



2024 MEMBER GUIDE



Contact details

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

FOR MEMBERSHIP, BENEFITS AND CLAIMS QUERIES

De Beers Benefit Society

☎ 053 807 3111

@ benefitpost@dbbs.co.za

📄 053 807 3499

🌐 www.dbbs.co.za

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

✉ PO Box 1922, Kimberley, 8300



FOR PRE-AUTHORISATIONS

To pre-authorise hospital admissions, CT and MRI scans

For SA and Namibia-based members: PPSHA

☎ RSA members: 0800 111 669

☎ Non-RSA members: +27 12 679 4022

@ debeerspreauth@ppsha.co.za

🌐 www.ppsa.co.za

🚶 1262 Heuwel Road, Centurion Central, Centurion, 0157

✉ Private Bag X1031, Lyttelton, 0140

For Botswana-based members only:

☎ 053 807 3111 (Option 6)

@ managedcare@dbbs.co.za

To pre-authorise the following:

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

 053 807 3111 (Option 6)

 managedcare@dbbs.co.za

FOR DISEASE RISK MANAGEMENT (DRM)

 053 807 3111 (option 5)

 DBBSdisease@ppsba.co.za

FOR PHARMACY/COURIER PHARMACY QUERIES

DSP: Dis-Chem Pharmacies and Dis-Chem Direct

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

 Non-RSA members: +27 11 589 2788

 debeers@dischem.co.za

 086 529 0228

 www.dischem.co.za

 Private Bag X21, North Riding, 2162

FOR CHRONIC MEDICINE / STOMA AUTHORISATIONS AND QUERIES

Mediscor Pharmaceutical Benefits Management

 Contact centre: 086 011 3238

 ChroniLine: 086 011 9553

 Non-RSA members: +27 12 674 8000

 Claims enquiries: info@mediscor.co.za

 Chronic authorisation: preauth@mediscor.co.za

 Oncology authorisation: dbbsonco@mediscor.co.za

 Claims enquiries: 012 674 8001

 Chronic authorisation fax: 086 615 1509

 www.mediscor.co.za

 PO Box 8796, Centurion, 0046

TO REPORT SUSPECTED FRAUD

 0800 204 724

FOR OPTOMETRY QUERIES

DSP: Preferred Provider Negotiators (PPN)

- 📞 RSA members: 086 110 3529
- 📞 Non-RSA members: +27 41 065 0650
- @ dbbs@ppn.co.za or claims@ppn.co.za
- 📄 041 586 4184
- 🌐 www.ppn.co.za
- ✉️ PO Box 12450, Centrahil, 6006

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

Download the DBBS Member App for
your specific device.



FOR EMERGENCY TRANSPORT/ ASK A NURSE HELPLINE

DSP: ER24

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

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ABBREVIATIONS / ACRONYMS

ACT	Medical Schemes Act (No 131 of 1998)
CDL	Chronic Disease List
CMS	Council for Medical Schemes
CT	Computed Tomography
CPAP	Continuous Positive Airway Pressure
DSP	Designated Service Provider
DTP	Diagnosis and Treatment Pairs
DRM	Disease Risk Management
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
MCC	Medicines Control Council
MRI	Magnetic Resonance Imaging

