MEDICAL SCHEMES ACT
131 OF 1998

REGULATIONS

GNR.1262 of 20 October 1999: Regulations

DEPARTMENT OF HEALTH

as amended by

Notice	*Government Gazette*	Date
R.570	21256	5 June 2000
R.650	21313	30 June 2000
R.247	23193	1 March 2002
R.1360	24007	4 November 2002
1397	25537	6 October 2003
R.1410	27055	3 December 2004

The Minister of Health has, in terms of section 67 of the Medical Schemes Act, 1998 (Act No. 131 of 1998), after consultation with the Council for Medical Schemes, made the regulations in the Schedule.

M.E. TSHABALALA MSIMANG
Minister of Health

SCHEDULE

ARRANGEMENT OF REGULATIONS

CHAPTER 1
DEFINITIONS

1. Definitions.—In these Regulations any expression defined in the Act bears that meaning and, unless the context otherwise indicates—

"broker" . . . . . .
[Definition of "broker" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"child dependant" means a dependant who is under the age of 21 or older if he or she permitted under the rules of a medical scheme to be a dependant;

"creditable coverage" . . . . . .
[Definition of "creditable coverage" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"enhanced option" . . . . . .
[Definition of "enhanced option" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"hospital treatment" . . . . . .
[Definition of "hospital treatment" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"late joiner" . . . . . .
[Definition of "late joiner" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"managed health care" . . . . . .
[Definition of "managed health care" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"practice code number" means the number allotted to a supplier of a relevant health service as a practice number by an organisation or body approved by the Council;

"pre-existing sickness condition" . . . . . .
[Definition of "pre-existing sickness condition" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"public hospital system" . . . . . .
[Definition of "public hospital system" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"the Act" means the Medical Schemes Act, 1998 (Act No. 131 of 1998).

CHAPTER 2
ADMINISTRATIVE REQUIREMENTS

2. Registration of medical scheme.—(1) Every application for registration of a medical scheme must be in writing and signed by the person applying for the registration of the medical scheme and must contain—

(*a*) the full name under which the proposed medical scheme is to be registered;

(*b*) the date on which the proposed medical scheme is to come into operation;

(*c*) the physical and postal addresses of the registered office of the proposed medical scheme;

(*d*) two copies of the rules of the proposed medical scheme, which must comply with regulation 4 (1), and must be duly certified by the applicant as being true copies of the rules which will come into operation on the date of registration of the proposed medical scheme or the date of commencement of the medical scheme, whichever date is applicable;

(*e*) the full names, physical and postal addresses and *curriculum vitae* of the principal officer and trustees of the proposed medical scheme;

(*f*) in the case of a restricted membership medical scheme, the name or names of the participating employer(s);

(*g*) the name and address of the person who will administer the medical scheme;

(*h*) a copy of the administration agreement, in the case where the proposed medical scheme is to be administered by an administrator;

(*i*) a copy of any other joint-administration agreement between a medical scheme and any other party;

(*j*) the guarantees and the guarantee deposit vouchers as the Registrar may require;

(*k*) a detailed statement of services to be undertaken, directly or indirectly, on behalf of the proposed medical scheme by an administrator, broker and managed care organisation;

(*l*) a detailed business plan; and

(*m*) such other information as the Registrar may require.

(2) The application referred to in subregulation (1) must be accompanied by an application and registration fees as prescribed by regulation 31 (*a*) and (*b*).

(3) The minimum number of members required for the registration of a medical scheme established after these regulations have come into operation is 6 000, and this number must be admitted within a period of three months of registration of the medical scheme.

3. Proof of membership.—(1) Every medical scheme must issue to each of its members, written proof of membership containing at least the following particulars—

(*a*) the name of the medical scheme;

(*b*) the surname, first name, other initials if any, gender, and identity number of the member and his or her registered dependants;

(*c*) the membership number;

(*d*) the date on which the member becomes entitled to benefits from the medical scheme concerned;

(*e*) if applicable, details of waiting periods in relation to specific conditions;

(*f*) if applicable, the fact that the rendering of relevant health services is limited to a specific provider of service or a group or category of providers of services; and

(*g*) if applicable, a reference to the benefit option to which the member is admitted.

(2) A medical scheme must, within 30 days of the termination of membership or at any time at the request of any former member, or dependant, provide that member or dependant with a certificate, stating the period of cover, type of cover and whether or not the person qualified for late joiner status.

(3) A copy of the certificate contemplated in subregulation (2) must be forwarded on request to any medical scheme to which the former member or dependant subsequently applies for membership.

4. Administration of a medical scheme.—(1) The rules of a medical scheme which are sent to the Registrar and any amendment thereto must comply with the following requirements:

(*a*) they must be printed in at least 1,5 spacing and a font of at least 12 on A4 paper of at least 80 grams;

(*b*) they must be printed on one side of the paper only, with a margin of at least 30 mm on the left side and at least 25 mm at the top and bottom and on the right side;

(*c*) headings and subheadings must be printed in bold print;

(*d*) no underlining must be made in the document containing the rules; and

(*e*) the document referred to in paragraph (*d*) must at the beginning contain a detailed table of contents of the rules, with references to the relevant page numbers.

(2) A medical scheme that provides more than one benefit option may not in its rules or otherwise, preclude any member from choosing, or deny any member the right to participate in, any benefit option offered by the medical scheme, provided that a member or a dependant shall have the right to participate in only one benefit option at a time.

(3) A medical scheme may in its rules provide that a member may only change to any benefit option at the beginning of the month of January each year, and by giving written notice of at least three months before such change is made.

(4) A medical scheme must not in its rules or in any other manner structure any benefit option in such a manner that creates a preferred dispensation for one or more specific groups of members or to provide for the creation of ring-fenced nett assets by means of such benefit option or to transfer accumulated *pro rata* net assets of such option to another medical scheme.

5. Accounts by suppliers of services.—The account or statement contemplated in section 59 (1) of the Act must contain the following—

(*a*) The surname and initials of the member;

(*b*) the surname, first name and other initials, if any, of the patient;

(*c*) the name of the medical scheme concerned;

(*d*) the membership number of the member;

(*e*) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if

applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;

(*f*) the relevant diagnostic and such other item code numbers that relate to such relevant health service;

(*g*) the date on which each relevant health service was rendered;

(*h*) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine;

(*i*) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;

(*j*) where mention is made in such account or statement of the use of a theatre—

(i) the name and relevant practice number and provider number contemplated in paragraph (*e*) of the medical practitioner or dentist who performed the operation;

(ii) the name or names and the relevant practice number and provider number contemplated in paragraph (*e*) of every medical practitioner or dentist who assisted in the performance of the operation; and

(iii) all procedures carried out together with the relevant item code number contemplated in paragraph (*f*); and

(*k*) in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating—

(i) the expected total amount in respect of the treatment;

(ii) the expected duration of the treatment;

(iii) the initial amount payable; and

the monthly amount payable.

6. Manner of payment of benefits.—(1) A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month—

(*a*) from the last date of the service rendered as stated on the account, statement or claim; or

(*b*) during which such account, statement or claim was returned for correction.

(2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.

[Sub-r. (2) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(3) After the member and the relevant health care provider have been informed as referred to in subregulation (2), such member and provider must be afforded an

opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction.

[Sub-r. (3) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(4) If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2) or fails to provide an opportunity for correction and resubmission in terms of subregulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute.

[Sub-r. (4) inserted by GNR.1360 of 2002 wef 1 January 2003.]

(5) If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, a medical scheme must, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars—

(*a*) the name and the membership number of the member;

(*b*) the name of the supplier of service;

(*c*) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment;

(*d*) the total amount charged for the service concerned; and

(*e*) the amount of the benefit awarded for such service.

[Sub-r. (5), previously sub-r. (4), renumbered by GNR.1360 of 2002 wef 1 January 2003.]

6A. Disclosure of trustee remuneration.—The annual financial statements of a medical scheme shall contain the following information in relation to trustee remuneration, either in the income statement or by means of a note thereto, the amount paid, per trustee, in the following categories:

(*a*) disbursements, including but not limited to:

(i) travelling and other expenses for attendance of meetings or conferences;

(ii) accommodation and meals; and

(iii) telephone expenses for business purposes;

(*b*) fees for attendance of meetings of the board or committees of the board;

(*c*) fees due for holding particular office on the board or committees of the board;

(*d*) fees for consultancy work performed for the medical scheme by a trustee; and

(*e*) other remuneration paid to a trustee.

[R. 6A inserted by GNR.1360 of 2002 wef 1 January 2003.]

CHAPTER 3
CONTRIBUTIONS AND BENEFITS

7. Definitions.—For the purposes of this chapter—

"designated service provider" means a health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to

provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions;

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

"prescribed minimum benefits" means the benefits contemplated in section 29 (1) (*o*) of the Act, and consist of the provision of the diagnosis, treatment and care costs of—

(*a*) the Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A; and

(*b*) any emergency medical condition;

"prescribed minimum benefit condition" means a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition.

[R. 7 substituted by GNR.1360 of 2002 wef 1 January 2003.]

8. Prescribed Minimum Benefits.—(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.

(2) Subject to section 29 (1) (*p*) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that—

(*a*) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and

(*b*) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(3) For the purposes of subregulation (2) (*b*), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if—

(*a*) the service was not available from the designated service provider or would not be provided without unreasonable delay;

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

(*c*) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

(4) Subject to subregulations (5) and (6) and to section 29 (1) (*p*) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health

care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.

[R. 8 substituted by GNR.1360 of 2002 wef 1 January 2004.]

9. Limits on benefits.—A medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the prescribed minimum benefits, *pro rata* to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned.

9A. Non-accumulation of benefits.—A medical scheme may not provide in its rules for the accumulation of unexpended benefits by a beneficiary from one year to the next other than as provided for in personal medical savings accounts.

[R. 9A inserted by GNR.1360 of 2002 wef 1 January 2003.]

9B. Contributions in respect of dependants.—A medical scheme may in its rules provide that contributions in respect of a child dependant may be less than those determined in respect of other beneficiaries.

[R. 9B inserted by GNR.1360 of 2002 wef 1 January 2003.]

10. Personal medical savings accounts.—(1) A medical scheme, on behalf of a member, must not allocate to a member's personal medical savings account an amount that exceeds 25% of the total gross contribution made in respect of the member during the financial year concerned.

[Sub-r. (1) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(2) The limit on contributions into personal medical savings accounts apply to each individual member of a medical scheme.

(3) Funds deposited in a member’s personal medical savings account shall be available for the exclusive benefit of the member and his or her dependants but may not be used to offset contributions, provided that the medical scheme may use funds in a member’s personal medical savings account to offset debt owed by the member to the medical scheme following that member’s termination of membership of the medical scheme.

[Sub-r. (3) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(4) Credit balances in a member’s personal medical savings account shall be transferred to another medical scheme or benefit option with a personal medical savings account, as the case may be, when such member changes medical schemes or benefit options.

[Sub-r. (4) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(5) Credit balances in a member’s personal medical savings account must be taken as a cash benefit, subject to applicable taxation laws, when the member terminates his or her membership of a medical scheme or benefit option and then—

(*a*) enrols in another benefit option or medical scheme without a personal medical savings account; or

(*b*) does not enrol in another medical scheme.

[Sub-r. (5) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(6) The funds in a member's medical savings account shall not be used to pay for the costs of a prescribed minimum benefit.

[Sub-r. (6) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(7) Every medical scheme must provide the following to the Registrar with regard to members' personal medical savings accounts—

(*a*) details of amounts paid into members' personal medical savings accounts;

(*b*) details on both debit and credit balances in members' personal medical savings accounts;

(*c*) details on amounts paid to members or their estates on termination through resignation or death;

(*d*) details on benefits, by category, paid out of members' personal medical savings accounts; and

(*e*) any other reports that the Council may specify from time to time.

CHAPTER 4
WAITING PERIODS AND PREMIUM PENALTIES

11. Definitions.—For the purposes of this chapter—

"creditable coverage" means any period in which a late joiner was—

(*a*) a member or a dependant of a medical scheme;

(*b*) 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;

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

(*d*) a member or a dependant of the Permanent Force Continuation Fund,

but excluding any period of coverage as a dependant under the age of 21 years;

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

[R. 11 repealed by GNR.247 of 2002 and reinserted by GNR.1360 of 2002 wef 1 January 2003.]

12. Medical reports.—If a medical scheme requires a medical report to be provided to it by an applicant in terms of section 29A (7) of the Act, the medical scheme shall pay to the applicant or relevant health care provider the costs of any medical tests or examinations required by the medical scheme for the purposes of compilation of this report.

