



MEMBER GUIDE 2020





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.

Contact details

De Beers Benefit Society

- 📞 General queries: 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
- ✉ PO Box 1922, Kimberley, 8300

Preferred Provider Negotiators (PPN) (Optometry)

- 📞 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

Dis-Chem Pharmacies and Dis-Chem Direct (Courier Pharmacy)

-  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

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: 086 615 1509
-  www.mediscor.co.za
-  PO Box 8796, Centurion, 0046

PPSHA (Hospital Pre-Authorisation)

-  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

Botswana Hospitals Only (Hospital Pre-Authorisation)

-  053 807 3111 (Option 6)
-  managedcare@dbbs.co.za

ER24 (Emergency Transport DSP)

-  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

Contents

Overview	6
1. Introduction	14
• What is the role of the De Beers Benefit Society?	15
• How can this member guide help me?	15
• What are my responsibilities as a member?	15
• What abbreviations are used in this guide?	16
2. Contributions	17
• What are the monthly contributions for 2020?	17
3. Prescribed Minimum Benefits	18
• What are PMBs?	19
• Why do we have PMBs?	19
• Who are the Society's DSPs for PMBs, and why should I use them?	20
• How do I qualify to receive PMBs?	21
• What if circumstances force me to use a non-DSP for PMB treatment?	21
• Why do ICD-10 codes need to be reflected on invoices from service providers?	21
• Where can I get more information about PMBs?	22
4. Hospital Benefits	23
• What are Network Hospitals, and why should I use them?	24
• How are hospital benefits calculated?	24
• What is pre-authorisation, and when do I need it?	24
• How do I obtain pre-authorisation?	24
• What hospital benefits am I covered for and how will my service providers be paid?	25
• How do benefits for day procedures work?	26
• How can I minimise costs not covered by the Society if I elect to have an operation at a non-Network Hospital?	27
• What if the procedure can be done in the doctor's rooms?	27
5. Benefits due in the event of a medical emergency	28
• What must I do in an emergency requiring transportation by ambulance?	29
• What if the emergency occurs outside RSA?	30
• Will emergency admissions to any hospitals be covered?	30
• What if a non-ER24 service provider is dispatched?	30
6. Medicine Benefits	31
• How are medicine benefits provided by the Society?	32
• Who manages the Society's chronic medication programme?	32
• How do the FRP Plus and MRP work, and when will I be liable for a co-payment?	32
• What other information about the formularies and reference price lists used by the Society should I be aware of?	34
• Who are the Designated Service Providers (DSPs) for dispensing chronic medicines?	35
• What chronic conditions are covered by the Society?	35
• How do I register for chronic medicine benefits?	37
• How do I appeal a decision made by Mediscor ChroniLine®?	37
• How do I obtain my chronic medicine?	37
• How am I required to obtain oncology medicine?	38
• What if I need an additional supply of chronic medicine due to extended travel requirements?	39
• What else do I need to be aware of, regarding chronic medicines?	39

• May a pharmacist change the medication on my prescription to comply with the formulary requirements? 39 • How can I obtain acute medicine? 40 • How do I register my HIV status and/or medication? 40	
7. Day-to-day Benefits 41	
• What day-to-day benefits are covered by the Society? 42 • What happens to “unused” portions of benefit limits from the risk pool? 42	
8. Benefit details for 2020 43	
• Important notes 44 • Area of Operation 44 • Prescribed Minimum Benefits 45 • Consultations (out-of-hospital) 45 • Oncology 46 • Diagnostic testing 47 • Medicines 47 • Dental 48 • Optometry 49 • Medical equipment 51 • Care not in-hospital 53 • In-hospital 54 • Emergency transport 57 • Other 58 • What benefits are excluded by the Society? 59 • To what extent are benefits limited by the Society? 63	
9. More about the Society 64	
• Who governs the Society? 65	
10. All about membership 66	
• Who qualifies to be a member? 67 • How do I become a member of the Society? 68 • What waiting periods apply to new members and dependants? 69 • What if a beneficiary has not been a member of a medical aid before? 70 • Can I or any of my dependants belong to more than one medical scheme at the same time? 72 • When will my membership of the Society terminate? 72 • Under what circumstances can the Society terminate my membership? 73 • Under what circumstances can I terminate my membership or de-register a dependant? 73 • What documentation will I receive if I terminate my membership with the Society? 73	
11. Claiming and co-payments 74	
• How much time do I have to submit a claim? 75 • How can I ensure that my GP and other health-care service providers are paid timeously? 75	
12. Frequently asked questions 76	
• How can I avoid co-payments for after-hours/unscheduled doctors' consultations? 77 • What do I do if I suspect that someone is defrauding the Society? 77 • What is the role of the Society's call centre? 77 • What if I have a complaint against the Society or any of the Society's Third-Party Providers (PPSHA, Mediscor, PPN, Dis-chem, ICON)? 78 • What if I have a complaint related to other aspects of the health industry? 81	
13. List of Network Hospitals 82	



OVERVIEW

There for you

Many people regard their medical scheme mainly as a way to help cover visits to the doctors, 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 really 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 so 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. This "journey" shows different life stages and the type of healthcare challenges a member may face.

THE 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



Cataract surgery



Hip replacement



After retirement;
ageing process more
pronounced.



Specialised treatment
for back and neck pain,
to avoid surgery

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

How claims are paid

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. Should a provider charge more than the SRPL rate, the member will be liable for the difference between the SRPL rate and the rate charged by the provider. Benefit is 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.

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 benefits table on pages 45-58 for more 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 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.

The following pages offer a summary of the benefits offered by the Society, both in and out of hospital. Use the number in front of the benefit in which you are interested as a reference to find more detailed information about the specific benefit limits, conditions, co-payments, etc., in the benefits tables on pages 45-58.

 HEARING	24 Hearing aid
 TESTS	7 Pathology 8 Ra
 ONCOLOGY	5 Treatment out of

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT
 DIAGNOSTIC TESTING	
7. Pathology	+ Benefit is paid at 90% of SRPL + Unlimited, but subject to require
8. Radiology	+ Benefit is paid at 90% of SRPL + Unlimited, but subject to require
9. CT and MRI Scans (In- and out-of-Hospital)	+ Benefit is paid at SRPL rate. + Limited to 3 scans per benefici + Subject to managed care proto



DAY-TO-DAY HEALTHCARE NEEDS



HOW TO SAVE MONEY

- Use the Society's Designated Service Providers.
- Negotiate with service providers (such as orthodontists) before committing to treatment.
- Request an appropriate generic equivalent for prescribed medication from your doctor or pharmacist.

 CONSULTATIONS	2 GPs, specialists, registered homeopaths 3 GPs & specialists in-rooms procedures 27 Physiotherapy including Biokinetics and Chiropractic services 26 Auxilliary services, Audiology, Chiropody, Podiatry, Acupuncture, Dietician services, Occupational and Speech Therapy
 SIGHT	16 Optical consultations, frames, lenses/contact lenses
 TEETH/JAW	13 Conservative dentistry 14 Specialised dentistry 15 Orthodontic treatment
 MATERNITY	29 Home confinement/Natural birth delivery
 MENTAL	30 Mental health
 PROSTHESIS/TRANSPLANTS	23 Artificial limbs (including eyes)
 HEARING	24 Hearing aid
 TESTS	7 Pathology 8 Radiology 9 CT and MRI scans 10 Bone Density scans
 ONCOLOGY	5 Treatment out of hospital 6 PET and related CT scans
 NURSING	4 Nursing practitioner 28 Private nursing
 EQUIPMENT	20 Colostomy bags and catheters 21 Aids and appliances 21 Oxygen or renal 25 Wheelchairs
 MEDICINE	12 Acute medicine 11 Chronic medicine



HOSPITALISATION/ MAJOR MEDICAL EVENTS

Many of the hospital benefits are subject to pre-authorisation and managed care protocols. Please check the detailed benefit tables and call the Society if you are uncertain about a benefit.



HOW TO SAVE MONEY

- Use one of the Society's Network Hospitals for procedures to enjoy higher cover. For admission to a Network Hospital (and provided that you had the treatment pre-authorised), claims for the Network Hospital will be settled at negotiated rates and associated service providers at Scheme Rate. Voluntary admissions to a non-Network Hospital will be settled at the lower SRPL rate. See pages 82-90 for the list of Network Hospitals.
- A number of procedures will also be covered at the higher Scheme Rate if performed in a GP's or specialist's rooms rather than in hospital. See pages 27 and 46.

 HOSPITALISATION	31 Hospitalisation (Including Day Cases, Fixed Fee Cases for Cataracts, In-rooms procedures in lieu of hospitalisation and alternative facilities)
 CONSULTATIONS	32 Professional fees charged by service providers (GPs, specialists, etc.) 40 Physiotherapy 40 Occupational, Speech Therapy and Dietician
 SIGHT	17 Cataract removal 18 Intra-ocular lenses 19 Refractive surgery 47 Corneal transplants
 TEETH/JAW	33 Maxillofacial and oral surgery
 MATERNITY	36 Maternity
 MENTAL	35 Psychiatric hospitalisation
 PROSTHESIS/TRANSPLANTS	37 Internal prosthesis (such as bone cement, cages, plates, screws, stents and pacemakers, etc.) 46 Organ transplants 45 Dialysis
 HEARING	38 Cochlear implants
 TESTS	9 CT and MRI scans 42 Pathology 43 Radiology
 ONCOLOGY	5 Treatment in hospital
 OTHER	34 Blood transfusions 44 Emergency road and air transport
 MEDICINE	39 Hospital medicines



Introduction

In this section

- What is the role of the De Beers Benefit Society?
- How can this member guide help me?
- What are my responsibilities as a member?
- What abbreviations are used in this guide?

What is the role of the De Beers Benefit Society?

The Society provides medical insurance cover to you and your dependants for a wide range of medical services, prescribed medicine and medical events, such as hospitalisation and surgery.

How can this member guide help me?

All your benefits and related conditions and limits are explained in a summarised form in this guide. This guide is designed to answer most of the general questions you may have. Please read it carefully and keep it for future reference.

What are my 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;
- 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;
- 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 in all likelihood 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 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 (refer to page 77); and
- Ensure that you 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.

What abbreviations are used in this guide?

The following abbreviations are used in this guide:

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
OCT	Optical Coherent Tomography
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)



Contributions

What are the monthly contributions for 2020?

These are the total monthly contributions payable from 1 January 2020.

PER PRINCIPAL MEMBER / ADULT	PER CHILD DEPENDANT
R3 611	R972



BENEFITS

Prescribed Minimum Benefits (PMBs)

In this section

- What are PMBs?
- Why do we have PMBs?
- Who are the Society's DSPs for PMBs, and why should I use them?
- How do I qualify to receive PMBs?
- 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).

Why do we have PMBs?

PMBs were introduced into the Medical Schemes Act to ensure that members of medical schemes would not run out of benefits for the treatment of certain prescribed conditions. Medical schemes must pay in full, without the use of deductibles (co-payments), for the diagnosis, treatment and care costs of the PMB conditions. These PMBs cover a wide range of 270 diagnosis and treatment pairs that medical schemes must cover (according to set protocols), including but not limited to medical emergencies.