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

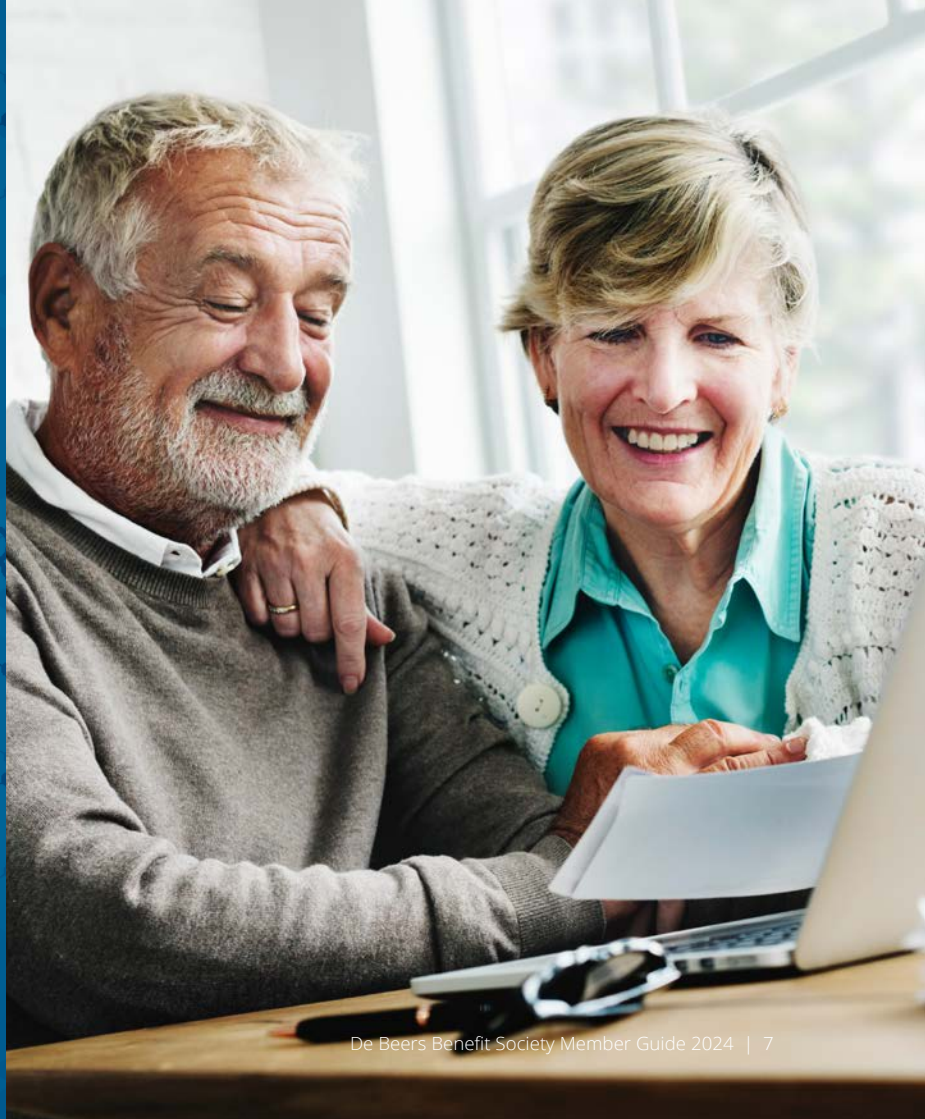
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OVERVIEW

In this section

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

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There for you

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

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

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

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

THE TYPICAL HEALTHCARE JOURNEY



Joins Scheme



Young and healthy;
minimal healthcare
needs



GP and Physio visits,
spectacles, etc.



Road accident or
sports injury



Tonsil surgery or
dental admissions



Child trauma injury



Premature birth



Maternity



Starts relationship;
needs medical cover for
partner



Chronic disease



Dread disease
such as cancer



Chronic 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 and
increased need for
medical care



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 your
medical needs.

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Your benefits in a nutshell

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



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



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



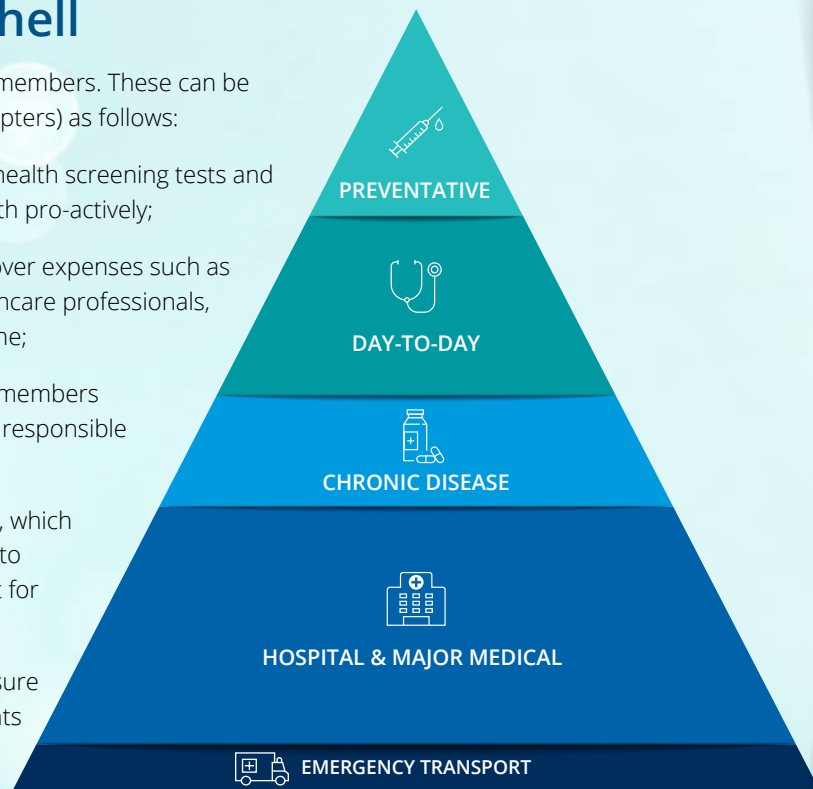
Chronic disease benefits, which help members manage certain chronic conditions in a responsible and cost-effective way;



