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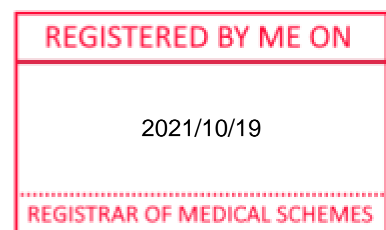
ANNEXURE D: CLAIMS PROCEDURE AND GENERAL PROVISIONS REGARDING BENEFITS

1. Every claim submitted by a member to the Scheme in respect of the rendering of any healthcare service or the supply of any medicine, requirement or accommodation in a hospital or nursing home, must be accompanied by an account or statement as prescribed in Regulation 5.

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

   (a) The name and the membership number of the member;
   (b) The name of the supplier of service;
   (c) The name of the beneficiary to whom the service was provided
   (d) The final date of service rendered by the supplier of service on the account or statement which is covered by the payment;
   (e) The total amount charged for the service concerned; and
   (f) The amount of the benefit awarded for such service.

   The scheme must inform the member of erroneous or unacceptable accounts within 30 days, where after the member must resubmit the corrected accounts to the scheme within 60 days.

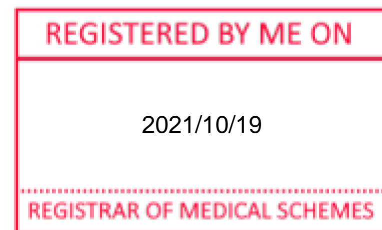


3. Period for Submission of Claims

3.1. In order to qualify for the payment of benefits, a claim must be submitted to the Scheme on or before the last day of the fourth month following the month during which the service was rendered. Such service must have been provided prior to the date of termination of membership. For the purpose of this rule,

each date of service shall be separately taken into account, irrespective of whether or not the services concerned formed part of an extended period of treatment for the same illness or condition. Where the Scheme is of the opinion that a claim is incorrect or unacceptable for payment, the Scheme will notify the member and the relevant health care provider, accordingly, within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is incorrect or unacceptable and afford such member and provider the opportunity to correct and re-submit such claim to the Scheme within sixty days following the date on which it was returned for correction. It is the member's responsibility to ensure that the account is submitted by the healthcare provider.

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



4. Extension of Time of Submissions of Claims

It shall be the duty of a member to obtain accounts for all services rendered from the supplier thereof. If, because of the extended nature of the treatment or for any other reason whatsoever, a member is unable to obtain an account for services, or if he has in fact received an account but, because of special circumstances beyond his control, is unable to submit it within the period referred to in rule 3 above, the Board may, in its discretion, extend this period on condition that a written application for extension is received by the Principal Officer before the expiration of the said period.

5. Accounts in Respect of Injuries

5.1. Accounts for services rendered in respect of injuries to a member or his dependant shall, when required by the Board, be supported by a statement setting out such particulars of the circumstances in which the injury was sustained as are adequate to enable the Board to assess the liability of the Scheme in terms of 5.2 of this annexure. The Board shall be entitled to call for

such further information and evidence as it may deem necessary in the circumstances.

5.2. The Scheme shall not be liable for costs of whatsoever nature incurred for treatment arising out of an injury sustained by a member or dependant and for which any other party is liable in terms of any law, agreement or contract. Where another party is liable in terms of the aforegoing provision of this paragraph, the Board shall nevertheless advance to or on behalf of the member for the benefit of the member and/or any of his registered dependants such amount/s as would not exceed the benefits that would have applied in normal conditions irrespective of the lapse of time, subject to the right of the Scheme to recover such advance from the member on successful conclusion of the member's claim against such other party and on the understanding that:

i. the member shall inform the Scheme of the potential claim against the other party and of the relevant health care expenses incurred, in the manner and within the time period normally applicable to similar claims for benefits under the Scheme.

ii. the member shall provide the Scheme with a written undertaking within a reasonable timeframe of receiving a request to this effect from the Scheme. This undertaking shall be signed by the member and in the event of the member being incapacitated, by anyone of the member's next of kin who is 18 years or older, and the member warrants that such next of kin is duly authorised to sign the undertaking on the member's behalf and to bind the member to the terms thereof.