***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.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

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

Although PMBs must be funded in full by medical schemes, the Medical Schemes Act does allow schemes to apply certain measures to manage the financial risk and accompanying costs associated with the unpredictable health needs of their members such as the use of DSPs. 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

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.

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 (see pages 82-90)
- Dis-Chem Pharmacies, Dis-Chem Direct, Lime Acres Pharmacy, Cullinan Health & Home Pharmacy, the Namaqualand Pharmacy in Springbok and Dr HA Burger in Springbok for the supply of medicine
- ER 24 – Emergency Transport Service provider
- PPN – Preferred Provider Negotiators for optical services
- ICON – Independent Clinical Oncology Network (Pty) Ltd. All oncology related consultation and treatment benefits will be subject to the ICON protocols and members are reminded that all oncology medicine must be obtained from Dis-Chem Direct as advised on page 38. Should an ICON provider not be used, oncology consultation benefits will be limited to 75% of the consultation cost and for all chronic medicines not obtained from Dis-Chem a co-payment of 30% will apply.

You have to use the above DSPs to receive the related PMBs, otherwise co-payments (see left) as per the Society's benefit structure will apply.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

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 member/service provider for completion. This form must be completed by the service provider and returned by fax to 086 632 9945 or e-mailed to benefitpost@dbbs.co.za. The Society will then inform the member/service provider of the outcome of their application for registration. For chronic, oncology and organ transplant medicines contact Mediscor [ChroniLine®](#) on 086 011 9553 to register. If your query is not satisfactorily resolved within 15 working days, you may appeal in writing (by letter or email) to the Principal Officer.

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 treated for and needs to be provided by your service provider on the account rendered for the service provided. 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. ICD-10 codes therefore ensure that the correct benefit allocation is made. Should you feel an error has been made in assessing your claim, you may follow the process below to query the account.

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.



Please contact the Society if you are unsure about any issues relating to PMBs and associated claims.



BENEFITS

Hospital benefits

In this section

- What are Network Hospitals and why should I use them?
- How are hospital benefits calculated?
- What is pre-authorisation, and when do I need it?
- How do I obtain pre-authorisation?
- What hospital benefits am I covered for and how will my service providers be paid?
- How do benefits for day procedures work?
- How can I minimise costs not covered by the Society if I elect to have an operation at a non-Network Hospital?
- What if the procedure can be done in the doctor's rooms?

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 a number of 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 refer to the list of Network Hospitals on pages 82-90.

! Please also note that the agreed rates only relate to hospital costs. Co-payments may be applicable to charges levied by other service providers (e.g. physician, physiotherapist etc.) while in hospital.

How are hospital benefits calculated?

Hospital benefits are calculated based on the rates that the Society has negotiated with its DSP Network Hospitals.

What is pre-authorisation, and when do I need it?

Pre-authorisation means obtaining prior approval for any planned admission to a hospital, planned procedures or other benefits as defined in the benefits table. All pre-authorisations must be obtained not less than **five working days prior** to the date of service (for example, hospital admissions, CT scans, oncology treatment or wheelchairs). Any associated treatment or procedures performed during hospitalisation must also be pre-authorised. In the case of emergency hospitalisation, the Society must be notified within 24 hours or on the first working day after such admission.

How do I obtain pre-authorisation?

RSA Hospital Pre-Authorisation

Obtain pre-authorisation at least **five working days** prior to admission for any planned admission to hospital by contacting the Society's hospital pre-authorisation department between 08h00 and 16h30 toll-free on 0800 111 669 (Non-RSA based members +27 12 679 4022 or e-mail debeerspreauth@ppsha.co.za).

Botswana Hospital Pre-Authorisation

+27 53 807 3111 (Option 6) / managedcare@dbbs.co.za

Introduction
Contributions
PMB
Hospital Benefits
Emergency
Medicine
Day-to-day
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

What hospital benefits am I covered for and how will my service providers be paid?

Hospital benefits in a Network Hospital

If you have a procedure performed in a Network Hospital for which you have obtained pre-authorisation from the Society, no co-payments will be due by you in respect of the hospital account, other than procedure co-payments indicated in the benefit table (refer to page 54).The Society will also settle accounts received directly from your service providers (e.g. specialist, GP, anaesthetist etc.) at the Scheme Rate.

The Scheme Rate means 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 limited to 165% of the SRPL rate where these services have been provided in an authorised Network Hospital and you have received pre-authorisation for any booked procedure. Members will be liable for any amount by which the professional fees exceed 165% of the SRPL rate.

Where certain procedures (for example, circumcisions, vasectomies, colonoscopies and gastroscopies) are performed in the doctor's rooms (see pages 46 and 54), these procedures will also be funded at the Scheme Rate.

Where service providers charge in excess of 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 therefore 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.

Hospital benefits in a non-Network Hospital

If you require a procedure for which you have obtained pre-authorisation from the Society and which will be performed in a non-Network Hospital, your hospital account will not be paid in full by the Society and co-payments will be incurred. In addition, claims from service providers (e.g. specialist, GP, anaesthetist, etc.) will not be funded at the Scheme Rate but at the lower SRPL rate.

Therefore, in cases where service providers charge the SRPL rate, the Society will pay the service provider directly and in full. Where service providers charge in excess of SRPL, the member will be responsible for paying the difference between the benefit provided by the Society in terms of its

Introduction
Contributions
PMB
Hospital Benefits
Emergency
Medicine
Day-to-day
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

Rules and the claimed amount. Such excess will be debited to the member where adequate member credit is available.

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 in excess of the Scheme Rate.

Psychiatric Benefits

The Scheme Rate will apply to providers treating psychiatric patients in Network and registered psychiatric hospitals. The hospitals will be paid at negotiated rates.

For psychiatric admissions to non-Network Hospitals, the SRPL rate will apply to the treating provider as well as the hospital.

How do benefits for day procedures work?

A same day hospital admission, if authorised as such, will qualify for benefits at the Scheme Rate if the admission and discharge occur on the same day without any overnight 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 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.

How can I minimise costs not covered by the Society if I elect to have an operation at a non-Network Hospital?

Find out from your referring doctor or specialist what service providers will be involved in your case, for example:

- the surgeon(s);
- the anaesthetist;
- any doctors or specialists assisting the surgeon; and
- follow-up treatments in hospital, such as physiotherapy, pathology tests, x-rays, etc.

Ask the doctors/service providers what they will charge in comparison to the SRPL rates. You can obtain information on SRPL rates from the Society on 053 807 3111 (Call centre option 5). 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.

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.

The procedures indicated below, performed in a doctor's consultation room, **must** be pre-authorised to qualify for payment at the Scheme Rate.

Co-payments of R1 500 will apply to gastroscopies, colonoscopies, circumcisions, male sterilisations and intravitreal injections that are performed in-hospital as it is standard practice for these procedures to be performed in doctors' consultation rooms. In the case of procedures that are normally done in doctors' consultation rooms, the co-payment due for in-hospital cases may be waived at the discretion of the Society where the member is already hospitalised and it becomes necessary to perform any of the above procedures.



BENEFITS

Benefits due in the event of a medical emergency

In this section

- What must I do in an emergency requiring transportation by ambulance?
- What if the emergency occurs outside RSA?
- Will emergency admissions to any hospital be covered?
- What if a non-ER24 service provider is dispatched?

RSA residents simply call
084 124

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

What must I do in an emergency* requiring transportation by ambulance?

You and your registered dependants who are resident in RSA, and qualifying members and registered dependants resident in Botswana and Namibia (subject to the conditions outlined and under Area of Operation on page 44), have unlimited access to emergency medical transportation 24 hours a day, provided that this is authorised by ER24. Members are also covered for emergency transportation/evacuation by ER24 within Lesotho and Swaziland. No benefits are, however, allowed for any treatment in Lesotho and Swaziland (see page 57).

In addition to emergency transportation, you can also obtain emergency medical advice and assistance from ER24. ER24's operators will guide you through a medical crisis situation, provide emergency advice and organise

for you to receive the support you need. This service is available on a 24-hour basis 365 days of the year.

Services offered by ER24:

- 24-hour access to the ER24 Emergency Call Centre
- Dispatch of emergency response
- Medical transportation
- Authorised one-way inter-hospital transfers

***Definition of a medical emergency:** 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.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

What if the emergency occurs outside RSA?

Please note that ER24 coverage will only apply to emergencies in RSA, Lesotho and Swaziland and for qualifying members and registered dependants resident in Botswana and Namibia as outlined in the Society's Area of Operation. If you are an RSA citizen, resident in RSA and are travelling on holiday to Botswana or Namibia or, for that matter, to any other country in the world, you will **NOT** be covered by ER24



or by the Society. 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.

Will emergency admissions to any hospitals 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 as outlined above at cost, provided that it is a justified admission and the Society is informed of the admission on the next working day. The Society has no liability for admissions to any facilities or medical treatment within Swaziland or Lesotho or in any other country you may travel to.

What if a non-ER24 service provider is dispatched?

If ER24 dispatches a non-ER24 ambulance service in response to your call, your ambulance benefit will be paid. However, please note that a member will receive no ambulance benefit when the benefit is declined by ER24 or where ER24 is not contacted.



BENEFITS

Medicine Benefits

In this section

- How are medicine benefits provided by the Society?
- Who manages the Society's chronic medicine programme?
- How do the FRP Plus and MRP work, and when will I be liable for a co-payment?
- What other information about the formularies and reference price lists used by the Society should I be aware of?
- Who are the DSPs for dispensing chronic medicines?
- What chronic conditions are covered by the Society?
- How do I register for chronic medicine benefits?
- How do I appeal a decision made by Mediscor ChroniLine®?
- How do I obtain my chronic medicine?
- How am I required to obtain oncology medicine?
- What if I need an additional supply of chronic medicine due to extended travel requirements?
- What else do I need to be aware of, regarding chronic medicines?
- May a pharmacist change the medication on my prescription to comply with the formulary requirements?
- How can I obtain acute medicine?
- How do I register my HIV status and/or medication?

How are medicine benefits provided by the Society?

The benefit for medicine is calculated as follows:

CHRONIC MEDICINE

A 100% benefit applies to chronic medicines dispensed for listed Conditions (see page 35) 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 disease treated 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 applicable as noted above.

ACUTE MEDICINE

A 70% benefit applies to acute medicines. Acute medicine claims are also subject to the MRP.

Who manages the Society's chronic medicine programme?

Mediscor, a professional pharmaceutical benefit management organisation, is contracted to advise the Society on chronic medicine benefits and to manage such benefits via its **ChroniLine®** facility.

ChroniLine® pharmacists and pharmacy assistants will therefore interact with you regarding your chronic medicine benefits. To receive the best possible service, contact Mediscor **ChroniLine®** and not the Society call centre if you have any queries about your chronic medicine benefits.