[R. 12 repealed by GNR.247 of 2002 and reinserted by GNR.1360 of 2002 wef 1 January 2003.]

13. Premium penalties for persons joining late in life.—(1) A medical scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

[Sub-r. (1) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(2) The premium penalties referred to in subregulation (1) shall not exceed the following bands:

Penalty bands	Maximum penalty
1–4 years	0,05 contribution
5–14 years	0,25 contribution
15–24 years	0,5 contribution
25+ years	0,75 contribution

[Sub-r. (2) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(3) To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in subregulation (2), the following formula shall be applied:

A = B minus (35 + C)

Where:

"A" means the number of years referred to in the first column of the table in subregulation (2), for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

[Sub-r. (3) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(4) Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

[Sub-r. (4) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(5) Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

(6) For the purposes of subregulations (3) and (4), it shall be sufficient proof of creditable coverage if the applicant produces a sworn affidavit in which he or she declares—

(*a*) the relevant periods in which he or she was a member or dependant and the name or names of the relevant medical schemes or other relevant entities corresponding with such period or periods; and

(*b*) that reasonable efforts have been made to obtain documentary evidence of such periods of creditable coverage, but have been unsuccessful.

[Sub-r. (6) substituted by GNR.570 of 2000 and by GNR.1360 of 2002 wef 1 January 2003.]

(7) A medical scheme must report annually to the Registrar on the number of late joiners enrolled in each band during the previous year and cumulatively.

14. . . . . . .

[R. 14 repealed by GNR.1360 of 2002 wef 1 January 2003.]

CHAPTER 5
PROVISION OF MANAGED HEALTH CARE

15. Definitions.—For the purposes of this Chapter—

"capitation agreement" means an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme;

"evidence-based medicine" means the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research;

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

"managed health care organisation" means a person who has contracted with a medical scheme in terms of regulation 15A to provide a managed health care service;

"participating health care provider" means a health care provider who, by means of a contract directly between that provider and a medical scheme in terms of regulation 15A, or pursuant to an arrangement with a managed health care organisation which has contracted with a medical scheme in terms of regulation 15A, undertakes to provide a relevant health service to the beneficiaries of the medical scheme concerned;

"protocol" means 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;

"rules-based and clinical management-based programmes" means a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of, health care services, procedures or settings, on the basis of which appropriate managed health care interventions are made.

[R. 15 substituted by GNR.1360 of 2002 wef 1 January 2003.]

15A. Prerequisites for managed health care arrangements.—(1) If a medical scheme provides benefits to its beneficiaries by means of a managed health care arrangement with another person—

(*a*) the terms of that arrangement must be clearly set out in a written contract between the parties;

(*b*) with effect from 1 January 2004, such arrangement must be with a person who has been granted accreditation as a managed health care organisation by the Council; and

(*c*) such arrangement must not absolve a medical scheme from its responsibility towards its members if any other party to the arrangement is in default with regard to the provision of any service in terms of such arrangement.

(2) To the extent that managed health care undertaken by the medical scheme itself or by a managed health care organisation results in a limitation on the rights or entitlements of beneficiaries, the medical scheme must furnish the Registrar with a document clearly stating such limitations, which document must be resubmitted to the Registrar within 30 days of any amendment to such limitations taking effect, including the relevant amendments.

(3) Limitations referred to in subregulation (2) include, but are not limited to, restrictions on coverage of disease states, protocol requirements, and formulary inclusions or exclusions.

[R. 15A inserted by GNR.1360 of 2002 wef 1 January 2003.]

15B. Accreditation of managed health care organisations.—(1) Any person desiring to be accredited as a managed health care organisation must apply in writing to the Council.

(2) An application for accreditation as a managed health care organisation must be accompanied by—

(*a*) the full name and *curriculum vitae* of the person who is the head of the managed health care organisation's business;

(*b*) the home and business address and telephone numbers of the person referred to in paragraph (*a*);

(*c*) a copy of the proposed managed health care agreement or agreements between the managed health care organisation and the medical scheme or medical schemes concerned; and

(*d*) such information as the Council may deem necessary to satisfy it that such person—

(i) is fit and proper to provide managed health care services;

(ii) has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide; and

(iii) is financially sound.

(3) In considering an application for accreditation in terms of this regulation, the Council may take into consideration any other information regarding the applicant, derived from whatever source, if such information is disclosed to the applicant and she or he is given a reasonable opportunity to respond thereto.

(4) The Council must, after consideration of an application—

(*a*) if satisfied that an applicant meets the criteria listed in items (i), (ii) and (iii) of subregulation (2) (*d*), grant the application subject to any conditions that it may deem necessary; or

(*b*) if not so satisfied, refuse the application and provide reasons to the applicant for such refusal.

(5) If accreditation is granted by the Council in terms of subregulation (4) (*a*), it shall be granted for twenty-four months, and shall be accompanied by a certificate from

the Registrar clearly specifying the expiry date of the accreditation and any conditions imposed by the Council in terms of subregulation (4) (*a*).

(6) The Council may at any time after the issue of a certificate of accreditation, on application by a managed health care organisation or on own initiative add, withdraw or amend any condition or restriction in respect of the accreditation, after having given the relevant managed health care organisation a reasonable opportunity to make submissions on the proposed addition, withdrawal or amendment and having considered those submissions, if the Council is satisfied that any such addition, withdrawal or amendment is justified and will not unfairly prejudice the interests of the clients of the managed health care organisation, and must in every such case issue an appropriately amended certificate to the managed health care organisation.

(7) A person wishing to renew accreditation as a managed health care organisation shall apply to the Council for such renewal in such format as the Council may from time to time determine, provided that—

(*a*) such application for renewal shall be made at least three months prior to the date of expiry of the accreditation; and

(*b*) such person shall furnish the Council with any information that the Council may require.

(8) The provisions of subregulations (4) to (6) shall apply *mutatis mutandis* to an application for renewal of accreditation in terms of subregulation (7).

[R. 15B inserted by GNR.1360 of 2002 wef 1 January 2003.]

15C. Suspension or withdrawal of accreditation.—(1) The Council may, subject to subregulation (2), at any time suspend or withdraw any accreditation granted in terms of regulation 15B if the Council is satisfied on the basis of available information, that the relevant managed health care organisation—

(*a*) no longer meets the criteria contemplated in regulation 15B (2) (*d*);

(*b*) did not, when applying for accreditation, make a full disclosure of all relevant information to the Council, or furnished false or misleading information;

(*c*) has, since the granting of such accreditation, contravened or failed to comply with any provision of this Act;

(*d*) has, since the granting of such accreditation, conducted his or her business in a manner that is seriously prejudicial to clients or the public interest;

(*e*) is financially unsound; or

(*f*) is disqualified from providing managed health care services in terms of any law.

(2) (*a*) Before suspending or withdrawing any accreditation, the Council must inform the managed health care organisation concerned of—

(i) the intention to suspend or withdraw the accreditation and the grounds therefor;

(ii) in the case of suspension, the intended period therefor; and

(iii) any terms attached to the suspension or withdrawal, including such measures as the Council may determine for the protection of the interests of the clients of the managed health care organisation,

and must give the managed health care organisation a reasonable opportunity to make a submission in response thereto.

(*b*) The Council must consider any such response, and may thereafter decide to withdraw or suspend or not to withdraw or suspend the accreditation, and must notify the managed health care organisation of the decision.

(*c*) Where the accreditation is suspended or withdrawn, the Council must make known the terms of the suspension or withdrawal or subsequent lifting thereof, by means of any appropriate public media announcement.

(3) During the period that the accreditation of a managed health care organisation has been suspended, such person may not apply for renewal of the accreditation or reapply for accreditation.

(4) On withdrawal of the accreditation of a person as a managed health care organisation, the Council may determine a reasonable period within which such person may not reapply for accreditation as a managed health care organisation, taking into account the nature of the circumstances giving rise to such withdrawal.

[R. 15C inserted by GNR.1360 of 2002 wef 1 January 2003.]

15D. Standards for managed health care.—If any managed health care is undertaken by the medical scheme itself or by a managed health care organisation, the medical scheme must ensure that—

(*a*) a written protocol is in place (which forms part of any contract with a managed health care organisation) that describes all utilisation review activities, including a description of the following:

(i) procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of relevant health services, and to intervene where necessary, as well as the methods to inform beneficiaries and health care providers acting on their behalf, as well as the medical scheme trustees, of the outcome of these procedures;

(ii) data sources and clinical review criteria used in decision-making;

(iii) the process for conducting appeals of any decision which may adversely affect the entitlements of a beneficiary in terms of the rules of the medical scheme concerned;

(iv) mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

(v) data collection processes and analytical methods used in assessing utilisation and price of health care services;

(vi) provisions for ensuring confidentiality of clinical and proprietary information;

(vii) the organisational structure (e.g. ethics committee, managed health care review committees, quality assurance or other committee) that periodically assesses managed health care activities and reports to the medical scheme; and

(viii) the staff position functionally responsible for day-to-day management of the relevant managed health care programmes;

(*b*) the managed health care programmes use documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost-effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions;

(*c*) the managed health care programmes use transparent and verifiable criteria for any other decision-making factor affecting funding decisions and are evaluated periodically to ensure relevance for funding decisions;

(*d*) qualified health care professionals administer the managed health care programmes and oversee funding decisions, and that the appropriateness of such decisions are evaluated periodically by clinical peers;

(*e*) health care providers, any beneficiary of the relevant medical scheme or any member of the public are provided on demand with a document setting out—

(i) a clear and comprehensive description of the managed health care programmes and procedures; and

(ii) the procedures and timing limitations for appeal against utilisation review decisions adversely affecting the rights or entitlements of a beneficiary; and

(iii) any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states; protocol requirements and formulary inclusions or exclusions.

[R. 15D inserted by GNR.1360 of 2002 wef 1 January 2003.]

15E. Provision of health services.—(1) If managed health care entails an agreement between the medical scheme or a managed health care organisation, on the one hand, and one or more participating health care providers, on the other—

(*a*) the medical scheme is not absolved from its responsibility towards its members if any other party is in default to provide any service in terms of such contract;

(*b*) no beneficiary may be held liable by the managed health care organisation or any participating health care provider for any sums owed in terms of the agreement;

(*c*) a participating health care provider may not be forbidden in any manner from informing patients of the care they require, including various treatment options, and whether in the health care provider's view, such care is consistent with medical necessity and medical appropriateness;

(*d*) such agreement with a participating health care provider, may not be terminated as a result of a participating health care provider—

(i) expressing disagreement with a decision to deny or limit benefits to a beneficiary; or

(ii) assisting the beneficiary to seek reconsideration of any such decision;

(*e*) if the medical scheme or the managed health care organisation, as the case may be, proposes to terminate such an agreement with a participating health care provider, the notice of termination must include the reasons for the proposed termination.

(2) A managed health care organisation or a medical scheme, as the case may be, may place limits on the number or categories of health care providers with whom it may contract to provide relevant health services, provided that—

(*a*) there is no unfair discrimination against providers on the basis of one or more arbitrary grounds, including race, religion, gender, marital status, age, ethnic or social origin or sexual orientation; and

(*b*) selection of participating health care providers is based upon a clearly defined and reasonable policy which furthers the objectives of affordability, cost-effectiveness, quality of care and member access to health services.

[R. 15E inserted by GNR.1360 of 2002 wef 1 January 2003.]

15F. Capitation agreements.—A medical scheme shall not enter into a capitation agreement, unless—

(*a*) the agreement is in the interests of the members of the medical scheme;

(*b*) the agreement embodies a genuine transfer of risk from the medical scheme to the managed health care organisation;

(*c*) the capitated payment is reasonably commensurate with the extent of the risk transfer.

[R. 15F inserted by GNR.1360 of 2002 wef 1 January 2003.]

15G. Limitation on disease coverage.—If managed health care entails limiting coverage of specific diseases—

(*a*) such limitations or a restricted list of diseases must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and

(*b*) the medical scheme and the managed health care organisation must provide such limitation or restricted list to health care providers, beneficiaries and members of the public, upon request.

[R. 15G inserted by GNR.1360 of 2002 wef 1 January 2003.]

15H. Protocols.—If managed health care entails the use of a protocol—

(*a*) such protocol must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;

(*b*) the medical scheme and the managed health care organisation must provide such protocol to health care providers, beneficiaries and members of the public, upon request; and

(*c*) provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause harm to a beneficiary, without penalty to that beneficiary.

[R. 15H inserted by GNR.1360 of 2002 wef 1 January 2003.]