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



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



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

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

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

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



Maintain a healthy lifestyle, as prevention is always the better option.



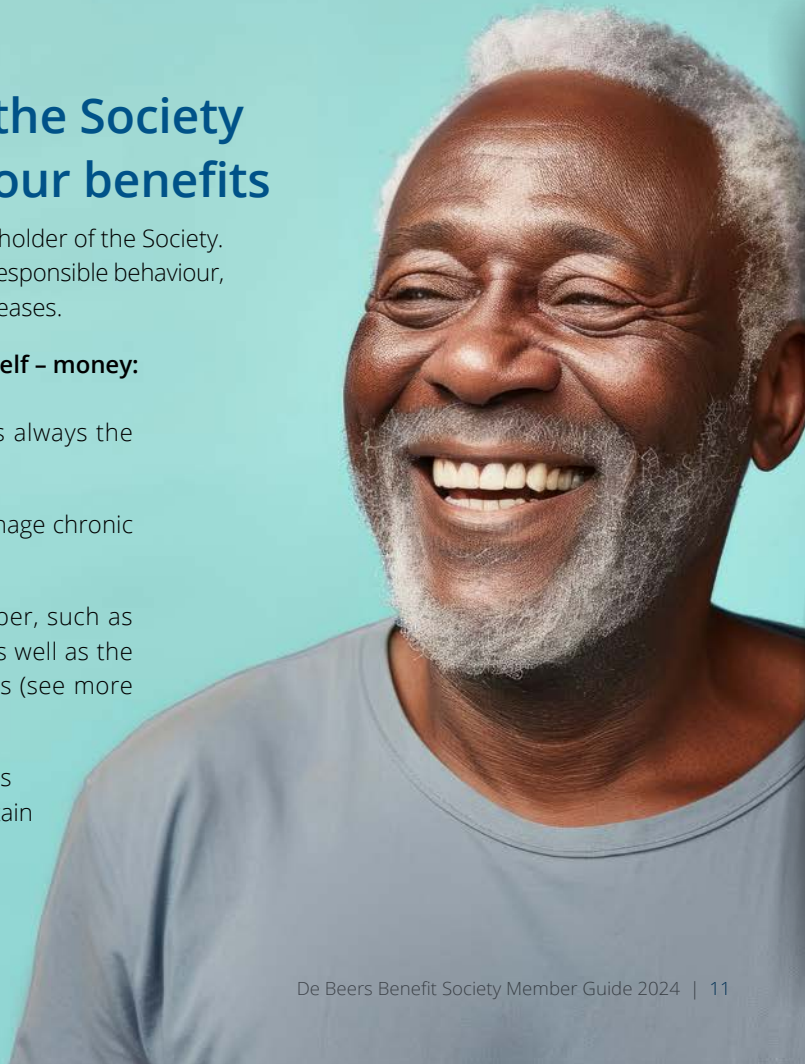
Make healthier choices to avoid or better manage chronic lifestyle-related diseases.



Understand your responsibilities as a member, such as knowing and understanding your benefits, as well as the Society's Rules, processes, and requirements (see more information later in this chapter).



Use the vaccines and screening tests offered as part of your Preventative Benefits to avoid certain illnesses and to identify potential chronic lifestyle diseases early.





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



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

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



Ask for generic medicine whenever possible.



Consider paying in cash and then claiming back to get discounts.



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



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

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

Your responsibilities as a member

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

Specifically, as a member you should:

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



- Retain 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;
- Inform the Society of any changes to a beneficiary's status that may result in the beneficiary no longer satisfying the eligibility conditions of being a dependant, in terms of the Society's Rules;
- If you suspect fraudulent activity in relation to the Society, please report such; and
- Notify the Society of your cell phone number, valid postal and residential address, other contact details and email address and any changes to this information, to ensure that you receive Society-related correspondence and communication material.