- Call 086 011 9553 on weekdays from 08h00 to 17h00
- Non-RSA members call +27 12 674 8000
- For chronic medicine authorisations:
Email **ChroniLine®** at preauth@mediscor.co.za
- For oncology authorisations:
Email **ChroniLine®** at dbbsonco@mediscor.co.za

How do the FRP Plus and MRP work, and when will I be liable for a co-payment?

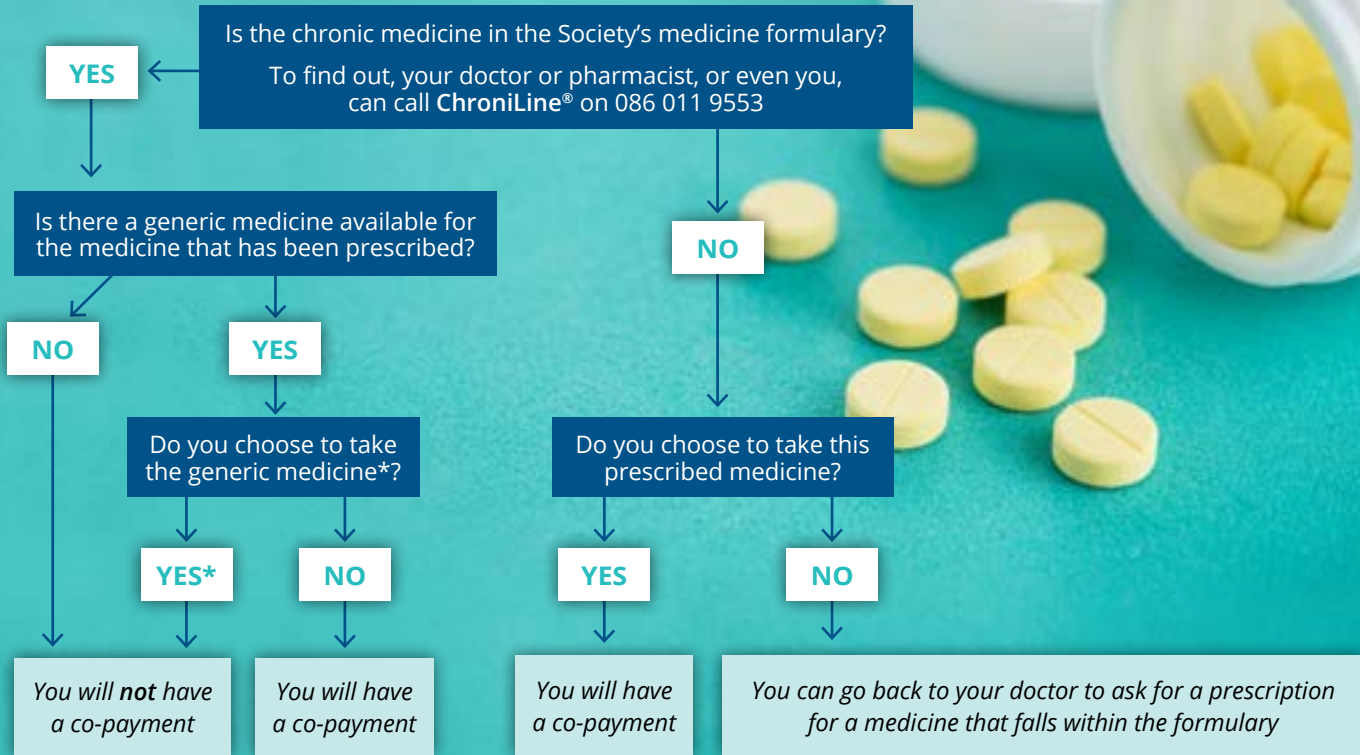
Members will receive treatment for all registered chronic conditions without any co-payment, provided that:

- the actual medicines used are within the Society's preferred formulary;
- a less expensive/cost-effective generic alternative medicine, below the reference price, is chosen where applicable; and
- you have not exceeded your benefit limit.

The chart on the next page shows when you will have a co-payment as a result of the option exercised by you.



You receive a prescription for chronic medicine from your doctor



**If the generic reference priced medicine is above the formulary reference price then a co-payment will apply.*

What other information about formularies and reference price lists used by the Society should I be aware of?

The medicine formularies applied by the Society are costed on a therapeutic reference price referred to as FRP Plus. FRP Plus sets a maximum reimbursable price for a list of therapeutically similar products that fall outside of the preferred formulary lists. If a member chooses to use a non-preferred medicine that is more expensive than the FRP Plus reference price, the member will have to pay the difference between the price of the chosen medicine and that of the FRP Plus reference price. All preferred formulary items are still subject to generic reference pricing according to the MRP.

MRP sets a maximum reimbursable price for a list of generically similar products with a cost lower than that of the original (branded) medicine. This means that, if you choose to use the original product, and a less expensive generic alternative is available, you will have to pay the difference between the price of the chosen original medicine and the price of the generic equivalent medicine reflected in the MRP. This is also applicable to preferred formulary medicines. The

Society encourages the use of generic-equivalent medicines in the interests of cost-effective care and to avoid member co-payments.

If you do not register a Chronic Disease List (CDL) PMB condition listed on page 35, one month's supply of chronic medicine will be funded from your Acute Medicine benefit, with a 30% co-payment; whereafter, if the condition is not registered with Mediscor, the medication claim will be rejected and you will have to pay for it in full.

If you do not register a non-prescribed condition listed on page 36, the cost of the medicine will be deducted from your Acute Medicine benefit limit and you will be liable for a 30% co-payment.



Please note that the MRP (and therefore member co-payments where applicable) may change from time to time as a result of regular changes in the price of medicines. The MRP changes can occur on a monthly basis and it is not practical for the Society to advise members of these price changes. However, beneficiaries who could be impacted by FRP Plus changes will be individually notified bi-annually by the Society when this occurs.

Who are the Designated Service Providers (DSPs) for dispensing chronic medicines?

To receive the full chronic medicine benefit, you have to 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),
- Lime Acres Pharmacy,
- Cullinan Health & Home Pharmacy,
- The Namaqualand Pharmacy in Springbok, and
- Dr HA Burger in Springbok.

Summary

In view of the above it should therefore be noted that there will be no co-payment for any chronic medicine used in the treatment of chronic conditions listed on pages 35-36, provided that the following criteria are met:

- You have registered your chronic condition and obtained the required pre-authorisation from [ChroniLine®](#) (see page 37 on how to register);
- You obtain your chronic medicine from a DSP;
- The prescribed medicine falls within the Society's Formulary (FRP Plus);

- The medicine is within the MRP limits (generic medicines); and
- You have not exhausted your chronic medicine benefits for non-PMB conditions.

What chronic conditions are covered by the Society?

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

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

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.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

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.

How do I appeal a decision made by Mediscor ChroniLine®?

In the event that you are not satisfied with the decision made by Mediscor **ChroniLine®** regarding your chronic authorisation request and you or your doctor have additional evidence that may influence the decision, you may request Mediscor **ChroniLine®** in writing to forward the additional information to their Appeals Committee for review. Failing that you may appeal to the CMS if you are still not convinced of the appropriateness of the final decision (see page 80 regarding the appeals process).

How do I obtain my chronic medicine?

Submit your original prescription to the DSP pharmacy of your choice and they will dispense your chronic medicine. Society members can collect their chronic medicine from one of the following DSPs: any of the retail Dis-Chem Pharmacies nationwide, Lime Acres Pharmacy, Cullinan Health & Home Pharmacy, the Namaqualand Pharmacy in Springbok or directly from Dr HA Burger in Springbok. If collection is not possible, or if you do not have a DSP pharmacy where you live, your chronic medicine will be delivered to you free of charge by Dis-Chem Direct, via courier. In such a case you must fax your prescription, with your instructions, to 086 529 0228 or email it to debeers@dischem.co.za. (You are required by law to send the original prescription to the pharmacy; in this case Dis-Chem Direct at Private Bag X21, North Riding 2162.)

Remember that if you make use of the courier pharmacy (Dis-Chem Direct), you need to re-order your chronic medicine at least 10 working days before your current supply is depleted.

Chronic medicine is not automatically dispensed.



In the event that you obtain your chronic medicine from any other provider than those listed above (also known as out-of-network providers), the claim will be subject to a 30% out-of-network levy plus any co-payment for other overpricing or formulary non-compliance.



Please note that submission of your prescription does not automatically instruct Dis-Chem Direct to forward your chronic medicine. You have to give them specific instructions via the call centre 086 122 6668 or by fax 086 529 0228 or e-mail debeers@dischem.co.za detailing each item required and providing your preferred delivery method, address, membership number and contact telephone numbers.

How am I required to obtain oncology medicine?

All oral oncology medicine may be obtained from any of the Society's DSPs.

Parenteral oncology medicine must be obtained from the Dis-Chem Direct Oncology division by your Oncologist or by you as appropriate and must comply with normal MRP and FRP Plus rules.

If you do not obtain your oncology medicine, as noted above, from a DSP, a 30% out-of-network co-payment will be applied.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

What if I need an additional supply of chronic medicine due to extended travel requirements?

Only Mediscor is permitted to approve an extended supply of chronic medication. Should you be travelling for an extended period outside RSA, a further supply of chronic medication may be authorised and obtained (four months maximum), following the procedure below:

- The member is required to obtain an application form for extended supply of chronic medicine from Mediscor [ChroniLine®](#) by calling 086 011 9553 or via e-mail from advancesupply@mediscor.co.za;
- The completed form must be returned to Mediscor at advancesupply@mediscor.co.za with the appropriate travel documentation attached as proof of travel outside the country;
- Once approved, Mediscor will send an e-mail or fax with the approved medicines listed as well as the date the DSP can submit the claim.

What else do I need to be aware of, regarding chronic medicines?

All chronic medicine prescriptions are only valid for a maximum period of six months from the date of issue.

Members must obtain a new prescription before this period expires.

Homeopathic medicines do not qualify for chronic medicine benefits.

May a pharmacist change the medication on my prescription to comply with the formulary requirements?

A pharmacist may not substitute a medicine that falls outside of the Society's formulary with a therapeutic equivalent product. To obtain a medicine that falls within the Society's formulary, you will have to obtain a new prescription from your treating doctor. Your treating doctor may call the [ChroniLine®](#) to ask what medicine falls within the formulary.

Alternatively the formularies are also available on www.mediscor.co.za/search-client-medicine-formulary.

If a generic equivalent exists for the medication as prescribed by your doctor, the pharmacist is obliged to suggest that this be replaced with a less expensive generic equivalent.

A pharmacist may only substitute medicine prescribed with a generic equivalent medicine (MRP) but may not substitute the medication with a medicine (therapeutic equivalent) that falls within the Society's formulary (FRP Plus).

How can I obtain acute medicine?

