part of the second tier family as listed below:

4.13.1. Parents and parents-in-law; grandchildren; nephews and nieces; brothers and sisters; third generation dependants or children placed with a legal guardian other than a foster child; domestic employees and their children.

4.13.2. Special Dependants rates determinants will apply to all Special dependants as reflected under Benefit Brochure.

4.14. "Dependent"

In relation to a dependant other than the member's spouse or partner, a dependant who is not in receipt of a regular remuneration of more than the maximum social pension per month or a child who, due to a mental or physical disability, is dependent upon the member.

4.15. "Designated service provider"

A healthcare provider or group of providers selected by the scheme as preferred provider/s to provide to the members, diagnosis, treatment and care.

4.16. "Domicilium citandi et executandi"

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

4.17. "Emergency medical condition"

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

4.18. "Employee"

A person in the employment of a company located within Botswana. The employee must be a resident of Botswana.

4.19. "Employer"

Any company/business which has contracted with the Scheme for purposes of admission of its employees as members of the Scheme.

4.20. "Waiting period"

A period during which a beneficiary is not entitled to claim benefits in respect of all conditions for which medical advice, diagnosis, care or treatment was recommended or received.

4.21. "Income"

For the purposes of calculating contributions in respect of:

4.21.1. A member - gross monthly earnings.

4.22. "Member"

Any person who is admitted as a member of the Scheme in terms of these rules.

4.23. "Member family"

The member and all the registered dependants.

4.24. "Option change"

When a member upgrades/downgrades or changes to a different benefit option for increased or reduced cover.

4.25. "Botsogo Health Plan Price List"

The price list for health services published by the Scheme.

4.26. "Partner"

A person with whom the member has a committed relationship based on objective criteria of mutual dependency irrespective of the gender of either party.

4.27. "Proration"

The monthly apportioning of benefit limits according to member benefit year exposure to a particular option.

"Shareholder"

Metropolitan International Holdings

4.28. "Spouse"

The person to whom the member is married in terms of any law or custom.

4.29. "Social pension"

The appropriate maximum basic social pension prescribed by the relevant Act / Law.

4.30. "Underwriting"

The process whereby the Scheme determines whether cover will be offered and if so, the extent the risk of the applicant and what premium rate to set.

5. OBJECTIVES

The objectives of the Scheme are to:

5.1. undertake liability, in respect of relevant health and health-related expenses for its members and their dependants, in return for a monthly contribution;

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

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

5.4. 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. MANAGEMENT CONTRACT

The Company has entered into a Management Contract with Metropolitan Health Botswana (Pty) Ltd, (hereinafter referred to as the "Administrator"), for the administration of the "Botsogo Health Plan". Metropolitan Health Botswana (Pty) Ltd are hereby authorized:

6.1. to accept or reject a proposal at such terms and conditions as they deem it in the interest of Botsogo Health Plan and/or of the Company,

6.2. to accept the Insured's premium payments for and on behalf of the Company, and

6.3. to negotiate any claim made by the Insured Person or his Dependants under the present Contract.

7. MEMBERSHIP CARD

7.1. Every adult Insured Person will be furnished with a Membership Card, containing such particulars as may be prescribed. This card must be produced to the supplier of a service on request. It remains the property of the Scheme (and will be returned to the Scheme on termination of membership).

7.2. The utilization of a membership card by any person other than the Insured Person or his registered dependants, with the knowledge or consent of the Insured Person or his dependants, is not permitted and is construed as an abuse of the privileges of membership of the Scheme. This is fraud and may result in pressing of criminal charges.

7.3. Any Insured Person who has lost his membership card, can on request and on payment of a reasonable fee obtain a new card.

8. MEMBERSHIP

8.1. Eligibility

8.1.1. Subject to rule 10, membership is open to any employee of the Employer. The employer and the employee must be residing in Botswana.