Stretch your benefits by knowing how claims are covered

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

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

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

*SRPL rates

Aligned to medical aid industry practice, the Society has its own reference price list, the Society Recommended 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 (DSP) Hospitals for the direct payment of hospital accounts.

***Scheme Rate

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

Where you are covered

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

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

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

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CONTRIBUTIONS

Contributions for 2024

These are the total monthly contributions payable from 1 January 2024.

PER MEMBER / ADULT DEPENDANT	PER CHILD DEPENDANT
R4 546	R1 223

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BENEFITS:

PREVENTATIVE



In this section

- Why should I go for screening tests?
- Which screening tests and vaccines do the Society cover?



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Why should I go for screening tests?

Having screening tests done is one of the most important things you can do for your health. Screenings are medical tests that check for diseases before there are any known symptoms. Screenings can help doctors find diseases early, which can then be easier to treat. Bear in mind, that screening tests are only a guideline, for a more accurate diagnosis of a disease, your doctor may refer you for more extensive blood tests to determine whether you require medication and/or medical treatment.

Which screening tests and vaccines do the Society cover?

The following Preventative Benefits are available to beneficiaries:



HEALTH SCREENING

You will be covered for the following diagnostic tests:

- Blood sugar;
- Blood pressure;

- Cholesterol;
- Bone density scan for beneficiaries over the age of 50 years;
- Measurement of height, weight and waist circumference; and
- Body Mass Index (BMI) calculation.



HIV SCREENING

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

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

WHERE CAN I ACCESS THE PHARMACY-BASED BENEFITS?

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



VACCINATIONS

The following vaccinations are included under the vaccination benefit:

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

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



CANCER SCREENING TESTS

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

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

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



4

BENEFITS: **DAY-TO-DAY**



In this section

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

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What are day-to-day benefits?

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

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

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

 CONSULTATIONS	
General Practitioners (GPs), specialists and registered homeopaths	• Paid at 90% of SRPL rate. • Combined GP, specialist, and homeopath limit of 15 consultations. • For elective non-emergency after-hours consultations, the benefit is limited to the SRPL rate for a normal consultation. See page 70 on how to avoid additional co-payments in this regard. • Doctors' house calls will be paid at normal consultation rates unless clinically assessed to be required due to a medical emergency.
Physiotherapy, biokinetics and chiropractic services	• Paid at 90% of SRPL rate. • Combined limit of R8 510.
Audiology, chiropody, podiatry, acupuncture, dietician services, occupational therapy, and speech therapy	• Paid at 90% of SRPL rate. • Combined limit of R4 010.
Nursing practitioner	• Paid at 100% of SRPL rate. • Limited to R2 250. • This benefit is applicable to consultations and in-rooms procedures and does not include private nursing, wound care or palliative care.



MEDICINE

Acute medicine (for chronic medicine benefits, see the separate chapter **BENEFITS: CHRONIC MEDICINE**)

Also see **How to obtain acute medicine** below this table for more information.

- Paid at 70% of the negotiated rate, limited to **R5 560**.
- Includes prescribed homeopathic medicine, contraceptive preparations and devices (pre-authorisation required for Mirena® device procedure).
- Benefit for self-medication (OTC - over the pharmacy counter) limited to a maximum of **R145** per event with a sub-limit of a maximum of **6 fills per year**, and subject to the acute medicine limit of **R5 560**.

The MRP is a generic reference price that is the maximum amount that will be reimbursed for a list of generic medicines that cost less than the original brand name medicine. The member will be liable for the price difference should the beneficiary elect to receive medicine above the MRP price.

