DE BEERS BENEFIT SOCIETY

2023

MEMBER GUIDE

Contact details

If you have any queries, please contact the Society on **053 807 3111**, or visit the Society's website at **www.dbbs.co.za**. You can also visit the website for easy access to all your personal medical information online, provided you have registered to use this facility.

FOR QUERIES AROUND MEMBERSHIP, BENEFITS AND CLAIMS

De Beers Benefit Society

053 807 3111

benefitpost@dbbs.co.za

053 807 3499

www.dbbs.co.za

De Beers Benefit Society, Kimberley House,
84 Du Toitspan Rd, Kimberley, 8301

PO Box 1922, Kimberley, 8300

FOR PRE-AUTHORISATIONS

To pre-authorise hospital admissions, CT and MRI scans

For SA and Namibia members: PPSHA

RSA members: 0800 111 669

Non-RSA members: +27 12 679 4022

debeerspreauth@ppsha.co.za

www.ppsha.co.za

1262 Heuwel Road, Centurion Central, Centurion

Private Bag X1031, Lyttelton,0140

For Botswana Hospitals only:

053 807 3111 (Option 6)

managedcare@dbbs.co.za

To pre-authorise the following:

Oncology treatment, PET and CT planning scans; oxygen; artificial limbs; wheelchairs; hearing aids; private nursing; wound care; renal dialysis and in-rooms procedures

053 807 3111 (Option 6)

managedcare@dbbs.co.za

FOR CHRONIC MEDICINE AUTHORISATIONS AND QUERIES, AND STOMA AUTHORISATIONS

Mediscor Pharmacy Benefit Management

Contact centre: 086 011 3238

ChroniLine: 086 011 9553

Non-RSA members: +27 12 674 8000

Claims enquiries: info@mediscor.co.za

Chronic authorisation: preauth@mediscor.co.za

Oncology authorisation: dbbsonco@mediscor.co.za

Claims enquiries: 012 674 8001

Chronic authorisation fax: 086 615 1509

www.mediscor.co.za

PO Box 8796, Centurion, 0046

FOR PHARMACY/COURIER PHARMACY QUERIES

DSP: Dis-Chem Pharmacies and Dis-Chem Direct

RSA members: 086 122 6668 (Dis-Chem Direct RSA)

Non-RSA members: +27 11 589 2788

debeers@dischem.co.za

086 529 0228

www.dischem.co.za

All Dis-Chem Pharmacies

Dis-Chem Direct, Private Bag X21,
North Riding, 2162

TO REPORT SUSPECTED FRAUD

0800 204 724

FOR OPTOMETRY QUERIES

DSP: Preferred Provider Negotiators (PPN)

- RSA members: 086 110 3529
- Non-RSA members: +27 41 506 5900
- dbbs@ppn.co.za or claims@ppn.co.za
- 041 586 4184
- www.ppn.co.za
- PO Box 12450, Centrahil, 6006

FOR EMERGENCY TRANSPORT/ ASK A NURSE HELPLINE

DSP: ER24

- RSA members: **084 124**
- Non-RSA members: +27 10 205 3000
- info@er24.co.za
- 086 682 8442
- www.ER24.co.za
- PO Box 242, Paulshof, 2056

Make use of our multi-function Member App to interact with the Society at home or on the go, to make your life easier!

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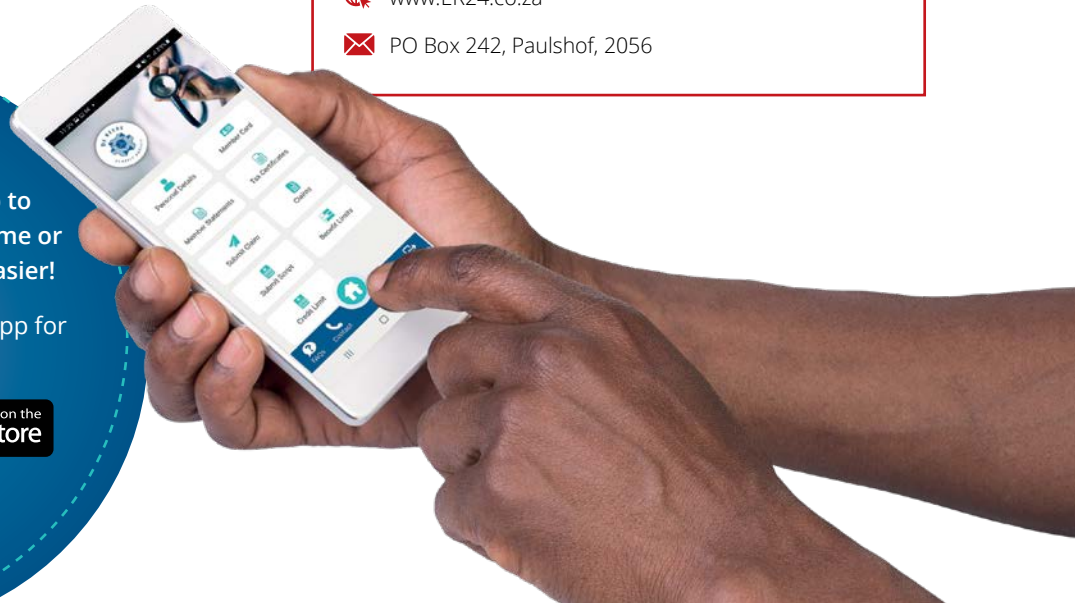
Available on the AppGallery



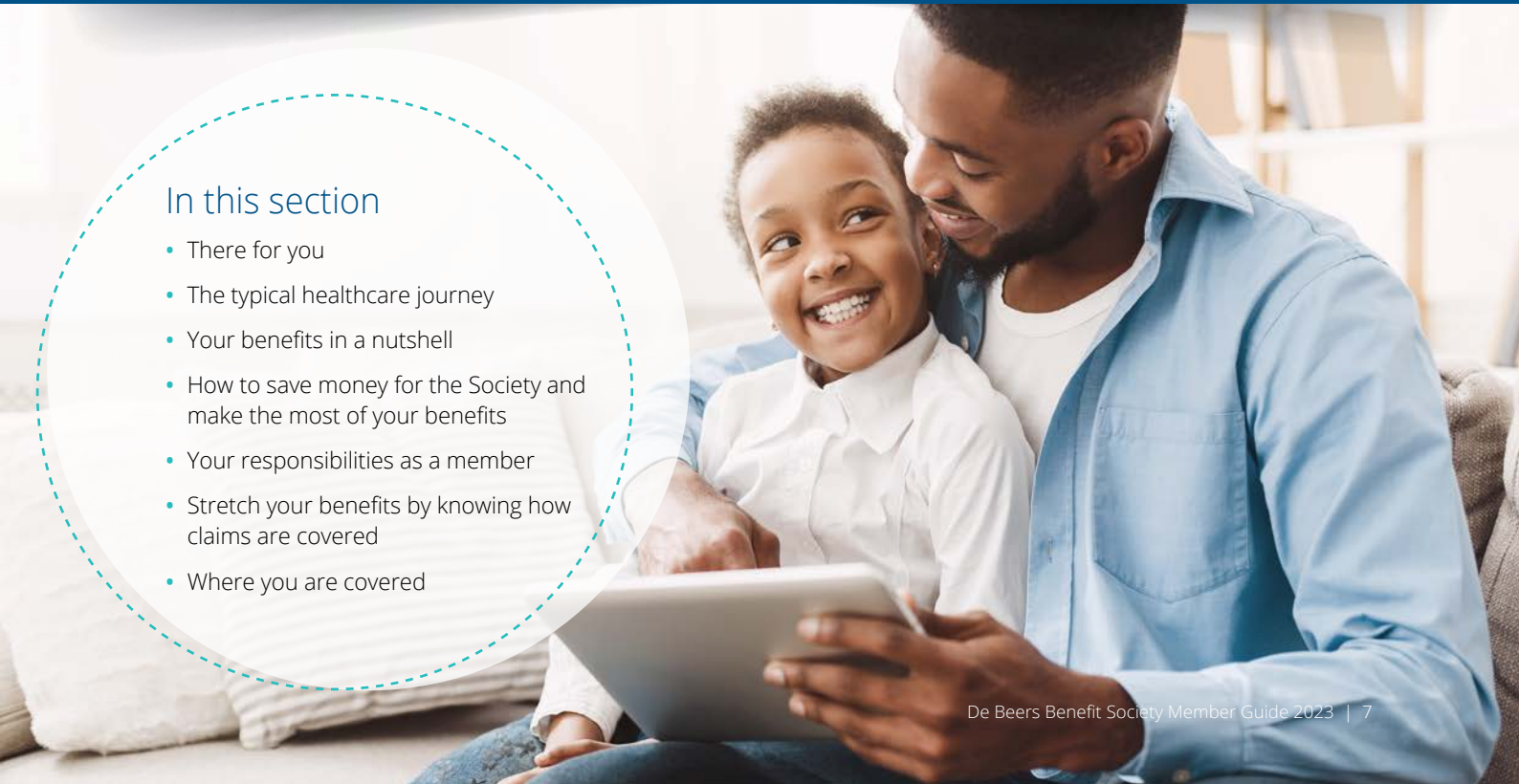
Contents

ABBREVIATIONS / ACRONYMS

ACT	Medical Schemes Act (No 131 of 1998)
CDL	Chronic Disease List
CMS	Council for Medical Schemes
CT	Computed Tomography
CPAP	Continuous Positive Airway Pressure
DSP	Designated Service Provider
DTP	Diagnosis and Treatment Pairs
FRP (Plus)	Formulary Reference Price (Plus)
GP	General Practitioner
ICD 10	International Statistical Classification of Diseases and Related Health Problems
ICON	Independent Clinical Oncology Network
ICU	Intensive Care Unit
MCC	Medicines Control Council

MRI	Magnetic Resonance Imaging
MRP	Mediscor Reference Price
OTC	Over-the-counter medicine
PET	Positron Emission Tomography
PMBs	Prescribed Minimum Benefits
PPN	Preferred Provider Negotiators for optometry benefits
PPSHA	PPS Healthcare Administrators (Hospital Pre-authorisation)
SEP	Single Exit Price for medicines
SRPL	Society Reference Price List – the rate at which the Society will pay for relevant health services
TTO	To-Take-Out (medicine to take-home from hospital)

1 OVERVIEW



In this section

- There for you
- The typical healthcare journey
- Your benefits in a nutshell
- How to save money for the Society and make the most of your benefits
- Your responsibilities as a member
- Stretch your benefits by knowing how claims are covered
- Where you are covered

There for you

Many people regard their medical scheme mainly as a way to help cover visits to the doctor or dentist, or to fund a new pair of spectacles. The monthly contributions then seem disproportionately high, and many medical scheme members (whatever scheme they belong to) complain that they are not getting value for money.

The first thing to understand is that a medical scheme is mainly there to help you when things go wrong. It's comparable to your short-term insurance. You may go many years without claiming for anything, but when you're burgled, it's great to be able to claim for everything you've insured.

Likewise, members who are in accidents, develop cancer or need life-saving procedures are usually extremely relieved that they have a medical scheme to fall back on. And because the costs involved in these major medical events are often very high, this is where the benefit amounts are typically the highest, and where the Society spends most of its money.

During a typical member's lifetime, there will be many occasions where the Society's benefits would be extremely valuable. The "journey" on the next page shows different life stages, and the type of healthcare challenges a member may face.

THE TYPICAL HEALTHCARE JOURNEY

Joins Scheme

Young and healthy; minimal healthcare needs

GP and Physio visits, spectacles, etc.

Road accident or sports injury

Tonsil surgery or dental admissions

Child trauma injury

Premature birth

Maternity

Starts relationship; needs medical cover for partner

Chronic disease

Dread disease such as cancer

Lifestyle disease such as high blood pressure

Healthy lifestyle becomes increasingly important

Cardiac conditions or stroke

Medical costs can arise at any stage of your life. The Society offers a wide range of benefits to cater for these.