8.1.2. New applicants aged 55 years and over will not be eligible for membership, unless special approval for this has been granted by the Board. Such approval would need to be supported by medical reports and written approval by the Board. After investigation of the doctors report a general waiting period, and/or a condition specific waiting period can be applied if the application is accepted or the application can be rejected.

8.2. Retirees

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

8.2.2. Existing members of the Scheme may retain their membership as described in sub paragraph 8.2.1 of these rules, irrespective of age.

8.2.3. 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.

8.3. Dependants of deceased members

8.3.1. The employer and/or dependants of the deceased member must inform the scheme within 30 days of the death of the member.

8.3.2. 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.

8.3.3. 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.

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

9. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

9.1. Registration of dependants

9.1.1. A member may apply for the registration of his dependants at the time that he applies for membership in terms of Rule 10.

9.1.2. If a member applies to register a new born or newly adopted child as a dependent, within 30 days of the date of birth or adoption of the child, increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption. A birth certificate or legal adoption papers will be required.

9.1.3. For newlyweds, a principal member must add the new spouse under the scheme within 30 days of marriage. A marriage certificate will be required.

9.1.4. Any other dependant not registered with the initial enrolment of the member will be subject to underwriting, which may result in the imposing of general or condition-specific waiting periods.

9.2. De-registration of Dependants

9.2.1. 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.

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

10. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

10.1. A minor (a person who has not reached the age of 18) may become a member with the consent of his parent or guardian.

10.2. No person may be a member of more than one medical scheme or a dependent:

10.2.1. Of more than one member of a particular medical scheme; or

10.2.2. Of members of different medical schemes or;

10.2.3. 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.

10.3. Underwriting

Underwriting is a process where the Medical Scheme determines whether cover will be offered and if so, the extent the risk of the applicant and what premium rate to set.

Prospective members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in respect of himself and his dependants, of age, income, state of health and of any prior membership or admission as dependant of any other medical scheme. All applications are to be verified by the employer, where applicable. The Scheme may require an applicant to provide the Scheme with a medical report in respect of any proposed beneficiary. Any report required by the Scheme for admission purposes will be for the account of the applicant.

Waiting periods, as in section 10.4 will apply, depending on the results from the underwriting process.

10.4. Waiting periods

10.4.1. The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant:

10.4.1.1. a general waiting period of up to three months;

10.4.1.2. a condition-specific exclusion for the duration of membership;

10.4.1.3. a condition-specific waiting period of up to 24 months; and

10.4.1.4. a condition-specific waiting period for maternity benefits of 12 months from the date that the member and/or dependent joined the scheme will apply.

10.4.2. No waiting periods may be imposed on:

10.4.2.1. a beneficiary who changes from one benefit option to another within the scheme, within the specified time frame for option changes, unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining waiting period may be applied;

10.4.2.2. a child dependant born during the period of membership, provided registration takes place within 30 days of date of birth;

10.5. The registered dependants of a member must participate in the same benefit option as the member.

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

10.7. A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a 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.

11. CHANGE OF ADDRESS OF MEMBER

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

12. TERMINATION OF MEMBERSHIP

12.1. Voluntary Resignation

12.1.1. A participating employer may terminate his participation with the scheme on giving three calendar months written notice.

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

12.1.3. If membership is terminated due to employment termination, the Company will be obliged to pay the Premium Fee in respect of such member and his dependants until the last day of the month during which employment was terminated.

12.1.4. A member may voluntarily terminate his/her membership of the scheme, where membership is not a condition of employment, on giving one calendar month's written notice. All rights to benefits cease after the last day of membership. The Premium fee is payable until the last day of membership.

12.1.5. A member may elect to terminate a dependant's membership with the Medical Scheme by giving one calendar month's written notice.

12.1.6. Upon termination of a Members' membership of the Medical Scheme, all the dependants of such a Member shall also automatically cease to be beneficiaries of the Medical Scheme.

12.2. Death

12.2.1. Membership of a member terminates on his/her death.

12.2.2. In the event of the death of the Principal Member, the membership of the dependants, if any, will be allowed to continue as stipulated in rules 8.3.