iii. a claim in respect of all past medical expenses for which the Board advanced any amounts to or on behalf of the member or dependant shall be lodged by the member or dependant against the other party concerned within the time limits prescribed in any applicable laws and pursued with due diligence, with the Scheme being kept fully informed. Should the

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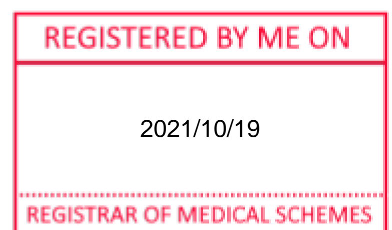
member or dependant fail to pursue the claim against such other party to the satisfaction of the Board, the member shall, if required to do so by the Scheme, cede or procure the cession of such claim to the Scheme, in which event the member or dependant shall provide the Scheme with all such assistance and co-operation as it may reasonably require in pursuing such claim. The member shall be obliged to repay to the Scheme that portion of the damages actually recovered by him or his dependant from the other party as relates to the costs and service in respect of which he or his dependant has received or benefited from advances contemplated above ("the past medical expenses").

iv. In the event that it is not specifically indicated how much of the damages or compensation recovered by the member or the dependant is in respect of "the past medical expenses", the amount payable by the member to the Scheme shall be such percentage of the damages or compensation received, as would be equal to the percentage that "the past medical expenses" constituted of the total reasonable damages or compensation that was initially claimed from the other party, expressed in Rand;

6. Accounts Paid Directly and in Full by the Member

The benefit determined in accordance with the provisions of Annexure B annexed to these rules, will be paid to the member in respect of an account paid by the member direct to the supplier of service: provided that the account complies with the requirements of these rules and that proof of payment to the satisfaction of the Board is submitted.



7. Claims for Services Rendered outside the Rand Monetary Area

Members submitting claims for services obtained outside the Rand monetary area must ensure that accounts are specified as detailed in this Annexure, before submission to the Scheme. Such claims shall reflect the amount(s) in the equivalent South African

currency and the rate of exchange used for conversion and shall bear a detailed description, in English, of each service rendered. Benefits on such claims shall be calculated as if the services had been rendered in the Republic of South Africa at the relevant Scheme rate or DSP rate covered by the Scheme in South Africa.

It being noted that the provisions of the Medical Schemes Act (Act 131 of 1998) and the regulations pertaining to prescribed minimum benefits (PMBs) do not apply to treatment obtained outside the borders of South Africa (foreign claims), the submission and payment of such foreign claims shall be subject to the following:

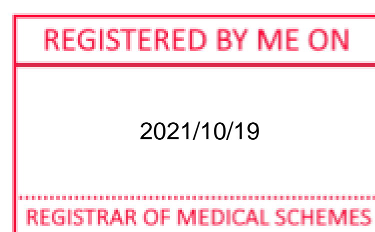
7.1. the exclusions set out in Annexure C;

7.2. coverage for all incidents that are not excluded, being limited to the same benefit limit and Rand value for each service, as would have been granted if the services had been obtained in South Africa, at the relevant Scheme rate or negotiated/contracted rate usually applicable to a normal (non-PMB) claim within a specified service category; or from Savings

7.3. all non-emergency/planned hospital admissions being subject to prior approval by the Scheme;

8. Over-payments

Where the Scheme has paid a benefit or portion of a benefit to which a member is not entitled, whether payment is made to the member or to the supplier of a service, the amount of any such overpayment shall be recoverable by the Scheme from the party concerned.



9. Certification of Claims and Provision of Original Documents

The Board may require that, where possible, a claim be certified by the member, or, in the case of a faxed, photocopied or e-mailed claim that the original document be presented, on request.

10. Claims Relating to Statutory Prescribed Minimum Benefits

In order to qualify to be treated as a claim for benefits relating to the statutory prescribed minimum benefits, the ICD10 diagnostic code that relates to the relevant health service must be recorded on the claim. In the absence of such coding the claim will be subject to ordinary benefit conditions.

Notwithstanding any provisions to the contrary contained in these rules, it is to be noted that the statutory obligations arising from prescribed minimum benefit regulations do not apply to claims for services rendered outside the borders of South Africa. All foreign claims shall be treated as normal (non-PMB) claims as specified in rule 7 of this annexure.

11. ADDITIONAL PROVISIONS REGARDING BENEFITS

Additional provisions regarding benefits are contained in rule 16 of the main body rules.