Cataract surgery

Hip replacement

After retirement; ageing process more pronounced and increased need for medical care

Specialised treatment for back and neck pain, to avoid surgery

Your benefits in a nutshell

The Society offers a wide range of benefits to its members. These can be categorised (and are covered in the following chapters) as follows:

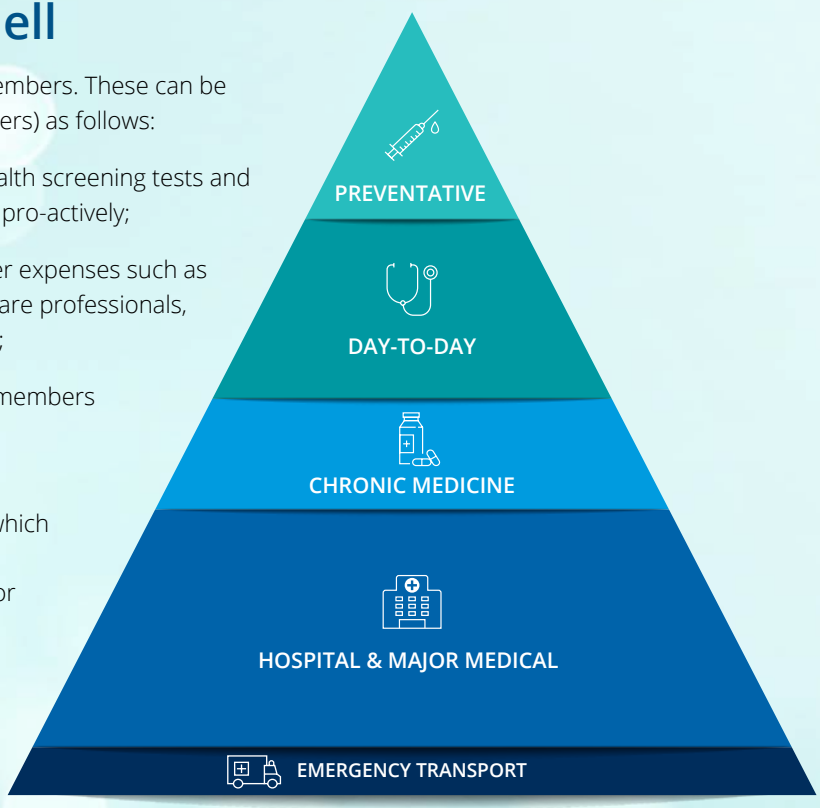
Preventative benefits, which include health screening tests and vaccines to help you manage your health pro-actively;

Day-to-day benefits, which typically cover expenses such as consultations with GPs and other healthcare professionals, optometry, dentistry, and acute medicine;

Chronic medicine benefits, which help members manage certain chronic conditions in a cost-effective way;

Hospital and major medical benefits, which cover from small in-rooms procedures to high-cost hospitalisation and treatment for trauma cases, oncology and more; and

Emergency transport benefits, to ensure that you and your beneficiaries can get emergency medical care when you urgently need it.



Unless otherwise specified, the benefits described in this guide apply to the Society's benefit year, which runs from 1 January to 31 December. Benefits are not transferable from one benefit year to another, or from one benefit category to another.

How to save money for the Society and make the most of your benefits

Remember that every member is in a sense a shareholder of the Society. This means everyone benefits from sensible behaviour, as lower claims can result in lower contribution increases.

This is how you can save the Society – and yourself – money:

- Maintain a healthy lifestyle, as prevention is always the better option.
- Make healthier choices to avoid or better manage lifestyle-related chronic conditions.
- Understand your responsibilities as a member, such as knowing your benefits, as well as the Society's Rules, processes, and requirements (see more information later in this chapter).
- Use the vaccines and screening tests offered as part of your Preventative Benefits to avoid certain illnesses and to identify potential lifestyle diseases early.

Stretch your benefits by knowing how claims are covered, as well as where you are covered (see more information later in this chapter).

Use the Society's Designated Service Providers (DSPs) to avoid unnecessary co-payments. The Society's DSPs are:

- Network Hospitals (see our website or call the Society)
- Dis-Chem Pharmacies, Dis-Chem Direct, Cullinan Health & Home Pharmacy, the Namaqualand Pharmacy in Springbok and Dr HA Burger in Springbok for the supply of medicine
- ER24 for emergency transport
- PPN (Preferred Provider Negotiators) for optical services
- ICON [Independent Clinical Oncology Network (Pty) Ltd] for oncology treatment
- BBraun Avitum / E Owen & Partners for renal dialysis services

Ask for generic medicine whenever possible.

Consider paying in cash and then claiming back to get discounts (unless you are registered for chronic medicine).

If your doctor recommends a particular line of treatment and you feel uncertain about whether it is necessary, ask for a second opinion.

Think twice about undergoing elective surgery procedures. If you do need a surgical procedure that is not an emergency –

- obtain authorisation from the Society for the procedure,
- use a Network hospital,
- get a quote from your doctor and other service providers such as the anaesthetist before-hand and check with the Society how much will be paid,
- consider negotiating with your providers to charge (at least closer to) the amount covered by the Society.
- If an operation is scheduled for the afternoon or evening, arrange for hospital admission after 12pm.

Your responsibilities as a member

While the Society is accountable for member communication, you have a duty (and are accountable) to ensure that you remain updated regarding both the benefits provided by the Society and the developments affecting the Society, as well as to act responsibly in relation to the Society. That is because members' behaviour (claiming patterns) has a direct impact on the total costs and therefore an indirect impact on your contributions and the future sustainability and viability of the Society.

Specifically, as a member you should:

- Familiarise yourself with the Society's structure and your benefits;
- Use your benefits responsibly;
- Ensure that your medical claims are submitted timeously (within 4 months from the date of service);
- Adhere to the Rules of the Society;
- Read all communication sent to you, attend Society information sessions as appropriate, refer queries to the Society for clarification and provide the Society with feedback if your information needs are not met;
- Keep the Society up to date regarding any changes to your and your dependants' membership status and details;
- Check all accounts from service providers as well as your weekly and monthly member statements from the Society to make sure that all details are correct and that your claims have been processed correctly;
- **Obtain pre-authorisation from the Society before you are admitted to hospital or for any other procedures requiring pre-authorisation (but remember that authorisation does not confirm funding in full by the Society and that co-payments may still apply);**
- Ensure you are aware of the limits imposed on various benefits, for example prosthesis, when a hospital or any other authorisation is sought. The limits are set for the year and will likely be exhausted after any one event. You may therefore be faced with high co-payments despite hospital authorisation being approved in the case of any second similar major event in a one-year cycle;

- File all your documentation received from the Society so that you can refer to it when necessary;
- Keep your membership card in a safe place so that no one else can use it fraudulently;
- If you suspect fraudulent activity in relation to the Society, please report it; and
- Notify the Society of your cell phone number, valid postal address, contact details and email address and any changes to this information, to ensure that you receive Society-related correspondence and communication material.

Stretch your benefits by knowing how claims are covered

Remember that the Society operates on a not-for-profit basis. To understand how the Society covers various claims so that you can stretch your benefits, look at the following distinction:

DAY-TO-DAY HEALTHCARE	HOSPITALISATION / MAJOR MEDICAL EVENTS
These claims are paid at the **Society Reference Price List (SRPL)*** rate for the service rendered or benefit obtained. If a provider charges more than the SRPL rate, the member will be liable for the difference between the SRPL rate and the rate charged by the provider. Benefits are paid at various percentages of the SRPL rate - for example, a GP consultation is a 90% benefit, orthodontics a 75% benefit and dentistry a 100% benefit.	**If you use a Network Hospital (and obtained pre-authorisation)** • the hospital claim will be paid at the Negotiated Rate**. • service providers' professional fees at Network Hospitals will be paid at the Scheme Rate***, which is limited to 165% of the SRPL rate. **If you voluntarily use a non-Network Hospital (and obtained pre-authorisation)** • the hospital claim, as well as service providers, will be paid at the SRPL rate, and you may have a sizeable co-payment. **If you voluntarily use a non-Network Hospital (and did NOT obtain pre-authorisation)** • the hospital claim, as well as service providers, will be paid at the SRPL rate, and you will be liable for a 30% co-payment on the total hospital account.

The above is a generalisation, to help you understand your benefits. There are also benefits paid at other rates (for example, in the case of medicine). Please see the tables in the respective benefits chapters for specific information on how various benefits are covered.

*SRPL rates

Aligned to medical aid industry practice, the Society has its own reference price list, the De Beers Benefit Society Reference Price List (SRPL), according to which benefits are calculated and claims are paid. The SRPL is adjusted annually to take account of inflation and other changes.

**Negotiated Rate

This is the rate that the Society negotiates with Network Hospitals for the direct payment of hospital accounts.

***Scheme Rate

This is the rate at which the Society pays benefits to all service providers for services rendered in **Network Hospitals** and for defined in-room procedures. The Scheme Rate is 165% of the SRPL rate.

Where you are covered

Cover for benefits as outlined in this guide generally only applies within South Africa (also known as the Society's Area of Operation), except in specific circumstances (see below). If you live in South Africa, you cannot claim benefits when you are outside the country. If you travel to foreign countries for work purposes, contact your Employer regarding cover. **If you travel on holiday outside South Africa, you should obtain your own private medical travel insurance.**

Only in the following instances will cover be provided in Botswana and Namibia:

- While members are employed by the Employer (or an Associated Employer) in Botswana or Namibia, such members and their dependants will be eligible for benefits in either of those countries; and
- When members who are eligible for benefits in Botswana or Namibia retire and become pensioner members of the Society, they and their registered dependants will continue to enjoy these benefits for as long as they remain permanent residents of that country.

2 CONTRIBUTIONS

Contributions for 2023

These are the total monthly contributions payable from 1 January 2023.

PER PRINCIPAL MEMBER / ADULT	PER CHILD DEPENDANT
R4 289	R1 154

3 BENEFITS: PREVENTATIVE

In this section

- Why should I go for screening tests?
- What screening tests and vaccines does the Society cover?

Why should I go for screening tests?

Having screening tests done is one of the most important things you can do for your health. Screenings are medical tests that check for diseases before there are any known symptoms. Screenings can help doctors find diseases early, then the diseases may be easier to treat. Bear in mind, that screening tests are only a guideline, for a more accurate diagnosis of a chronic condition, your doctor may refer you for more extensive blood tests to determine whether you require chronic medication. For more information, see the chapter BENEFITS: Chronic Medicine (page 31).

What screening tests and vaccines does the Society cover?

The following Preventative Benefits are available to members and beneficiaries:

HEALTH SCREENING

You will be covered for the following diagnostic tests at a pharmacy:

- Blood sugar
- Blood pressure
- Cholesterol
- Measurement of height, weight and waist circumference
- Body Mass Index (BMI) calculation

HIV SCREENING

You also have cover for the following HIV tests and services:

- Pre-testing counselling
- Testing and post-test counselling

WHERE CAN I ACCESS THE PHARMACY-BASED BENEFITS?

You can obtain your pharmacy-based health screening benefits from any pharmacy, but it would be preferable to use a Dis-Chem pharmacy, where possible.

VACCINATIONS

The following vaccinations are included under the vaccination benefit:

- One flu vaccine per beneficiary per benefit year.
- Covid-19 vaccine(s) as per PMB.
- One pneumococcal vaccine per beneficiary aged 65 or over every 5 years.
- One HPV vaccine course per beneficiary aged 9-26.

PLEASE NOTE: Vaccines are covered from this benefit and any consultation fees will be paid according to your day-to-day benefits limit for consultations.

CANCER SCREENING TESTS

- **Pap smear** (usually performed by a GP or gynaecologist)
- **Prostate Specific Antigen** (a blood test to screen for prostate cancer)
- **Mammogram** (performed at a radiology practice)
- **Colorectal screening** (where a sample of your stool is screened by a pathologist)

PLEASE NOTE: The above tests are covered **according to your pathology and radiology benefit** and any consultation fees will be paid according to your day-to-day benefits limit for consultations.

All screening tests will be covered at the SRPL rate or negotiated rate for DSPs. If the provider charges more than these rates; the difference will be for your account.

4 BENEFITS: DAY-TO-DAY

In this section

- What are day-to-day benefits?
- What day-to-day benefits are covered by the Society?

What are day-to-day benefits?

Day-to-day benefits typically include (but are not limited to) consultations with doctors and other healthcare practitioners, dentist visits, acute medicines, and optometry benefits.

What day-to-day benefits are covered by the Society?

See the table below. Unless otherwise specified, limits in this table are per beneficiary per benefit year.

CONSULTATIONS	
General Practitioners (GPs), specialists and registered homeopaths	• Paid at 90% of Society Reference Price List (SRPL) rate. • Combined GP, specialist, and homeopath limit of **15 consultations**. • For elective non-emergency **after-hours** consultations, the benefit is limited to the SRPL rate for a normal consultation. See page 70 on how to avoid additional co-payments in this regard. • Doctors' house calls will be paid at normal consultation rates unless clinically assessed to be required due to a medical emergency.
Physiotherapy, biokinetics and chiropractic services	• Paid at 90% of SRPL rate. • Combined limit of **R8 510**.
Audiology, chiropody, podiatry, acupuncture, dietician services, occupational therapy, and speech therapy	• Paid at 90% of SRPL rate. • Combined limit of **R3 810**.
Nursing practitioner	• Paid at SRPL rate. • Limited to **R2 250**. • This benefit is applicable to consultations and in-rooms procedures and does not include private nursing, wound care or palliative care.