15I. Formularies.—If managed health care entails the use of a formulary or restricted list of drugs—

(*a*) such formulary or restricted list must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability;

(*b*) the medical scheme and the managed health care organisation must provide such formulary or restricted list to health care providers, beneficiaries and members of the public, upon request; and

(*c*) provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.

[R. 15I inserted by GNR.1360 of 2002 wef 1 January 2003.]

15J. General provisions.—(1) Any managed health care contract, contemplated in Regulation 15A, must require either party to give at least 90 days notice before terminating the contract, except in cases of material breach of the provisions of the contract, or where the availability or quality of health care rendered to beneficiaries of a medical scheme is likely to be compromised by the continuation of the contract.

(2) Notwithstanding anything to the contrary in these regulations—

(*a*) a medical scheme and a managed health care organisation may not use any incentive that directly or indirectly compensates or rewards any person for ordering, providing, recommending or approving relevant health services that are medically inappropriate;

(*b*) any information pertaining to the diagnosis, treatment or health of any beneficiary of a medical scheme must be treated as confidential;

(*c*) subject to the provisions of any other legislation, a medical scheme is entitled to access any treatment record held by a managed health care organisation or health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary;

(*d*) where provision is made by a managed care provider for complaints or appeals procedures or mechanisms, such provision shall in no way impact upon the entitlement of a beneficiary to—

(i) complain to, or lodge a dispute with, his or her medical scheme;

(ii) lodge a complaint with Council; or

(iii) take any other legal action to which he or she would ordinarily be entitled.

[R. 15J inserted by GNR.1360 of 2002 wef 1 January 2003.]

CHAPTER 6
ADMINISTRATORS OF MEDICAL SCHEMES

16. In this Chapter—

"internal financial controls" means controls which are established in order to ensure a reasonable safeguarding of assets against unauthorized use or disposition, the maintenance of proper accounting records and the reliability of financial information used within the business of the administrator.

17. Accreditation of administrators.—(1) Any person desiring to be accredited as an administrator must apply in writing to the Council.

(2) An application for accreditation as an administrator must be accompanied by—

(*a*) the full name and *curriculum vitae* of the person who is the head of the administrator's business;

(*b*) the home and business addresses and telephone numbers of the person referred to in paragraph (*a*);

(*c*) the name of the auditor referred to in regulation 20;

(*d*) a report prepared by the auditor in the form set out in Part 1 of Annexure C, indicating whether or not the administrator's system of financial control is adequate for the size and complexity of the business of the medical scheme or schemes to be administered;

(*e*) a copy of the proposed administration agreement or agreements between the administrator and the medical scheme or medical schemes concerned; and

(*f*) such information as the Council may deem necessary to satisfy it that such person—

(i) is fit and proper to provide administration services;

(ii) has the necessary resources, systems, skills and capacity to render the administration services which it wishes to provide; and

(iii) is financially sound.

(3) In considering an application for accreditation in terms of this regulation, the Council may take into consideration any other information regarding the applicant, derived from whatever source, if such information is disclosed to the applicant and she or he is given a reasonable opportunity to respond thereto.

(4) The Council must, after consideration of an application—

(*a*) if satisfied that an applicant meets the criteria listed in subregulation (2) (*f*), grant the application subject to any conditions that it may deem necessary; or

(*b*) if not so satisfied, refuse the application and provide reasons to the applicant for such refusal.

(5) If accreditation is granted by the Council in terms of subregulation (4) (*a*), it shall be granted for twenty-four months, and shall be accompanied by a certificate from the Registrar clearly specifying the expiry date of the accreditation and any conditions imposed by the Council in terms of subregulation (4) (*a*).

(6) The Council may at any time after the issue of a certificate of accreditation, on application by an administrator or on own initiative add, withdraw or amend any condition or restriction in respect of the accreditation, after having given the relevant administrator a reasonable opportunity to make submissions on the proposed addition, withdrawal or amendment and having considered those submissions, if the Council is satisfied that any such addition, withdrawal or amendment is justified and will not unfairly prejudice the interests of the clients of the administrator, and must in every such case issue an appropriately amended certificate to the administrator.

(7) A person wishing to renew accreditation as an administrator shall apply to the Council for such renewal in such format as the Council may from time to time determine, provided that—

(*a*) such application for renewal shall be made at least three months prior to the date of expiry of the accreditation; and

(*b*) such person shall furnish the Council with any information that the Council may require.

(8) The provisions of subregulations (4) to (6) shall apply *mutatis mutandis* to an application for renewal of accreditation in terms of subregulation (7).

[R. 17 substituted by GNR.1360 of 2002 wef 1 January 2003.]

17A. Suspension or withdrawal of accreditation.—(1) The Council may, subject to subregulation (2), at any time suspend or withdraw any accreditation granted in terms of regulation 17 if the Council is satisfied on the basis of available information, that the relevant administrator—

(*a*) no longer meets the criteria contemplated in regulation 17 (2) (*f*);

(*b*) did not, when applying for accreditation, make a full disclosure of all relevant information to the Council, or furnished false or misleading information;

(*c*) has, since the granting of such accreditation provided direct or indirect compensation to a broker resulting in a contravention of regulation 28 (6) (*b*);

[Para. (*c*) corrected by GN 1397 of 2003 wef 6 October 2003.]

(*d*) has, since the granting of such accreditation, contravened or failed to comply with any provision of this Act;

(*e*) has, since the granting of such accreditation, conducted his or her business in a manner that is seriously prejudicial to clients or the public interest;

(*f*) is financially unsound; or

(*g*) is disqualified from providing administration services in terms of any law.

(2) (*a*) Before suspending or withdrawing any accreditation, the Council must inform the administrator concerned of—

(i) the intention to suspend or withdraw the accreditation and the grounds therefor;

(ii) in the case of suspension, the intended period therefor; and

(iii) any terms attached to the suspension or withdrawal, including such measures as the Council may determine for the protection of the interests of the clients of the administrator,

and must give the administrator a reasonable opportunity to make a submission in response thereto.

(*b*) The Council must consider any such response, and may thereafter decide to withdraw or suspend or not to withdraw or suspend the accreditation, and must notify the administrator of the decision.

(*c*) Where the accreditation is suspended or withdrawn, the Council must make known the terms of the suspension or withdrawal or subsequent lifting thereof, by means of any appropriate public media announcement.

(3) During the period that the accreditation of an administrator has been suspended, such person may not apply for renewal of the accreditation or reapply for accreditation.

(4) On withdrawal of the accreditation of a person as an administrator, the Council may determine a reasonable period within which such person may not reapply for accreditation as an administrator, taking into account the nature of the circumstances giving rise to such withdrawal.

[R. 17A inserted by GNR.1360 of 2002 wef 1 January 2003.]

18. Agreement in respect of administration.—(1) Prior to an administrator commencing administrative functions with regard to a particular medical scheme, the medical scheme must enter into a written agreement with the administrator in which the terms and conditions of the administration of the medical scheme are recorded.

[Sub-r. (1) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(2) The agreement referred to in subregulation (1) must provide—

(*a*) for the scope and duties of the administrator;

(*b*) that the administrator must, on behalf of the medical scheme, administer the business of a medical scheme in accordance with the Act and as provided for in the rules of the medical scheme;

(*c*) for the basis on which the administrator is to be remunerated;

(*d*) for the termination of the agreement at the instance of either party after notice in writing of not less than three calendar months and not more than twelve calendar months;

[Para. (*d*) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(*e*) that all registers, minute books, records and all other data pertaining to the medical scheme, must at all times remain the sole property of the medical scheme concerned, and that no lien may be held over them by the administrator.

[Para. (*e*) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(3) Any changes to the agreement referred to in subregulation (1) must be in writing and must be effected by way of an addendum to the existing agreement or a new agreement between the administrator and the medical scheme.

(4) If on the date of coming into operation of this Chapter, an agreement is in force in terms of which an administrator is administering a medical scheme and the existing agreement does not comply with the requirements of this Chapter, such administrator must enter into a new agreement which complies with this Chapter with every medical scheme within six months from the date of coming into operation of this Chapter, unless the medical scheme notifies the Registrar that the interests of the medical scheme are protected in terms of the existing agreement.

19. Termination of administration agreements.—(1) If the administration agreement between a medical scheme and an administrator is terminated, such administrator must furnish a report to the Registrar not later than 60 days after such termination, confirming—

(*a*) that all documents of title relating to assets, the assets register, minute books, members' records and other records and information pertaining to the medical scheme have been delivered to the trustees of the medical scheme or the new administrators, as the case may be;

(*b*) the date and address of such delivery; and

(*c*) the name of the trustee or person at the new administrator's business to whom the documents referred to in paragraph (*a*) have been delivered.

(2) If an administrator is for any reason unable to comply fully or partially with this regulation, the report referred to in subregulation (1) must contain full particulars regarding documentation which has not been delivered, the reasons therefor as well as a plan with the dates on which compliance will take place, to enable the Registrar to approve of such further period as may be determined by him or her.

(3) In the circumstances contemplated in subregulation (1), the trustees of the medical scheme concerned must take steps to ensure the integrity of all documents, data and information transferred to the new administrator.

[Sub-r. (3) added by GNR.1360 of 2002 wef 1 January 2003.]

20. Appointment of auditor.—An administrator must appoint an auditor who must examine the accounting records and annual financial statements of the administrator in accordance with the South African auditing standards and satisfy himself or herself that—

(*a*) the accounting records comply with the requirements of the Act and these regulations; and

(*b*) that the annual financial statements are in agreement with the accounting records and properly drawn up to fairly present the financial position, changes in equity, results of operations and cash flows of the

administrator in accordance with generally accepted accounting practice and in the manner required by the Act and these regulations.

21. Indemnity and fidelity guarantee insurance.—An administrator must take out and maintain an appropriate level of indemnity and fidelity guarantee insurance.

[R. 21 substituted by GNR.1360 of 2002 wef 1 January 2003.]

22. Maintenance of financially sound condition.—An administrator must at all times maintain his or her business in a financially sound condition by—

(*a*) having assets which are at least sufficient to meet current liabilities;

(*b*) providing for liabilities; and

(*c*) generally conducting the business to ensure that the business is at all times in a position to meet its liabilities.

23. Depositing of medical scheme moneys.—(1) An administrator must deposit any medical scheme moneys under administration, not later than the business day following the date of receipt thereof, into a bank account opened in the name of the medical scheme.

(2) When medical scheme moneys, including contributions, are paid by means of electronic funds transfer, such moneys shall be deposited directly into a bank account opened in the name of the medical scheme.

(3) Moneys contemplated in subregulations (1) or (2) shall at no time be deposited in any bank account other than that of the medical scheme.

[R. 23 substituted by GNR.1360 of 2002 wef 1 January 2003.]

24. Safe custody of documents of title.—(1) Whenever a document of title relating to assets held by a medical scheme or to be held on behalf of a medical scheme comes into possession of the administrator, the administrator must make adequate arrangements to ensure the continued safety of the assets held in safe custody.

(2) The administrator must mark the document referred to in subregulation (1) in a manner which will render it possible to establish readily that the medical scheme is the owner of such assets, and maintain a register to identify ownership of assets.

25. Annual report.—Within four months after the end of the financial year of the administrator, the administrator must furnish the Registrar with—

(*a*) a report by the auditor of the administrator in the format set out in Part 2 of Annexure C; and

[Para. (*a*) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(*b*) a representation letter from the management of the administrator in the format set out in Annexure D.

26. Furnishing of other information.—(1) An administrator must furnish the Registrar with such information concerning the administrator's shareholders, directors, members, partners and senior employees as the Registrar may from time to time require.

(2) If there is a change of owners, directors, members or shareholders and such change has an effect on the control of the administrator in question, the administrator must apply for accreditation in terms of regulation 17 (2).

27. Ceasing, dissolution or liquidation of business.—(1) If an administrator ceases to conduct business, is dissolved, liquidated or the administrator's accreditation

has been withdrawn, the administrator's auditor must furnish a report to the Registrar confirming—

(*a*) that all documents of title relating to assets, the assets register, minute books, computer records, data and other records pertaining to the medical scheme under administration have been delivered to the trustees of the medical scheme or the new administrators, as the case may be;

(*b*) the date and address of delivery contemplated in paragraph (*a*); and

(*c*) the name of the trustee or other person at the administrator to whom the documents referred to in paragraph (*a*) have been delivered.

(2) If the auditor is for any reason unable to comply fully or partially with subregulation (1), the report must contain full particulars concerning the documents which have not been delivered, full reasons therefor as well as a plan with the dates on which compliance will take place to enable the Registrar to approve of such further period as may be determined by him or her.