12.3. Failure to pay amounts due to the Scheme

If an employer or member fails to pay amounts due to the Scheme, his/her membership may be terminated as provided in these rules.

12.4. Abuse of privileges, False claims, Misrepresentation and Non-disclosure of Factual information

The Board may exclude from benefits or terminate the membership of a member or dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information. In such event he may 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 total monthly contributions payable to the Scheme by or in respect of a member shall be as stipulated in the Schedule of the Scheme option in which he/she participates. It shall be the responsibility of the member and/or employer to notify the Scheme of changes in income that may necessitate a change in contribution in terms of the Annexure hereto.

13.2. Contributions shall be due monthly in advance and only by special arrangement 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 ten (10) 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 period of default;

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

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. No refund of any assets of the scheme or any portion of a contribution shall be paid to any person where such member's membership or cover in respect of any dependant terminates during the course of a month.

13.5. For the purpose of contributions, a child dependant will be a dependent minor child under 21 years of age, or under the age of 26 and a full time student, or considered a child due to disability.

14. LIABILITIES OF EMPLOYER AND MEMBER

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

14.2. The liability of a member to the scheme is limited to the amount of his unpaid contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his dependants which has not been repaid to the Scheme.

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

15. CLAIMS PROCEDURE

15.1. Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement as prescribed.

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 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 of the supplier of service;

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

15.2.4. The total amount charged for the service concerned; and

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

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

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

15.5. Accounts for treatment of injuries or expenses recoverable from third parties, must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained.

15.6. Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the relevant service provider within 30 days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and service provider the opportunity to resubmit such corrected claim to the Scheme within 60 days following the date from which it was returned for correction.

15.7. Foreign claims

15.7.1. Emergency claims

In the event of an emergency (Emergency is defined in section 4) whilst outside Botswana members will pay upfront for all the medical services and claim back from the scheme. A retrospective authorization will be required within 24h of receiving the claim.

All claims must have a detailed description the diagnosis ,full detail of the treatment and services rendered showing the charge per service and proof of payment in the form of an authentic receipt. Members will need to submit the original account from the providers and may be required to submit a motivation from the treating doctor.

Claims will be paid subject to the agreed tariff and in the Botswana currency (BWP).

15.7.2. Non-emergency claims (only in South Africa)

A pre-authorization is required for services rendered in South Africa to check the availability of benefits. Claims without a pre-arranged authorization will be declined and the account rejected, to be paid by the member.

Claims will be paid subject to the agreed tariff and in the Botswana currency (BWP).

16. BENEFITS

16.1. Members are entitled to benefits during a benefit year, as per benefit schedules appended to these Rules, 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 the benefit schedules.

16.2. A member is entitled to change from one to another benefit option subject to the following conditions:

16.3. The change may be made only with effect from the beginning of any benefit year, as is specified in the employer agreement. The Board may, in its absolute discretion, permit a member to change from one to another benefit option on any other date provided that the member may change to another option in the case of midyear contribution increases or benefit changes.

16.4. Application to change from one benefit option to another must be in writing and lodged with the Scheme by no later than two months preceding the year upon which it is intended that the change will take place for both downgrading and upgrading, provided that the member has had prior notification of any intended changes in benefits or contributions for the next year.

16.5. 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.

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

16.6.1. All costs for operations, medicines, treatment and procedures for cosmetic purposes.

16.6.2. Holidays for recuperative purposes.

16.6.3. Purchase of the following:

16.6.3.1. Medicines not registered with the recognized, professional body;

16.6.3.2. Toiletries and beauty preparations;

16.6.3.3. Slimming products;

16.6.3.4. Homemade remedies; and

16.6.3.5. Alternative medicines.

16.6.4. All costs that are more than the annual maximum benefit to which a beneficiary is entitled to in terms of the rules of the Scheme.