MEDICINE

Acute medicine *(for chronic medicine benefits, see the separate chapter BENEFITS: CHRONIC MEDICINE)* Also see ***How to obtain acute medicine*** below this table for more information.	• Paid at 70% of the negotiated DSP rate, limited to **R5 280**. • Includes prescribed homeopathic medicine, contraceptive preparations and devices (pre-authorisation required for Mirena® device). • Benefit for self-medication (OTC - over the pharmacy counter) limited to a maximum of **R145** per event with a sub-limit of a maximum of **6 fills per year**, and subject to the acute medicine limit of **R5 280**. • MRP is a generic reference price that is the maximum amount that will be reimbursed for a list of generic medicines that cost less than the original brand name medicine. The member will be liable for the price difference should the beneficiary elect to receive medicine above the MRP price.

EYE CARE

Composite consultation (including refraction, glaucoma screening, visual field screening and artificial intelligence screening for retinopathy)	• Benefit is provided at the PPN agreed tariffs. • The benefit applies over a two-year cycle (new cycle started on 1 January 2022) for all beneficiaries and is subject to annual availability. • Benefits are limited to PPN tariffs when consulting a non-PPN provider. (A co-payment will apply if you use a non-PPN provider.)

EYE CARE (CONTINUED)	
Frame and lens enhancements **Lenses (per lens)** a. Single vision or b. Bifocal or c. Multifocal **Contact lenses** **Hard contact lenses**	• Composite consultation limited (per 2-year cycle) to a maximum of **R770** at a PPN provider and **R365** at a non-PPN Network provider. • Composite consultation includes refraction, glaucoma screening, visual field screening and artificial intelligence screening for retinopathy. • The PPN network consists of approximately 87% of all registered optometrists in RSA. • Visit the PPN website www.ppn.co.za to find your nearest PPN provider. **+** **1. Frame and lens enhancements – R1 600** for a PPN Network provider and **R1 280** for a non-PPN Network provider. This component of the optical benefit can be used to purchase a frame or for lens enhancements (tints and coatings), or a combination of both. **2. Per lens** a) Single vision – **R215** OR b) Bifocal – **R460** OR c) Multifocal – **R860** **OR** **Contact lenses** a. Soft contact lenses - **R1 500** per year **OR** b. Hard contact lenses - **R3 000** per 2-year cycle (Subject to pre-authorisation)

- Prescriptions less than 0.50 dioptre will not be covered. No bi/multifocal lenses with a reading of less than 1.00 dioptre will be covered.
- Bi/multifocal lenses for under 40-year-old beneficiaries must be motivated.
- Contact lenses for children under 16 years of age must be motivated.
- **Beneficiaries can claim either spectacles or contact lenses (soft or hard) but not both in the 24-month cycle.**
- No liability for repairs of damage, or for loss of spectacles.

DENTAL	
Conservative dentistry	• Paid at SRPL rate. • Limited to **R4 610**, with a sub-limit of 1 check-up and scale and polish every 6 months, from date of last service. • Includes preventative and diagnostic consultations, fillings, extractions, cleanings, and X-rays. • Managed-care protocols apply, and pre-authorisation is required in respect of: - Elective procedures where general anaesthesia is required. - Children under the age of nine (limited to one admission per year). - Removal of impacted wisdom teeth, apicectomies, removal of teeth and roots or exposure of teeth for orthodontic reasons. • No limit applies in respect of dentistry required as a result of trauma.
Specialised dentistry	• **PRE-AUTHORISATION REQUIRED ONLY IF DONE IN HOSPITAL** From the Society's Hospital pre-authorisation department • Paid at SRPL rate. • Limited to **R8 800**. • Includes crowns, dentures, bridges and periodontal treatment. • Managed-care protocols apply.
Orthodontic treatment	• **PRE-AUTHORISATION REQUIRED** From the Society's Claims department • Paid at 75% of SRPL rate. • Limited to **R27 910** per lifetime. • Benefits are not provided for treatment starting after a beneficiary's 18th birthday.

MENTAL	
Mental health (out of hospital)	• Paid at 90% of SRPL rate. • Limited to **R16 020**.
PROSTHESIS	
Artificial limbs (including prosthetic eyes)	• **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department • Paid at 90% of the cost as approved by the Society. • Limited to **R59 500**. • Repairs and maintenance are included in the limit, to a sub-limit of 15% of the annual limit. • The benefit applies over a five-year cycle (starting from 1 January 2021). • Managed-care protocols apply.
TESTS	
Pathology	• Paid at 90% of SRPL rate, out of hospital. • Unlimited, but subject to request by a medical practitioner.
Radiology	• Paid at 90% of SRPL rate, out of hospital. • Unlimited, but subject to request by a medical practitioner. • No benefit in respect of bone density scans in hospital.

HEARING

Hearing aids	• **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department • Paid at 90% of the cost as approved by the Society. • Limited to **R22 110**. • Repairs and maintenance are included in the limit, to a sub-limit of 15% of the annual limit. • The benefit applies over a five-year cycle (starting from 1 January 2021). • No benefit payable in respect of hearing aid batteries. • Managed-care protocols apply.

MEDICAL EQUIPMENT	
Colostomy bags and catheters	• PRE-AUTHORISATION REQUIRED From Mediscor • Paid at 90% of the cost as approved by the Society. • Limited to **R24 250**. • Subject to motivation by a doctor. • Managed-care protocols apply.
Aids and appliances	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at 50% of the cost as approved by the Society. • Limited to **R9 150**. • Includes insulin pumps, continuous glucose monitoring (CGM) devices including all test strips, orthopaedic boots, surgical collars, prosthesis, nebulisers, and hiring of equipment. • The type of appliance covered by this benefit will be at the discretion of the Society and all repairs and maintenance are included in the limit, to a sub-limit of 15% of the annual limit. • Managed-care protocols apply.
Continuous Oxygen Supply Machine and/or Oxygen	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at cost as approved by the Society. • Limited to **R22 870**. • Portable Oxygen Concentrator subject to Society approval up to the annual limit. • Managed-care protocols apply.

MEDICAL EQUIPMENT (CONTINUED)	
Wheelchairs	• **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department • Paid at 90% of the cost as approved by the Society. • Limited to **R12 150**. • Quadriplegics and paraplegics only: limited to **R35 010**. • No benefit for motorised carts / tricycles other than motorised wheelchairs in appropriate cases. • Repairs and maintenance are included in the limit to a sub-limit of 20% of the annual limit. • The benefit applies over a five-year cycle (starting from 1 January 2021). • Managed-care protocols apply.

Where to obtain acute medicine

You can obtain your acute medicine from any registered pharmacy, but the Society has an agreement with its DSPs (Dis-Chem Pharmacies) to ensure that the agreed Society rate is charged, so that you would not have an out-of-pocket expense other than the standard 30% co-payment that applies to acute medicine.

If you have a Dis-Chem Pharmacy in your area, or live in the vicinity of Cullinan Health & Home Pharmacy, or the Namaqualand Pharmacy in Springbok*, you may collect your acute medicine from these pharmacies. (*Members in the Northern Cape can also collect acute medicine from Dr HA Burger in Springbok.)

If this is not convenient, you may also collect your acute medicine from any other retail pharmacy in RSA. However, keep in mind that if you do not obtain your acute medicine from a DSP, you could have additional out-of-pocket expenses, over and above the standard 30% co-payment that applies to acute medicine, if such a pharmacy charges a higher dispensing fee than the one negotiated with DSPs and covered by the Society.

5 BENEFITS: CHRONIC MEDICINE

In this section

- What is a chronic condition?
- What chronic conditions are covered by the Society?
- When would it make sense to register for chronic medicine benefits?
- What is the benefit for chronic medicines?
- Where do I find a designated service provider (DSP) for chronic medicine?
- How do I register for chronic medicine benefits?

What is a chronic condition?

A chronic condition is a condition that requires ongoing long-term or continuous medical treatment. However, not all these conditions are necessarily covered by the Society's Chronic Medicine Benefits. The Society specifies the chronic conditions that qualify for this benefit.

What chronic conditions are covered by the Society?

There are two main categories of chronic conditions that are covered by the Society:

- Chronic Disease List (CDL) of Prescribed Minimum Benefits (CDL PMB) conditions
- Listed non-CDL conditions

Chronic Disease List (CDL) of Prescribed Minimum Benefits (CDL PMB) conditions		
1. Addison Disease	9. Coronary Artery Disease	18. Hyperlipidaemia
2. Asthma	10. Crohn Disease	19. Hypertension
3. Bipolar Mood Disorder	11. Diabetes Insipidus*	20. Hypothyroidism
4. Bronchiectasis	12. Diabetes Type 1 & 2	21. Multiple Sclerosis*
5. Cardiac Failure	13. Dysrhythmia	22. Parkinson Disease
6. Cardiomyopathy	14. Epilepsy	23. Rheumatoid Arthritis
7. Chronic Obstructive Pulmonary Disease	15. Glaucoma	24. Schizophrenia
8. Chronic Renal Disease	16. Haemophilia*	25. Systemic Lupus Erythematosus
	17. HIV/AIDS	26. Ulcerative Colitis

*Medical conditions marked * will only qualify for benefits under specific circumstances. Please contact Mediscor for details in this regard.*

In addition to the benefits available in respect of the chronic conditions included in the PMBs, beneficiaries may, subject to the conditions set out in the Benefit Schedule and other provisions of the Rules, be entitled to a chronic medication benefit in respect of the chronic conditions listed below (referred to as Listed non-CDL conditions).

Listed non-CDL conditions		
1. Acne	11. Gout	21. Osteoporosis
2. Allergic Rhinitis	12. Hypoparathyroidism	22. Paget's Disease
3. Attention Deficit Hyperactivity Disorder	13. Hyperthyroidism	23. Paraplegia, Quadriplegia
4. Alzheimer Disease	14. Incontinence	24. Peripheral Vascular Disease
5. Ankylosing Spondylitis	15. Depression	25. Pituitary Adenomas
6. Benign Prostatic Hypertrophy	16. Meniere's Disease	26. Psoriasis
7. Cushing Disease	17. Menopausal and Perimenopausal Disorders	27. Pulmonary Interstitial Fibrosis
8. Cystic Fibrosis	18. Motor Neuron Disease	28. Stroke / Cerebrovascular Accident
9. Deep Vein Thrombosis	19. Myasthenia Gravis	29. Systemic Connective Tissue Disorders (incl. Scleroderma and Dermatomyositis)
10. Reflux Disease	20. Osteoarthritis	

In the case of the treatment of medical conditions reflected in the above table which may attract a PMB entitlement in terms of the diagnosis and treatment pairs as per Annexure A to the Regulations of the Act, they will be reimbursed a PMB as per Regulation 8.

When would it make sense to register for chronic medicine benefits?

If you use medicine for a chronic condition without being registered for chronic medicine benefits, it will be covered from your acute medicine benefit limit (or not covered at all) and you will probably exhaust this benefit limit quite quickly. On the other hand, by registering for chronic medicine benefits (if you have a qualifying chronic condition as provided for by the Society – see pages 32 and 33), you have access to a far higher benefit limit for your chronic medicine.

Certain terms and conditions apply to the conditions covered, the medicine formularies available for those conditions, and the service providers through which you have to get the medicine [see the question 'Where do I find a designated service provider (DSP)?' below]. However, for most members the financial benefit of registering for chronic medicine benefits far outweigh the restrictions.

What is the benefit for chronic medicines?

A 100% benefit applies to chronic medicines dispensed for listed conditions (see earlier in this chapter), limited to the lesser of either the Formulary Reference Price (FRP Plus) or the Mediscor Reference Price (MRP) value applicable to the medicine. This is on condition that the medicine is included in the formulary for the authorised condition treated, is below the reference price applied and is obtained from one of the Society's DSPs. If chronic medicine is obtained from a non-DSP a 30% co-payment will apply in addition to any FRP Plus and MRP co-payments.