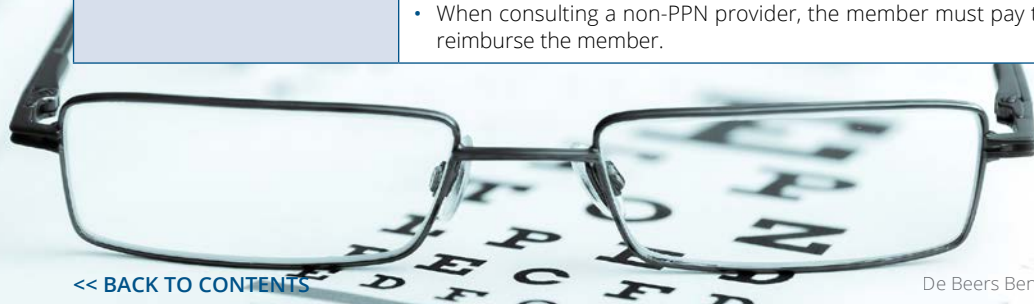


EYE CARE

Composite consultation

(including refraction, glaucoma screening, visual field screening and artificial intelligence screening for retinopathy)

- Benefit is provided at 100% of the PPN agreed tariffs.
- The benefit applies over a two-year cycle (new cycle started on 1 January 2024) for all beneficiaries and is subject to annual availability.
- Benefits are limited to PPN tariffs when consulting a non-PPN provider and a co-payment may apply.
- When consulting a non-PPN provider, the member must pay the provider and the Society will reimburse the member.





EYE CARE (Continued)

Frame and lens enhancements

Lenses (per lens)

- a. Single vision or
- b. Bifocal or
- c. Multifocal

Contact lenses

Hard contact lenses

- Composite consultation limited (per 2-year cycle) to a maximum of **R820** at a PPN provider and **R380** at a non-PPN provider.

+

1. Frame and lens enhancements – R1 680 for a PPN provider and **R1 344** for a non-PPN provider.

This component of the optical benefit can be used to purchase a frame or for lens enhancements (tints and coatings), or a combination of both.

2. Per lens

- a) Single vision – **R215** OR
- b) Bifocal – **R460** OR
- c) Multifocal – **R860**

OR

Contact lenses

- a. Soft contact lenses - **R1 500** per year.

OR

- b. Hard contact lenses - **R3 000** per 2-year cycle.

(Subject to pre-authorisation and benefit limit.
Only applicable for diagnosed conditions such as Keratoconus.)

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



DENTAL

Conservative dentistry	• Paid at 100% of SRPL rate. • Limited to R4 850, with a sub-limit of 1 oral examination, scale and polish every 6 months, from date of last service. • Includes preventative and diagnostic consultations, fillings, extractions, cleanings, and X-rays. • Managed-care protocols apply, and pre-authorisation is required in respect of: - Elective procedures where general anaesthesia is required; - Children under the age of nine (limited to one admission per year); and - Removal of impacted wisdom teeth, apicectomies, removal of teeth and roots or exposure of teeth for orthodontic reasons. • No limit applies in respect of dentistry required as a result of trauma.
Specialised dentistry	• PRE-AUTHORISATION REQUIRED ONLY IF DONE IN HOSPITAL From the Society's Hospital pre-authorisation department. • Paid at 100% of SRPL rate. • Limited to R9 270. • Includes crowns, dentures, bridges and periodontal treatment. • Managed-care protocols apply for procedures performed in-hospital.
Orthodontic treatment	• PRE-AUTHORISATION REQUIRED From the Society's Claims department. • Paid at 75% of SRPL rate. • Limited to R27 910 per lifetime. • Benefits are not provided for treatment starting after a beneficiary's 18th birthday. • Managed-care protocols apply.



MENTAL

Mental health (out of hospital)

- Paid at 90% of SRPL rate.
- Limited to **R16 870**.



TESTS

Pathology

- Paid at 90% of SRPL rate, out of hospital.
- Unlimited, but subject to request by a medical practitioner.

Radiology

- Paid at 90% of SRPL rate, out of hospital (except for one bone density scan every 2 years for all beneficiaries over the age of 50 which will be paid at 100% of SRPL rate).
- Unlimited, but subject to request by a medical practitioner.



HEARING

Hearing aids

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Paid at 90% of the cost as approved by the Society.
- Limited to **R23 280**.
- Repairs and maintenance are included in the limit, to a sub-limit of 15% of the limit.
- The benefit applies over a five-year cycle (starting from 1 January 2021).
- No benefit payable in respect of hearing aid batteries.
- Managed-care protocols apply.



