

WOOLTRU HEALTHCARE FUND

CLAIMS PROCEDURES



1. PARTICULARS TO BE CONTAINED IN CLAIMS

- 1.1. Every claim submitted by a Member to the Fund in respect of the rendering of any service or the supply of any medicine, or accommodation in a hospital or nursing home, shall contain the surname and initials of the Member;
- 1.2. the surname, first name and other initials, if any, of the patient;
- 1.3. the name of the Fund;
- 1.4. the membership number of the Member;
- 1.5. the name and practice code number, where applicable, of the supplier of the service;
- 1.6. the date on which each service was rendered;
- 1.7. the nature and the cost of each service;
- 1.8. the relevant diagnostic and other item code numbers that relate to the relevant health service;
- 1.9. where the account is a photocopy of the original, certification by the supplier of the service by way of a rubber stamp or signature on such photocopy;
- 1.10. the name of the referring practitioner;
- 1.11. the name, quantity, dosage and the nett price payable by the Member in respect of each supply of medicine, requirement or apparatus and in the case where a pharmacist has prescribed and supplied such medicine, the diagnosis of the condition for which such medicine was prescribed;

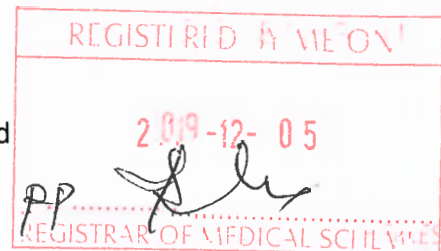
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- 1.12. mention of, in the case where an account or statement refers to the use of an operating theatre where an operation was performed on a Member or a Dependant of that member -
- 1.12.1. the name and practice number of the practitioner who performed the operation concerned; and
- 1.12.2. the name or names of the practitioner or practitioners who assisted at such operation;
- 1.13. in the case where a pharmacist supplied medicine on the strength of a prescription to a Member or a Dependant of a member, as addendum to the account or statement, a photocopy of the original prescription, certified by the pharmacist connected with the pharmacy which supplied such medicine, as a true and exact copy or photocopy of such prescription.

2. ORTHODONTIC TREATMENT

Where an account refers to a service that is to be rendered in respect of orthodontic treatment or other advanced dentistry, a statement containing the following information shall accompany the first account submitted to the Fund -

- 2.1. the diagnostic and item code numbers that relate to the treatment;
- 2.2. a plan of treatment indicating the following -
- 2.2.1. the expected total amount in respect of the treatment;
- 2.2.2. the expected duration of the treatment;
- 2.2.3. the initial primary amount payable by the Member; and
- 2.2.4. the monthly amount which the Member must pay.

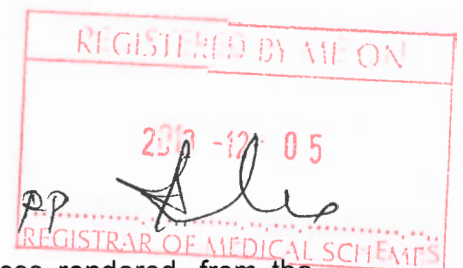


3. PERIOD FOR SUBMISSION OF CLAIMS

In order to qualify for the payment of benefits, a claim must be submitted to the Fund 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 Fund is of the opinion that a claim is incorrect or unacceptable for payment, the Fund will notify the Member or the health care provider, whichever applies, accordingly, within 30 days after receipt thereof. The Fund shall state the reasons why such claim is incorrect or unacceptable and afford such Member or provider the opportunity to correct and re-submit such claim to the Fund within 60 days following the date on which it was returned for correction.

4. EXTENSION OF TIME FOR SUBMISSION 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

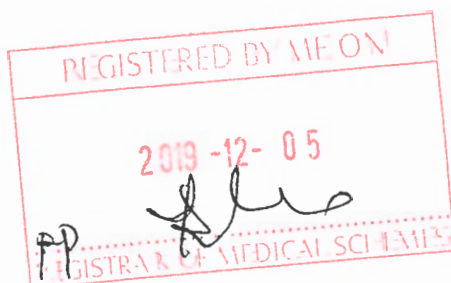
Accounts for services rendered in respect of injuries to a Member or his Dependant shall, when required by the Board, be supported by a statement setting out such particulars of the circumstances in which the injury was sustained as are adequate to enable the Board to assess the liability of the Fund in terms of these Rules. The Board shall be entitled to call for such further information and evidence, as it may deem necessary in the circumstances.

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 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 receiving services outside Southern Africa shall in the first instance pay all medical accounts or accounts received in respect of other benefits and thereafter submit the detailed accounts, together with receipts, to the Fund for refund at the appropriate rate laid down in the relevant annexures to these Rules.



8. OVERPAYMENTS

Where the Fund 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 Fund from the party concerned.

9. CERTIFICATION OF CLAIMS

The Board may require that, where possible, a claim be certified by the member.

10. CLAIM STATEMENTS

On finalisation of a claim the Fund shall send to the Member an advice regarding the benefit paid or the reason why a claim was rejected and if the full amount of any benefit is not paid to the Member, the reason therefore. This will be sent twice a month (provided claims have been submitted).