CHRONIC MEDICINE	
Overall cumulative benefit limit (both CDL PMB and listed non-CDL)	• **PRE-AUTHORISATION REQUIRED** From the Society's Managed-Care department • Limited to **R43 940**. • If this limit is reached before year-end, the CDL PMB medicine will continue to be covered in terms of PMB protocols, provided a DSP is used to obtain the medicine and a valid authorisation exists. • Managed-care protocols apply. • 100% of the negotiated DSP rate. • If this limit is reached before year-end, non-CDL (chronic) medicine will no longer be paid.
All Biologicals	• **PRE-AUTHORISATION REQUIRED** From the Society's Managed-Care department • Limited to **R271 380** (combined sub-limit for Chronic medicine and Oncology). • Subject to available limit for chronic medicine. • Managed care protocols apply.

Where do I find a designated service provider (DSP) for chronic medicine?

To receive the full chronic medicine benefit, you must obtain your chronic medicines from one of the Society's approved DSPs. These are:

- All Dis-Chem Retail Pharmacies,
- Dis-Chem Direct (Dis-Chem's Courier pharmacy),
- Cullinan Health & Home Pharmacy,
- The Namaqualand Pharmacy in Springbok, and
- Dr HA Burger in Springbok.

How do I register for chronic medicine benefits?

Your doctor or pharmacist should contact Mediscor ChroniLine® on 086 011 9553 to obtain pre-authorisation for chronic medicine benefits. A Mediscor ChroniLine® pharmacist will check the request against the Society's protocols and confirm whether the medicine is authorised to be funded from your chronic benefit or not. A dedicated team of experts will assist with any queries in getting your chronic condition and medicine registered.

Alternatively, you may send your prescription via fax to 086 615 1509 or e-mail to preauth@mediscor.co.za.

6 BENEFITS: HOSPITAL & MAJOR MEDICAL

In this section

- What would typically qualify as hospital/major medical expenses?
- How can I avoid spending unnecessary money in terms of hospital/major medical costs?
- What are Network Hospitals, and why should I use them?
- How does pre-authorisation work?
- What if the procedure can be done in the doctor's rooms?
- How do benefits for day procedures work?
- What are Managed-care protocols?
- What are the benefits and benefit limits for hospital/major medical benefits for 2023?

What would typically qualify as hospital/major medical expenses?

In contrast to day-to-day medical healthcare needs such as visiting a doctor or a dentist, there are sometimes medical events that are more serious and costly. These would be, for example, surgical procedures, rehabilitation after a car accident, treatment for cancer and other medical treatments that most people would struggle to pay for, if they do not have medical aid. It is in terms of these costs that medical aids offer members the most peace of mind.

Not all these services take place in a hospital – for example, in-rooms procedures such as colonoscopies, and many of the expensive treatments for cancer (under the oncology benefit) take place out of hospital.

On the other hand, just because you are obtaining a medical service inside a hospital building (for example, visiting the Emergency Rooms (ER), or the pathologists), does not mean that such a service will be covered in terms of your hospital benefits, as it may form part of your day-to-day benefits, instead. (A visit to the emergency rooms [ER] that is of a serious nature and results in admission to hospital would qualify under hospital/major medical benefits.)

This chapter outlines the hospital/major medical expenses covered by the Society.

How can I avoid spending unnecessary money in terms of hospital/major medical costs?

- Use one of the Society's Network Hospitals for procedures to enjoy higher cover. See the next page for more about how Network Hospitals will save you money.
- Make sure that all hospital admissions are pre-authorised.
- If you need a procedure that can be done either in a GP's or specialist's rooms or in hospital, opt for an in-rooms procedure, as several procedures are covered at the higher Scheme Rate if performed in the rooms rather than in hospital. See later in this chapter for more information.

What are Network Hospitals, and why should I use them?

- A Network Hospital is a DSP with which the Society has negotiated and agreed rates*.
- The Society has DSP arrangements with several hospitals throughout Southern Africa.
- Members using such hospitals will not be liable for hospital co-payments, except where co-payments are noted (for diagnostic arthroscopy, for example).
- Members are encouraged to always make use of Network Hospitals, as failure to do so will result in the member being liable for co-payments.

**Please note that the agreed rates only relate to hospital costs. Co-payments may apply to claims by other service providers (physician, physiotherapist, etc.) while in hospital.*

Hospital and Service provider benefit payments in a Network Hospital

- The hospital claim will be paid at the negotiated rate.
- Service providers (Specialist, GP, Anaesthetist, etc.) will be paid at Scheme Rate.
- The Scheme Rate means the rate at which the Society pays benefits to all service providers for services rendered in Network Hospitals. The Scheme Rate is limited to 165% of the SRPL rate.
- Where service providers charge more than the Scheme Rate, the member will be responsible for paying the difference between the benefit provided by the Society in terms of its Rules and the claimed amount.
- Members are encouraged to ask service providers what their charges will be, before undergoing any test or surgery.
- Such excess will be debited to the member where adequate member credit is available.

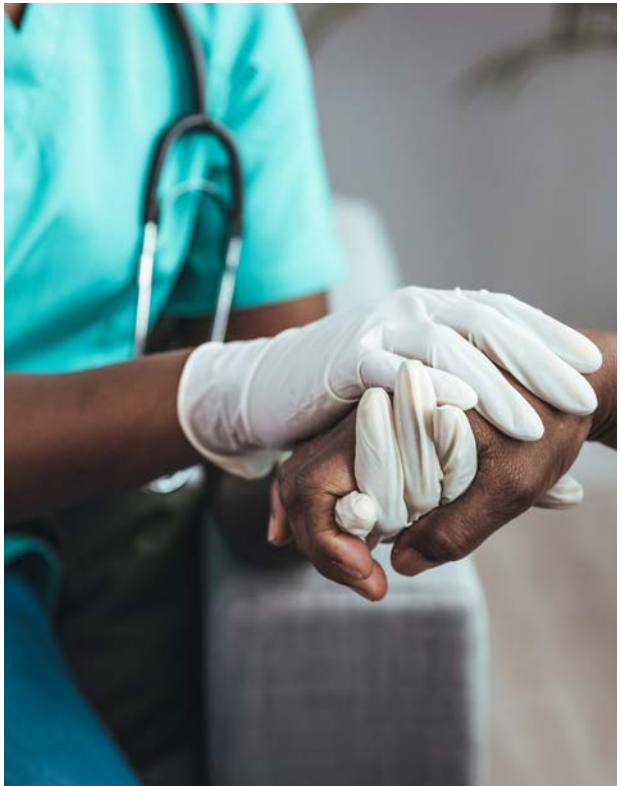
* You can access an up-to-date list of Network Hospitals on our website, at **www.dbbs.co.za**, or call **0800 111 669** to find out where your nearest Network Hospital is.

Hospital and Service provider benefit payments in a NON-NETWORK Hospital

- The hospital claim will be paid at the lower SRPL rate and co-payments will apply.
- Service providers (Specialist, GP, Anaesthetist, etc.) with be paid at the lower SRPL rate, should the provider charge the SRPL rate the claim will be paid in full by the Society.
- Should Service providers charge more than SRPL, the member will be liable for the co-payment.
- Ask the doctors/service providers what they will charge in comparison to the SRPL rates, negotiate with all your service providers to charge the SRPL rate if they quote a higher rate. If you are not successful, consider using a Network Hospital as you will be personally liable for all the additional costs over and above the SRPL rate.
- Such excess will be debited to the member where adequate member credit is available.
- You can obtain more information on SRPL rates from the Society on 053 807 3111 (Call centre option 5).

Overcharges by providers

Where a provider overcharge is identified as excessive by the Society, the Society will pay only its liability directly to the Service Provider (benefit due) and the member must



settle the difference directly with the service provider. Members are encouraged to check their weekly/monthly statements to identify whether a service provider has been paid in full by the Society or whether they are required to pay the service provider directly.

Hospital benefits in other facilities

Pre-authorised admissions to day clinics, step-down facilities and other forms of care are not impacted by the above restriction regarding admissions to non-Network Hospitals, and payments to these service providers will be at the Scheme Rate. Co-payments may however still apply under certain circumstances, for example an admission for a day procedure that converts to an overnight stay in a non-Network Hospital or providers charging more than the Scheme Rate.

Psychiatric benefits

Network or Registered Psychiatric Admissions – The treating providers will be paid at Scheme Rate and the hospital at negotiated rates.

Non-Network Admissions - The treating providers and the hospital will be paid at SRPL rate.

How does pre-authorisation work?

Pre-authorisation means obtaining prior approval for any planned admission to a hospital, planned procedures or other benefits as defined in the benefits table.

Pre-authorisation should be obtained at least **five working days** prior to the date of service (for example, hospital admissions, CT scans, oncology treatment, procedures, or wheelchairs) by contacting the Society's relevant pre-authorisation department – see contact details at the front of this guide. Where an admission has not been pre-authorised in the case of a pre-planned non-emergency admission, a 30% co-payment will be levied on the total hospital account.

BUT WHAT IF IT IS AN EMERGENCY?

In the case of emergency hospitalisation, the Society must be notified within 24 hours or on the first working day after such admission.

Any associated treatment or procedures performed during hospitalisation must also be pre-authorised.

Authorisation is not a guarantee of payment, and is subject to the patient being a valid member/ dependant of the Society on the date of admission. Payment for services rendered will be made in accordance with the Society's registered rules and is at all times subject to the Society's protocols, clinical review, negotiated rates and available benefits on the date of admission.

What if the procedure can be done in the doctor's rooms?

Certain medical procedures can be performed in a doctor's consultation room and it is therefore not necessary for members to endure the inconvenience of being admitted to hospital.

No authorisation is required for minor (non-booked) in-rooms procedures, but please contact the Society's claims department if you require clarification.

See page 44 under Hospital/Major Medical Benefits for more information on the procedures typically covered and that require pre-authorisation.

How do benefits for day procedures work?

A same day hospital admission, if authorised as such, will qualify for benefits at the Scheme Rate/negotiated rate if the admission and discharge occur on the same day without any over- night stay.

If an admission to a non-Network Hospital for a day procedure subsequently results in an overnight stay, the entire account will change from the Scheme Rate/ negotiated rate to the SRPL rate and the member will be liable for any difference in costs between that charged for a day admission and the actual final account rendered, based on the actual time and date of discharge.

Members are encouraged to ensure that, if they are admitted for a day procedure in a non-Network Hospital, their doctor performs the procedure early enough on the day in question. This will ensure that an overnight stay is not required due to the need to recover from the anaesthetic administered or for any other purpose and will thus avoid any additional co-payments being applied.

What are Managed-care protocols?

Many of the benefits in the table that follows are subject to managed-care protocols. Managed-care protocols are strategies employed by medical schemes and their health-care service providers to offer appropriate benefits to members in a cost-effective way. These include, for example, having medicines lists, requiring pre-authorisation before certain procedures or admission to hospital, setting certain financial limits up to which the scheme will pay, or prescribing certain treatment 'recipes' that healthcare providers should follow for specific conditions; based on evidence-based medicine.

What are the benefits and benefit limits for hospital/major medical benefits for 2023?

See the table that follows. Unless otherwise specified, limits in this table are per beneficiary per benefit year.

If you are uncertain about any of these benefits, and would like to find out more, please call 053 807 3111 (Option 5).

IN-ROOMS PROCEDURES

GP and specialist in-rooms procedures	• Paid at Scheme Rate. • The in-rooms procedure costs are unlimited but subject to the 15-consultations limit. • **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department for the following special in-rooms procedures: - gastroscopy - colonoscopy - vasectomy - circumcision - intravitreal injection • IF THE ABOVE PROCEDURES ARE DONE IN HOSPITAL - A co-payment of **R1 500** will apply to any of the above procedures, as it is standard practice for these procedures to be performed in doctors' rooms or a facility other than a hospital. - Should any of the above in rooms procedure take place while the patient is in hospital, the Society at its discretion may waive the co-payment. - Where two or more of the above procedures are performed simultaneously in hospital, only one co-payment will be applied.

HOSPITALISATION

Hospitalisation (including day cases, fixed-fee cases for cataracts, in-rooms procedures instead of hospitalisation, and alternative facilities)	• **PRE-AUTHORISATION REQUIRED** From the Society's pre-authorisation department • Negotiated Rate applies to DSP Network Hospital authorisations, day clinics, fixed-fee cataract procedures and sub-acute facilities. • Scheme Rate applies to all service providers providing their services at Network Hospitals. • A co-payment of **R1 500** will apply to all arthroscopic and laparoscopic procedures performed for diagnostic purposes. • The following laparoscopic procedures may be authorised in terms of the Society's protocols but will be subject to a capped overall benefit limit (inclusive of all hospital costs): - Laparoscopic-assisted vaginal hysterectomy - **R43 780** - Laparoscopic unilateral inguinal hernia - **R34 140** - Laparoscopic incisional/ventral hernia – **R54 290** - RALP (Robotic assisted laparoscopic procedure) capped overall at **R160 560**, being made up of the capped fee for the hospital procedure only, at **R102 180**, and this includes the anaesthetic time limited to a maximum of 3 hours. All the associated providers are capped at a combined total of **R58 380**. • Managed-care protocols apply.