You can obtain your acute medicine from any registered pharmacy, but the Society has an agreement with its DSPs to ensure that the agreed Society rate is charged that would not result in an additional co-payment above the 30% standard acute medicine co-payment. If you live in the vicinity of any Dis-Chem Pharmacy, Lime Acres Pharmacy, Cullinan Health & Home Pharmacy, or the Namaqualand Pharmacy in Springbok, you may collect your acute medicine from these pharmacies or directly 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. If you do not obtain your acute medicine at a DSP, you could have a higher than 30% co-payment based on their dispensing fee structure. The DSP charges a negotiated fee and the Society is only liable to pay to this level as a maximum. Any higher professional fees charged will be levied as a co-payment in addition to the normal 30% co-payment due for acute medicines in terms of the Rules of the Society.

How do I register my HIV status and/or medication?

Aid for AIDS (AfA) is responsible for the registration and approval of all HIV conditions and medication for Society members who are HIV positive.

- The provider / member is required to obtain an application form from the Society via e-mail from HIV@dbbs.co.za or the Society website www.dbbs.co.za;
- The completed form must be returned to the Society at HIV@dbbs.co.za with the required supporting documentation attached;
- Once approved, AfA will contact the provider and member directly.



BENEFITS

Day-to-day Benefits

In this section

- What day-to-day benefits are covered by the Society?
- What happens to “unused” portions of benefit limits from the risk pool?

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

In addition to the major medical benefits described in Sections 3 to 6 above, the Society offers a variety of day-to-day benefits.

Typically these benefits include (but are not limited to) doctors’ consultations, x-rays, dentist visits and associated treatment, medicines and optometry benefits.

What happens to “unused” portions of benefit limits from the risk pool?

The Society is a traditional medical scheme where all members’ contributions are pooled together in a single risk pool from which benefits are paid. 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.



BENEFITS

Benefit details for 2020

In this section

- Important notes
- Area of Operation
- Prescribed Minimum Benefits
- Consultations (out-of-hospital)
- Oncology
- Diagnostic testing
- Medicines
- Dental
- Optometry
- Medical equipment
- Care not in-hospital
- In-hospital
- Emergency transport
- Other
- What benefits are excluded by the Society?
- To what extent are benefits limited by the Society?

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefit details for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

Important notes

The Society's financial year is from 1 January to 31 December. Unless otherwise specified, the benefits described in this guide apply to this annual period. Benefits are not transferable from one financial year to another, from one category to another, or from one beneficiary to another.

Waiting periods and late joiner penalties may apply to new members. For more information in this regard, please refer to page 69-70 for a summary of the applicable Rules.

Area of Operation

Cover for benefits as outlined in the benefit table starting on the next page only applies within RSA (Area of Operation), except for the following instances where coverage will be provided in Botswana and Namibia:

- Benefits will be extended to members and their dependants in Botswana or Namibia during the employment of such Members by the Employer or an Associated Employer in either of those countries; and
- Members or dependants who enjoyed benefits in respect of relevant health services rendered in Botswana or Namibia will, on becoming pensioner members, continue to enjoy such benefits for as long as they



remain permanent residents of the country in which they were receiving benefits at the time when they became pensioners as provided for in Rule 6.2, or became eligible for membership as provided for in Rule 6.3.

Members should note that no benefits may be claimed by members who reside in RSA whilst they are outside the country, even in Namibia and Botswana. If you travel to foreign countries for work, your Employer should be contacted regarding cover and if you travel on holiday outside RSA you should obtain your own private medical travel insurance.

The benefits listed below only apply to the Society's Area of Operation as defined above.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
 PRESCRIBED MINIMUM BENEFITS	
1. Statutory PMBs	• Benefit is diagnosis, treatment and care costs of the prescribed treatment. • Benefits are subject to the provisions set out in paragraph 2 of Annexure B of the Rules and shall, insofar as may be applicable, override any restrictions or limitations imposed in respect of benefits set out below. • Notwithstanding any provisions to the contrary in this schedule, the Society will fund: - diagnosis, treatment and care costs of the PMBs subject to PMB regulations, if those services are obtained from a DSP; or - the relevant SRPL for the diagnosis, treatment and care costs of the PMBs if a beneficiary voluntarily accesses PMBs via a non-DSP, subject to PMB regulations; or - the cost for involuntary use of a non-DSP, subject to PMB regulations. • When annual limits are specified in this schedule, the limit will first be utilised for the payment of the relevant claims, and thereafter continued funding will apply for PMB claims only, subject to PMB regulations. • Diagnosis costs are only regarded as a PMB if the result of the diagnostic investigations confirms a PMB diagnosis. • In terms of the PMB regulations, protocols and treatment plans may be applied.
 CONSULTATIONS (OUT-OF-HOSPITAL)	
2. General Practitioners (GPs), Specialists and registered Homeopaths	• Benefit is paid at 90% of Society Reference Price List (SRPL) rate. • Combined GP, specialist and homeopathic limit of 15 consultations per beneficiary. • For elective non-emergency after hours consultations, the benefit shall be limited to the SRPL rate for a normal consultation. See page 77 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.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
3. General Practitioner and Specialist in-rooms procedures	• Benefit is paid at SRPL rate. • The following in-rooms procedures must be pre-authorised by the Society's Managed-care department and will be reimbursed at the Scheme Rate: - Gastroscopy, Colonoscopy, Vasectomy, Circumcision and Intravitreal Injection • The in-rooms procedure costs are unlimited but subject to the above 15 consultations limit per beneficiary.
4. Nursing Practitioner	• Benefit is paid at SRPL rate. • Unlimited.
 ONCOLOGY	
5. Treatment in and out of hospital	• Benefit is according to the ICON Advanced Option. • Benefit is limited to R275 360 per beneficiary. • In-hospital treatment – ICON protocols apply and pre-authorisation is required from the hospital pre-authorisation department. • Out-of-hospital treatment – ICON protocols apply and pre-authorisation is required from Mediscor and the Society's Managed-care department. • Should an ICON provider not be used, the consultation benefit will be limited to 75% 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.
6. PET and related CT planning scans	• Benefit is paid at SRPL rate. • Accrues to Oncology benefit limit. • Subject to ICON protocols and must be pre-authorised by the Society's Managed-care department.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
 DIAGNOSTIC TESTING	
7. Pathology	- Benefit is paid at 90% of SRPL rate, out of hospital. - Unlimited, but subject to request by a medical practitioner.
8. Radiology	- Benefit is paid at 90% of SRPL rate, out of hospital. - Unlimited, but subject to request by a medical practitioner.
9. CT and MRI Scans <i>(In- and out-of-Hospital)</i>	- Benefit is paid at SRPL rate. - Limited to 3 scans per beneficiary per year. - Subject to managed care protocols and pre-authorisation from the hospital pre-authorisation department.
10. Bone density scans	- Benefit is paid at 90% of SRPL rate, out of hospital. - No benefit in-hospital.
 MEDICINES	
11. Chronic medicine <i>(CDL PMB and listed non-CDL chronic)</i> (See pages 35-36)	- Benefit is paid at the negotiated DSP rate. - Benefit is limited to R37 780 for CDL and non-CDLs (cumulative) but remains unlimited for all PMBs once the chronic medicine limit is reached. - If a non-DSP (any supplier not on the DSP list) is voluntarily used, benefit will be 70% of the MRP or 70% of the FRP, whichever is less. - Subject to Mediscor approval for all chronic conditions. - Medicines used for the treatment of ADHD will only be funded from the chronic medicine benefit until the end of the year in which the beneficiary turns 18. Motivation by a psychiatrist will be considered by Mediscor, subject to their protocol, for chronic medicine benefit authorisation requests after the 18th birthday. Note: <i>The overall cumulative benefit limit for both CDL PMB and listed non-CDL chronic medicine is R37 780 per beneficiary per year. If this limit is reached before year-end, the CDL PMB chronic 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.</i> - The MRP will apply where a generic medicine exists and the additional cost of any medication obtained voluntarily at a value above this reference price will be the member's liability. - See page 35 for more detail.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
12. Acute medicine	- Benefit is paid at 70% of the negotiated DSP rate, limited to R4 540 per beneficiary per year. - Includes prescribed homeopathic medicine, contraceptive preparations and devices (pre-authorisation required for Mirena® device). - Benefit for self-medication (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 R4 540 per beneficiary. - MRP will apply and where a generic medicine exists and a beneficiary elects to receive the original medicine, the value above the reference price will be the member's liability. - See page 40 for more detail.
 DENTAL	
13. Conservative dentistry	- Benefit is paid at SRPL rate. - Limited to R3 970 per beneficiary with a sub-limit of 1 check-up and scale and polish every 6 months. - Includes preventative and diagnostic consultations, cleaning, fillings, extractions and x-rays. - Managed care protocols apply and pre-authorisation is required in respect of elective procedures where general anaesthesia is required for dentistry on children under the age of nine (limited to one admission per year), the 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.
14. Specialised dentistry	- Benefit is paid at SRPL rate. - Limited to R6 580 per beneficiary. - Includes crowns, dentures, bridges, implants and periodontal treatment. - Managed care protocols apply and where hospitalisation is required contact the Society's hospital pre-authorisation department for authorisation.
15. Orthodontic treatment	- Benefit is paid at 75% of SRPL rate. - Limited to R24 000 per beneficiary per lifetime. - Benefits are not provided for treatment starting after a beneficiary's 18th birthday. - Pre-authorisation is required from the Society's Claims department.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
OPTOMETRY 16. Composite consultation (Including Refraction, Tonometry, Visual Field screening, Biometrics readings and Authenticate IT) Frame and Lens Enhancements Lenses a. Single vision or b. Bifocal or c. Multifocal Contact Lenses Hard Contact Lenses	- Benefit is the Preferred Provider Negotiators (PPN) agreed tariffs. - The benefit applies over a two-year cycle (new cycle commenced on 1 January 2020) for all beneficiaries and is subject to annual availability. - Benefits are limited to DSP tariffs when consulting an out-of-network provider. - Composite consultation limit per 2-year cycle to a maximum of R675 at a PPN provider and R330 at a Non-PPN provider. - Composite consultation includes: Refraction, Tonometry and Visual Fields tests. - The PPN network consists of approximately 75% 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 550 for a PPN Network provider and R1 200 for a non-Network provider This component of the optical benefit can be used to purchase a frame or lens enhancements (tints and coatings), or a combination of both. 2. One pair of lenses a. Single vision – R370 OR b. Bifocal - R840 OR c. Multifocal - R1 490 OR 1. 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. Fundus Photography: R150 - Only payable by the Society in the event of positive pathology Optical Coherent Tomography (OCT): R255 – Only payable by the Society in the event of positive pathology

