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GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 1360 **4 November 2002**

MEDICAL SCHEMES ACT, 1998 (ACT No. 131 of 1998)

AMENDMENT TO THE GENERAL REGULATIONS MADE IN TERMS OF THE MEDICAL SCHEMES ACT, 1998 (ACT No. 131 of 1998)

The Minister of Health has, in terms 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.

SCHEDULE

Definitions

1. In this Schedule, "the Regulations" means the regulations published under Government Notice No. R.1262 of 20 October 1999, as amended by the following Government Notices: No. R. 570 of 5 June 2000; No. R. 650 of 30 June 2000 and No. R.247 of 1 March 2002.

Amendment of regulation 1 of the Regulations

2. Regulation 1 of the Regulations is hereby amended by the deletion of the following definitions:
   (a) "broker";
   (b) "creditable coverage";
   (c) "enhanced option";
   (d) "hospital treatment";
   (e) "late joiner";
   (f) "managed health care";
   (g) "pre-existing sickness condition"; and
   (h) "public hospital system".

Amendment of regulation 6 of the Regulations

3. Regulation 6 of the Regulations is hereby amended –

(a) by the substitution for subregulation (2) of the following subregulation:

"(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.";

(b) by the substitution for subregulation (3) of the following subregulation:

"(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.";

(c) by the insertion of the following subregulation, the existing subregulation (4) becoming subregulation (5):

"(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.".

Insertion of regulation 6A of the Regulations

4. The following regulation is hereby inserted in the Regulations after regulation 6:

"**Disclosure of trustee remuneration**

6A. 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."

Substitution of regulation 7 of the Regulations

5. The following regulation is hereby substituted for regulation 7 of the Regulations:

"**Definitions**

7. 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.".

Substitution of regulation 8 of the Regulations

6. The following regulation is hereby substituted for regulation 8 of the Regulations:

"**Prescribed Minimum Benefits**

8. (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 copayment 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."

Insertion of regulations 9A and 9B of the Regulations

7. The following regulation is hereby inserted in the Regulations after regulation 9:

"**Non-accumulation of benefits**

9A. 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.

Contributions in respect of dependants

9B. 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."

Amendment of regulation 10 of the Regulations

8. Regulation 10 of the Regulations is hereby amended –

(a) by the substitution for subregulation (1) of the following subregulation:

"(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.";

(b) by the substitution for subregulation (3) of the following subregulation:

"(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.";

(c) by the substitution for subregulation (4) of the following subregulation:

"(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."

(d) by the substitution for subregulation (5) of the following subregulation:

"(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."

(e) by the substitution for subregulation (6) of the following subregulation:

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

Substitution of regulation 11 of the Regulations

9. The following regulation is hereby substituted for regulation 11 of the Regulations:

"**Definitions**

11. 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."

Substitution of regulation 12 of the Regulations

10. The following regulation is hereby substituted for regulation 12 of the Regulations:

"**Medical reports**

12. 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."

Amendment of regulation 13 of the Regulations

11. Regulation 13 of the Regulations is hereby amended –

(a) by the substitution for subregulation (1) of the following subregulation:

"(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."

(b) by the substitution for subregulation (2) of the following subregulation:

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

Penalty Bands	***Maximum penalty***
1 - 4 years	0.05 x contribution
5 - 14 years	0.25 x contribution
15 - 24 years	0.5 x contribution
25 + years	0.75 x contribution

(c) by the substitution for subregulation (3) of the following subregulation:

"(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.

(d) by the substitution for subregulation (4) of the following subregulation:

"(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."

(e) by the substitution for subregulation (6) of the following subregulation:

"(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."

Substitution of regulation 14 of the Regulations

12. Regulation 14 of the Regulations is hereby deleted.

Deletion of regulation 15 of the Regulations

13. The following regulation is hereby substituted for regulation 15 of the Regulations:

"**Definitions**

15. 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.".

Insertion of regulations 15A to 15H of the Regulations

14. The following regulations are hereby inserted in the Regulations after regulation 15:

"**Prerequisites for managed health care arrangements**

15A. (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.

Accreditation of managed health care organisations

15B. (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).

Suspension or withdrawal of accreditation

15C. (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.

Standards for managed health care

15D. 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.

Provision of health services

15E. (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.

Capitation agreements

15F. 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.

Limitation on disease coverage

15G. 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.