CONSULTATIONS	
Professional fees charged by service providers in hospital	• Scheme Rate applies to service providers where authorisation has been provided for a Network Hospital admission, as well as for day clinics and sub-acute facilities. • The SRPL rate applies to all voluntary non-Network Hospital admissions for hospital and service provider claims. • Managed-care protocols and limits apply, where applicable.
Physiotherapy, occupational therapy, speech therapy and dietician	• Paid at Scheme Rate (if Network Hospital is used), or SRPL rate (if non-Network Hospital is used). • Managed-care protocols apply.
TESTS	
Pathology	• Paid at Scheme Rate (if Network Hospital is used), or SRPL rate (if non-Network Hospital is used). • Subject to a request by a medical practitioner.
Radiology (other than CT and MRI Scans)	• Paid at Scheme Rate (if Network Hospital is used), or SRPL rate (if non-Network Hospital is used). • Subject to a request by a medical practitioner. • No benefit for bone density scans in hospital.
CT and MRI Scans	• **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department • Paid at SRPL rate. • Limited to **3 scans**. • Managed-care protocols apply.

MEDICINE	
Hospital medicines	• Benefit is Single Exit Price (SEP). • TTO medicine (take home medicine) up to a maximum of 7 days' supply.
MATERNITY	
Home confinement or natural birth delivery	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at SRPL rate. • Limited to the in-hospital maternity benefit costs. • Managed-care protocols apply.
Delivery in hospital	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department • Benefit is Scheme Rate (if Network Hospital is used), or SRPL rate (if non-Network Hospital is used). • Limited to 2 days' hospitalisation for normal delivery and 3 days' hospitalisation for a caesarean delivery. • Managed-care protocols apply.
EYE CARE	
Corneal transplants	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department • Paid at Scheme Rate (if Network Hospital is used), or SRPL rate (if non-Network Hospital is used). • Graft benefit limited to **R12 800**. • Harvesting cost limited to a maximum of **R16 650**. • Managed-care protocols apply.

EYE CARE (CONTINUED)	
Cataract removal	• **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department • Benefit is the cost as approved by the Society. • The Society will pay for one post-operative cataract consultation per year. • If an optometrist refers a beneficiary for a cataract examination by an ophthalmologist, the prescription may not be completed until the outcome of the referral is known. Should the optometrist prescribe and dispense spectacles before any surgery that may subsequently be performed, then the beneficiary will not qualify for additional optical benefits post-surgery within the 24-month optical benefit cycle. • Preferred providers contracted specifically for cataract procedures should be first choice. Should a preferred provider not be within a 25km radius of the beneficiary's residential address, then a DSP Network hospital is to be used. • Managed-care protocols apply.
Intra-ocular lenses	• **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department • Benefit is the cost as approved by the Society, limited to single vision lenses and to a maximum of **R3 540** per lens. • Managed-care protocols apply.
Refractive surgery	• **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department • Benefit for hospital and associated provider costs is 50% of Scheme Rate (if Network Hospital is used, or if done in rooms) or 50% of SRPL rate (if non-Network Hospital is used). • Limited to one procedure per eye per lifetime. • Lenses limited to single vision lenses. • Including but not limited to Excimer Laser and eye surgery required for astigmatism, hypermetropia, presbyopia, myopia and hypermyopia. • Managed-care protocols apply.

ORAL SURGERY

Maxillofacial and oral surgery	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department • Benefit for hospital and associated provider costs is paid at Scheme Rate (if pre-authorised and Network Hospital is used, or if done in rooms) or SRPL rate (if pre-authorised and non-Network Hospital is used). • This excludes surgery in preparation for osseo-integrated implants and orthognathic surgery. • Managed-care protocols apply.

MENTAL HEALTH

Psychiatric hospitalisation for mental disorders	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department • Limited to **21 days** per year, provided that the treatment of PMB conditions is limited as per Annexure A of the Regulations. • Paid at Negotiated Rate (if Network Hospital or registered mental health hospital is used), or SRPL rate (if non-Network Hospital is used).
Alcohol and drug dependency in-hospital rehabilitation	• Limited to **24 days** per year, provided that the treatment of PMB conditions are limited as per Annexure A of the Regulations. • Paid at Negotiated Rate (if pre-authorised and Network Hospital or Rehabilitation hospital is used), or SRPL rate (if non-Network Hospital is used). **For both admissions above the following will apply:** • Scheme Rate will apply to providers treating patients in Network and registered psychiatric hospitals. • For admissions to non-Network Hospitals, the SRPL rate will apply to the treating provider as well as the hospital. • Managed-care protocols apply.

NURSING

Private nursing	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at 90% of SRPL rate. • Limited to **R11 630**. • The provider must have a registered practice number.
Wound care	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at 90% of SRPL rate. • Limited to **R11 630**.
Hospice care	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at 100% of SRPL rate, subject to PMB. • Treatment plan is required.

ONCOLOGY	
Treatment in and out of hospital	• PRE-AUTHORISATION REQUIRED • For ***in-hospital treatment***, from the Society's Hospital pre-authorisation department; • For ***out-of-hospital treatment***, Society's Managed-care department • Benefit is according to the ICON Advanced Option. • Limited to **R320 270**. • Should an ICON provider not be used, the consultation and treatment will be limited to 80% of the SPRL rate and accrue to the Oncology benefit. • If you do not obtain your oncology medicine from one of the Society's DSPs, a 30% out-of-network co-payment will be applied. • All parenteral medicine for oncology treatment must be obtained from Dis-Chem Direct and comply with normal MRP and Formulary rules. • 6 follow-up visits are provided for at an ICON provider. • ICON protocols apply.
All Biologicals	• Limited to **R271 380** (combined sub-limit for Chronic medicine and Oncology). • Subject to available limit for oncology treatment. • Managed care protocols apply.
PET and related CT planning scans	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at SRPL rate. • Accrues to Oncology benefit limit. • ICON protocols apply.

PROSTHESIS/TRANSPLANTS

Internal prosthesis	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department • Paid at the cost as approved by the Society. • Limited to an overall benefit of **R56 460** (inclusive of bone cement, cages, screws, plates, coronary and vascular stents, pacemakers, aortic and valve replacements). • The overall annual limit is cumulative for all the sub-limits below: - Joint replacements – **R56 460** - Spinal prosthesis – **R56 460** - Coronary & vascular stents, pacemakers, aortic & mitral valve replacements – **R56 460** - Mesh (Gortex slings and Permacol®) – **R16 100** • Managed-care protocols apply.
Renal dialysis (applicable to PMB-confirmed cases only)	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at 100% of DSP Rate in and out of hospital. • Managed-care protocols apply.
Organ transplants (applicable to PMB-confirmed cases only)	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department • Paid at SRPL or Scheme Rate. • Managed-care protocols apply.

HEARING

Cochlear implants	• **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation • Paid at SRPL or Scheme Rate. • Device limit of **R293 540** for internal and external components only. • Replacement & repair of the external processing system will be paid from the Hearing Aid benefit, of which the limit applies over a five-year cycle starting from 1 January 2021 (see page 28 for more information). • Managed-care protocols apply.

OTHER

Blood transfusion	• Paid at negotiated rates. • Unlimited.

7 BENEFITS: EMERGENCY TRANSPORT

In this section

- What must I do in an emergency?
- What qualifies as an emergency?
- When should I call an ambulance, and when not?
- What if a non-ER24 service provider is dispatched?
- Will an emergency admission to any hospital be covered?
- What if the emergency occurs while I am on holiday outside RSA?

ER24 is the Society's contracted service provider for emergency medical transportation. All Society members resident in South Africa, as well as those members who are employed by the Employer (or an Associated Employer) in Botswana or Namibia, are eligible for ER24 benefits.

RSA residents simply call
084 124

FOR QUALIFYING BOTSWANA OR NAMIBIAN RESIDENTS CALL
+27 10 205 3000

What must I do in an emergency?

1. Always call **084 124**. This number operates 24 hours a day, 7 days a week, to ensure that you and your family are always guaranteed assistance in the case of a medical emergency that requires transportation.
2. Inform the ER24 operator that you are a De Beers Benefit Society member – they will guide you, or the person calling on your behalf, through the process to obtain all the information they require to get help to you.

Non-emergency calls: If you call for an ambulance and it is not a medical emergency, you may have to pay the account from your own pocket.

Please note that a beneficiary will receive no ambulance benefit where the call-out was not medically justified and ER24 did not authorise the claim, or where ER24 is not contacted.

What qualifies as an emergency?

The definition is as follows: "An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death."

Here are some examples:

- You have been seriously injured;
- You are unconscious or having a fit;
- You are in premature labour or have a problem with your pregnancy;
- You are unable to breathe;
- You are having chest pain;
- Children who have swallowed poison; or
- You have been caught in a fire and burnt.

When should I call an ambulance, and when not?

PLEASE remember that ambulance transfers are costly to the Society and **non-emergency ambulance transfers will NOT be covered by the Society**, for example:

- Where you or your family are well enough to go in a car, bus or taxi to see your doctor or go to the hospital as an outpatient;
- If you do not require urgent medical attention for a life-threatening condition;

- Transport home from hospital when you are well enough to be discharged;
- When you are pregnant, with no complications and starting with labour; or
- When you need to be admitted for a pre-planned operation or procedure.

You can see more detailed information about when you should call for an ambulance on our Society website, www.dbbs.co.za.

If you need help deciding whether an ambulance is required, call ER24 and ask to be put through to their 24-hour "Ask the Nurse" Health Line. You will then be advised to do one of the following:

1. Go to the hospital (ER24 will dispatch an ambulance if medically necessary);
2. Go to the doctor; or
3. Go the pharmacy to obtain over-the-counter medication.

What if a non-ER24 service provider is dispatched?

Even if you know ER24 does not operate an ambulance service in your area, always call **084 124** to request an ambulance service. The call center will dispatch an ambulance nearest to you, either as a private ambulance, or a state ambulance if that is the only option in your immediate area.

If you voluntarily call another emergency medical transport provider, you may have to pay the account from your own pocket.

ER24 may dispatch a non-ER24 ambulance service in response to your call, but a reference number will always be given for your call.

Should you be involved in an accident or in a public place and someone else calls for an ambulance, the claim will be paid.

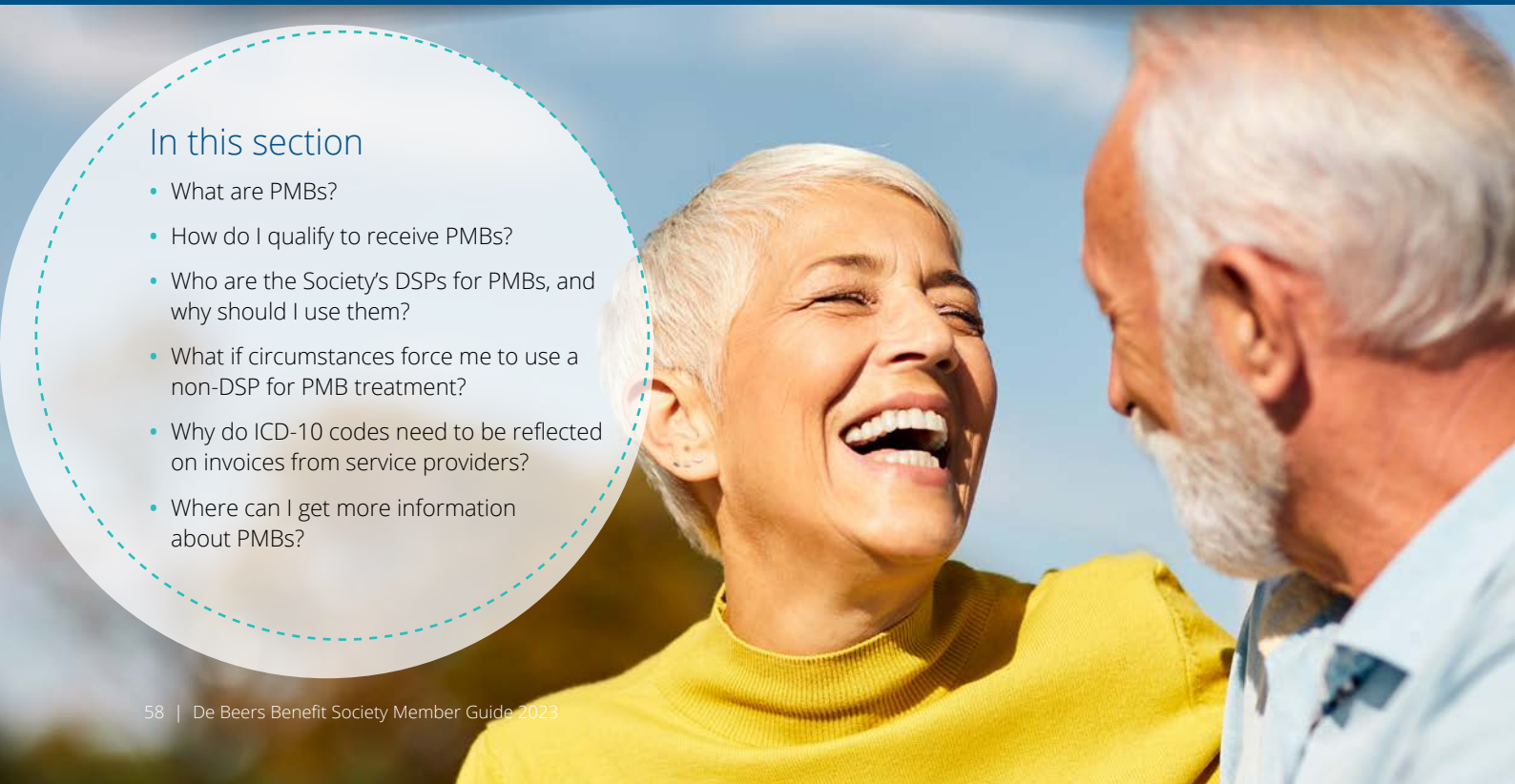
Will an emergency admission to any hospital be covered?