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
17. Cataract removal	• Benefit is the cost as approved by the Society. • Subject to pre-authorisation and managed care protocols. • The Society will pay for one post-operative cataract consultation per year. • In the event that 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 are to be providers of 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.
18. Intra-ocular lenses	• Benefit is the cost as approved by the Society, limited to single vision lenses and to a maximum of R2 330 per lens per lifetime. • Managed care protocols apply and pre-authorisation is required from the hospital pre-authorisation department.
19. Refractive surgery	• Benefit for hospital and associated provider costs is 50% of Scheme Rate (if pre-authorised and Network Hospital is used, or done in rooms) or 50% of SRPL rate (if pre-authorised and 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.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
 MEDICAL EQUIPMENT	
20. Colostomy bags and catheters	- Benefit is paid at 90% of the cost as approved by the Society. - Limited to R20 860 per beneficiary. - Mediscor protocols apply and pre-authorisation is required from Mediscor.
21. Aids and appliances	- Benefit is paid at 50% of the cost as approved by the Society. - Limited to R7 870 per beneficiary. - Includes, but is not limited to: insulin pumps, continuous glucose monitoring (CGM) devices including test strips, CPAP machines, orthopedic boots, surgical collars, external breast 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 for medical equipment are included in the limit. - Managed care protocols apply and pre-authorisation is required from the Society's Managed-care department.
22. Continuous Oxygen Supply machine rental and/or oxygen	- Benefit is paid at cost as approved by the Society. - Limited to R19 680 per beneficiary. - Portable Oxygen Concentrator subject to Society approval up to the annual limit. - Managed care protocols apply and pre-authorisation is required from the Society's Managed-care department.
23. Artificial limbs <i>(including prosthetic eyes)</i>	- Benefit is paid at 90% of the cost as approved by the Society. - Limited to R51 160 per beneficiary per five-year cycle from date of first supply. - Managed care protocols apply and pre-authorisation is required from the Society's Managed-care department. - No benefit is payable in respect of repairs to artificial limbs. - Where a rolling five-year benefit limit is applicable, the benefit limit due will remain fixed at the benefit limit that applied at the time of initial utilisation of the benefit. The benefit limit will only increase to the increased benefit limit in place at the time of the commencement of the next rolling five-year benefit cycle.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
24. Hearing aids	• Benefit is paid at 90% of the cost as approved by the Society. • Limited to R19 020 per beneficiary per five-year cycle from date of last supply. • Managed care protocols apply and pre-authorisation is required from the Society's Managed-care department. • No benefit is payable in respect of hearing aid repairs or batteries. • Where a rolling five-year benefit limit is applicable, the benefit limit due will remain fixed at the benefit limit that applied at the time of initial utilisation of the benefit. The benefit limit will only increase at the beginning of the next rolling five-year benefit cycle.
25. Wheelchairs	• Benefit is paid at 90% of the cost as approved by the Society. • Limited to R10 450 per beneficiary per rolling five-year cycle from date of last supply. • Quadriplegics and Paraplegics ONLY: limited to R30 100 per rolling five-year cycle from date of last supply. • Managed care protocols apply and pre-authorisation is required from the Society's Managed-care department. • No benefit for motorised carts / tricycles other than motorised wheelchairs in appropriate quadriplegic cases. • No benefit for repairs to any wheelchairs. • Where a rolling five-year benefit limit is applicable, the benefit limit due will remain fixed at the benefit limit that applied at the time of initial utilisation of the benefit. The benefit limit will only increase at the beginning of the next rolling five-year benefit cycle.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
 CARE NOT IN-HOSPITAL	
26. Audiology, Chiropody, Podiatry, Acupuncture, Dietician services, Occupational and Speech Therapy	• Benefit is paid at 90% of SRPL rate. • Combined limit of R3 280 per beneficiary.
27. Physiotherapy including Biokinetics and Chiropractic Services	• Benefit is paid at 90% of SRPL rate. • Combined limit of R7 320 per beneficiary.
28. Private Nursing, Hospice and Wound Care	• Benefit is paid at 90% of SRPL rate. • Limited to R10 500 per beneficiary. • Pre-authorisation is required from the Society's Managed-care department and the provider must have a registered practice number.
29. Home confinement/ Natural birth delivery	• Benefit is paid at SRPL rate. • Limited to the in-hospital maternity benefit costs. • Subject to pre-authorisation and managed care protocols.
30. Mental health	• Benefit is paid at 90% of SRPL rate. • Limited to R13 770 per beneficiary.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
 IN-HOSPITAL	
31. Hospitalisation <i>(Including Day Cases, Fixed Fee Cases for Cataracts, In-rooms procedures in lieu of hospitalisation and alternative facilities)</i>	• Benefit is the Negotiated Rate where a Network Hospital has been authorised. • Subject to pre-authorisation and managed care protocols in a facility and manner which the Society deems appropriate. • Negotiated Rate applies to DSP Network Hospital authorisations, day clinics, fixed-fee cataract procedures and sub-acute facilities and Scheme Rate applies to all service providers providing their services at Network Hospitals. • The SRPL rate applies to all voluntary admissions to a non-Network Hospital and for facilities not deemed appropriate. • Pre-authorisation is required from the hospital pre-authorisation department at least 5 working days prior to admission. • A co-payment of R1 500 per procedure will apply to all Colonoscopies, Gastrosopies, Circumcisions, Vasectomies and Intravitreal Injections authorised to take place in-hospital. - Where two or more of the above procedures are performed simultaneously in-hospital, only one co-payment will be applied. - No co-payment will be applied to the above procedures if pre-authorised and done in rooms out of hospital. • The Society in its discretion may waive any co-payment in respect of treatment and procedures associated with an approved hospital admission. • 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 (R37 650), Laparoscopic Unilateral Inguinal Hernia (R29 360), Laparoscopic Incisional/Ventral Hernia (R46 690). RALP (Robotic assisted laparoscopic procedure) capped overall at R138 050 being made up of the capped fee for the hospital procedure only, at R87 850, and this includes the anaesthetic time limited to a maximum of to 3 hours. All the associated provider costs are capped at a combined total of R50 200 for the RALP.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
32. 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. - Subject to managed care protocols and limits where applicable.
33. Maxillofacial and oral surgery	- Benefit for hospital and associated provider costs is paid at Scheme Rate (if pre-authorised and Network Hospital is used, or done in rooms) or SRPL rate (if pre-authorised and non-Network Hospital is used). - Pre-authorisation is required from hospital pre-authorisation department and managed care protocols will apply. - This excludes surgery in preparation for Osseo-integrated implants and Orthognathic surgery.
34. Blood transfusions	- Benefit is paid at SRPL rate. - Unlimited.
35. Psychiatric hospitalisation Alcohol and drug dependency in-hospital rehabilitation	- Limited to 21 days per beneficiary per year provided that the treatment of PMB conditions is limited as per Annexure A of the Regulations. - Benefit is paid at Negotiated Rate (if pre-authorised and Network Hospital or registered mental health hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). - Limited to 24 days per beneficiary per year provided that the treatment of PMB conditions are limited as per Annexure A of the Regulations. - Benefit is paid at Negotiated Rate (if pre-authorised and Network Hospital or Rehabilitation hospital is used), or SRPL rate (if pre-authorised and 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. - Pre-authorisation is required from the hospital pre-authorisation department and managed care protocols will apply.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
36. Maternity	• Benefit is Scheme Rate (if pre-authorised and Network Hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). • Subject to pre-authorisation and managed care protocols. • Limited to 2 days hospitalisation for normal delivery and 3 days for hospitalisation for a caesarean delivery.
37. Internal prosthesis <i>(such as bone cement, cages, plates, screws, stents and pacemakers, etc.)</i>	• Benefit is paid at the cost as approved by the Society. • Limited to an overall benefit of R48 540 per beneficiary (inclusive of bone cement, cages, screws, plates, coronary and vascular stents, pacemakers, aortic and valve replacements). • Managed care protocols will apply and pre-authorisation is required from the hospital pre-authorisation department. • The overall annual limit is cumulative for all the sub-limits below: - Joint replacements – R48 540; - Spinal prosthesis – R48 540; - Coronary and vascular stents, pacemakers, aortic and mitral valve replacements – R48 540; and - Mesh (Gortex slings and Permacol®) – R13 850
38. Cochlear implants	• Benefit is paid at SRPL rate. • Managed care protocols will apply and pre-authorisation is required from the hospital pre-authorisation department.
39. Hospital medicines	• Benefit is Single Exit Price (SEP). • TTO medicine (take home medicine) up to a maximum of 7 days' supply.
40. Physiotherapy	• Benefit is paid at Scheme Rate (if pre-authorised and Network Hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). • Subject to pre-authorisation and managed care protocols.

BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
41. Occupational, Speech Therapy and Dietician	- Benefit is paid at Scheme Rate (if pre-authorised and Network Hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). - Subject to pre-authorisation and managed care protocols.
42. Pathology	- Benefit is paid at Scheme Rate (if pre-authorised and Network Hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). - Subject to a request by a medical practitioner.
43. Radiology	- Benefit is paid at SRPL rate. - Subject to a request by a medical practitioner. - Pre-authorisation is required from the hospital pre-authorisation department for all MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans. - Limited to 3 scans per year in and out of hospital. - No benefit for Bone Density scans in hospital.
 EMERGENCY TRANSPORT	
44. Emergency road and air transport	- Benefit is paid at cost for emergency transport to hospital and for inter-hospital transfers, if pre-authorised by ER24. - ER24 is the DSP for all emergency and ambulance services. - No benefit for use of any other unauthorised ambulance services or when declined by ER24. - Coverage only in RSA, Lesotho and Swaziland and limited to qualifying residents in Botswana and Namibia subject to conditions as outlined on page 29. - Although members are covered for emergency evacuation within Lesotho and Swaziland, no hospital or other benefits apply in these countries.



BENEFIT DESCRIPTION	NOTES RE EXTENT OF BENEFIT/ ANNUAL LIMIT/ CONDITIONS
+ OTHER	
45. Dialysis <i>(applicable only to PMB confirmed cases)</i>	- Benefit is paid at Scheme Rate (if pre-authorised and Network Hospital is used or done out of hospital, or SRPL rate (if pre-authorised and non-Network Hospital is used). - Managed care protocols will apply and pre-authorisation required from the Society's Managed-care department.
46. Organ transplants <i>(applicable only to PMB confirmed cases)</i>	- Benefit is paid at Scheme Rate (if pre-authorised and Network Hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). - Managed care protocols will apply and pre-authorisation required from the hospital pre-authorisation department.
47. Corneal transplants	- Benefit is paid at Scheme Rate (if pre-authorised and Network Hospital is used), or SRPL rate (if pre-authorised and non-Network Hospital is used). - Graft benefit limited to R11 010 per beneficiary. - Harvesting cost limited to a maximum of R14 320. - Managed care protocols will apply and pre-authorisation required from the hospital pre-authorisation department.

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:
 - a. any medicine not registered by the Medicines Control Council or similar authority (except for Homeopathic Medicines); or
 - b. 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:

- a. Pre-natal vitamins; and
- b. 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 any telephonic consultations.
20. Expenses relating to accommodation and nursing 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.
21. Expenses relating to any contact lens preparations.
22. Expenses relating to all non-prescription sunglasses.
23. Expenses relating to lost or damaged devices, apparatus, spectacles or contact lenses.
24. Expenses relating to sleep therapy.
25. 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.

26. Expenses incurred without a pre-authorisation as required by the rules.

27. Expenses relating to:

- a. 3D and 4D gestational sonars
- b. 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.
- c. Artificial Discs unless used in the treatment of a PMB condition at a PMB level of care.
- d. 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.
- e. Motorised carts/tricycles, other than motorised wheelchairs in appropriate cases.

f. 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.

g. Orthodontic treatment of beneficiaries older than 18 years.