CHAPTER 7
CONDITIONS TO BE COMPLIED WITH BY BROKERS

28. Compensation of brokers.—(1) No person may be compensated by a medical scheme in terms of section 65 for acting as a broker unless such person enters into a prior written agreement with the medical scheme concerned.

(2) Subject to subregulation (3), the maximum amount payable to a broker by a medical scheme in respect of the introduction of a member to a medical scheme by that broker and the provision of ongoing service or advice to that member, shall not exceed—

(*a*) R50, plus value added tax (VAT), per month, or such other monthly amount as the Minister shall determine annually in the *Government Gazette*, taking into consideration the rate of normal inflation; or

(*b*) 3% plus value added tax (VAT) of the contributions payable in respect of that member,

whichever is the lesser.

(3) A medical scheme may not differentiate the amount of compensation offered to brokers for the introduction of members to the scheme based upon the anticipated claims experience, age, health status or employment status of the members being introduced.

(4) Subregulation (2) must not be construed to restrict a medical scheme from applying a sliding scale based on the size of the group being introduced provided that—

(*a*) the maximum amount in respect of any member introduced as specified in subregulation (2) is not exceeded; and

(*b*) a medical scheme may not pay a lesser amount for the introduction of individual members than the per capita amount payable in respect of introduction of members who form part of a group.

(5) Payment by a medical scheme to a broker in terms of subregulation (2) shall be made on a monthly basis and upon receipt by the scheme of the relevant monthly contribution in respect of that member.

(6) The ongoing payment by a medical scheme to a broker in terms of this regulation is conditional upon the broker—

(*a*) continuing to meet service levels agreed to between the broker and the medical scheme in terms of the written agreement between them; and

(*b*) receiving no other direct or indirect compensation in respect of broker services from any source, other than a possible direct payment to the broker of a negotiated professional fee from the member himself or herself (or the relevant employer, in the case of an employer group).

(7) A medical scheme shall immediately discontinue payment to a broker in respect of services rendered to a particular member if the medical scheme receives notice from that member (or the relevant employer, in the case of an employer group), that the member or employer no longer requires the services of that broker.

(8) A medical scheme may not compensate more than one broker at any time for broker services provided to a particular member.

(9) Any person who has paid a broker compensation where there has been a material misrepresentation, or where the payment is made consequent to unlawful conduct by the broker, is entitled to the full return of all the money paid in consequence of such material misrepresentation or unlawful conduct.

[R. 28 amended by GNR.570 of 2000 and substituted by GNR.1360 of 2002 wef 1 January 2003.]

28A. Admission of members to a medical scheme.—A medical scheme must not prevent a person from applying for membership of a medical scheme for the reason that that person is not using a broker to apply for such membership.

[R. 28A inserted by GNR.1360 of 2002 wef 1 January 2003.]

28B. Accreditation of brokers.—(1) Any person desiring to be accredited as a broker must apply in writing to the Council, and the application must be accompanied by—

(*a*) documentary proof of a recognised educational qualification and appropriate experience;

(*b*) documentary evidence of having passed or current enrolment in a relevant course of study recognised by the Council;

(*c*) in the case of a juristic person, documentary proof and a sworn affidavit that any person employed by the person, or acting under the auspices of the person, who provides or will provide advice on medical schemes to clients, is accredited with Council as a broker or an apprentice broker; and

(*d*) such additional information as the Council may deem necessary.

(2) A recognized educational qualification and appropriate experience, for the purposes of this regulation, means—

(*a*) Grade 12 education or equivalent educational qualification; and

(*b*) a minimum of two years demonstrated experience as broker or apprentice broker in health care business.

(3) Individuals not meeting the qualifications for a broker may apply to the Council for accreditation as apprentice brokers and such applications must be accompanied by documentary proof of—

(*a*) Grade 12 education or equivalent educational qualification;

(*b*) agreement by a fully accredited broker to supervise the applicant;

(*c*) current accreditation of the supervising broker;

(*d*) having passed or current enrolment in a relevant course of study recognised by the Council; and

(*e*) such additional information as the Council may deem necessary.

(4) In the case of a natural person, an application for accreditation as a broker or an apprentice broker must also be accompanied by information to satisfy the Council that the applicant complies with—

(*a*) any requirements for fit and proper brokers which may be determined by the Council, by notice in the *Gazette*; and

(*b*) any relevant requirements for fit and proper financial services providers or categories of providers which may be determined by the Registrar of Financial Service Providers in terms of section 8 (1) of the Financial Advisory and Intermediary Services Act, 2002.

(5) In considering an application for accreditation in terms of this regulation, the Council may take into consideration any other information regarding the applicant, derived from whatever source, if such information is disclosed to the applicant and she or he is given a reasonable opportunity to respond thereto.

(6) The Council must, after consideration of an application—

(*a*) if satisfied that an applicant complies with the requirements of this Act, grant the application subject to any conditions that he or she may deem necessary; or

(*b*) if not so satisfied, refuse the application and provide reasons to the applicant for such refusal.

(7) If accreditation is granted by the Council to a broker or an apprentice broker, it shall be granted for twenty-four months, and shall be accompanied by a certificate from the Registrar clearly specifying the expiry date of the accreditation and any conditions imposed by the Council in terms of subregulation (6) (*a*).

(8) The Council may at any time after the issue of a certificate of accreditation, on application by the broker or apprentice broker or on own initiative add, withdraw or amend any condition or restriction in respect of the accreditation, after having given the relevant broker or apprentice broker a reasonable opportunity to make submissions on the proposed addition, withdrawal or amendment and having considered those submissions, if the Council is satisfied that any such addition, withdrawal or amendment is justified and will not unfairly prejudice the interests of the clients of the broker or apprentice broker, and must in every such case issue an appropriately amended certificate to the broker or apprentice broker, as the case may be.

(9) A broker or apprentice broker wishing to renew his or her accreditation shall apply to the Council for such renewal in such format as the Council may from time to time determine, provided that—

(*a*) such application for renewal shall be made by the broker or apprentice broker at least three months prior to the date of expiry of the accreditation;

(*b*) the broker or apprentice broker shall furnish the Council with any information that the Council may require.

(10) The provisions of subregulations (6) to (8) shall apply *mutatis mutandis* to an application for renewal of accreditation in terms of subregulation (9).

(11) A person is disqualified from accreditation as a broker or an apprentice broker if he or she—

(*a*) is an unrehabilitated insolvent;

(*b*) is disqualified under any law from carrying on his or her profession; or

(*c*) has at any time been convicted (whether in the Republic of South Africa or elsewhere) of theft, fraud, forgery or uttering a forged document, perjury, an offence under the Corruption Act, 1992 (Act No. 94 of 1992), or any offence involving dishonesty, and has been sentenced therefor to imprisonment without the option of a fine.

[R. 28B inserted by GNR.1360 of 2002 wef 1 January 2003.]

28C. Suspension or withdrawal of accreditation.—(1) The Council may, subject to subregulation (2), at any time suspend or withdraw any accreditation granted in terms of regulation 28B if the Council is satisfied on the basis of available information, that the relevant broker or apprentice broker—

(*a*) no longer meets the requirements contemplated in regulation 28B;

(*b*) did not, when applying for accreditation, make a full disclosure of all relevant information to the Council, or furnished false or misleading information;

(*c*) has, since the granting of such accreditation, contravened or failed to comply with any provision of this Act;

(*d*) has, since the granting of such accreditation, failed to comply in a material manner with any relevant code of conduct for financial service providers published in terms of section 15 of the Financial Advisory and Intermediary Services Act, 2002;

(*e*) has, since the granting of such accreditation, conducted his or her business in a manner that is seriously prejudicial to clients or the public interest;

(*f*) or is disqualified from performing broker services in terms of regulation 28B (11).

(2) (*a*) Before suspending or withdrawing any accreditation, the Council must inform the broker or apprentice broker concerned of—

(i) the intention to suspend or withdraw the accreditation and the grounds therefor;

(ii) in the case of suspension, the intended period therefor; and

(iii) any terms attached to the suspension or withdrawal, including such measures as the Council may determine for the protection of the interests of the clients of the broker or apprentice broker,

and must give the broker or apprentice broker a reasonable opportunity to make a submission in response thereto.

(*b*) The Council must consider any such response, and may thereafter decide to withdraw or suspend or not to withdraw or suspend the accreditation, and must notify the broker or apprentice broker of the decision.

(*c*) Where the accreditation is suspended or withdrawn, the Council must make known the terms of the suspension or withdrawal or subsequent lifting thereof, by means of any appropriate public media announcement.

(3) During the period that the accreditation of a broker or apprentice broker has been suspended, such person may not apply for renewal of the accreditation or reapply for accreditation.

(4) On withdrawal of the accreditation of a person as a broker or apprentice broker, the Council may determine a reasonable period within which such person may not reapply for accreditation as a broker or apprentice broker, taking into account the nature of the circumstances giving rise to such withdrawal.

[R. 28C inserted by GNR.1360 of 2002 wef 1 January 2003.]

CHAPTER 8
ACCUMULATED FUNDS AND ASSETS

29. Minimum accumulated funds to be maintained by a medical scheme.—(1) In this Regulation "accumulated funds" means the nett asset value of the medical scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves.

(2) Subject to subregulations (3), (3A) and (4), a medical scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%.

[Sub-r. (2) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(3) A medical scheme must maintain accumulated funds, expressed as percentage of gross annual contributions, of not less than 10% during the first year after these regulations have come into operation, 13,5% during the second year, 17,5% during the third year, and not less than 22% during the fourth year.

(3A) Notwithstanding the provisions of subregulation (3), a medical scheme which is registered for the first time after the coming into operation of these regulations must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than —

(*a*) 10% during the first year after the scheme was registered;

(*b*) 13,5% during the second year;

(*c*) 17,5% during the third year; and

(*d*) 22% during the fourth year.

[Sub-r. (3A) inserted by GNR.1360 of 2002 wef 1 January 2003.]

(4) A medical scheme that for a period of 90 days fails to comply with subregulations (2), (3) or (3A) must notify the Registrar in writing of such failure, and must provide information relating to—

(*a*) the nature and causes of the failure, and

(*b*) the course of action being adopted to ensure compliance therewith.

[Sub-r. (4) substituted by GNR.1360 of 2002 wef 1 January 2003.]

30. Limitation on assets.—(1) A medical scheme must have assets of the kinds and categories specified in column 2 of Annexure B, the aggregate fair value of which, on any day, is not less than—

(*a*) the aggregate of the aggregate fair value on that day of its liabilities; and

(*b*) the minimum accumulated funds to be maintained in terms of Regulation 29,

excluding accounts receivable and intangible assets.

[Sub-r. (1) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(2) The assets that a medical scheme is required to have in terms of subregulation (1), when expressed as a percentage of the aggregate fair value of the liabilities and the minimum accumulated funds to be maintained in terms of Regulation 29, must not exceed the percentage specified against it in column 3 of Annexure B.

[Sub-r. (2) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(3) Subject to subregulation (3A), assets held in excess of the aggregate fair value of the liabilities and the minimum accumulated funds to be maintained in terms of

Regulation 29 must be held in the kinds and categories specified in column 2 of Annexure B.

[Sub-r. (3) substituted by GNR.1360 of 2002 wef 1 January 2003.]

(3A) Assets referred to in subregulation (3) must be allocated according to the relevant percentages specified against them in column 3 of Annexure B, unless the medical scheme can provide the Registrar with a certified statement from a suitably qualified professional, who has no direct or indirect financial interest in the relevant transaction, that—

(*a*) alternative percentages should apply to such assets; and

(*b*) the medical scheme is in full compliance with subregulation (2),

provided that the relevant percentages specified in column 3 of Annexure B, corresponding to items 3, 4 (*b*), 5 (*b*), 6 (*b*) and 7 of Annexure B, may not be exceeded.

[Sub-r. (3A) inserted by GNR.1360 of 2002 wef 1 January 2003.]

(4) In this Regulation and Annexure B—

"convertible debenture" means a debenture which is convertible into equity shares of a company;

"fair value" in relation to—

(i) a credit balance, deposit or margin deposit, means the amount thereof;

(ii) property, plant and equipment, means the difference between the cost and the total amount provided or written off for depreciation or reduction in value since the date of acquisition;

(iii) an asset which is listed on a licensed stock exchange, means the selling price at which it was quoted on that stock exchange on the date at which the value is calculated;

(iv) an asset which is a long-term policy, means the amount which would be payable to the policyholder upon the surrender of the policy on the date at which the value is calculated;

(v) an asset referred to as a unit trust, means the price at which the unit would have been repurchased by the unit trust management company on the date at which the value is calculated, and, in the case of a property unit trust, the market value on the date at which the value is calculated, and, if it is listed on a stock exchange, the selling price at which it was quoted on that stock exchange on the date at which the value is calculated;

(vi) a futures contract, means the mark-to-market value, as defined in the rules of SAFEX referred to in section 17 of the Financial Markets Control Act, 1989;

(vii) an option contract, means the price at which it was quoted on a stock exchange on the date at which the value is calculated;

(viii) . . . . . .