Protocols

15H. 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.

Formularies

15I. 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.

General provisions

15J. (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."

Substitution of regulation 17 of the Regulations

15. The following regulation is hereby substituted for regulation 17 of the Regulations:

"**Accreditation of administrators**

17. (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 address 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)."

Insertion of regulations 17A of the Regulations

16. The following regulation is hereby inserted in the Regulations after regulation 17:

"Suspension or withdrawal of accreditation

17A. (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(5)*(b)*;

(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."

Amendment of regulation 18 of the Regulations

17. Regulation 18 of the Regulations is hereby amended –

(a) by the substitution for subregulation (1) of the following subregulation:

"(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.";

(b) in subregulation (2), by --

(i) the substitution for paragraph *(d)* of the following paragraph:

"*(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;";

(ii) the substitution for paragraph *(e)* of the following paragraph:

"*(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."

Amendment of regulation 19 of the Regulations

18. Regulation 19 of the Regulations is hereby amended by the addition of the following subregulation:

"(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."

Substitution of regulation 21 of the Regulations

19. The following regulation is hereby substituted for regulation 21 of the Regulations:

"**Indemnity and fidelity guarantee insurance**

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

Substitution of regulation 23 of the Regulations

20. The following regulation is hereby substituted for regulation 23 of the Regulations:

"**Depositing of medical scheme moneys**

23. (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.".

Amendment of regulation 25 of the Regulations

21. Regulation 25 of the Regulations is hereby amended by the substitution for paragraph *(a)* of the following paragraph:

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

Amendment of regulation 28 of the Regulations

22. The following regulation is hereby substituted for regulation 28 of the Regulations:

"**Compensation of brokers**

28. (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."

Insertion of regulations 28A to 28C of the Regulations

23. The following regulations are hereby inserted in the Regulations after regulation 28:

"**Admission of members to a medical scheme**

28A. 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.

Accreditation of brokers

28B. (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 therefore to imprisonment without the option of a fine.

Suspension or withdrawal of accreditation

28C. (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; or

(f) 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.

Amendment of regulation 29 of the Regulations

24. Regulation 29 of the Regulations is hereby amended --

(a) by the substitution for subregulation (2) of the following subregulation:

"(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%."

(b) by the addition of the following subregulation after subregulation (3):

"(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."

(c) by the substitution for subregulation (4) of the following subregulation:

"(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.".

Amendment of regulation 30 of the Regulations

25. Regulation 30 of the Regulations is hereby amended --

(a) by the substitution for its heading of the following heading:

"**30. Limitation on assets**";

(b) by the substitution for subregulation (1) of the following subregulation:

"(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.";

(c) by the substitution for subregulation (2) of the following subregulation:

"(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.";

(d) by the substitution for subregulation (3) of the following subregulation:

"(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.";

(e) by the insertion of subregulation 3A:

"(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.";

(f) in subregulation (4) –

(i) in the definition of "fair value," by the deletion of item (viii);

(ii) by the deletion of the definition of "regulated market";

(g) by the deletion of subregulation (5).

Amendment to Annexure A of the Regulations

26. Annexure A of the Regulations is hereby amended –

(a) in the part entitled "Brain and Nervous System," by the substitution for Code 950A of the following:

"Code:	950A
Diagnosis:	Benign and malignant brain tumours, treatable
Treatment:	Medical and surgical management which includes radiation therapy and chemotherapy";

(b) in the part entitled "Eye," by the substitution for Code 950B of the following:

"Code: 950B

Diagnosis: Cancer of eye & orbit – treatable

Treatment: Medical and surgical management, which includes radiation therapy and chemotherapy";

(c) in the part entitled "Gastro-intestinal System," by the substitution for Code 950F of the following:

"Code: 950C

Diagnosis: Cancer of the gastro-intestinal tract including oesophagus, stomach, bowel, rectum, anus – treatable

Treatment: Medical and surgical management, which includes radiation therapy and chemotherapy";

(d) in the part entitled "Skin and Breast" –

(i) by the substitution for Code 954J of the following:

"Code: 954J

Diagnosis: Cancer of skin, excluding malignant melanoma – treatable

Treatment: If histologically confirmed, medical and surgical management, which includes radiation therapy";

(ii) by the substitution for Code 953J of the following:

"Code: 953J

Diagnosis: Malignant melanoma of the skin – treatable

Treatment: Medical and surgical management, which includes radiation therapy";

(e) in the part entitled "Female Reproductive System," by the substitution for Code 954M of the following:

"Code: 954M

Diagnosis: Cancer of cervix – treatable

Treatment: Medical and surgical management, which includes radiation therapy and chemotherapy";

(f) in the part entitled "Haematological, Infectious and Miscellaneous Systemic Conditions," –

(i) by the substitution for Code 168S of the following:

"Code: 168S

Diagnosis: #HIV-infection

Treatment:[1] HIV voluntary counselling and testing
Co-trimoxazole as preventive therapy
Screening and preventive 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.

(ii) by the substitution for Code 910S of the following:

"Code: 910S
Diagnosis: Multiple myeloma and chronic leukemias
Treatment: Medical management, which includes chemotherapy and radiation therapy";

(g) in the part entitled "Mental Illness," –

(i) by the substitution for Code 182T of the following:

"Code: 182T
Diagnosis: Abuse or dependence on psychoactive substance, including alcohol
Treatment: Hospital-based management up to 3 weeks/year";

(ii) by the substitution for Code 901T of the following:

"Code: 901T
Diagnosis: Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse
Treatment: Hospital admission for psychotherapy / counselling up to 3 days, or up to 12 outpatient psychotherapy / counselling contacts";

(iii) by the substitution for Code 908T of the following:

"Code: 908T
Diagnosis: Anorexia nervosa and bulimia nervosa

Treatment: Hospital-based management up to 3 weeks/year or minimum of 15 outpatient contacts per year";

(iv) by the substitution for Code 903T of the following:

"Code: 903T

Diagnosis: Attempted suicide, irrespective of cause

Treatment: Hospital-based management up to 3 days or up to 6 outpatient contacts";

(v) by the substitution for Code 902T of the following:

"Code: 902T

Diagnosis: Major affective disorders, including unipolar and bipolar depression

Treatment: Hospital-based management up to 3 weeks/year (including inpatient electro-convulsive therapy and inpatient psychotherapy) or outpatient psychotherapy of up to 15 contacts";

(h) by the insertion of the following part after the part entitled "Mental Illness":

"**CHRONIC CONDITIONS**

Diagnoses:

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

Systemic Lupus Erythromatosis

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."

(i) in the Explanatory Notes and Definitions to Annexure A –

(i) by the insertion after note (2) of the following note:

"(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."

(ii) by the insertion after note (8) of the following note:

"(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 counseling and advice on sexual behaviour, temperature charts etc.

(i) treatment of local infections."

Substitution of Annexure B of the Regulations

27.The following Annexure is hereby substituted for Annexure B of the Regulations:

"**Annexure B**

Limitation on Assets

Column 1	**Column 2**	**Column 3**
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 R 5 billion	35%
	(ii) per bank with net qualifying capital and reserve funds per Reserve Bank DI900 return greater than	10%

	R 100 million	
	(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	35%

	Reserve Bank DI900 return greater than R5 billion	
	(xii) Per bank with net qualifying capital and reserve funds per Reserve Bank DI900 return greater than R100 million	10%
	(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 Bond 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, or 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 R 50 billion	7.5%
	ii. Per company with a market capitalisation of between R 5 billion and R 50 billion	5%
	iii. Per company with a market capitalisation of less than R 5 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	40%

	diversified holdings across the component sectors of the JSE Securities Exchange	
	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	90%

	a balanced manner across the asset classes and categories stipulated in Sections 1 – 7 above – complying with all the stated maxima and minima	
	(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."

Amendment to Annexure C of the Regulations

28. Annexure C of the Regulations is hereby amended --

(a) by the insertion immediately above the first *pro forma* report of the words:

"**Part C 1**";

(b) by the substitution for the heading of the first *pro forma* report of the following heading:

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

(c) by the insertion immediately above the second *pro forma* report of the words:

"**Part C 2**";

(d) by the substitution for paragraph A1 of the second *pro forma* report of the following paragraph:

"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."

Commencement of the regulations

29. These regulations, with the exceptions of regulations 6 (substituting regulation 8) and 26(h) (amending annexure A), come into operation on 1 January 2003. Regulations 6 and 26(h) come into operation on 1 January 2004.

ME TSHABALALA-MSIMANG
MINISTER OF HEALTH