16.6.5. Charges for appointments that a beneficiary fails to keep.

16.6.6. Costs for services rendered by:

16.6.6.1. Persons not registered with a recognized, professional body constituted in terms of an Act; or

16.6.6.2. Any institution, nursing home or similar institution not registered in terms of any law except a state or provincial hospital.

16.7. The funds of the Scheme shall not be used for the payment of claims arising from an accident or event in respect of which a member or dependant has received or is likely to receive compensation from any source. The Board may in its discretion pay such a benefit as would be the benefit of the Scheme calculated on the difference between the amount of the account and the amount, from any source whatsoever, which will be

finally paid to the said member or dependant in respect of the accident or event. The Scheme shall consider benefits only after compensation from whatsoever source has been finally settled. In addition the Scheme will not be liable to pay for claims that were originally authorized by another medical aid Scheme.

16.8. Proration of benefits

Benefit year: 12 months, 1 June to 31 May of each year. Benefits will be prorated from commencement date of cover.

Proration: the monthly apportioning of benefit limits according to member benefit year exposure to a particular option.
Benefits will need to be prorated in the following events:

1. A new employer joining the scheme other than on the benefit year start date;
2. New members coming onto the scheme or babies being registered as child dependents during the benefit year (given the members have gone through the underwriting process in place); or,
3. In the event of an existing member upgrading an option, when adhering to the above mentioned criteria, during any particular benefit year.

16.9. Beneficiaries admitted during the course of a benefit year are entitled to the benefits set out in the relevant benefit option chosen, with benefits being adjusted in proportion to the period of the membership calculated from the date of admission to the end of the particular financial year.

16.10. Option changes will only be allowed at the start of the benefit year. .

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

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 to which the member is entitled in terms of the applicable benefit.

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

17.3. 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.

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

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

18. Exclusions

18.1. General exclusions

No benefits shall be paid by the Scheme in respect of the following:

18.1.1. Travel expenses except if provided for in the benefit option chosen.

18.1.2. Reports, examinations and tests requested for emigration, immigration, visas, insurance policies, employment, and admission to schools or universities, court medical reports, muscle-function tests, fitness examinations and tests, adoption of children, retirement because of ill-health and annual examinations.

18.1.3. Operations, treatment and procedures for cosmetic reasons, including all cosmetic substances.

18.1.4. Accounts for services rendered by persons not registered with a recognized professional body constituted in terms of an Act of Parliament and any institution, nursing home or similar institution except a state or provincial hospital not registered in terms of any law.

18.1.5. Accounts for appointments not kept by members or their dependents.

18.1.6. Hospitalization for orthodontic related surgery, periodontal surgery and elective Maxillo-facial and oral surgery.

18.1.7. Accounts in respect of:

18.1.7.1. Conditions for which the costs are recoverable from another party

18.1.7.2. A condition arising from self-inflicted injuries, suicide or attempt to commit suicide, whether or not the person was criminally accountable

18.1.7.3. Injuries arising from professional sport and power-driven vehicle sport, scuba diving, bungee or parachute jumps

18.1.7.4. Appliances and medication to prevent injuries during sport and recreational activities

18.1.7.5. Injuries arising from actions on account of a criminal transgression on which the member or his dependents were found guilty

18.1.7.6. Accommodation in an old-age home or institution providing general care and nursing services to persons, e.g. the infirm, aged or chronically sick patients, or similar institutions

18.1.7.7. Examinations, test and treatment of impotence and of infertility or artificial insemination of a person within or outside the human body

18.1.7.8. Cost in excess of the annual maximum benefits to which the member is entitled under the Rules of the Scheme

18.1.7.9. Accommodation in spa's, health resorts or places of rest

18.1.7.10. The cost of holidays for recuperation purposes

18.1.7.11. Benefits not mentioned in this Schedule or services not rendered in terms of accepted protocol or not aimed at the treatment of an actual or supposed condition or deficiency, disadvantaging or endangering essential body functions

18.1.7.12. Mammary surgery and breast reconstruction/reduction except where this is related to carcinoma, tumors and abscesses