[Item (viii) deleted by GNR.1360 of 2002 wef 1 January 2003.]

(ix) any other asset or liability, means the price at which the asset could be exchanged, or the liability settled, between knowledgeable, willing parties in an arm's length transaction, as estimated by the medical scheme;

"linked policy" means a long-term policy in relation to which the liabilities of the long-term insurer are linked liabilities as defined in the Long-term Insurance Act, 1998 (Act No. 52 of 1998);

"margin" in relation to a stock exchange, means the margin as defined in regulations issued or approved by the appropriate authority of the state in which the stock exchange is situated or which is required by that stock exchange;

"margin deposit" means a margin with SAFEX and a stock exchange;

"margin with SAFEX" means the margin as defined in the rules of SAFEX referred to in section 17 of the Financial Markets Control Act, 1989 (Act No. 55 of 1989);

"property company" means a company—

(*a*) whose ownership of—

(i) immovable property; or

(ii) all of the shares in the company whose principal business consists of the ownership of immovable property or which exercises control over a company whose principal business consists of the ownership of immovable property; or

(iii) a linked policy, to the extent that the policy benefits thereunder are determined by reference to the value of immovable property,

constitutes in the aggregate, 50 per cent or more of the market value of its assets;

(*b*) which derives 50 per cent or more of its income, in the aggregate, from—

(i) investments in immovable property; or

(ii) investments in another company which derives 50 per cent or more of its income from investments in immovable property; or

(iii) a linked policy to the extent that the policy benefits thereunder are determined by reference to the value of immovable property; or

(*c*) which exercises control over a company referred to in paragraphs (*a*) or (*b*);

"regulated market" . . . . . .

[Definition of "regulated market" deleted by GNR.1360 of 2002 wef 1 January 2003.]

"SAFEX" means the South African Futures Exchange;

"securities" include bills, bonds, debentures and debenture stock, loan stock, promissory notes, annuities, negotiable certificates of deposit and other financial instruments of whatever nature; and

"shares" include share stock.

(5) . . . . . .

[Sub-r. (5) deleted by GNR.1360 of 2002 wef 1 January 2003.]

(6) For the purposes of calculating the fair value of assets there must be disregarded—

(*a*) any amount of premium, excluding a premium in respect of a reinsurance policy, which is due and payable;

(*b*) an amount, excluding a premium in respect of a reinsurance policy, which remains unpaid after the expiry of a period of 12 months from the date on which it became due and payable;

(*c*) an amount representing administrative, organisational or business extension expenses incurred directly or indirectly in the carrying on of the business of a medical scheme;

(*d*) an amount representing a liability or a reinsurance contract in terms of which the medical scheme concerned is the policy holder; and

(*e*) an asset to the extent to which such asset is encumbered.

(7) If the Registrar is satisfied that the value of an asset or liability, when calculated in accordance with subregulations (4), (5) and (6) does not reflect a fair value, he or she may direct the medical scheme to appoint another person, at the cost of the medical scheme, to place a fair value on that asset or liability, or the Registrar may direct the medical scheme to calculate the value in another manner which he or she determines and which will produce a fair value for that asset or liability.

(8) A medical scheme that for a period of 30 days fails to comply with subregulations (1) and (2) must notify the Registrar in writing of such failure, providing information relating to—

(*a*) the nature and causes of the failure, and

(*b*) the course of action being adopted to ensure compliance therewith.

CHAPTER 9
GENERAL MATTERS

31. Fees payable.—The following fees are payable in respect of the matters as indicated—

(*a*) an application for registration of a medical scheme: R5 000,00;

(*b*) the registration of a medical scheme: R1 000,00;

(*c*) to change the name of a medical scheme: R500,00;

(*d*) registration of amendments, rescissions or additions to the rules of a medical scheme in terms of section 31 of the Act, per A4 page or part thereof: R50,00;

(*e*) inspection of documents in terms of section 41 (3) of the Act, per document: R50,00;

(*f*) a copy or extract made by the Registrar of or from a document referred to in section 41 (3) of the Act, per A4 page or part thereof: R20,00;

(*g*) application for approval as an administrator contemplated in section 58 (4) of the Act: R10 000,00;

(*h*) application for accreditation as a broker contemplated in section 65 of the Act: R1 000,00;

(*i*) an appeal contemplated in section 50 (3) of the Act: R2 000,00;

(*j*) An application for accreditation to provide a managed health care service to a medical scheme: R10 000,00.

32. Penalties.—The penalty for every day which a failure contemplated in section 66 (3) of the Act continues, is R1 000,00.

33. Commencement of the regulations.—These regulations, with the exception of chapters 3, 4 and 8 come into operation on **1 November 1999**. Chapters 3, 4, 8, and Annexures A and B come into operation on **1 January 2000**.

Annexure A

EXPLANATORY NOTE

[Annexure A amended by GNR.1360 of 2002 wef 1 January 2004, by GN 1397 of 2003 wef 6 October 2003 and by GNR.1410 of 2004 wef 1 January 2005.]

The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of Private and Public health care resources.

The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of—

(i) inconsistencies or flaws in the current regulations;

(ii) the cost-effectiveness of health technologies or interventions;

(iii) consistency with developments in health policy; and

(iv) the impact on medical scheme viability and its affordability to Members.

PRESCRIBED MINIMUM BENEFITS

Categories (Diagnosis and Treatment Pairs) constituting the Prescribed Minimum Benefits Package under section 29 (1) (*o*) of the Medical Schemes Act (listed by Organ-System chapter)

BRAIN AND NERVOUS SYSTEM		
Code:	*Diagnosis:*	*Treatment:*
906A	Acute generalised paralysis, including polio and Guillain-Barre	Medical management; ventilation and plasmapheresis
341A	Basal ganglia, extra-pyramidal disorders; other dystonias nos	Initial diagnosis; initiation of medical management
950A	Benign and malignant brain tumours, treatable	Medical and surgical management, which includes radiation therapy and chemotherapy
49A	Compound/depressed fractures of skull	Craniotomy/craniectomy
213A	Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury	Medical and surgical management; ventilation
83A	Encephalocele; congenital hydrocephalus	Shunt; surgery
902A	Epilepsy (status epilepticus, initial diagnosis, candidate for neurosurgery)	Medical management; ventilation; neurosurgery
211A	Intraspinal and intracranial abscess	Medical and surgical management

905A	Meningitis – acute and subacute	Medical and surgical management
513A	Myasthenia gravis; muscular dystrophy; neuro-myopathies nos	Initial diagnosis; initiation of medical management; therapy for acute complications and exacerbations
510A	Peripheral nerve injury with open wound	Neuroplasty
940A	Reversible CNS abnormalities due to other systemic disease	Medical and surgical management
1A	Severe/moderate head injury: haematoma/edema with loss of consciousness	Medical and surgical management; ventilation
84A	Spina bifida	Surgical management
941A	Spinal cord compression, ishaemia or degenerative disease nos	Medical and surgical management
901A	Stroke – due to haemorrhage, or ischaemia	Medical management; surgery
28A	Subarachnoid and intracranial haemorrhage/haematoma; compression of brain	Medical and surgical management
305A	Tetanus	Medical management; ventilation
265A	Transient cerebral ischemia; life-threatening cerebrovascular conditions nos	Evaluation; medical management; surgery
109A	Vertebral dislocations/fractures, open or closed with injury to spinal cord	Repair/reconstruction; medical management; inpatient rehabilitation up to 2 months
684A	Viral meningitis, encephalitis, myelitis and encephalomyelitis	Medical management

EYE		
Code:	*Diagnosis:*	*Treatment:*
47B	Acute orbital cellulitis	Medical and surgical management
394B	Angle-closure glaucoma	Iridectomy; laser surgery; medical and surgical management
586B	Bell's palsy; exposure keratoconjunctivitis	Tarsorrhaphy; medical and surgical management
950B	Cancer of eye and orbit – treatable	Medical and surgical management, which includes radiation therapy and chemotherapy
901B	Cataract; aphakia	Extraction of cataract; lens implant
911B	Corneal ulcer; superficial injury of eye and adnexa	Conjunctival flap; medical management
405B	Glaucoma associated with disorders of the lens	Surgical management
386B	Herpes zoster and herpes simplex with ophthalmic complications	Medical management
389B	Hyphema	Removal of blood clot; observation
485B	Inflammation of lacrimal passages	Incision; medical management

909B	Open wound of eyeball and other eye structures	Medical and surgical management
407B	Primary and open angle glaucoma with failed medical management	Trabeculectomy; other surgery
419B	Purulent endophthalmitis	Vitrectomy
922B	Retained intraocular foreign body	Surgical management
904B	Retinal detachment, tear and other retinal disorders	Vitrectomy; laser treatment; other surgery
906B	Retinal vascular occlusion; central retinal vein occlusion	Laser surgery
409B	Sympathetic uveitis and degenerative disorders and conditions of globe; sight-threatening thyroid optopathy	Enucleation; medical management; surgery

EAR, NOSE, MOUTH AND THROAT		
Code:	*Diagnosis:*	*Treatment:*
33C	Acute and chronic mastoiditis	Mastoidectomy; medical management
482C	Acute otitis media	Medical and surgical management, including myringotomy
900C	Acute upper airway obstruction, including croup, epiglottitis and acute laryngotracheitis	Medical management; intubation; tracheostomy
950C	Cancer of oral cavity, pharynx, nose, ear, and larynx – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
241C	Cancrum oris	Medical and surgical management
38C	Choanal atresia	Repair of choanal atresia
133C	Cholesteatoma	Medical and surgical management
910C	Chronic upper airway obstruction, resulting in cor pulmonale	Surgical and medical management
901C	Cleft palate and/or cleft lip without airway obstruction	Repair
12C	Deep open wound of neck, including larynx; fracture of larynx or trachea, open	Medical and surgical management; ventilation
346C	Epistaxis – not responsive to anterior packing	Cautery/repair/control haemorrhage
521C	Foreign body in ear and nose	Removal of foreign body; and medical and surgical management
29C	Foreign body in pharynx, larynx, trachea, bronchus and oesophagus	Removal of foreign body
339C	Fracture of face bones, orbit, jaw; injury to optic and other cranial nerves	Medical and surgical management
219C	Leukoplakia of oral mucosa, including tongue	Incision/excision; medical management
132C	Life-threatening diseases of pharynx nos, including retropharyngeal abscess	Medical and surgical management
457C	Open wound of ear-drum	Tympanoplasty; medical management

240C	Peritonsillar abscess	Incision and drainage of abscess; tonsillectomy; medical management
347C	Sialoadenitis; abscess/fistula of salivary glands	Surgery
543C	Stomatitis, cellulitis and abscess of oral soft tissue; Vincent's angina	Incision and drainage; medical management

RESPIRATORY SYSTEM		
Code:	*Diagnosis:*	*Treatment:*
903D	Bacterial, viral, fungal pneumonia	Medical management, ventilation
158D	# Respiratory failure, regardless of cause	# Medical management; oxygen; ventilation
157D	Acute asthmatic attack; pneumonia due to respiratory syncytial virus in persons under age 3	Medical management
125D	Adult respiratory distress syndrome; inhalation and aspiration pneumonias	Medical management; ventilation
315D	Atelectasis (collapse of lung)	Medical and surgical management; ventilation
340D	Benign neoplasm of respiratory and intrathoracic organs	Biopsy; lobectomy; medical management; radiation therapy
950D	Cancer of lung, bronchus, pleura, trachea, mediastinum and other respiratory organs – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
170D	Empyema and abscess of lung	Medical and surgical management
934D	Frank haemoptyisis	Medical and surgical management
203D	Hypoplasia and dysplasia of lung	Medical and surgical management
900D	Open fracture of ribs and sternum; multiple rib fractures; flail chest	Medical and surgical management, ventilation
5D	Pneumothorax and haemothorax	Tube thoracostomy/thoracotomy