MEDICAL EQUIPMENT

Colostomy bags and catheters	• PRE-AUTHORISATION REQUIRED From Mediscor. • Paid at 90% of the cost as approved by the Society. • Limited to R24 250. • Managed-care protocols apply.
Aids and appliances	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department. • Paid at 50% of the cost as approved by the Society. • Limited to R9 630. • Includes insulin pumps, continuous glucose monitoring (CGM) devices including all test strips, orthopaedic boots, surgical collars, prosthesis, nebulisers, and hiring of equipment. • The type of appliance covered by this benefit will be at the discretion of the Society and all repairs and maintenance are included in the limit, to a sub-limit of 15% of the limit. • Managed-care protocols apply.
Continuous Oxygen Supply Machine and/or Oxygen	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department. • Paid at 100% of cost as approved by the Society. • Limited to R22 870. • Portable Oxygen Concentrator subject to Society approval up to the limit. • Managed-care protocols apply.



MEDICAL EQUIPMENT *(Continued)*

Wheelchairs

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Paid at 90% of the cost as approved by the Society.
- Limited to **R12 150**.
- Quadriplegics and paraplegics only: limited to **R36 870**.
- No benefit for motorised carts / tricycles other than motorised wheelchairs in appropriate cases.
- Repairs and maintenance are included in the limit to a sub-limit of 20% of the limit.
- The benefit applies over a five-year cycle (starting from 1 January 2021).
- Managed-care protocols apply.

Where to obtain acute medicine

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

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

5

BENEFITS:

CHRONIC CONDITIONS



In this section

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

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What is a chronic condition?

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

Which chronic conditions are covered by the Society?

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

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

Chronic Disease List (CDL) of Prescribed Minimum Benefits conditions

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

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

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

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

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

DRM: Helping members to manage their chronic conditions

The importance of managing a chronic condition effectively is undeniably vital for long-term wellbeing. That is why the Trustees introduced a new Disease Risk Management (DRM) programme from 2023, in partnership with PPSHA.

As reported in a previous issue of [Benefit Beat](#), the DRM programme is aimed at identifying beneficiaries who are at risk of developing chronic conditions, suffering complications due to existing chronic conditions, or experiencing an advancement of their existing chronic conditions, and then assisting them to better manage these and to maintain or even improve their quality of life.

Registration of those identified Society beneficiaries on the DRM has been completed and newly diagnosed beneficiaries are registered daily. Continuous interaction between PPSHA and the registered beneficiaries will ensure better compliance with agreed treatment plans and ultimately reduce the number of hospital admissions that the Society beneficiaries will experience thereby resulting in significant cost savings for both the Society and members in general.

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

If you use medicine for a chronic condition without being registered for chronic medicine benefits:

- It will be covered from your acute medicine benefit limit (you will probably exhaust this benefit limit quite quickly); or
- it will not be covered at all.

However by registering your chronic condition you will have access to a far higher benefit limit for your chronic medicine. In order to encourage beneficiaries to register their chronic conditions, chronic medicine will be paid from the acute limit once and rejected thereafter.

Certain terms and conditions apply to the chronic conditions covered.

What is the benefit for chronic medicines?

A 100% benefit applies to chronic medicines dispensed for CDL and listed non-CDL conditions (see earlier in this chapter), limited to the lesser of either the Formulary Reference Price (FRP Plus) or the Mediscor Reference Price (MRP) value applicable to the medicine. This is on condition that the medicine is included in the formulary for

the authorised condition treated, is below the reference price applied and is obtained from one of the Society's DSPs. If chronic medicine is obtained from a non-DSP a 30% co-payment will apply in addition to any FRP Plus and MRP co-payments.

 CHRONIC MEDICINE	
Overall cumulative benefit limit (both CDL and listed non-CDL)	• PRE-AUTHORISATION REQUIRED From Mediscor Chroniline®. • Limited to R43 940. • If this limit is reached before year-end, CDL medicines will continue to be covered in terms of PMB protocols, provided a DSP is used to obtain the medicine and you are registered for the condition. • If this limit is reached before year-end, non-CDL (chronic) medicine will no longer be paid. • Treatment of ADHD will only be funded until the beneficiary turns 18, thereafter a motivation from a psychiatrist will be required. • Managed-care protocols apply. • 100% of the negotiated DSP rate.
All Biologicals	• PRE-AUTHORISATION REQUIRED From the Society's Managed-Care department. • Limited to R271 380 (combined sub-limit for Chronic medicine and Oncology). • Subject to available limit for chronic medicine. • Managed care protocols apply.

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

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

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

How do I register for chronic medicine benefits?