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

i. Vasovasostomy

28. Expenses relating to the following services unless authorised by the Society:

a. Genetic or Biomarker tests.

b. Oncotype tests.

c. Gynaecomastia and Mammary surgery. The only exception will be for PMB and PMB related conditions.

d. Kyphoplasty.

29. 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:

- a. The treatment is required to restore the normal function of an affected limb, organ or system;
- b. 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;
- c. The treatment is not rendered for the convenience of the relevant beneficiary or service provider;
- d. Outcome studies are available and acceptable to the Society; and
- e. 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 taking into account 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.

- 30. 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.
- 31. Expenses arising from the treatment of obesity, for example, but not limited to Bariatric surgery.
- 32. Expenses for healthcare services rendered during any waiting periods applied.
- 33. Expenses for healthcare services that do not meet the Society's clinical protocols.
- 34. 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?

- 1. 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.
- 2. Any benefits obtained in terms of PMBs shall be offset against any other applicable benefit limit available, at a facility the Society deems appropriate, thereafter paid unlimited.
- 3. 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.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefit details for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals



More about the Society

In this section

- Who governs the Society?

Who governs the Society?

The Society is governed by a Board of Trustees and the Trustees elect the Chairman and Vice Chairman of the Board from within their ranks. The Board is made up of eight members, of which four are Employer-appointed Trustees and four are member-elected Trustees. The current member-elected Trustees began their term of office on 14 May 2015. The next member-elected Trustee election process will start towards the end of 2019 with the newly elected Trustees taking office in May 2020.

Employer-appointed Trustees also serve a term of office of five years and will serve until May 2020:

- Colin Blanckenberg (Chairman)
- Wayne Smerdon (Vice-Chairman)
- Zahir Astrie
- Craig Coltman

Member-elected Trustees (to serve until May 2020):

- Ali Erasmus
- Huck Endersby
- Roger Ketley

The Society and the Board of Trustees maintain a firm focus on upholding the highest standards of corporate governance and proactively monitor and manage risks in terms of a formal risk management policy and process.

Good corporate governance requires continuous review for the relevance, effectiveness and compliance of processes, systems and documents. To this end the Society maintains its focus on continuous business improvement. The Board of Trustees receives timely, accurate and relevant reporting and other information to enable the Trustees to fulfil their duties.

The following Board Committees assist the Board of Trustees in carrying out its duties and operate in accordance with their written Terms of Reference that govern each Board Committee’s membership, authority and duties:

- Audit and Risk Committee
- Benefit Review Committee
- Communication and Education Committee
- Investment Committee
- Remuneration Committee



All about membership

In this section

- Who qualifies to be a member?
- How do I become a member of the Society?
- 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 terminate?
- Under what circumstances can the Society terminate my membership?
- Under what circumstances can I terminate my membership or de-register a dependant?
- What documentation will I receive if I terminate my membership with the Society?

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

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 the dependant of his 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-retrenchment 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.

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

Dependant

- 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 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.

Child

- 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 child

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

How do I become a member of the Society?

On joining one of the De Beers Group of Companies (the Employer) you are required to join the De Beers Benefit Society. Should you have been a member of another medical aid prior to joining the Society, you will need to provide the

Society with a copy of the membership certificate obtained from your previous medical aid(s).

The Company's HR Department will supply you with the relevant forms for completion in order to become a member.

What waiting periods apply to new members and dependants?

Provided that no waiting period shall be imposed on a person in respect of whom an application is made for membership or registration as a dependant within 30 days after the date on which the person first becomes eligible to be registered as a member or dependant, the following shall apply:

A general three-month waiting period may be imposed by the Society on a beneficiary under specific circumstances and no claims will be paid in respect of the registered beneficiary during this period. In cases where a condition-specific waiting period of 12 months has been imposed, the beneficiary is not entitled to claim any benefits related to the specific condition in question for a period of 12 months.

The Society may impose upon a person in respect of whom an application is made for membership or registration as

a dependant and who was not a beneficiary of a medical scheme during the period of 90 days preceding the date of application –

- a general waiting period of up to three months; and
- a condition-specific waiting period of up to 12 months.

These waiting periods shall also apply in respect of any treatment or diagnostic procedures covered by the PMBs. The Society may impose upon any person in respect of whom an application is made for membership or registration as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application –

- a condition specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the PMBs; and
- where the previous medical scheme had imposed a general or condition specific waiting period, and such waiting period had not expired at the time of termination, a general or condition specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

The Society may impose upon any person in respect of whom an application is made for membership or registration as a dependant and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating more than 90 days immediately prior to the date of application, a general waiting period of up to three months, except in respect of any treatment or diagnostic procedures covered within the PMBs.

No waiting periods shall be imposed on:

- a person in respect of whom an application is made for membership or registration as a dependant, who was previously a beneficiary of a medical scheme and whose membership with such medical scheme terminated less than 90 days immediately prior to the date of application, where the change of membership is required as a result of:
 - a change of employment;
 - an Employer changing or terminating the medical scheme of its employees and a transfer of membership occurs at the beginning of the Society's financial year, provided that reasonable written notice of such change of membership was given to the Society;

- a child born during the period of membership when registered from date of birth.

What if a beneficiary has not been a member of a medical aid 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 aid (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 aid member since attaining the age of 35 years and is calculated as a percentage of the contribution as shown in the table below.

PENALTY BANDS	MAXIMUM PENALTY
1 – 4 years	0.05 x contribution
5 – 14 years	0.25 x contribution
15 – 24 years	0.5 x contribution
25 + years	0.75 x contribution



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 terminate?

Your membership of the Society will terminate should you resign from the employment of the Employer. A member who ceases to be an employee of the Employer during a calendar month shall be entitled to retain his membership to the last day of such calendar month. A member who is retrenched from the service of the 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;
- the Society may terminate the membership of such member if he secures permanent employment with any employer other than De Beers, entitling him to membership of another medical scheme by virtue of such permanent employment; and

- such members will be responsible for payment of the full contributions (of him/herself and any additional 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.



Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

Under what circumstances can the Society terminate my membership?

Contributions must be paid in advance, by no later than the 10th of every month. The Society may terminate your membership if you have outstanding contributions and/ or debt to the Society. As such, the Society has the right to suspend all benefit payments, following 21 days’ notice, in respect of you and your dependants after the date on which your contribution or debt was due. The Society will first provide you with written notice (sent by registered post) of the debt owing. Written notices will be deemed to have been received by you on the 7th day after posting. This is why you need to ensure that your address with the Society is correct. If you do not notify the Society of a change of address and it happens that your contributions are late, you will not receive the notice to pay and your membership will be terminated permanently.

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

A member who is not required in terms of his/her conditions of employment to be a member, may terminate his/her membership of the Society on one months’ prior written

notice to the Society. His/her membership of the Society and all his/her dependants’ rights to benefits shall cease after the last day of the calendar month during which such notice expires.

A member shall be entitled to de-register a dependant on giving 30 days prior written notice to the Society.

A member remains liable for full contributions for the whole notice period even in instances where he/she requests immediate termination of membership.

What documentation will I receive if I terminate my membership with the Society?

On termination of membership or on de-registration of a dependant, the Society shall, within 30 days of such termination or at any time at the request of any former member or dependant, provide the member or dependant or medical scheme to which such member or dependant applies for membership, with a certificate stating the period of cover by the Society, whether he/she was covered as a member or as a dependant and whether or not a late joiner penalty was imposed by the Society.



Claiming and co-payments

In this section

- How much time do I have to submit a claim?
- How can I ensure that my GP and other health-care service providers are paid timeously?

Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

How much time do I have to submit a claim?

Please submit your claims as soon as possible, but no later than **4 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.

How can I ensure that my GP and other health-care service providers are paid timeously?

In the interest of efficiency and reducing the risk of fraud, the Society's policy is to pay all service providers only via electronic funds transfer (EFT) and claims are processed and paid within a maximum period of 21 calendar days of receipt. In view of this, members are encouraged to advise

their service providers accordingly and to ensure that the Society is provided with their banking details to ensure that they receive their payments timeously.

In cases where members settle service provider accounts directly, claims may be submitted to the Society via e-mail to benefitpost@dbbs.co.za or fax 086 636 8923. Such claims should include the original invoice, which indicates the member and beneficiary's detail, ICD 10 code, the tariff and the amount per tariff claimed, together with a receipt confirming payment. Such claims will be processed and refunded in terms of the Society's Rules and benefits via the member's payroll/pension.





Frequently asked questions

In this section

- How can I avoid co-payments for after-hours/unscheduled doctors' consultations?
- What do I do if I suspect that someone is defrauding the Society?
- What is the role of the Society's call centre?
- What if I have a complaint against the Society or any of the Society's Third-Party Providers (PPSHA, Mediscor, PPN, Dis-chem, ICON)?
- What if I have a complaint related to other aspects of the health industry?

How can I avoid co-payments for after-hours/unscheduled doctors' consultations?

Unscheduled or after-hours doctor consultations attract a normal consultation fee (Tariff - 0190) as well as an emergency consultation fee (Tariff – 0147 etc.). The Society will settle the normal consultation fee at the SRPL rate. The additional emergency consultation will not be settled by the Society and the member will need to pay the provider directly.

The member may provide written motivation of circumstances, should it be considered to have been an emergency as defined on page 29, to the Society by emailing benefitpost@dbbs.co.za or faxing to 086 636 8923. Such motivations will be reviewed against prescribed protocols. Members should refer to their next monthly statement for the outcome on such requests.

Remember to check with the receptionist when an “after-hours or unscheduled visit” fee will be charged.

Most doctors (including facilities such as Medicross) charge an after-hours consultation fee for consultations conducted after normal working hours and during weekends. Please also note that, if you phone your doctor during normal working hours and he/she fits you in on that specific day without an official pre-booked appointment, you will be

charged for an unscheduled consultation. Where a service provider (for example, Medicross) charges a facility fee for the use of the group practice and no tariff code can be provided, the Society has no liability for this charge.



Doctor’s house calls will be paid at normal consultation rates unless clinically assessed to be medical emergencies.

What do I do if I suspect that someone is defrauding the Society?

Phone the Society's toll-free Fraud Line on 080 020 4724 or use the anonymous email facility on www.dbbs.co.za (under Fraud).

All calls and emails will be treated confidentially and you will not have to disclose any personal details. Please give as much detail about the suspected instance of fraud as possible to assist in the investigation.

What is the role of the Society's call centre?

As a service oriented organisation, the role of the Society's call centre staff is to provide members and other stakeholders with a professional and friendly service in order to resolve any queries raised. The call centre staff are trained and well versed in terms of the Rules and the benefit

structure, and where they are not able to answer a query immediately, they will take the necessary details and resolve the query within 48 hours. All the Society's calls are recorded for the protection of both the member and the Society and are also used for training purposes where appropriate.

What if I have a complaint against the Society or any of the Society's Third-Party Providers (PPSHA, Mediscor, PPN, Dis-chem, ICON)?