HEART AND VASCULATURE		
Code:	*Diagnosis:*	*Treatment:*
155E	Myocarditis; cardiomyopathy; transposition of great vessels; hypoplastic left heart syndrome	Medical and surgical management; cardiac transplant
108E	Pericarditis	Medical and surgical management
907E	Acute and subacute ischemic heart disease, including myocardial infarction and unstable angina	Medical management; surgery; percutaneous procedures
284E	Acute pulmonary heart disease and pulmonary emboli	Medical and surgical management
35E	Acute rheumatic fever	Medical management
908E	Aneurysm of major artery of chest, abdomen, neck, unruptured or ruptured nos	Surgical management
26E	Arterial embolism/thrombosis: abdominal aorta, thoracic aorta	Medical and surgical management

204E	Cardiac failure: acute or recent deterioration of chronic cardiac failure	Medical treatment
98E	Complete, corrected and other transposition of great vessels	Repair
97E	Coronary artery anomaly	Anomalous coronary artery ligation
309E	Diseases and disorders of aortic valve nos	Aortic valve replacement
210E	Diseases of endocardium; endocarditis	Medical management
314E	Diseases of mitral valve	Valvuloplasty; valve replacement; medical management
902E	Disorders of arteries: visceral	Bypass graft; surgical management
18E	Dissecting or ruptured aortic aneurysm	Surgical management
915E	Gangrene; severe atherosclerosis of arteries of extremities; diabetes mellitus with peripheral circulatory disease	Medical and surgical management including amputation
294E	Giant cell arteritis, kawasaki disease, hypersensitivity angiitis	Medical management
450E	Hereditary haemorrhagic telangiectasia	Excision
901E	Hypertension – acute life-threatening complications and malignant hypertension; renal artery stenosis and other curable hypertension	Medical and surgical management
111E	Injury to major blood vessels – trunk, head and neck, and upper limbs	Repair
19E	Injury to major blood vessels of extremities	Ligation
903E	Life-threatening cardiac arrhythmias	Medical and surgical management, pacemakers, cardioversion
900E	Life-threatening complications of elective cardiac and major vascular procedures	Medical and surgical management
497E	Multiple valvular disease	Surgical management
355E	Other aneurysm of artery – peripheral	Surgical management
905E	Other correctable congenital cardiac conditions	Surgical repair; medical management
100E	Patent ductus arteriosus; aortic pulmonary fistula – persistent	Ligation
209E	Phlebitis and thrombophlebitis, deep	Ligation and division; medical management
914E	Rheumatic pericarditis; rheumatic myocarditis	Medical management
16E	Rupture of papillary muscle	Medical and surgical management
627E	Shock/hypotension – life threatening	Medical management; ventilation
99E	Tetralogy of fallot (TOF)	Total repair tetralogy
93E	Ventricular septal defect – persistent	Closure

GASTRO-INTESTINAL SYSTEM

Code:	*Diagnosis:*	*Treatment:*
920F	Anal fissure; anal fistula	Fissurectomy; fistulectomy; medical management
41F	Abscess of intestine	Drain abscess; medical management
489F	Acquired hypertrophic pyloric stenosis and other disorders of the stomach and duodenum	Surgical management
254F	Acute diverticulitis of colon	Medical and surgical management, including colon resection
124F	Acute vascular insufficiency of intestine	Colectomy
337F	Amoebiasis; typhoid	Medical management
264F	Anal and rectal polyp	Excision of polyp
9F	Appendicitis	Appendectomy
952F	Cancer of retroperitoneum, peritoneum, omentum and mesentery – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
950C	Cancer of the gastro-intestinal tract including oesophagus, stomach, bowel, rectum, anus – treatable	Medical and surgical management, which includes radiation therapy and chemotherapy
95F	Congenital anomalies of upper alimentary tract – excluding tongue	Medical and surgical management
214F	Oesophageal stricture	Dilation; surgery
516F	Oesophageal varices	Medical management; surgical shunt; sclerotherapy
902F	Gastric or intestinal ulcers with haemorrhage or perforation	Surgery; endoscopic diagnosis; medical management
901F	Gastroenteritis and colitis with life-threatening haemorrhage or dehydration, regardless of cause	Medical management
6F	Hernia with obstruction and/or gangrene; uncomplicated hernias under age 18	Repair; bowel resection
20F	Intestinal obstruction without mention of hernia; symptomatic foreign body in stomach, intestines, colon and rectum	Excision; surgery; medical management
232F	Paralytic ileus	Medical management
498F	Peritoneal adhesion	Surgical management
3F	Peritonitis, regardless of cause	Medical and surgical management
555F	Rectal prolapse	Partial colectomy
292F	Regional enteritis; idiopathic proctocolitis – acute exaccerbations and complications only	Medical and surgical management
900F	Rupture of intra-abdominal organ	Repair; splenectomy; resection
507F	Thrombosed and complicated haemorrhoids	Haemorrhoidectomy; incision

LIVER, PANCREAS AND SPLEEN

Code:	*Diagnosis:*	*Treatment:*
325G	Acute necrosis of liver	Medical management
327G	Acute pancreatitis	Medical management, and where appropriate, surgical management
36G	Budd-Chiari syndrome, and other venous embolism and thrombosis	Thrombectomy/ligation
910G	Calculus of bile duct with cholecystitis	Medical management; cholecystectomy; other open or closed surgery
950G	Cancer of liver, biliary system and pancreas – treatable	Medical and surgical management
255G	Cyst and pseudocyst of pancreas	Drainage of pancreatic cyst
156G	Disorders of bile duct	Excision; repair
910G	Gallstone with cholecystitis and/or jaundice	Medical management; cholecystectomy; other open or closed surgery
743G	Hepatorenal syndrome	Medical management
27G	Liver abscess; pancreatic abscess	Medical and surgical management
911G	Liver failure; hepatic vascular obstruction; inborn errors of liver metabolism; biliary atresia	Liver transplant, other surgery, medical management
231G	Portal vein thrombosis	Shunt

MUSCULOSKELETAL SYSTEM; TRAUMA NOS		
Code:	*Diagnosis:*	*Treatment:*
353H	Abscess of bursa or tendon	Incision and drainage
32H	Acute osteomyelitis	Medical and surgical management
950H	Cancer of bones – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
206H	Chronic osteomyelitis	Incision and drainage
902H	Closed fractures/dislocations of limb bones/epiphyses – excluding fingers and toes	Reduction/relocation
85H	Congenital dislocation of hip; coxa vara and valga; congenital clubfoot	Repair/reconstruction
147H	Crush injuries of trunk, upper limbs, lower limb, including blood vessels	Surgical management; ventilation; acute renal dialysis
491H	Dislocations/fractures of vertebral column without spinal cord injury	Medical management; surgical stabilisation
500H	Disruptions of the achilles/quadriceps tendons	Repair
178H	Fracture of hip	Reduction; hip replacement
445H	Injury to internal organs	Medical and surgical management
900H	Open fracture/dislocation of bones or joints	Reduction/relocation; medical and surgical management
34H	Pyogenic arthritis	Medical and surgical management

901H	Traumatic amputation of limbs, hands, feet, and digits	Replantation/amputation

SKIN AND BREAST		
Code:	*Diagnosis:*	*Treatment:*
465J	Acute lymphadenitis	Incision and drainage; medical management
900J	Burns, greater than 10% of body surface, or more than 5% involving head, neck, hands, perineum	Debridement; free skin graft; medical management
950J	Cancer of breast – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
954J	Cancer of skin, excluding malignant melanoma – treatable	If histologically confirmed, medical and surgical management, which includes radiation therapy
952J	Cancer of soft tissue, including sarcomas and malignancies of the adnexa – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
349J	Cellulitis and abscesses with risk of organ or limb damage or septicemia if untreated; necrotising fasciitis	Medical and surgical management
901J	Disseminated bullous skin disease, including pemphigus, pemphigoid, epidermolysis bullosa, epidermolytic hyperkeratosis	Medical management
951J	Lethal midline granuloma	Medical management, which includes radiation therapy
953J	Malignant melanoma of the skin – treatable	Medical and surgical management, which includes radiation therapy
373J	Non-superficial open wounds – non life-threatening	Repair
356J	Pyoderma; body, deep-seated fungal infections	Medical management
112J	Toxic epidermal necrolysis and staphylococcal scalded skin syndrome; Stevens-Johnson syndrome	Medical management

ENDOCRINE, METABOLIC AND NUTRITIONAL		
Code:	*Diagnosis:*	*Treatment:*
331K	Acute thyroiditis	Medical management
951K	Benign and malignant tumours of pituitary gland with/without hypersecretion syndromes	Medical and surgical management; radiation therapy
30K	Benign neoplasm of islets of Langerhans	Excision of tumor; medical management
950K	Cancer of endocrine system, excluding thyroid – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
952K	Cancer of thyroid – treatable; carcinoid	Medical and surgical management, which includes chemotherapy and

	syndrome	radiation therapy
61K	Congenital hypothyroidism	Medical management
902K	Disorders of adrenal secretion nos	Medical management; adrenalectomy
447K	Disorders of parathyroid gland; benign neoplasm of parathyroid gland	Medical and surgical management
904K	Hyper and hypothyroidism with life-threatening complications or requiring surgery	Medical management; surgery
31K	Hypoglycemic coma; hyperglycemia; diabetic ketoacidosis	Medical management
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management
901K	Life-threatening congenital abnormalities of carbohydrate, lipid, protein and amino acid metabolism	Medical management
903K	Life-threatening disorders of fluid and electrolyte balance, nos	Medical management

URINARY AND MALE GENITAL SYSTEM		
Code:	*Diagnosis:*	*Treatment:*
354L	Abscess of prostate	Turp; drain abscess
904L	Acute and chronic pyelonephritis; renal and perinephric abscess	Medical and surgical management
903L	Acute glomerulonephritis and nephrotic syndrome	Medical management
954L	Cancer of penis and other male genital organ – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
953L	Cancer of prostate gland – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
950L	Cancer of testis – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
952L	Cancer of urinary system including kidney and bladder – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
906L	Congenital anomalies of urinary system – symptomatic and life threatening	Nephrectomy/repair
901L	End stage renal disease regardless of cause	Dialysis and renal transplant where Department of Health criteria are met only (see criteria published in GPS 004-9001)
900L	Hyperplasia of the prostate, with acute urinary retention or obstructive renal failure	Transurethral resection; medical management
905L	Obstruction of the urogenital tract, regardless of cause	Catheterization; surgery; endoscopic removal of obstructing agent: lithotripsy

436L	Torsion of testis	Orchidectomy; repair
43L	Trauma to the urinary system including ruptured bladder	Cystorrhaphy; suture; repair
289L	Ureteral fistula (intestinal)	Nephrostomy
359L	Vesicoureteral reflux	Medical management; replantation

FEMALE REPRODUCTIVE SYSTEM		
Code:	*Diagnosis:*	*Treatment:*
539M	Abscesses of Bartholin's gland and vulva	Incision and drainage; medical management
288M	Acute pelvic inflammatory disease	Medical and surgical management
954M	Cancer of cervix – treatable	Medical and surgical management, which includes radiation therapy and chemotherapy
952M	Cancer of ovary – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
950M	Cancer of uterus – treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
953M	Cancer of vagina, vulva and other female genital organs nos – treatable	Medical and surgical management, which includes radiation therapy and chemotherapy
960M	Cervical and breast cancer screening	Cervical smears; periodic breast examination
645M	Congenital abnormalities of the female genitalia	Medical and surgical management
266M	Dysplasia of cervix and cervical carcinoma-in-situ; cervical condylomata	Medical and surgical management
53M	Ectopic pregnancy	Surgery
460M	Fistula involving female genital tract	Closure of fistula
951M	Hydatidiform mole; choriocarcinoma	D and C; hysterectomy; chemotherapy
902M	Infertility	Medical and surgical management
528M	Menopausal management, anomalies of ovaries, primary and secondary amenorrhoea, female sex hormones abnormalities nos, including hirsutism	Medical and surgical management, including hormone replacement therapy
434M	Non-inflammatory disorders and benign neoplasms of ovary, fallopian tubes and uterus	Salpingectomy; oophorectomy; hysterectomy; medical and surgical management
237M	Sexual abuse, including rape	Medical management; psychotherapy
903M	Spontaneous abortion	Medical and surgical management
435M	Torsion of ovary	Oophorectomy; ovarian cystectomy
530M	Uterine prolapse; cystocele	Surgical repair
296M	Voluntary termination of pregnancy	Induced abortion; medical and surgical management