18.1.7.13. Any cost charged by a provider of service for motivations or prior motivations

18.1.7.14. Breathing exercises

18.1.7.15. Preparations for the specific treatment of obesity/overweight, including dietary supplements

18.1.7.16. Applicators, toilet preparations, cosmetics

18.1.7.17. Hyperbaric oxygen treatment

18.1.7.18. Services rendered by social workers

18.1.7.19. Telephone consultations

18.1.7.20. Costs for services rendered outside the borders of Botswana, unless the option makes provision for this

18.1.7.21. Bio-kinetics

18.1.7.22. Injuries sustained during participation in illegal strikes, during illegal picketing or riot.

18.1.7.23. No benefit shall be paid in respect of the following medicine even if it is prescribed by a medical practitioner, dentist or a legally authorized person:

18.1.7.24. Patent and household remedies not promoted by the medical profession

18.1.7.25. Nutritional supplements (including patent and baby foods)

18.1.7.26. Aphrodisiacs

18.1.7.27. Sun-screening agents (medicated or otherwise)

18.1.7.28. All soaps and shampoos (medicated or otherwise)

18.1.7.29. Anti-habit substances

18.1.7.30. Contraceptives and devices to prevent pregnancy: Provided that no contribution shall be made on such contraceptives even if they are prescribed for ailments

18.1.7.31. Anabolic steroids

18.1.7.32. Voluntary termination of pregnancy

18.1.7.33. Vaccines (biological) oral and parental

18.1.7.34. Contact lens preparations

18.1.7.35. Malaria prophylactics

18.1.7.36. Tonics, stimulants, biological substances, vitamins, minerals and vitamin/mineral combinations unless proven medical indications can be submitted.

18.2. Dental exclusions

18.2.1. Orthogenetic surgery (jaw correction surgery) and Osteotomy, and associated hospitalization cost is not covered, unless in the case of severe congenital deformities and after severe facial deformity caused by trauma on certain options. Benefits will be determined by the scheme if authorized. Only Orthodontic treatment without the outcome of such surgery will be considered for benefits.

18.2.2. Dental implants in or out of hospital, including placement or replacement, costs of implant or components, associated restorative or prosthodontics therapy and complications arising from implant therapy. Bone regeneration procedures for compensation of Denton-alveolar bone loss, including sinus lift procedures.

18.2.3. If a procedure does not attract a benefit, and then any associated treatment will also not attract a benefit. E.g. if an asymptomatic wisdom tooth is removed, the hospitalization will also not attract a benefit.

18.2.4. Cosmetic dental procedures such as bleaching, resin and porcelain inlays, laminate veneers.

18.2.5. Mouthwash and toothpastes

18.2.6. Oral hygiene instructions

18.2.7. Fissure sealants on patients older than 16 years

18.2.8. Professionally applied topical fluoride in adults 18 years and above

18.2.9. Oral/facial image of dentist work not covered only for orthodontics

18.2.10. Peril chip

18.2.11. Cost of Mineral Trioxide

18.2.12. Ozone therapy

18.2.13. Electrognathographic recordings

18.2.14. Therapy of healed extraction sites

18.2.15. Oral appliance or the ligation of temporal arteries for treatment of headaches or vascular surgery for treatment of headaches

