No. R. 326 **29 April 2014**

PUBLICATION OF PROPOSED AMENDMENTS TO DRAFT DEMARCATION REGULATIONS MADE UNDER SECTION 72 OF THE LONG-TERM INSURANCE ACT, NO. 52 OF 1998

The Minister of Finance, in accordance with section 72(2B) of the Long-term Insurance Act No. 52 of 1998, hereby publishes for public comment, proposed amendments to draft Demarcation Regulations made under section 72 of the Long-term Insurance Act No. 52 of 1998 and published under GNR.1492 of 27 November 1998, to be made under sections 72(1) and 72(2A) of the Long-term Insurance Act No. 52 of 1998.

The amendments proposed in this draft Demarcation Regulation takes into account comments received in response to the first draft Demarcation Regulations that were published in GNR. 192 of 2 March 2012.

Comments on the proposed amendments in this draft Demarcation Regulation are invited from all interested stakeholders. Written comments should be sent to Ms Reshma Sheoraj at LTdemarcation@treasury.gov.za faxed to 012 315 5206 on or before **7 July 2014**.

The draft Demarcation Regulations, explanatory memorandum and summary of public comments are also available on the National Treasury's website at http://www.treasury.gov.za, and the Financial Services Board's website at http://www.fsb.co.za.

1. Amendment of Part 3A in the Regulations under the Long-term Insurance Act, 1998 as published in GN R1492 of 1998 and amended by GN R197 of 2000, GN R164 of 2002, GN R1209 of 2003, GNR.1218 of 2006, GN R186 of 2007, GN R952 of 2008 and GN R1076 of 2011:

Part 3A of the Regulations are hereby amended by:

(a) the substitution for subregulation (2) in Regulation 3.2 of the Regulations for the following subregulation:

"(2) Subject to subregulation (3A), no commission shall be paid or accepted otherwise than in accordance with this Part generally, and specifically as specified in the Table.";

(b) the insertion after subregulation (2A) in Regulation 3.2 of the Regulations of the following subregulation:

"(3A) Commission payable in respect of a contract identified as an accident and health policy under Part 7 of the Regulations is subject to the maximum compensation and other requirements prescribed under regulation 28 of the Regulations made under the Medical Schemes Act, 1998 (Act No. 131of 1998) pursuant to section 65(2) of that Act, 1998 (Act No. 131 of 1998) ."; and

(c) the insertion after the last note in the Notes to Annexure 1 to Part 3A of the following note:

" a health policy under item 5 refers to a health policy other than a contract identified as a health policy under Part 7 of the Regulations"."

2. Substitution of Part 7 in the Regulations under the Long-term Insurance Act, 1998 as published in GN R1492 of 1998 and amended by GN R197 of 2000, GN R164 of 2002, GN R1209 of 2003, GNR.1218 of 2006, GN R186 of 2007, GN R952 of 2008 and GN R1077 of 2011:

Part 7 of the Regulations is hereby substituted for the following Part:

"PART 7

CONTRACTS IDENTIFIED AS HEALTH POLICIES UNDER PARAGRAPH (b) OF THE DEFINITION OF HEALTH POLICY

Definitions and interpretation

7.1 In this Part 7, unless the context indicates otherwise -

"insurer" means a long-term insurer;

"medical scheme" has the meaning assigned under section 1 of the Medical Schemes Act;

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

"member" has the meaning assigned under section 1 of the Medical Schemes Act;

"policy" means a long-term policy;

"related" has the meaning assigned in the Companies Act, 2008 (Act No. 71 of 2008);

"relevant health service" has the meaning assigned under section 1 of the Medical Schemes Act; and

"this Part" means this Part 7.

Categories of contracts identified as health policies under paragraph (b) of the definition of health policy

7.2 (1) A contract is a health policy under paragraph (b) of the definition of health policy if that contract –

(a) matches any of the categories of contracts, meets the criteria and provides for the policy benefits associated with that category, as set out in the table below.

Category	Name	Policy benefits	Criteria
1	**Lump sum or income replacement policy benefits payable on a health event**	Covers loss of income and contingency expenses associated with insured persons experiencing a specified health event.	▪ Policy benefits are one or more sums assured stated in the contract in Rand terms. ▪ The aggregate of the policy benefits payable under all policies issued by an insurer and its related parties to a specific person may not exceed the maximum amount referred to in sub-regulation (4) per day per insured person. ▪ Contract must provide for an annual term and monthly premiums. ▪ An elimination or deferred period may apply before policy benefits are paid.
2	**Frail care**	Covers custodial care (assistance with activities of daily living) for insured persons.	▪ Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract. ▪ Policy benefits may be paid in kind or to a provider of a relevant health service. ▪ Policy benefits may be linked to actual costs or expenses of a relevant health service. ▪ Policy benefits may be paid on a pre-funded or immediate needs basis. ▪ An elimination or deferred period may apply before policy benefits are paid.
3	**HIV and Aids**	Covers expenses for HIV-related	Same as for category 2.

		testing and HIV and Aids treatment on an employee group basis for employees and their dependents.	
4	**Emergency Evacuation or Transport**	Covers guaranteed access to and utilisation of specialised medical transportation and / or guaranteed hospital admission to ensure that the insured person is admitted to an emergency treatment facility and stabilised.	▪ Policy benefits are ancillary to the main policy benefits provided under the policy. ▪ Policy benefits may be payable in kind or to a provider of a relevant health service. ▪ Policy benefits may be linked to actual costs or expenses of a relevant health service.