PREGNANCY AND CHILDBIRTH		
Code:	*Diagnosis:*	*Treatment:*
67N	# Low birth weight (under 1 000g) with respiratory difficulties	# Medical management not including ventilation
967N	# Low birth weight (under 2 500 grams and > 1 000g) with respiratory difficulties	Medical management, including ventilation; intensive care therapy
71N	Birth trauma for baby	Medical management; surgery
901N	Congenital systemic infections affecting the newborn	Medical management, ventilation
904N	Haematological disorders of the newborn	Medical management
54N	Necrotizing enterocolitis in newborn	Medical and surgical management
74N	Neonatal and infant git abnormalities and disorders, including malrotation and atresia	Medical and surgical management
902N	Neonatal endocrine, metablic and toxin-induced conditions	Medical management
903N	Neurological abnormalities in the newborn	Medical management
52N	Pregnancy	Antenatal and obstetric care necessitating hospitalisation, including delivery
56N	Respiratory conditions of newborn	Medical management; ventilation

HAEMATOLOGICAL, INFECTIOUS AND MISCELLANEOUS SYSTEMIC CONDITIONS		
Code:	*Diagnosis:*	*Treatment:*
50S	Syphilis – congenital, secondary and tertiary	Medical management
168S	# HIV-Infection	HIV voluntary counselling and testing Co-trimoxazole as preventative therapy Screening and preventative therapy for TB Diagnosis and treatment of sexually transmitted infections Pain management in palliative care Treatment of opportunistic infections Prevention of mother-to-child transmission of HIV Post-exposure prophylaxis following occupational exposure or sexual assault Medical management and medication, including the provision of anti-retroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector (*The national*

		guidelines are set out in the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa; and the National Anti-retroviral Treatment Guidelines. Both documents are available at the office of the Director-General: National Department of Health).
260S	# Imminent death regardless of diagnosis	# Comfort care; pain relief; hydration
113S	Acquired haemolytic anaemias	Medical management
901S	Acute leukaemias, lymphomas	Medical management, which includes chemotherapy, radiation therapy, bone marrow transplantation
277S	Anaerobic infections – life-threatening	Medical management; hyperbaric oxygen
48S	Anaphylactic shock	Medical management; ventilation
900S	Aplastic anaemia; agranulocytosis; other life-threatening hereditary immune deficiencies	Bone marrow transplantation; medical management
197S	Botulism	Medical management
338S	Cholera; rat-bite fever	Medical management
196S	Chronic granulomatous disease	Medical management, which includes radiation therapy
916S	Coagulation defects	Medical management
246S	Cysticercosis; other systemic cestode infection	Medical management
903S	Deep-seated (excluding nail infections), disseminated and systemic fungal infections	Medical management; surgery
44S	Erysipelas	Medical management
179S	Hereditary angioedema; angioneurotic adema	Medical and surgical therapy
174S	Hereditary haemolytic anaemias (eg. sickle cell); dyserythropoietic anaemia (congenital)	Medical management
201S	Herpetic encephalitis; Reye's syndrome	Medical management
913S	Immune compromise nos and associated life-threatening infections nos	Medical management
912S	Leprosy and other systemic mycobacterial infections, excluding tuberculosis	Medical management
336S	Leptospirosis; spirochaetal infections nos	Medical management
252S	Life-threatening anaemia nos	Medical management; transfusion
908S	Life-threatening conditions due to exposure to the elements, including hypo- and hyperthermia; lightning	Medical management

	strikes	
907S	Life-threatening rickettsial and other arthropod-borne diseases	Medical management
172S	Malaria; trypanosomiasis; other life-threatening parasitic disease	Medical management
904S	Metastatic infections; septicemia	Medical management
910S	Multiple myeloma and chronic leukaemias	Medical management; which includes chemotherapy and radiation therapy
247S	Poisoning by ingestion, injection, and non-medicinal agents	Medical management
911S	Sexually transmitted diseases with systemic involvement not elsewhere specified	Medical management
128S	Tetanus; anthrax; Whipple's disease	Medical management
122S	Thalassemia and other haemoglobinopathies – treatable	Medical management; bone marrow transplant
316S	Toxic effect of gases, fumes, and vapours	Medical therapy
11S	Tuberculosis	Diagnosis and acute medical management; successful transfer to maintenance therapy in accordance with DoH guidelines
937S	Tumour of internal organ (excludes skin): unknown whether benign or malignant	Biopsy
15S	Whooping cough, diptheria	Medical management

MENTAL ILLNESS		
Code:	*Diagnosis:*	*Treatment:*
182T	Abuse or dependence on psychoactive substance, including alcohol	Hospital-based management up to 3 weeks/year
901T	Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse	Hospital admission for psychotherapy/counselling up to 3 days, or up to 12 outpatient psychotherapy/counselling contacts
910T	Acute delusional mood, anxiety, personality, perception disorder and organic mental disorder caused by drugs	Hospital-based management up to 3 days
910T	Alcohol withdrawal delirium; alcohol intoxication delirium	Hospital-based management up to 3 days leading to rehabilitation
908T	Anorexia nervosa and bulimia nervosa	Hospital-based management up to 3 weeks/year or minimum of 15 outpatient contacts per year
903T	Attempted suicide, irrespective of cause	Hospital-based management up to 3 days or up to 6 outpatient contacts
184T	Brief reactive psychosis	Hospital-based management up to 3 weeks/year
910T	Delirium: amphetamine, cocaine, or other psychoactive substance	Hospital-based management up to 3 days

902T	Major affective disorders, including unipolar and bipolar depression	Hospital-based medical management up to 3 weeks/year (including inpatient electro-convulsive therapy and inpatient psychotherapy) or outpatient psychotherapy of up to 15 contacts
907T	Schizophrenic and paranoid delusional disorders	Hospital-based medical management up to 3 weeks/year
909T	Treatable dementia	Admission for initial diagnosis; management of acute psychotic symptoms – up to 1 week

CHRONIC CONDITIONS	
Diagnosis:	
Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	Hyperlipidaemia
Cardiac Failure	Hypertension
Cardiomyopathy	Hypothyroidism
Chronic Renal Disease	Multiple Sclerosis
Chronic Obstructive Pulmonary Disease	Parkinson's Disease
Coronary Artery Disease	Rheumatoid Arthritis
Crohn's Disease	Schizophrenia
Diabetes Insipidus	Systemic Lupus Erythematosus
Diabetes Mellitus Type 1 & 2	Ulcerative Colitis
Dysrhythmias	

Treatment:
Diagnosis, medical management and medication, to the extent that this is provided for by way of a therapeutic algorithm for the specified condition, published by the Minister by notice in the *Gazette*

Explanatory notes and definitions to Annexure A

(1) Interventions shall be deemed hospital-based where they require:

– An overnight stay in hospital.

or

– The use of an operating theatre together with the administration of a general or regional anaesthetic.

or

– The application of other diagnostic or surgical procedures that carry a significant risk of death, and consequently require on-site resuscitation and/or surgical facilities.

or

– The use of equipment, medications or medical professionals not generally found outside hospitals.

(2) Where the **treatment component of a category in Annexure A is stated in general terms** (i.e. "medical management" or "surgical management"), it should be interpreted as referring to prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition. Where significant differences exist between Public and Private sector practices, the interpretation of the Prescribed Minimum Benefits should follow the predominant Public Hospital practice, as outlined in the relevant provincial or national public hospital clinical protocols, where these exist. Where clinical protocols do not exist, disputes should be settled by consultation with provincial health authorities to ascertain prevailing practice. The following interventions shall however be excluded from the generic medical/surgical management categories unless otherwise specified:

(i) Tumour chemotherapy

(ii) Tumour radiotherapy

(iii) Bone marrow transplantation/rescue

(iv) Mechanical ventilation

(v) Hyperbaric oxygen therapy

(vi) Organ transplantation

(vii) Treatments, drugs or devices not yet registered by the relevant authority in the Republic of South Africa.

(2A) In respect of treatments denoted as "medical management" or "surgical management", note (2) above describes the standard of treatment required, namely "prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition." Note (2) does not restrict the setting in which the relevant care should be provided, and should not be construed as preventing the delivery of any prescribed minimum benefit on an outpatient basis or in a setting other than a hospital, where this is clinically most appropriate.

(3) **"Treatable" cancers.**—In general, solid organ malignant tumours (excluding lymphomas) will be regarded as treatable where:

(i) they involve only the organ of origin, and have not spread to adjacent organs

(ii) there is no evidence of distant metastatic spread

(iii) they have not, by means of compression, infarction, or other means, brought about irreversible and irreparable damage to the organ within which they originated (for example brain stem compression caused by a cerebral tumour) or another vital organ

(iv) or, if points (i) to (iii) do not apply, there is a well demonstrated five-year survival rate of greater than 10% for the given therapy for the condition concerned.

(4) **Tumour chemotherapy with or without bone marrow transplantation and other indications for bone marrow transplantation.**—These are included in the prescribed minimum benefits package only where Annexure A explicitly mentions such interventions. Management may include a first full course of chemotherapy (including, if indicated, induction, consolidation and myeloablative components). Where specified in terms of Annexure A, this may be followed by bone marrow transplantation/rescue, according to tumour type and prevailing practice. The following conditions would also apply to the bone marrow transplantation component of the prescribed minimum benefits:

(i) the patient should be under 60 years of age

(ii) allogeneic bone marrow transplantation should only be considered where there is an HLA matched family donor

(iii) the patient should not have relapsed after a previous full course of chemotherapy

(iv) (points (i) and (ii) shall also apply to bone marrow transplantation for non-malignant diseases).

(5) **Solid organ transplants.**—The prescribed minimum benefits Annexure includes solid organ transplants (liver, kidney and heart) only where these are provided by Public hospitals in accordance with Public sector protocols and subject to public sector waiting lists.

(6) In certain cases, **specified categories shall take precedence** over others present. Such "overriding" categories are preceded by the sign "#" in their descriptions within Annexure A. For example, where someone is suffering from pneumonia and HIV, because the HIV category (168S) is an overriding category, the entitlements guaranteed by the "pneumonia" category (903D) are overridden.

(7) **Hospital treatment where the diagnosis is uncertain and/or admission for diagnostic purposes.**—Urgent admission may be required where a diagnosis has not yet been made. Certain categories of prescribed minimum benefits are described in terms of presenting symptoms, rather than diagnosis, and in these cases, inclusion within the prescribed minimum benefits may be assumed without a definitive diagnosis. In other cases, clinical evidence should be regarded as sufficient where this suggests the existence of a diagnosis that is included within the package. Medical schemes may, however, require confirmatory evidence of this diagnosis within a reasonable period of time, and where they consistently encounter difficulties with particular providers or provider networks, such problems should be brought to the attention of the Council for Medical Schemes for resolution.

(8) NOS – not otherwise specified.

(9) In respect of Code 902M (Diagnosis: Infertility), 'medical and surgical management' shall be limited to the following procedures or interventions:

(*a*) hysterosalpingogram

(*b*) the following blood tests:

a. Day 3 FSH/LH

b. Oestradiol

c. Thyroid function (TSH)

d. Prolactin

e. Rubella

f. HIV

g. VDRL

h. Chlamydia

i. Day 21 Progesterone

(*c*) laparoscopy

(*d*) hysteroscopy

(*e*) surgery (uterus and tubal)

(*f*) manipulation of ovulation defects and deficiencies

(*g*) semen analysis (volume; count; mobility; morphology; MAR-test)

(*h*) basic counselling and advice on sexual behaviour, temperature charts, etc.

(*i*) treatment of local infections.

Annexure B
LIMITATION ON ASSETS

[Annexure B substituted by GNR.1360 of 2002 w.e.f. 1 January 2003.]