The Society will cover the hospital and specialist charges for emergency hospital admissions in RSA and for qualifying members resident in Botswana and Namibia at cost, provided that it is a justified admission and the Society is informed of the admission on the next working day.

What if the emergency occurs while I am on holiday outside RSA?

Please note that you are not eligible for ER24 transportation if you travel on holiday from South Africa to a foreign country, including Namibia and Botswana. You are therefore encouraged to arrange appropriate travel insurance including medical evacuation (except for Lesotho and Swaziland for medical evacuation) in good time before your departure.

8 PRESCRIBED MINIMUM BENEFITS



In this section

- What are PMBs?
- How do I qualify to receive PMBs?
- Who are the Society's DSPs for PMBs, and why should I use them?
- What if circumstances force me to use a non-DSP for PMB treatment?
- Why do ICD-10 codes need to be reflected on invoices from service providers?
- Where can I get more information about PMBs?

What are PMBs?

PMBs are minimum benefits which by law must be provided by all medical schemes and include the provision of diagnosis, treatment, and care costs for:

- any emergency medical condition as defined*;
- a set of 270 medical conditions (called the DTPs**, listed in the Regulations to the Medical Schemes Act); and
- the Chronic Disease List (26 chronic conditions).

Medical schemes must pay for these conditions in full, without member co-payments.

How do I qualify to receive PMBs?

- Members or service providers may contact the Society's Claims Department on 053 807 3111 (Call centre option 5) and inform the agent of their request to register for a PMB condition.
- The Society's agent will then e-mail or fax the PMB request/application form to the service provider for completion.

* Emergency medical condition as defined

This is a medical or health condition which is of sudden and unexpected onset that requires immediate medical and/or surgical treatment, where failure to provide this treatment would result in impairment of bodily functions, serious and lasting dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. In the case of such an emergency medical condition occurring, the Society must be informed on the first business day following the date of the resultant admission or treatment.

**DTPs

Certain conditions cannot be classified as a PMB condition on their own. To be classified as a PMB condition, the condition must be treated in a specific way in accordance with set protocols. These protocols are known as Diagnosis and Treatment Pairs (DTPs). Only when all the DTP criteria as per the regulations are met, will claims for the treatment of the relevant condition be classified as a PMB.

- The completed form must be returned by e-mail to benefitpost@dbbs.co.za.
- The Society will then inform the service provider of the outcome of their application for registration.
- If your query is not satisfactorily resolved within 15 working days, you may appeal in writing (by letter or email) to the Principal Officer.

Who are the Society's DSPs for PMBs, and why should I use them?

DSPs are health care providers that have been selected by the Society to provide its members with diagnosis, treatment and care in respect of one or more of the PMB conditions.

It is extremely important that you understand the use of DSPs so that you do not end up facing unnecessary co-payments, should you have a PMB-related claim.

The Society's DSPs are:

- Network Hospitals (Please refer to the Society's website www.dbbs.co.za for a full list of Network Hospitals.)
- ER 24 – Emergency Transport Service provider
- Dis-Chem Pharmacies, Dis-Chem Direct, Cullinan Health & Home Pharmacy, the Namaqualand Pharmacy in Springbok and Dr HA Burger in Springbok for the supply of medicine
- PPN – Preferred Provider Negotiators for optical services
- ICON – Independent Clinical Oncology Network (Pty) Ltd.
- BBraun Avitum / E Owen & Partners for renal dialysis services

What if circumstances force me to use a non-DSP for PMB treatment?

The following circumstances may leave you with no choice but to obtain medical treatment from a non-DSP for the treatment of a PMB condition and in such cases the Society will pay for the costs of your treatment, diagnosis and care in full when:

- the required service from the list of DSPs listed above is not readily available;

- an emergency medical condition as defined above occurs; or
- there is no DSP within reasonable proximity to where you are when an emergency occurs.

Please note the Society retains the right to move a patient admitted as a result of an emergency to an appropriate (DSP) facility once the patient has been stabilised if additional treatment and care is required.

If, however, you **voluntarily** obtain diagnosis, treatment and/or care in respect of a PMB condition from a provider other than a DSP, the benefit payable in respect of such service is subject to co-payments and/or benefit limitations as are normally applicable in terms of the Rules of the Society.

Why do ICD-10 codes need to be reflected on invoices from service providers?

ICD-10 codes provide accurate and specific information regarding the condition that you have been diagnosed with and/or treated for and needs to be provided by your service provider on the account. These codes enable the Society to determine what benefits you are entitled to receive and how these benefits must be paid. This becomes very important when you are claiming for the treatment of a PMB condition, as the ICD-10 codes allow the Society to accurately identify the PMB condition. If the PMB condition is treated by one of the DSPs listed above, the account will be paid in full by the Society with no member co-payments.

Where can I get more information about PMBs?

A full list of the PMB conditions can be accessed on the Council for Medical Schemes website www.medicalschemes.com as well as regular publications and updates on this subject. A link to the Council for Medical Schemes website is available on the Society's website www.dbbs.co.za.

9 MEMBERSHIP

In this section

- Who qualifies to be a member?
- What waiting periods apply to new members and dependants?
- What if a beneficiary has not been a member of a medical aid before?
- Can I or any of my dependants belong to more than one medical scheme at the same time?
- When will my membership of the Society end?
- Under what circumstances can I terminate my membership or de-register a dependant?

Who qualifies to be a member?

Employees

Employees are required to join the Society, provided that a member who ceases to be an employee during a calendar month shall be entitled to retain his membership up to the last day of such calendar month.

Retirees

A member shall retain his membership of the Society when he retires from the service of the Employer or an Associated Employer, or when his employment is terminated by his Employer or Associated Employer on account of his retirement or becoming entitled to an insured disability benefit offered by the Employer. Unless such member informs the Society in writing of the termination of his membership, he shall continue to be a member.

Dependants of deceased members

The dependants of a deceased member who are registered with the Society as his dependants at the time of such member's death shall be entitled to continuation membership of the Society.

The Society shall in writing inform dependants of their right to membership with effect from the date of death of the member and of the contributions payable in respect thereof. Unless such dependant informs the Society in writing of his intention to not become a member, he shall be admitted as a member of the Society.

Such dependant's membership terminates if he becomes a member or a dependant of a member of another medical scheme.

Retrenched employees

A member who is retrenched from the service of the Employer or Associated Employer may continue membership of the Society, provided that:

- the member does not become entitled to membership of another medical scheme by virtue of any post-re-trenchment employment; and
- the Society may terminate the membership of such member if he secures permanent employment with any employer, other than the Principal Employer or Associated Employer, entitling him to membership of another medical scheme by virtue of such permanent employment.

- Such members will be responsible for payment of the full contributions (for themselves and any registered dependants), as well as any co-payments due to the Society, by way of authorising the Society to make these deductions directly from their bank account.

Dependant

The following persons qualify as dependants:

- a member's spouse or life partner who is not a member of another medical scheme or a registered dependant of a member of another medical scheme;
- a member's child who is dependent on the member and is not a member of another medical scheme or a registered dependant of a member of another medical scheme;
- a member of the member's immediate family (the parents, including adoptive parents, as well as brothers and sisters of a member) for whom the member is liable for family care and support; or
- any sibling of a child dependant, if such child dependant has been orphaned or if such child dependant's remaining parent does not qualify for registration as a member and, as a consequence thereof, such child dependant is registered as a member in terms of Rule 6.3.1, provided that such sibling was registered as a dependant of the deceased member at the time of the death of the member and provided that such sibling:
  - is under the age of 21; or
  - is over the age of 21 but under the age of 26 and not in receipt of a regular income (refer to Ruling 9 on the Society's website for the criteria for dependency test); or
  - is over the age of 21 but due to a mental or physical disability is not independent.

Children

- a member's, spouse's or life partner's natural child, stepchild or legally adopted child; and
- a deceased member's natural child, stepchild or legally adopted child who, on the death of the member, is entitled to be registered as a member in terms of Rule 6.3.1 under circumstances where such child is orphaned, or such child's remaining parent does not qualify for continuation membership.

Dependent children

- a child under the age of 21; or
- a child over the age of 21 but who is dependent upon the member.

What waiting periods apply to new members and dependants?

The Medical Schemes Act provides for waiting periods to be imposed on new applicants to a medical scheme, and to members who move from one scheme to another. There are two different waiting periods:

- **A 3-month general waiting period** – During this general waiting period no claims will be funded by the Society; and
- **A 12-month condition-specific waiting period** – This is a period during which a member is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period before application for membership was made.

Condition-specific waiting periods may therefore not be imposed on related conditions unless a direct link can be demonstrated between the relevant conditions. In cases where an applicant never belonged to a medical scheme in the past or where the member had a break in coverage of more than 90 days, the waiting periods may also include prescribed minimum benefit (PMB) conditions.

Break between medical schemes of 90 days or more	
Period of Previous Membership	**Waiting period**
Regardless of previous membership	• 3-month general waiting period • 12-month condition-specific waiting period • Waiting period may include PMB conditions

Break between medical schemes of up to 89 days	
Period of Previous Membership	**Waiting period**
24 months and longer	• 3-month general waiting period • Waiting period may not apply to PMB conditions
Shorter than 24 months (previous waiting periods may still be in place)	• 12-month condition-specific waiting period • Waiting period may not apply to PMB conditions
Regardless of previous membership in case of: • Change of employment • Employer changing/ terminating medical scheme	• No general or condition-specific waiting periods may be imposed

No waiting period will apply if application for membership or registration as a dependant takes place within 30 days after the date on which the person first becomes eligible to be registered as a member or dependant.

What if a beneficiary has not been a member of a medical scheme before?

Late-joiner penalties may be imposed on beneficiaries over the age of 35 depending on the number of years that they have not belonged to a medical scheme (excluding spouses/life partners as per Ruling 8).

A late-joiner penalty will be added to the member's monthly contribution in respect of the beneficiary. It is based on the total number of years the beneficiary has not been a medical scheme member since the age of 35 years and is calculated as a percentage of the contribution, as shown in the table below.

1 – 4 years	**0.05 x contribution**
5 – 14 years	**0.25 x contribution**
15 – 24 years	**0.50 x contribution**
25 + years	**0.75 x contribution**

Can I or any of my dependants belong to more than one medical scheme at the same time?

Please note that it is illegal to belong to more than one medical scheme at the same time.

When will my membership of the Society end?

Your membership of the Society will end/terminate if you resign from the employment of the Employer.

A member who ceases to be an employee of the Employer during a calendar month will be entitled to retain his/her membership to the last day of such calendar month.