18.2.16. Bite plate below 25 years old

18.2.17. Polishing of restorations

18.2.18. Caries susceptibility tests

18.2.19. Restorative treatment of attrition or abrasion

18.2.20. Tariff for amalgam fillings will apply, regardless of the material used

18.2.21. Direct/ Indirect pulp capping

- 18.2.21.1. Endodontic procedures are not covered on third molars (wisdom teeth) or primary teeth
- 18.2.21.2. Endodontic re-treatment is not covered within 2 years of initial endodontic treatment
- 18.2.21.3. Emergency root canal / Pulp removal (pulpectomy) charged on the same day as complete therapy
- 18.2.21.4. Crowns used to restore teeth for cosmetic reasons
- 18.2.21.5. Crowns where the tooth has been recently restored to function
- 18.2.21.6. Laboratory fabricated crowns are not covered on primary teeth or third molars (wisdom teeth)
- 18.2.21.7. Dental laboratory procedures relating to excluded procedures are not covered
- 18.2.21.8. Crowning of teeth involving failed root canal therapy
- 18.2.21.9. Temporary /provisional and emergency crowns including lab costs
- 18.2.21.10. Acrylic or resin crowns and Pontiacs, including laboratory aspects, placed for any reason are excluded from benefits
- 18.2.21.11. Fixed prosthodontics (crowns) where a reasonable attempt has not been made to restore/replace the tooth conservatively

18.2.22. Fixed prosthodontics where the members mouth is periodontal compromised

- 18.2.22.1. Fixed prosthodontics used to restore teeth for cosmetic reasons
- 18.2.22.2. Fixed prosthodontics used to repair occlusal wear (teeth damaged due to bruxism) erosions or fluorosis
- 18.2.22.3. Fixed prosthodontics where the tooth has been recently restored to function

18.2.23. Composite or porcelain veneers

18.2.24. Benefit for the cost of metal would be in accordance to the tooth type

18.2.25. Metal substitute coping material for laboratory cost for crowns. For metal free crowns, metal substitute coping material will be paid at the same rate as metal

18.2.26. Cost of gold, precious metal, semi-precious metal and platinum foil

18.2.27. Lab costs where the associated dental procedure is not covered

18.2.28. Cantilevers bridges

18.2.29. Pontiacs on second molars

18.2.30. Inlays and on lays regardless of material used, will not be covered

18.2.31. Metal bases to full dentures

18.2.32. Diagnostic dentures, or Diagnostic setup (orthodontics)

18.2.33. Basic Denture rate would apply to Complicated Dentures

18.2.34. High impact acrylic

18.2.35. Metal base to full dentures

18.2.36. Diagnostic models (Study models-unmounted) will only be covered with orthodontic treatment

18.2.37. Adult orthodontics over 18 years

18.2.38. Orthodontics to align teeth for cosmetic reasons

18.2.39. Orthodontic re-treatment

18.2.40. Orthodontic retainer/fixed/removable appliance repairs

18.2.41. Lingual orthodontics/ceramic brackets

18.2.42. Surgical periodontal treatment is not covered. Benefits for periodontal treatment is limited to conservative (non-surgical) management

18.2.43. Gingivectomy

18.2.44. Apisectomies

18.2.45. Dentectomies in hospital

18.2.46. Frenectomies in hospital

18.2.47. Removal of asymptomatic wisdom teeth in or out of hospital

18.2.48. Fillings, extractions and root canal therapy in hospital over age of 7 years

18.2.49. Preventative dentistry procedures in hospital

18.2.50. Assistant fee to be assessed on individual cases

18.2.51. MRI and CAT scans for any dento-aleolar procedures will not be covered

18.2.52. Extra-oral radiograph only for orthodontic treatment planning below 18 years and removal of impacted teeth for beneficiaries above 18 years.

19. GOVERNANCE

19.1. The affairs of the Scheme must be managed according to these Rules by a Board consisting of at least three persons appointed by the Shareholder who are fit and proper to be trustees.

19.2. The Shareholder may fill by appointment, any vacancy arising during the term of office of a member of the Board due to such member resigning or ceasing to hold office

19.3. The Board may co-opt a knowledgeable person to assist it in it's deliberations provided that such person shall not have a vote

19.4. A quorum is constituted by a number of members of the Board physically present or via telephone or electronic conferencing at a meeting of that Board, which number shall be not less than half of the members of the Board plus one. Members of the Board will, for the purposes of constituting a quorum, not include suspended Board members.

19.5. The Board must elect from its number the vice-chairperson. The chairman will be appointed by the Shareholder.

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

19.7. 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.