Item	*Categories or kinds of assets*	*Maximum percentage of aggregate fair value of liabilities and the minimum accumulated funds to be maintained in terms of Regulation 29*
1.	(*a*) Inside the Republic—	
	Deposits and balances in current and savings accounts with a bank, including negotiable deposits, money market instruments and structured bank notes in terms of which such a bank or mutual bank is liable, as well as margin deposits with SAFEX, and collateralised deposits:	100%
	(i) Per bank with net qualifying capital and reserve funds per Reserve Bank DI900 return greater than R5 billion	35%
	(ii) Per bank with net qualifying capital and reserve funds per Reserve Bank DI900 return greater than R100 million	10%
	(iii) Deposits collateralised with securities issued by the government of the RSA where an appropriate International Securities Masters Agreement (ISMA) has been concluded	20%
	(*b*) Territories outside the Republic	
	Deposits and balances in current and savings accounts with a bank, including negotiable deposits, and money market instruments in terms of which such a bank is liable:	15%
	(i) Per bank	10%
2.	Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by:	
	(*a*) Inside the Republic	100%
	(i) Instruments guaranteed by the government of the RSA	100%
	(ii) A local authority authorized by law to levy rates upon immovable property	10%
	(iii) Development Bank	20%
	(iv) Industrial Development Corporation (IDC)	20%
	(v) Infrastructure Finance Corporation Limited (INCA)	20%
	(vi) Land and Agricultural Bank	20%
	(vii) Trans-Caledonian Tunnel Authority (TCTA)	20%
	(viii) SA Roads Board	20%
	(ix) Eskom	20%
	(x) Transnet	20%
	(xi) Per bank with net qualifying capital and reserve funds per Reserve Bank DI900 return greater than R5 billion	35%
	(xii) Per bank with net qualifying capital and reserve	10%

	funds per Reserve Bank DI900 return greater than R100 million.....	
	(xiii) Per corporate institution not included in above categories where debt is traded on the Bond Exchange of South Africa and included in the Other Bond Index (OTHI) or All Bod Index (ALBI)	10%
	(xiv) Per other institution not included in above categories, which is approved by the Registrar	10%
	(*b*) Territories outside the Republic	15%
	(i) Per institution	10%
3.	Immovable property and claims secured by mortgage bonds thereon. Units in unit trust schemes in property shares and shares in, loans to and debentures, both convertible and non-convertible, of property companies—	
	(*a*) Inside the Republic	10%
	(i) Per single property, property company or development project	2.5%
	(*b*) Territories outside the Republic	0%
4.	Preference and ordinary shares in companies excluding shares in property companies. Convertible debentures, whether voluntary or compulsory convertible, exchange traded funds, units in equity unit trust schemes with the objective to invest mainly in shares and linked policies of insurance with the proceeds and value determined by the performance of an underlying equity portfolio. These investments are subject to the following limitations—	
	(*a*) Inside the Republic	40%
	(i) Unlisted shares, unlisted debentures and shares and convertible debentures listed in the Development Capital and Venture Capital sectors of the JSE Securities Exchange	2.5%
	(ii) Shares and convertibles listed on the JSE Securities Exchange other than in the Development Capital and Venture Capital sectors—	
	i. Per company with a market capitalisation of more than R50 billion	7.5%
	ii. Per company with a market capitalisation of between R5 billion and R50 billion	5%
	iii. Per company with a market capitalisation of less than R5 billion	2.5%
	(iii) Exchange traded funds traded on the JSE Securities Exchange—	
	i. Per fund with diversified holdings across the component sectors of the JSE Securities Exchange	20%
	ii. Per fund with holdings focused in sub-sectors of the JSE Securities Exchange	10%
	(iv) Units in equity unit trusts or pooled equity managed funds—	
	i. Per unit trust with diversified holdings across the component sectors of the JSE Securities Exchange	40%
	ii. Per fund with holdings focused in sub-sectors of the JSE Securities Exchange	20%
	(v) Policies of insurance linked to the performance	

	of underlying equities or equity indices—	
	i. Per policy of insurance with diversified equity holdings across the component sectors of the JSE Securities Exchange	20%
	ii. Per policy of insurance with underlying equity investment focused in sub-sectors of the JSE Securities Exchange	10%
	(*b*) Territories outside the Republic	0%
5.	Listed and unlisted debentures—	
	(*a*) Inside the Republic	5%
	(*b*) Territories outside the Republic	0%
6.	Policies of insurance with—	
	(*a*) Insurers registered in the Republic.....	90%
	(i) Per registered insurer where the policy proceeds are not directly linked to the market value of the underlying assets	35%
	(ii) Per registered insurer where the policy proceeds are directly linked to the market value of the underlying assets and the underlying assets are invested in a balanced manner across the asset classes and categories stipulated in sections 1–7 above — complying with all the stated maxima and minima	90%
	(*b*) Insurers registered in territories outside of the Republic .	0%
7.	Any other assets not referred to elsewhere in this Annexure—	
	(*a*) Inside the Republic	2.5%
	(i) Where inventories are included, inclusion at the smaller of book and realisable value	2.5%
	(ii) Other	2.5%
	(*b*) Territories outside the Republic	0%

Explanatory notes and conditions for Annexure B

1. In respect of items 1 (*a*) (i) and 1 (*a*) (ii), for banks that are subsidiaries of foreign banks, the foreign parent's capital may not be taken into account.
2. The sum of deposits in categories 1 (*a*) (i) and 1 (*a*) (ii) shall not be less than 20%.
3. Total amounts in categories 1 (*b*) and 2 (*b*) are subject to an aggregate maximum of 15%.
4. The aggregate of amounts in categories 1 (*a*) (ii), 2 (*a*) (ii) and 2 (*a*) (xiii) shall be subject to a maximum limit of 30%.
5. The total exposure allowance per bank, being the aggregate of amounts included in categories 1 (*a*) (i) and 2 (*a*) (xi) is subject to an aggregate maximum of 35%.
6. The total exposure allowance per bank, being the aggregate of amounts included in categories 1 (*a*) (ii) and 2 (*a*) (xii) is subject to an aggregate maximum of 10%.
7. The total exposure allowance for all banks within categories 1 (*a*) (ii) and 2 (*a*) (xii) is subject to an aggregate maximum of 30%.
8. Unit trusts and policies of insurance may not be utilised to circumvent the limitations of these regulations. Medical schemes are required to demonstrate on a "look through" basis that such avenues have not been utilised to bypass the limitations imposed by Annexure B.

(b) **Annexure C**

Part C1

Report of the independent auditors of ..... (name of the administrator) to the Registrar of Medical Schemes in compliance with Regulation 17 (2) (*d*) under the Medical Schemes Act, 1998

[Heading substituted by GNR.1360 of 2002 wef 1 January 2003.]

1. We have reviewed the [proposed] system of internal financial control of ..... (name of administrator)/[that ..... name of administrator) intends to implement from .....].

2. The [implementation and] maintenance of an adequate system of internal financial control [are] is the responsibility of the directors/partners/sole proprietor. Our responsibility is to report on whether or not, based on our review, anything has come to our attention that would indicate that the [proposed] system of internal financial control is not adequate for the size and complexity of the business of the medical scheme or medical schemes [to be] administered.

Scope

3. We conducted our review in accordance with the statement of South African Auditing Standards applicable to review engagements. This standard requires that we plan and perform the review to obtain moderate assurance with regard to the [proposed] system of internal financial control. A review is limited primarily to inquiries of personnel of the administrator, inspection of evidence and observation of, and enquiry about, the operation of the internal control procedures for a small number of transactions. [A review is limited primarily to inquiries of personnel of the administrator about the proposed operation of the system of internal financial control and inspection of related evidence.]

Inherent limitations

4. Because of the inherent limitations of a system of internal financial control, including concealment through collusion or forgery, it is possible that errors and irregularities may occur and not be detected.

   A review is not designed to detect all weaknesses in the system of internal financial control as it is not performed continuously throughout the period and the tests performed are on a sample basis. [A review is not designed to detect all weaknesses in the proposed system of internal financial control.]

   [As the proposed system of internal financial control has not yet been implemented, we do not provide any assurance as to whether or not the system will operate adequately.]

5. Any projections of the evaluation of the system of internal financial control to future periods is subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with them may deteriorate.

6. Also, a review does not provide all the evidence that would be required in an audit, thus the level of assurance provided is less than given in an audit. We have not performed an audit and, accordingly, we do not express an audit opinion.

(b) **Review opinion**

7. Based on our review, nothing of significance has come to our attention that causes us to believe that the [proposed] system of internal financial control is not adequate for the size and complexity of the business of the medical scheme or schemes [to be] administered.

Name

Registered Accountants and Auditors
Chartered Accountants (SA)
Date
Address

Note: In the case of a new administrator, i.e. where the system of internal financial control has not yet been implemented by the administrator, the text in the square brackets should be included in the report.

Part C2

[Heading inserted by GNR.1360 of 2002 wef 1 January 2003.]

Report of the independent auditors of ..... (name of administrator) to the Registrar of Medical Schemes in compliance with Regulation 17 (25) under the Medical Schemes Act, 1998

A. Annual financial statements

1. We have audited the annual financial statements of ..... (name of administrator) ("the administrator") set out on pages ..... to ..... for the year ended ..... The annual financial statements are the responsibility of the directors/partners/sole proprietor. Our responsibility is to express an opinion on these financial statements based on our audit.

[Para. A1 substituted by GNR.1360 of 2002 wef 1 January 2003.]

Scope

2. We conducted our audit in accordance with statements of South African Auditing Standards. Those standards require that we plan and perform the audit to obtain reasonable assurance that the annual financial statements are free of material misstatement. An audit includes:

   2.1 examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements;

   2.2 assessing the accounting principles used and significant estimates made by management; and

   2.3 evaluating the overall financial statement presentation.

   We believe that our audit provides a reasonable basis for our opinion.

Audit opinion

3. In our opinion the annual financial statements fairly present, in all material respects, the financial position of the administrator at ..... and the results of its operations and cash flows for the year then ended in accordance with generally accepted accounting practice and in the manner required by the Companies Act, 1973 (include where appropriate).

B. Consideration of the system of internal financial controls

4. In planning and performing the above-mentioned audit, we considered the system of internal financial control of the administrator in order to determine our audit procedures for the purpose of expressing our audit opinion on the annual financial statements, not to provide assurance on the system of the internal financial control.

5. The directors/partners/sole proprietor of ..... (name of the administrator) are/is responsible for establishing and maintaining an effective system of internal financial control. In fulfilling this responsibility, estimates and judgements by the directors/partners/sole proprietor are required to assess the expected benefits and related costs of internal financial control policies and procedures. Two of the objectives of a system of internal financial control are to provide the directors/partners/sole proprietor with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorised use or disposition and that transactions are executed in accordance with their/his/her authorisation and recorded properly to permit preparation of annual financial statements in conformity with generally accepted accounting practice.

6. Because of the inherent limitations of a system of internal financial control, it is possible that errors or irregularities may occur and not be detected. Furthermore, any projection of the evaluation of a system of internal financial control to future periods is subject to the risk that the procedures may become inadequate because of changes in circumstances, or that the degree of compliance with them may deteriorate.
7. Our consideration of the system of internal financial control would not necessarily disclose all matters in the system that might be material weaknesses. A material weakness is a condition in which the design or operation of the specific internal financial control does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the annual financial statements being audited, may occur and not be detected within a timely period by employees in the normal performance of their assigned functions.
8. However, based on our consideration of the system of internal financial control for purposes of our audit, nothing of significance has come to our attention that causes us to believe that the financial record keeping and the system of internal financial control are not adequate for the size and complexity of the business the administrator is presently conducting. All changes to the system of internal financial control that came to our attention during the course of our audit have been recorded in writing.
9. This report is intended solely for the use of the Registrar of Medical Schemes and is not to be distributed to other parties.

Name

Registered Accountants and Auditors

Chartered Accountants (SA)

Date

Address

Note: In the case of a sole proprietor, reference to "administrator" should be read as reference to the administration business of the sole proprietor.

Annexure D

(For completion on letterhead of Administrator)

Management representation letter to the Registrar of Medical Schemes in compliance with Regulation 25 under the Medical Schemes Act, 1998

This representation letter is provided in connection with the financial statements of ..... (name of the administrator) for the year ended ..... (date) to enable the Registrar to evaluate whether or not ..... (name of the administrator) has complied with the Medical Schemes Act and related regulations.

We confirm, to the best of our knowledge and belief, the following representations:

1. We had ..... (quantity) registered funds under our administration at the year-end.
2. The fidelity guarantee and professional indemnity insurance cover is adequate to cover the risks of losses due to fraud, dishonesty and negligence.
3. We deposited the moneys of the medical schemes under our administration in the bank accounts of the schemes on no later than the business day following the receipt of the schemes' moneys.
4. No changes in ownership, directors, members or shareholders having the effect of a *de facto* change of control took place during the year ended ..... (date), without the approval of the Registrar.

5. Administration agreements entered into with medical schemes during the year ended ..... are in writing and conform to regulation 18.
6. The following administration agreements were terminated during the year ended ..... (date) and in respect of them, regulation 19 have been complied with:
7. For the year ended ....., we have maintained a register of documents of title in our safe custody as contemplated in regulation 24. Furthermore, all these assets are held in the names of the respective medical schemes.
8. We conducted the business in terms of the Act, the regulations, the agreements with medical schemes and the rules of these medical schemes.
9. The administration business is maintained in a financially sound condition as contemplated in regulation 22.
10. The system of internal control is adequate for the size and complexity of the business.
11. We believe that the business will continue in operational existence for the foreseeable future.

....

Managing Director Financial Director