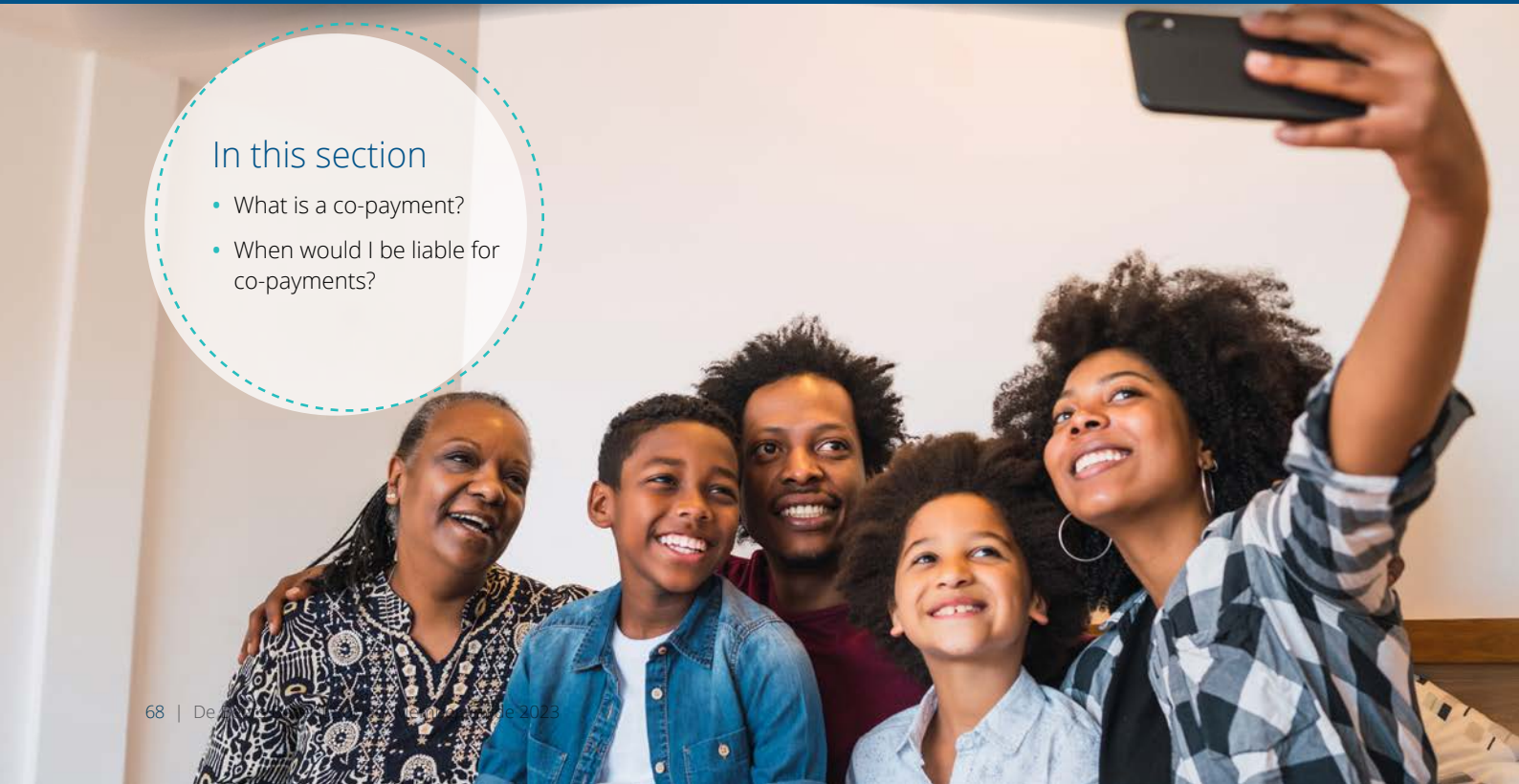
Under what circumstances can I terminate my membership or de-register a dependant?

A member who is not required in terms of his conditions of employment to be a member, may terminate his membership of the Society by giving one month's written notice to the Society. His membership of the Society and all his dependants' rights to benefits shall cease after the last day of the calendar month during which such notice expires.

A member may de-register a dependant by giving **30 days written notice** to the Society.

Such a member will remain liable for full contributions for the whole notice period, even where he requests immediate termination of membership.

10 | CO-PAYMENTS



In this section

- What is a co-payment?
- When would I be liable for co-payments?

What is a co-payment?

A co-payment is the amount of money or the portion of the account that the Society may require you to pay from your own pocket. This could be either a percentage of the fee, a fixed fee or the difference between the amount charged for a tariff by the service provider that attended to you and the benefit provided by the Society in terms of its Rules and benefit structure.

The co-payment will be collected via your salary or pension, provided you have sufficient credit limit. You may contact the Society to confirm your available credit limit. In the case of pensioners receiving a pension from an outside insurer, the co-payment will be recovered via debit order.

Note: The examples below do not represent all co-payments that can be incurred for services received from a 3rd party and is just for explanatory purposes

When would I be liable for co-payments?

Consultations

If you...	...you will have to pay	What you can do to avoid additional costs:
claim for a doctor's consultations and related services	the difference between what you are charged by the medical service provider and the Society's reimbursement rate. **Example:** GP claimed R600.00 SRPL rate is R455.00 10% co-payment (Benefit = 90% of SRPL rate) = R45.50 GP charges R145.00 more than the SRPL rate **Total co-payment = R45.50 plus R145.00 = R190.50**	• It is worth negotiating with the service providers, since they could be willing to reduce their service fee. • Consider using another service provider; one who charges SRPL rates.

After-hours consultation

If you...	...you will have to pay	What you can do to avoid additional costs:
consult with a medical service provider unscheduled* or after-hours for a non-emergency, your claims will be covered at **SRPL**, and * *Most medical practices charge an after-hours consultation fee for consultations conducted after normal working hours and during weekends. Please note that, if you phone your doctor during normal working hours and they fit you in on that specific day without an official pre-booked appointment, you will be charged for an unscheduled consultation.*	the difference between what you are charged by the medical service provider and the Society's reimbursement rate, PLUS the emergency consultation fee. **Example**: GP claimed R428.00 (normal consult) GP claimed R229.30 (emergency consult) SRPL rate is R455.00 10% co-payment (Benefit = 90% of SRPL rate) = R45.50 **Total co-payment = R45.50 plus R229.30 = R274.80**	• Confirm the normal operating hours of the medical service provider. • You may provide written motivation of circumstances, should it be considered to have been an emergency as defined on page 55, to the Society by emailing benefitpost@dbbs.co.za or faxing to 086 636 8923.

Hospital (Network) – associated provider overcharge

If you...	...you will have to pay	What you can do to avoid additional costs:
are admitted to a Network hospital for a non-emergency and the associated providers charge more than the Scheme Rate	the difference between what you are charged by the non-Network hospital and the medical service provider and the Society's reimbursement rate. **Example:** Anaesthetist claimed R766.00 SRPL rate is R431.00 Anaesthetist charges R54.85 more than the Scheme Rate (SRPL R431.00 x 165%) Specialist claimed R1 500.00 SRPL rate is R822.00 Specialist charges R143.70 more than the Scheme Rate (SRPL R822.00 x 165%) **Total co-payment = R54.85 plus R143.70 = R198.55**	It is worth negotiating with the service providers, since they could be willing to reduce their service fee.

Hospital (Network) – no pre-authorisation

If you...	...you will have to pay	What you can do to avoid additional costs:
are admitted to a Network hospital for a non-emergency and you do not contact the Society before you are admitted for pre-authorisation (unless it is a valid emergency),	a penalty of **30% that will be levied on the total hospital account** (and you will even run the risk of not having your hospital claims covered).	Always obtain pre-authorisation for a hospital admission at least five working days beforehand. In an emergency, the Society must be notified on the first working day after the admission.

Hospital (non-Network)

If you...	...you will have to pay	What you can do to avoid additional costs:
are admitted to a non-Network hospital (by choice) for a non-emergency, your claims will be covered at **SRPL Rate**, and	the difference between what you are charged by the medical service provider and the Society's reimbursement rate. **Example:** Hospital claimed R15 545.25 SRPL rate = R9 516.85 Hospital charges R6 028.40 more than the SRPL Rate Anaesthetist claimed R3 318.43 SRPL rate is R1 520.36 Anaesthetist charges R1 798.07 more than the SRPL Rate Surgeon claimed R5 476.00 SRPL rate is R5 476.00 Surgeon charged SRPL Rate **Total co-payment = R6 028.40 plus R1 798.07 = R7 826.47**	• Make sure that you are admitted to a Network Hospital, as your associated provider claims will then be covered at **Scheme Rate** and the hospital claims at **Negotiated Rate**. • When using a Non-network hospital obtain quotations from all service providers to determine the co-payments that will apply, so that you can make an informed decision.

Hospital – sub-limit applicable (prosthesis, capped procedure)

If you...	...you will have to pay	What you can do to avoid additional costs:
are admitted to a Network hospital for a non-emergency major surgery involving: • internal prosthesis; or • laparoscopic procedures, your claims will be covered at Scheme Rate, but sub-limits will apply, and	the difference between what you are charged by the medical service provider and the Society's Benefit Limit. **Example:** Hospital claimed R24 437.42 Hospital paid in full at Negotiated rate Prosthesis cost R116 023.90 Limit is R56 460 Prosthesis costs are R59 563.90 more than the limit. **Total co-payment = R59 563.90**	• Ensure the relevant authorisation department has negotiated the prosthesis cost if the quote is above limit. • Speak to your service provider about the options available to you.

Oncology – non-DSP (ICON not used)

If you...	...you will have to pay	What you can do to avoid additional costs:
receive oncology treatment from a non-ICON provider	the difference between what you are charged by the oncologist and the Society's reimbursement rate. **Example:** Oncologist claimed R4 385.82 SRPL rate is R4 385.82 20% co-payment (Benefit = 80% of SRPL rate) = R877.16 **Total co-payment = R877.16**	Use the Scheme's DSP for oncology treatment, Independent Clinical Oncology Network (ICON). ICON is a dedicated network of oncologists committed to the comprehensive management of members with cancer.

11 FREQUENTLY ASKED QUESTIONS

In this section

- What happens to "unused" benefits?
- What benefits are excluded by the Society?
- To what extent are benefits limited by the Society?
- What if I have a complaint against the Society or any of its third-party providers?
- What if I have a complaint related to other aspects of the health industry?
- How much time do I have to submit a claim?

What happens to "unused" benefits?

Your benefits are not transferable from one financial year to another, from one category to another, or from one beneficiary to another.

The Society is a traditional medical scheme where all members' contributions are pooled together in a single risk pool from which benefits are paid, and each beneficiary has his/her own limits.

On an annual basis the Trustees (with assistance from the actuary) set the budget for the ensuing year. This is a complex process and the Trustees take account of several factors including, for example:

- the benefit structure and any changes to it;
- past claims experience;
- projected future increases in the cost of various medical services;
- the changing demographics of the Society's membership and projected benefit utilisation versus contribution income;
- developments in the medical industry; and
- investment returns.

Based on the outcome of the above, the Trustees aim to set the contributions at a level that will cover the cost of the estimated benefits to be provided. If a situation occurs where too much or too little is collected from members, this has an influence on the solvency level of the Society and the outcome will either increase or decrease the reserves of the Society. The aim is to ensure that the Society remains solvent and sustainable over the long term so any "unused" benefits will increase the Society's reserves.

What benefits are excluded by the Society?