(2) A contract referred to under sub-regulation (1) may not -

(a) unfairly discriminate directly or indirectly against any person on any of the following or similar grounds: race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health;

(b) provide for waiting periods exceeding 6 months;

(c) provide that the policyholder or life insured must be a member of a medical scheme;

(d) entitle the insurer to refuse any claim for policy benefits on the grounds that the life insured had experienced a health event prior to the commencement of the applicable cover;

(e) provide for the cancellation, variation or non-renewal of the contract by the insurer as a result of the health or claims experience of a life insured; and

(f) in relation to a contract referred to in category 1 in the table under sub-regulation (1), -

(i) provide policy benefits that are fully or partially linked to indemnifying the policyholder against medical expenses incurred as a result of a relevant health service; or

(ii) allow for the cession or payment of any policy benefits payable under the contract to a provider of a relevant health service.

(3) The maximum amount referred to under category 1 in the table under sub-regulation (1) is R 3 000,00 (three thousand Rand) escalate annually from the effective date of this Part

by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999)).

Marketing and disclosures

7.3 Any marketing activity or marketing material in respect of a contract referred to under regulation7.2 must –

(a) not identify that contract by the term "medical", "hospital" or any derivative thereof;

(b) not in any manner create the perception that the contract –

(i) indemnifies a policyholder against medical expenses incurred as a result of a relevant health service; or

(ii) is a substitute for medical scheme membership;

(c) display the following statement in clear legible print in a prominent position:

"This is not a medical scheme and the cover is not equivalent to that of a medical scheme. This policy is not a substitute for medical scheme membership.";

(d) in relation to a contract referred to in category 1 in the table under regulation 7.2(1), in addition to paragraph (b) above, display the following statement in clear legible print in a prominent position:

"The intention of the policy is to cover contingencies other than medical expenses. This policy may not be ceded and no benefit payments are allowed to be paid to a provider of a relevant health service through cessions or similar means."; and

(e) clearly disclose and explain in easily understood language –

(i) the matters referred to in section 48 of the Act; and

(ii) that the contract is not a medical scheme and the cover is not a substitute for or equivalent to a medical scheme.

Limitation on combination of policies

7.4 An insurer may not alone or with a related party, directly or indirectly, develop or offer to policyholders or potential policyholders health policies referred to in this Part which policies collectively may result in the aggregate of the policy benefits under those policies being contrary to the objectives and purpose of the Medical Schemes Act and the principles referred to in sections 72(2A)(b)(i)(cc)(A) to (C) of the Act.

Reporting of product information

7.5 (1) An insurer must, at least 1 month prior to introducing or launching a new health policy referred to in this Part, submit to the Registrar and Registrar of Medical Schemes –

(a) a summary of the benefits, terms and conditions and marketing material of that health policy; and

(b) a summary of the benefits, terms and conditions and marketing material of other health policies referred to in this Part offered by the insurer or a related party of the insurer to policyholders and potential policyholders.

(2) The Registrar of Medical Schemes may, within the month referred to under sub-regulation (1) or at any time thereafter, advise the Registrar that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act and the principles referred to in sections 72(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for this opinion.

(3) The Registrar may within the month referred to under sub-regulation (1) or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (2), by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of a health policy submitted under sub-regulation (1), and –

(a) prohibit the insurer from introducing or launching the health policy; or

(b) instruct the insurer to stop offering or renewing those health policies to the public and within 90-days of the date determined by the Registrar, terminate any health policy; or

(c) require the insurer to amend any of the benefits, terms and conditions and marketing material of a health policy in accordance with the requirements of the Registrar.

Transitional arrangements

7.6 (1) An insurer must, 3 months after this Part comes into operation, submit a summary of the benefits, terms and conditions and marketing material of all existing health policies referred to in this Part introduced or launched on or after 15 December 2008 to the Registrar and Registrar of Medical Schemes.

(2) The Registrar of Medical Schemes may, within the 3 months referred to under sub-regulation (1), or at any time thereafter, advise the Registrar that the Registrar of Medical

Schemes is of the opinion that the benefits, terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act and the principles referred to in sections 72(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for this opinion.

(3) The Registrar may within the 3 months referred to under sub-regulation (1) or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (2), by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of a health policy submitted, and –

(a) instruct the insurer to stop offering or renewing those health policies to the public and within 90-days of the date determined by the Registrar, terminate any health policy; or

(b) instruct the insurer, by a date determined by the Registrar, to amend any of the benefits, terms and conditions and marketing material of a health policy in accordance with the requirements of the Registrar before offering those health policies or renewing any existing health policies to the public.

3. Insertion of Part 8 in the Regulations under the Long-term Insurance Act, 1998 as published in GN R1492 of 1998 and amended by GN R197 of 2000, GN R164 of 2002, GN R1209 of 2003, GNR.1218 of 2006, GN R186 of 2007, GN R952 of 2008 and GN R1077 of 2011:

Part 8 is hereby inserted after Part 7 of the Regulations:

"PART 8

TITLE AND COMMENCEMENT

7.1 These regulations are called the Regulations under the Long-term Insurance Act, 1998.

7.2 (1) Regulations 1 to 4 came into operation on commencement of the Act.

(2) Regulations 3A and 5A came into operation on 1 December 2006.

(3) Regulations 3B and 5B came into operation on 1 January 2009.

(4) Regulation 6 came into operation on 1 January 2011.

(5) Regulation 7 came into operation on [*insert date*].

(6) Any amendments to regulations 1 to 7 come into operation on the date of publication thereof in the *Government Gazette* or on such other date specified by the Minister in the *Government Gazette* or specified in a regulation."