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.



Introduction
Contributions
PMB
Hospital Benefits
Emergency Benefits
Medicine Benefits
Day-to-day Benefits
Benefits for 2020
About the Society
Membership
Claiming
FAQ
Network Hospitals

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

Laying a complaint with the Council for Medical Schemes (CMS) about the Society

Any beneficiary or any person who is aggrieved by the conduct of a medical scheme can submit a complaint to the CMS. It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme (as noted above in the case of the Society) before approaching the CMS for assistance. Complaints can be submitted by any reasonable means such as a letter, fax, e-mail or in person at the CMS office from Mondays to Fridays during 08:00 – 16:30.

Please access the Council's website for the complaint form.

The CMS governs the medical schemes industry and therefore your complaint should be related to your medical scheme.

CMS time limits for dealing with complaints

The CMS aims to provide a transparent, equitable, accessible, expeditious as well as a reasonable and procedurally fair dispute resolution process. The Registrar of the CMS will send a written acknowledgement of a complaint within three working days of its receipt, providing the name, reference

number and contact details of the person who will be dealing with a complaint.

In terms of Section 47 of the Medical Schemes Act 131 of 1998, a written complaint received in relation to any matter provided for in that Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the Registrar’s Office within 30 days. The Registrar’s Office shall analyse the complaint within four days of receiving the complaint from the member, and refer a complaint to a medical scheme for comments.

Upon receipt of the response from the medical scheme, the Registrar’s Office will analyse the response in order to make a decision or ruling. Decisions/rulings will be made within 120 days of the date of referral of a complaint and communicated to the parties.

The Registrar’s Ruling and appeal to Council

Section 49 of the Medical Schemes Act makes provision for any party who is aggrieved by the decision of the Registrar to appeal such a decision. This appeal is at no cost to either of the parties. An appeal must be lodged within 30 days of the date of the decision. The implementation of the decision shall be suspended pending review of the matter by the

Council’s Appeal Committee. The secretariat of the Appeals Committee will inform all parties involved of the date and time of the hearing. This notice should be provided no less than 14 days before the date of the hearing. The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative. The Appeals Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision as they see fit.

The Section 50 appeals process

Any party that is aggrieved by the decision of the Appeals Committee may appeal to the Appeal Board.

The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanations of the grounds of his or her appeal. The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing. Proceedings of the Appeal Board shall be open to the public unless the chairperson decides otherwise. The Appeal Board shall have the powers which the High Court has to summon witnesses, to cause an oath or affirmation to be administered to them, to examine them, and to call for the production of books, documents and objects. The decisions of the Appeal Board are in

writing and a copy thereof shall be furnished to parties.

A prescribed fee of R2 800 is payable by the complainant for Section 50 Appeals.

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.hpcs.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)



13. List of Network Hospitals

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Western Cape				
Mediclinic Cape Gate	Brackenfell	Cnr Tanner Street & Okavango Drive, Brackenfell	021 983 5600	0366714
Mediclinic Cape Town	Oranjezicht	21 Hof Street, Oranjezicht, 8001	021 464 5500	5808995
Mediclinic Constantiaberg	Plumstead	Burnham Road, Plumstead, 7800	021 799 2911	5807999
Mediclinic Worcester	Worcester	67 Fairbairn Street, Worcester, 6850	023 348 1500	5808006
Mediclinic Durbanville	Durbanville	45 Wellington Road, Durbanville, 7550	021 980 2100	5808766
Mediclinic Durbanville Day Clinic	Durbanville	45 Wellington Road, Durbanville, 7550	021 980 2135	0592781
Mediclinic Vergelegen	Somerset West	Main Road, Somerset West, 7130	021 850 9000	5808030
Mediclinic Geneva	George	7 Varing Avenue, Dormehlsdrift, George, 6529	044 803 2000	5709059
Mediclinic George	George	Cnr York Street & Gloucester Avenue, George, 6529	044 803 2000	5807905
Mediclinic Hermanus	Hermanus	Hospital Street, Hermanus, 7200	028 313 0168	5709091
Mediclinic Stellenbosch	Stellenbosch	Cnr Strand & Elsie Du Toit Drive, Stellenbosch, 7600	021 861 2000	5808405
Mediclinic Stellenbosch Day Clinic	Stellenbosch	Cnr Strand & Elsie Du Toit Drive, Stellenbosch, 7600	021 861 2000	0809608
Mediclinic Winelands Orthopaedic Hospital	Stellenbosch	Cnr Rokewood & Saffraan Street, Die Boord, Stellenbosch, 8600	021 861 2000	0819409
Mediclinic Strand	Strand	Altena Road, Strand, 7140	021 854 7663	5709075
Mediclinic Plettenberg Bay	Plettenberg Bay	Muller Street, Plettenberg Bay, 6600	044 501 5100	0283207
Mediclinic Klein Karoo	Oudtshoorn	185 Church Street, Oudtshoorn, 6625	044 272 0111	5808928

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Mediclinic Louis Leipoldt	Bellville	Broadway Road, Bellville, 7530	021 957 6000	5806860
Mediclinic Intercare Sub-Acute Tygervalley	Bellville	43 Old Oak Street, Tygervalley, Bellville, 7536	021 943 9800	0267791
Mediclinic Panorama	Parow	Rothschild Blvd, Panorama, 7506	021 938 2111	5807913
Mediclinic Milnerton	Milnerton	Cnr Racecourse & Koeberg Road, Milnerton, 7441	021 529 9000	5808669
Mediclinic Paarl	Paarl	Berlyn Street, Paarl North, 7646	021 807 8000	5808251
Melomed Gatesville Medical Centre	Athlone	Clinic Road, Gatesville	021 637 8100	5808103
Netcare UCT Private Academic Hospital	Observatory	D 18 New Main Building, Anzio Road, Observatory	021 442 1800	0071730
Mediclinic Intercare Day Hospital Century City	Century City	Building nr. 5, Central Park on Park Lane, Century City, Cape Town	021 879 0100	0597783
Netcare Ceres Private Hospital	Ceres	2 Faure Street	023 316 1304	5709032
Life Knysna Private Hospital	Knysna	Hunters Estate	044 384 1083	5808960
Melomed Mitchells Plain Medical Centre	Mitchells Plain	Symphony Walk, Town Centre	021 392 3126	5807948
Life Bay View Private Hospital	Mossel Bay	Cnr Alhof Drive & Ryk Tulbagh Street	044 691 3718	5808790
Life West Coast Private Hospital	Vredenburg	22 Voortrekker Road	022 719 1030	5808979
Northern Cape				
Lenmed Kathu Private Hospital	Kathu	Frikkie Meyer Way, Kathu, 8446	053 723 3231	0580619
Lenmed Royal Heart Hospital (Cardiac and Oncology Only)	Kimberley	3 Welgevonden Street, Royldene, Kimberley, 8301	053 045 0350	0761761
Mediclinic Gariep	Kimberley	112 McDougal Road, El Toro Park, 8301	053 838 1111	5808049
Mediclinic Upington	Upington	Cnr 4th Avenue & Du Toit Street, Upington, 8801	054 338 8900	5808804

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Gauteng				
Mediclinic Morningside	Morningside	Cnr Rivonia & Hill Road, Morningside, 2057	011 282 5000 /50/52	5807824
Mediclinic Intercare Sub-Acute Sandton	Morningside	200 Rivonia Road, Morningside, 2051	010 880 1600	0724556
Mediclinic Intercare Day Hospital Sandton	Morningside	200 Rivonia Road, Morningside, 2051	010 880 1400	0537756
Mediclinic Wits Donald Gordon Medical Centre	Parktown	21 Eton Road, Parktown, Johannesburg, 2193	011 356 600	5806682
Mediclinic Emfuleni	Vanderbijlpark	6 Jan van Riebeeck Boulevard, Town Centre, Vanderbijlpark, 1911	016 950 8000	5808375
Mediclinic Vereeniging	Vereeniging	Cnr Hofmeyer Ave & Joubert St, Vereeniging, 1939	016 440 5000	5808081
Mediclinic Sandton	Bryanston	Cnr Peter Place & Main Road, Bryanston, 2021	011 709 2000	5805139
Mediclinic Intercare Medfem Fertility Clinic	Bryanston	Cnr Nursery Lane and Peter Place, Brynston	011 463 2244	5709199
Netcare Clinton Hospital	Alberton	62 Clinton Road, New Redruth	011 724 2300	5708877
Netcare Mulbarton Hospital	Alberton	25 True North Road	011 682 4300	5808278
Netcare Union Hospital	Alberton	47 Clinton Road, New Redruth	011 724 2000	5804981
Life Bedford Gardens Private Hospital	Bedfordview	7 Leicester Road	011 677 8500	5808316
Life The Glynnwood Hospital	Benoni	33-35 Harrison Street	011 741 5000	5807743
NHN Sunshine Hospital	Benoni	1522 Soma Street, Actonville	011 420 3000	5808774
Netcare Optiklin Eye Hospital	Benoni	104 Klein Street, Lakefield Ext	011 918 5478	5708923
Netcare Sunward Park Hospital	Boksburg	Cnr Kingfisher Avenue, Aquarius & Bert Lacey Drive	011 897 1600	5808227
Life Dalview Clinic	Brakpan	11 Hendrik Potgieter Road	011 747 0747	5808146

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Life Carstenhof Clinic	Halfway House	21 Dane Road, Glen Austin, Midrand	011 655 5500	5808170
Life Suikerbosrand Clinic	Heidelberg	Cnr H F Verwoerd & Maré Streets	016 342 9200	5808987
Life Wilgeheuwel Hospital	Honeydew	Amplifier Street, Radio Kop Ext 13, Roodepoort	011 796 6500	5808839
Life Brenthurst Clinic	Johannesburg	4 Parklane Road, Parktown	011 647 9000	5803349
Netcare Garden City Hospital	Johannesburg	35 Bartlett Road, Mayfair West	011 495 5000	5805988
NHN Arwyp Medical Centre	Kempton Park	20 Pine Avenue, Kempton Park	011 922 1000	5807891
Netcare Bell Street Hospital	Krugersdorp	Cnr Bell & Shannon Road, Noordheuwel	011 954 1023	5808731
Netcare Krugersdorp Hospital	Krugersdorp	9 Burger Street	011 951 0200	5808111
Lenmed Ahmed Kathrada Private Hospital	Lenasia	K43 Highway Ext 8	087 087 0642	5808324
Life Roseacres Clinic	Primrose	Cnr of Castor & Saint Joseph Streets, Germiston	011 842 7500	5806968
Life Robinson Private Hospital	Randfontein	1 Hospital Road	011 278 8700	5804655
Clinix Tsepo Themba Private Hospital	Soweto	Cnr Bram Fischer & Elias Motswaledi Rd, Dobsonville	011 983 0300	5808782
Life Springs Parkland Hospital	Springs	86 Artemis Road, Pollak Park	011 812 4000	5807034
Life Flora Clinic	Weltevreden Park	William Nicol Street-North, Flora Cliff	011 470 7777	5807883
Pretoria				
Mediclinic Muelmed	Pretoria	577 Pretorius Street, Arcadia, Pretoria, 0083	012 440 0600	5808065
Mediclinic Heart Hospital	Pretoria	551 Park Street, Arcadia, Pretoria, 0083	012 440 0200	5808634
Mediclinic Medforum	Pretoria	412 Francis Baard (formerly Schoeman) Street, Arcadia, Sunnyside, Pretoria, 0002	012 317 6700	5807867