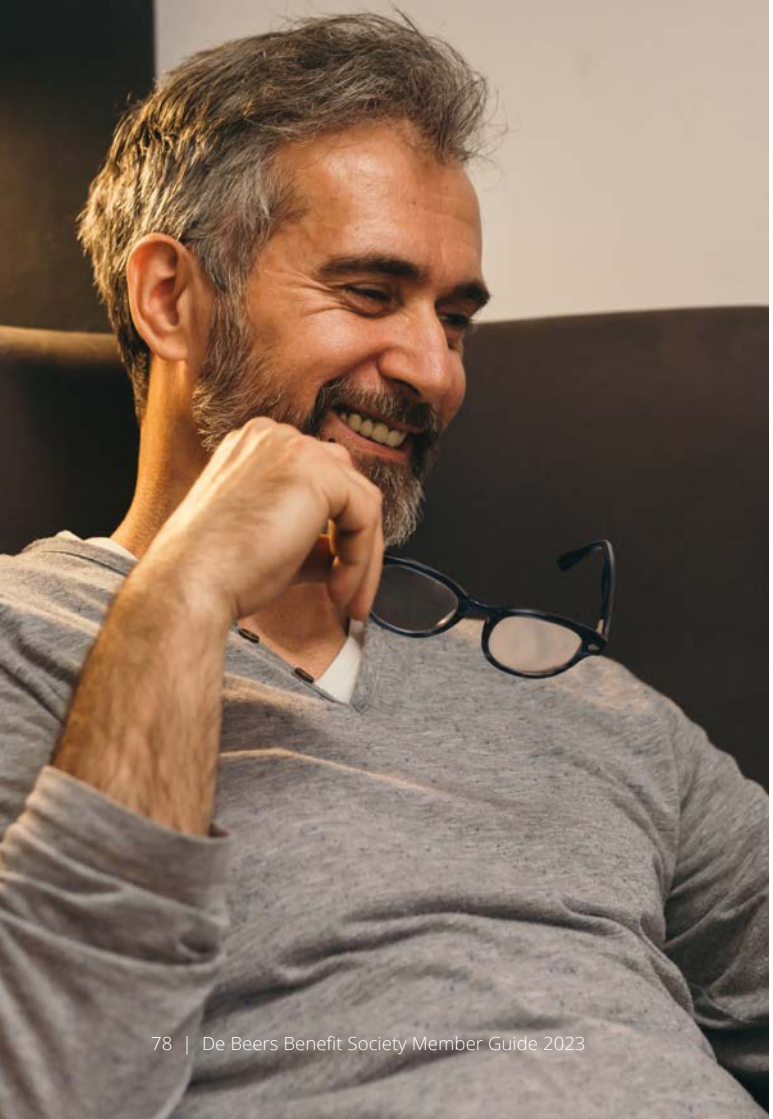
The scheme will pay in full, without co-payment or use of deductibles, for the diagnosis, treatment and care costs of the prescribed minimum benefits as per regulation 8 of the Medical Schemes Act. Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, the

scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Medical Schemes Act.

EXCLUSIONS

1. Expenses and medicines arising from examinations, treatment and/or operations for cosmetic purposes (the Society in its sole discretion may decide if any procedure is deemed to be cosmetic based on the motivation provided), infertility, artificial insemination, impotency and erectile dysfunction, gender reassignment, treatment of an experimental nature or treatment that does not constitute the prevailing medical or surgical diagnostic and treatment practice in the South African Public Sector (unless specifically authorised by the Society subject to such conditions as it may impose), and any complication that may arise from such examinations or treatment with the exception of any PMB.
2. Expenses (including expenses relating to any PMB) incurred outside the Area of operation.
3. Expenses in respect of the treatment of any learning, marital, social or family problems.
4. Expenses relating to the purchase of:
   i. any medicine not registered by the Medicines Control Council or similar authority (except for Homeopathic Medicines); or
   ii. medicines not registered for treatment of the condition for which such medicines are obtained and any patent and household remedies.
5. Expenses relating to services that do not relate to any sickness condition, including but not limited to examinations for insurance, employment, visas, pilot and driving licenses and school readiness tests.
6. Expenses relating to any recuperative or convalescent holidays.
7. Expenses relating to travel.
8. Expenses relating to any diagnostic preparations and instruments, orthopaedic beds, soaps, shampoos, and other topical applications (of a cosmetic nature), medicated or otherwise, but excluding those intended for treatment of lice, scabies and other parasitic or fungal infections.
9. Expenses relating to any anti-addiction and anti-habit agents not covered under PMB code 182T.

10. Expenses relating to any cosmetic items inclusive of hair-restorers.
11. Expenses relating to any sun screening and sun-tanning agents except those intended for the treatment of PMB skin disorders.
12. Expenses relating to any homeopathic and herbal medicines and remedies not prescribed by a registered homeopath.
13. Expenses relating to any food supplements except those required for use when approved as part of a discharge plan for a PMB condition, including all patent and baby foods and special milk preparations.
14. Expenses relating to any household bandages, dressings and diapers.
15. Expenses relating to any syringes and needles except those required for use in the treatment of diabetes or when approved as part of a discharge plan.
16. Expenses relating to any vitamins, mineral supplements, growth hormones, tonics and stimulants. However, benefits will be granted for the following:
    i. Pre-natal vitamins; and
    ii. Calcium supplements when prescribed and approved for the treatment of osteoporosis.
17. Appointments not kept by you.
18. Expenses relating to any telephone prescriptions, other than for repeat prescriptions.
19. Expenses relating to accommodation and services rendered in convalescent or old age homes or similar institutions catering for the aged or chronically ill other than specifically provided for in the rules.
20. Expenses relating to any contact lens preparations.
21. Expenses relating to all non-prescription sunglasses.
22. Expenses relating to lost or damaged devices, apparatus, spectacles or contact lenses.
23. Expenses relating to sleep therapy.
24. Expenses relating to ambulance transportation from a hospital to your home or from your home to a consulting room of any medical practitioner or hospital, unless deemed clinically necessary and pre-authorised.
25. Expenses incurred without a pre-authorisation as required by the rules.
26. Expenses relating to:



i. 3D and 4D gestational sonars
ii. Angioseal and similar closure devices when performing coronary angiograms where the patient is not considered a high risk for vascular complications, such high risk including but not limited to patients known to have peripheral vascular disease, advanced age, liver disease, coagulopathy, immunosuppression, post valve replacement and renal dysfunction.
iii. Artificial Discs unless used in the treatment of a PMB condition at a PMB level of care.
iv. Mammoplasty, including breast augmentation and reductions, which includes all costs for the operation, medicine and treatment of cosmetic or elective procedures. The only exception will be for PMB and PMB related conditions.
v. Motorised carts/tricycles, other than motorised wheelchairs in appropriate cases.
vi. Magnetic Resonance Imaging (MRI) of the breast is not considered to be a standard screening tool unless used in the treatment of staging a diagnosed

PMB condition by a registered Radiologist or where the mammogram does not yield conclusive results.

vii. Orthodontic treatment of beneficiaries older than 18 years.

viii. Orthognathic surgery. The only exception will be for PMB and PMB related conditions.

ix. Vasovasostomy

27. Expenses relating to the following services unless authorised by the Society:
    i. Genetic or Biomarker tests.
    ii. Oncotype tests.
    iii. Gynaecomastia and Mammary surgery. The only exception will be for PMB and PMB related conditions.
    iv. Kyphoplasty.
28. Expenses relating to services which are regarded as not being medically necessary, cost efficient and affordable, provided that a treatment, procedure, supply, medicine, hospital or specialised centre stay (or part of a hospital or specialised centre stay) shall be regarded as medically necessary if:
    i. The treatment is required to restore the normal function of an affected limb, organ or system;
    ii. The treatment is generally accepted as optimal and necessary for the specific condition and is supplied at an appropriate level to render safe and adequate care;
    iii. The treatment is not rendered for the convenience of the relevant beneficiary or service provider;
    iv. Outcome studies are available and acceptable to the Society; and
    v. No alternative exists that has a better outcome, is more cost effective and has a lower risk.

    Provided further, that the presence or absence of a medical necessity shall be determined by the Society considering the above requirements. The fact that a provider has prescribed, recommended, approved or provided a treatment, service, supply or confinement shall not in itself be regarded as proof that such service was medically necessary. The Society may refer cases to a medical specialist for an opinion, or a second opinion. The decision of the Society on the issue of medical necessity following the advice of such specialist shall be final.

29. Expenses (including expenses in respect of PMBs) for which a third party is liable including expenses associated with occupational injuries and diseases, participation in professional sport, motor vehicle accidents and medical services covered by other forms of insurance, provided that the Society may (other than in respect of PMBs in which case the Society shall be obliged to do so) provide benefits until the third party's liability has been established at which stage the expenditure shall be recouped from the third party or the member as the case may be.
30. Expenses arising from the treatment of obesity, for example, but not limited to Bariatric surgery.
31. Expenses for healthcare services rendered during any waiting periods applied.
32. Expenses for healthcare services that do not meet the Society's clinical protocols.
33. For interest charged by a service provider or a member due to delays in payment resulting from delays in submission or reprocessing of the claim.

To what extent are benefits limited by the Society?

- The maximum benefits to which a member and his dependants are entitled during any financial year of the Society are limited to the extent set out in Annexure B of the Rules.
- Any benefits obtained in terms of PMBs shall first be offset against applicable benefit limit available, at a facility the Society deems appropriate, **thereafter paid unlimited**.
- Should a proposed procedure not fall within the approved managed-care protocols of the Society, the Society may, in its sole discretion, and subject to such conditions as it may impose, approve funding for such proposed procedure; provided that such funding shall, subject to any benefit limits imposed by the rules, be based on current practice, evidence-based medicine, taking into consideration the cost effectiveness and affordability, and not exceed the total reasonable average cost as determined by the Society for the standard procedure approved in terms of the

managed-care protocols of the Society, including all the associated provider costs and any prosthesis and / or device costs.

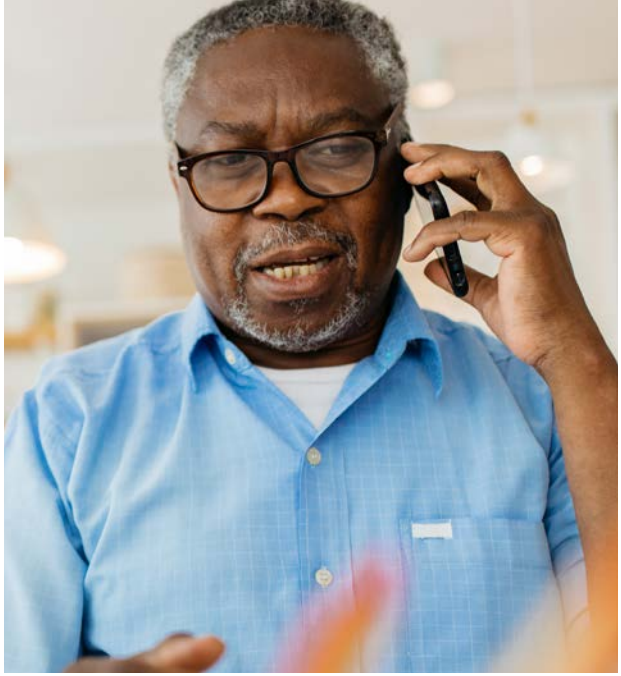
What if I have a complaint against the Society or any of its third-party providers?

Members may lodge complaints in writing to the Society via e-mail (complaints@dbbs.co.za) or post (PO Box 1922, Kimberley, 8300) for the attention of the Principal Officer.

All complaints received in writing will be responded to by the Society, in writing, within **30 days** of receipt thereof.

Any dispute may be referred to an expert committee for an opinion. A final decision re a dispute taken by the Principal Officer in consultation with the Chairman of the Board, will be binding in terms of the Rules.

Any member has the right to submit a complaint to the Council for Medical Schemes against the decision of the Principal Officer. Such complaint submitted to the Council needs to be lodged with the Registrar not later than three



months after the date on which the decision in question was made by the Principal Officer.

For a detailed process to follow to submit a complaint to the Council for Medical Schemes, please make use of their website www.medicalschemes.com or contact them as per the contact details below.

CMS Contact details

Customer Care Service Center
086 112 3267 / 086 112 3 cms
General Enquiries
Email Enquiries: support@medicalschemes.com
Reception
Telephone: 012 431 0500 | Fax: 012 430 7644
Complaints
Fax Complaints: 086 673 2466 Email Complaints: complaints@medicalschemes.com
Postal Address
Private Bag X34, Hatfield, 0028
Physical Address
Block A Eco Glades 2 Office Park 420 Witch-Hazel Avenue Eco Park, Centurion, 0157
Website: www.medicalschemes.com

What if I have a complaint related to other aspects of the health industry?

If you have a complaint related to any other aspect of the health industry, please follow the links below:

- For complaints regarding Health Professionals (doctors) – www.hpcsa.co.za
- For complaints regarding Private Hospitals – www.hasa.co.za
- For complaints regarding Nurses – www.sanc.co.za
- For complaints regarding any other health insurance products –

  www.osti.co.za (short term insurance ombudsman) or www.ombud.co.za (long term insurance ombudsman)

How much time do I have to submit a claim?

Please submit your claims as soon as possible, but no later than four months from the date on which the service was rendered. In terms of the Medical Schemes Act, claims not submitted within four months (stale claims) may not be considered for payment by the Society.

The information in this member guide is subject to the registered Rules of the De Beers Benefit Society (a registered medical scheme; registration no. 1068). The Rules of the Society will apply in all cases should there be any dispute, doubt or misunderstanding arising from the information provided in this guide. The full set of Society Rules may be viewed at the registered office of the Society: 84 Du Toitspan Road, Kimberley, 8301, or a copy may be obtained from your HR department, from the Society's website at www.dbbs.co.za or members may request that a printed copy be posted to them.

A registered medical scheme. Registration no. 1068