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

19.9. A member of the Board ceases to hold office if —

19.9.1. He becomes mentally ill or incapable of managing his affairs;

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

19.9.3. He is convicted of theft, fraud, forgery or uttering of a forged document or perjury;

19.9.4. He is removed by the court from any office of trust on account of misconduct;

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

19.9.6. He ceases to be an appointee of the Shareholder

19.9.7. He absents himself from three consecutive meetings of the Board without the permission of the Chairperson; or

19.9.8. He is removed from office

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

19.11. The chairperson may convene a special meeting should the necessity arise. Fifty percent or more of the members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

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

19.13. An honorarium as may from time to time be determined at the annual general meeting may be paid to members of the Board.

19.14. The Board may, subject to participation by sufficient members to form a quorum, discuss and resolve matters by telephone or electronic conferencing means and may adopt resolutions on that basis.

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

19.15.1. before a decision is taken to remove the 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;

19.15.2. The resolution to remove that member is taken by at least two thirds of the members of the Board;

19.15.3. The member shall have recourse to disputes procedures of the scheme or complaints and appeal procedures

20. DUTIES OF BOARD OF TRUSTEES

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

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

20.3. 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.

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

20.5. The chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

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

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

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

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

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

20.11. 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.

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

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

20.14. The Board must approve all disbursements.

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

20.16. 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.

21. POWERS OF BOARD

The Board has the power —

21.1. To cause the termination of the services of any employee of the Scheme;

21.2. To take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfillment of the Scheme's obligations under such appointments;

21.3. To appoint a committee consisting of such Board members and other experts as it may deem appropriate.

21.4. To appoint, contract with and compensate any accredited broker for the introduction or admission of a member to the Scheme and for ongoing broker services provided that a broker contract with an accredited broker will not unreasonable withheld;

21.5. To purchase movable and immovable property for the use of the Scheme.

21.6. To let or hire movable or immovable property;

21.7. To sell movable and immovable property of the Scheme subject to sound business practice and fair value prinicples;

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

21.9. 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;

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

21.11. 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;

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

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

21.14. To reinsure obligations in terms of the benefits provided for in these rules in the prescribed manner;

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

21.16. In general, do anything, which it deems necessary or expedient to perform its functions.

22. INDEMNIFICATION & FIDELITY GUARANTEE

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

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

23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the first day of July to the 30th day of June of the following year.

24. BANKING ACCOUNT

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

25. AUDITOR & AUDIT COMMITTEE

25.1. An auditor (who must be approved in terms of the relevant law) must be appointed by resolution at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.

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

25.2.1. A member of the Board;

25.2.2. An employee, officer or contractor of the Scheme;

25.2.3. An employee, director, officer of the Scheme's administrator, or of the holding company;

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

25.2.5. A person who is disqualified from acting as an auditor in terms of the relevant law.

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

25.4. If the members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this rule, the Board must within 30 days make such appointment.

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

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

25.7. The Board must appoint an audit committee in the prescribed manner.

26.1. Not required…….

26.1.1.

26. COMPLAINTS AND DISPUTES

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

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

27.3. The Board must appoint a disputes committee of three persons as and when necessary.

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

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

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

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

27. TERMINATION OR DISSOLUTION

28.1. The Scheme may be dissolved by order of a competent court or by voluntary dissolution or as determined by the Shareholder.

28. AMALGAMATION AND TRANSFER OF BUSINESS

The Scheme may amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person. The Board must arrange for the Shareholder to be furnished with an exposition of the proposed

transaction for consideration to enable the Shareholder to decide whether the proposed transaction should be proceeded with or not.

29. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

30.1. Any beneficiary must on request and on payment of a fee as set by the Scheme , be supplied by the Scheme with a copy of the following documents:

30.1.1. The rules of the Scheme;

30.1.2. and

30.2. A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in rule 30.1 and to make extracts therefrom.

30. AMENDMENT OF RULES

31.1. The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

31.2. Members must be furnished with a copy of such amendment within 30 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.