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Mediclinic Legae	Mabopane	8560 Unit M, Off Molefe Makinta (formerly Lucas Mangope) Highway, Mabopane, Pretoria, 0200	012 797 8000	5808499
Mediclinic Kloof	Erasmuskloof	511 Jochemus St, Erasmuskloof Ext 3, Pretoria, 0048	012 367 4000	0120928
Mediclinic Gynaecological Hospital	Sunnyside	132 Celliers Street, Sunnyside, Pretoria, 0002	012 400 8700	5703638
Pretoria Urology Hospital	Hatfield	Cnr Grosvenor & Pretorius Street, Hatfield	012 423 4000	5808847
NHN Pretoria Eye Institute	Arcadia	630 Francis Baard (formerly Schoeman) St, Arcadia	012 427 0000	5808421
Life Groenkloof (<i>Oncology Treatment</i>)	Groenkloof	50 George Storrar Drive, Groenkloof	012 424 3600	5804043
NHN Zuid Afrikaans Hospital (<i>Cardiac only</i>)	Muckleneuck	255 Bourke Street, Muckleneuk, Pretoria, 0002	012 343 0300	5805112
Mediclinic Midstream	Lyttelton	Cnr Midstream Drive and Midstream Hill Boulevard, Midstream Est	012 652 9000	0579068
Mediclinic Intercare Sub-Acute Irene	Centurion	Lower Ground floor, Southdowns Shopping Centre, C/o Nellmapius & John Vorster, Centurion	012 941 2600	0492256
Mediclinic Intercare Day Hospital Irene	Centurion	Lower Ground floor, Southdowns Shopping Centre, C/o Nellmapius & John Vorster, Centurion	012 941 2600	0492264
Mediclinic Intercare Sub-Acute Hazeldean	Pretoria East	Hazeldean Office Park, Silver Lakes Road, Tjiger Vallei Pretoria East	012 941 2600	0472964
Mediclinic Intercare Day Hospital Hazeldean	Pretoria East	Hazeldean Office Park, Silver Lakes Road, Tjiger Vallei Pretoria East	012 880 0700	0472395
Free State				
Mediclinic Bloemfontein	Westdene	Cnr Kellner Street & Parfitt Ave., Westdene, Bloemfontein, 9301	051 404 6666	5808154
Mediclinic Hoogland	Bethlehem	De Leeuw Street, Bethlehem, 9701	058 307 2000	5808707
Mediclinic Welkom	Welkom	Meulen Street, Welkom, 9459	057 916 5555	5808758

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Mediclinic Welkom Medical Centre – Day Clinic	Welkom	5 Lategan Street, St Helena, Welkom, 9459	057 352 2114	0399337
Mediclinic Welkom Medical Centre – Sub-Acute	Welkom	5 Lategan Street, St Helena, Welkom, 9459	057 352 2114	0512532
NHN Horizon Eyecare Centre (<i>Ophthalmology only</i>)	Bloemfontein	54 Pasteur Avenue Hospital Park	051 502 1900	0225681
Life Rosepark Hospital (<i>Oncology Treatment</i>)	Bloemfontein	57 Gustav Avenue, Fichardt park	051 505 5111	5808014
Riemland Hospital	Frankfort	Cnr Collin & Frankfort Street	058 813 2771	5709105
Netcare Kroon Hospital	Kroonstad	North Way	056 215 1881	5808383
Eastern Cape				
Life East London Private Hospital	East London	32 Albany Street	043 722 3128	5808448
Life St Dominic's Hospital	East London	45 St Marks Road, Southernwood	043 707 9000	5808294
Life St James' Hospital	East London	36 St James Road, Southernwood	043 722 9685	5703816
Life Isivivana Private Hospital	Humansdorp	Du Plessis Street	042 200 4250	0168386
Netcare Settlers Hospital	Grahamstown	Milner Street	046 602 5000	5600626
Netcare Port Alfred Hospital	Port Alfred	Southwell Road	046 604 4000	5605210
Life New Mercantile Hospital	Port Elizabeth	Cnr Kempston & Durban Roads, Korsten	041 404 0400	5808626
Life St Georges Hospital	Port Elizabeth	40 Park Drive, Central	041 392 6111	5807972
Life Queenstown Private Hospital	Queenstown	Cnr, Griffith & Ebdon Streets	045 838 4110	5709156
Netcare Cuyler Clinic	Uitenhage	34 Cuyler Street	041 995 9000	5808642
Life St Mary's Private Hospital	Mthatha	30 Durhan Road	047 505 5600	5706408

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
North West				
Mediclinic Brits	Brits	8 Kerk Street, Brits, 0250	012 252 8000	5808723
Mediclinic Potchefstroom	Potchefstroom	66 Meyer Street, Potchefstroom, 2531	018 293 7000	5808057
NHN Fochville Hospital	Fochville	10 3rd Street	018 771 2021	5701856
Life Anncron Clinic	Klerksdorp	Cnr Dr.Yusuf Dadoo & Hartley Streets, Wilkoppies	018 468 1031	5700159
Clinix Victoria Private Hospital	Mafikeng	Victoria Road, Mafikeng	018 397 7300	0223891
Life Peglerae Hospital	Rustenburg	173 Beyers Naude Drive	014 597 7200	5808359
NHN Vryburg Private Hospital	Vryburg	67 Molopo Street	053 928 3000	5808553
Limpopo				
Mediclinic Thabazimbi	Thabazimbi	1 Hospital Street, Thabazimbi, 0380	014 777 2097	5709202
Mediclinic Lephalale	Lephalale	Joe Slovo & Douwater Street, Onverwacht, Ext 16, Lephalale, 0556	014 768 2380	5708125
Mediclinic Limpopo	Polokwane	Cnr Thabo Mbeki & Burger Street, Polokwane, 0699	015 290 3600	5808189
Mediclinic Limpopo Day Clinic	Polokwane	70 Plein Street	015 230 9400	0603120
Mediclinic Tzaneen	Tzaneen	Wolkberg Drive, R71, Tzaneen, 0850	015 306 8500	0132454
Zoutpansberg Private Hospital	Louis Trichardt	47 Joubert Street	015 516 0720	0253871
Netcare Pholoso Hospital (<i>Cardiology only</i>)	Polokwane	Cnr Grobler St & Eland Ave, Savannah, Polokwane	015 296 6500	0603821
NHN St Vincent's Hospital	Warmbaths	Cnr. Kwagga & Meiminger Streets, Bela Bela	014 736 2310	5706548

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Mpumalanga				
Mediclinic Barberton	Barberton	Cnr Sheba & Havelock Street, Barberton, 1300	013 712 4279	5709148
Mediclinic Nelspruit	Nelspruit	1 Louise Street, Sonheuwel, Nelspruit, 1201	013 759 0500	5808340
Mediclinic Secunda	Secunda	Heunis St, Medforum Building, 1st Floor, Secunda	017 631 1772	0540110
Mediclinic Highveld	Secunda	Barney Molokwane Street, Trichardt, 2300	017 638 8000	5807956
Mediclinic Ermelo	Ermelo	25 Melmentz Street, Ermelo, 2356	017 801 2600	5808863
Life Midmed Hospital	Middelburg	Cnr OR Tambo & Joubert Street	013 283 8700	5808243
Life Cosmos Hospital	Witbank	Cnr OR Tambo & Beaty Street	013 653 8000	5807980
KwaZulu-Natal				
Mediclinic Newcastle	Newcastle	Cnr Hospital & Bird Street, Newcastle, 2940	034 317 2990	5808871
Mediclinic Newcastle Day Clinic	Newcastle	Cnr Hospital & Bird Street, Newcastle, 2940	034 317 0000	0767301
Mediclinic Pietermaritzburg	Pietermaritzburg	90 Payn Street, Pietermaritzburg, 3201	033 845 3700	5808073
Mediclinic Howick	Howick	107 Main Street, Howick, 3290	033 330 2456	0122092
Mediclinic Victoria	Tongaat	35 High Street, Tongaat, 4400	032 945 8200	5708567
Lenmed La Verna Private Hospital	Ladysmith	1 Convent Road, Ladysmith, 3370	087 087 2600	5808235
Netcare Kingsway Hospital	Amanzimtoti	607 Kingsway Road	031 904 7000	5808200
Netcare Alberlito Hospital	Ballito Bay	Kirsty Close, Ballito	032 946 6700	0250562
Life Entabeni Hospital	Durban	148 Mazisi Kunene Road, Berea	031 204 1300	5801982
Life Empangeni Garden Clinic	Empangeni	Cnr Ukulu and Biyela Streets	035 902 8000	5708494

HOSPITAL NAME	TOWN	STREET ADDRESS	TEL NUMBER	PRACTICE NUMBER
Netcare Margate Private Hospital	Margate	24 Wartsk Drive	039 312 7300	5808529
Life Mount Edgecombe Hospital	Phoenix	163-5 Redberry Road, Rockford	031 537 4000	5708664
NHN Hibiscus Private Hospital	Port Shepstone	George Street	039 688 9960	5808901
Netcare The Bay Hospital	Richards Bay	6 Krugerrand Road CBD	035 780 6111	5808472
Melomed Richards Bay Cardiac Centre of Excellence <i>(Cardiology only)</i>	Richards Bay	Cnr of N2 & MR496 John Ross Highway	035 791 5300	0721263
Netcare Umhlanga Hospital	Umhlanga	323 Umhlanga Rocks Drive	031 560 5500	5808936
Life Westville Hospital	Westville	7 Spine Road	031 251 6911	5807832
Namibia				
Mediclinic Windhoek	Windhoek	Heliodoor Street	00264 61 433 1000	5808162
Mediclinic Otjiwarongo	Otjiwarongo	Sonn Street, Otjiwarongo	00264 67 303 734	5708826
Mediclinic Swakopmund	Swakopmund	Franziska van Neel Street	00264 64 412 200	5708508
Roman Catholic Hospital	Windhoek	92 Werner Street	00264 61 270 2911	5807735
Botswana				
Life Gaborone Private Hospital	Gaborone	Segoditshane Road	00267 368 5600	9990400
Lenmed Bokamoso Private Hospital	Gaborone	Mmopane village	00267 369 4000	9990903
Orapa Mine Hospital	Orapa	Orapa Mine	00267 297 0691	9990500
Jwaneng Mine Hospital	Botswana	Private Bag 08, Jwaneng	00267 588 4706	9990300

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.

This guide is copyright protected and may not be reproduced in part or whole without the permission of the Trustees of the De Beers Benefit Society.





A registered medical scheme. Registration no. 1068