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

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



6

BENEFITS:

HOSPITAL & MAJOR MEDICAL

In this section

- What would typically qualify as hospital/major medical expenses?
- How can I avoid spending unnecessary money in terms of hospital/major medical costs?
- What are Network Hospitals, and why should I use them?
- How does pre-authorisation work?
- What if the procedure can be done in the doctor's rooms?
- How do benefits for day procedures work?
- What are Managed-care protocols?
- What are the benefits and benefit limits for hospital/major medical benefits for 2024?

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What would typically qualify as hospital/major medical expenses?

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

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

Just because you are obtaining a medical service inside a hospital facility (for example, visiting the Emergency Rooms (ER), or the pathologists), does not mean that such a service will be covered in terms of your hospital benefits, as it may form part of your day-to-day benefits, instead. (A visit to the emergency rooms [ER] that is of a serious

nature and results in admission to hospital would qualify under hospital/major medical benefits.)

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

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

- Use one of the Society's Network Hospitals for procedures to enjoy higher cover. See the next page for more about how Network Hospitals will save you money.
- Make sure that all hospital admissions are pre-authorised.
- If you need a procedure that can be done either in a GP's/specialist's rooms or in hospital, opt for an in-rooms procedure, as several procedures are covered at the higher Scheme Rate if performed in the rooms rather than in hospital and the R1 500 co-payment does not apply. See later in this chapter for more information.

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

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

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

Hospital and service provider benefit payments in a Network Hospital

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

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

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

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

Overcharges by providers

Where a provider overcharge is identified as excessive by the Society, the Society will pay only its liability directly to the service provider (benefit due) and the member must settle the difference directly with the service provider. Members are encouraged to check their weekly/monthly statements to identify whether a service provider has been paid in full by the Society or whether they are required to pay the service provider directly.

Hospital benefits in other facilities

Pre-authorised admissions to day clinics, step-down facilities and other forms of care facilities 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.

Psychiatric benefits

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

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

How does pre-authorisation work?

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

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

BUT WHAT IF IT IS AN EMERGENCY?

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

Please note that certain procedures and treatments performed during hospitalisation may also require pre-authorisation.

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

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

Certain 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. Certain procedures also require a R1 500 co-payment if performed in-hospital. Refer to page 41 for further information.

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

How do benefits for day procedures work?

A same day hospital admission, if pre-authorised as such, will qualify for benefits at the Scheme Rate/negotiated rate if the admission and discharge occur on the same day without any 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/negotiated rate to the SRPL rate and the member will be liable for any difference in costs between that charged for a day admission and the actual final account rendered, based on the actual time and date of discharge.

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

What are Managed-care protocols?

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

What are the benefits and benefit limits for hospital/major medical benefits for 2024?

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

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



IN-ROOMS PROCEDURES

GP and specialist in-rooms procedures

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



HOSPITALISATION

Hospitalisation

(including day cases, fixed-fee cases for cataracts, sub-acute and other facilities)

- **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department.
- Network Admissions – The treating providers will be paid at Scheme Rate and the hospital/facility at negotiated rates.
- Non-Network Admissions – The treating providers and the hospital/facility will be paid at SRPL rate.
- SRPL rate applies to the hospital/facility and service provider costs for all authorised non-DSP hospital, day clinic and sub-acute facility admissions.
- 30% co-payment on the total hospital account will be levied where pre-authorisation has not been obtained for pre-planned non-emergency admissions.
- A co-payment of **R1 500** will apply to all arthroscopic and laparoscopic procedures performed for diagnostic purposes as well as the procedures listed on page 41.
- 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 – **R46 100**
 - Laparoscopic unilateral inguinal hernia – **R35 950**
 - Laparoscopic incisional/ventral hernia – **R57 170**
 - RALP (Robotic assisted laparoscopic procedure) capped overall at **R169 070**, being made up of the capped fee for the hospital procedure only, at **R107 600**, and this includes the anaesthetic time limited to a maximum of 3 hours. All the associated providers are capped at a combined total of **R61 470**.
- Managed-care protocols apply.



CONSULTATIONS

Professional fees charged by service providers	• Network Admissions (including day clinics and sub-acute facilities) – The treating providers will be paid at Scheme Rate. • Non-Network Admissions – The treating providers will be paid at SRPL rate. • Managed-care protocols and limits apply, where applicable.
Physiotherapy, occupational therapy, speech therapy and dietician	• Network Admissions – The treating providers will be paid at Scheme Rate. • Non-Network Admissions – The treating providers will be paid at SRPL rate. • Managed-care protocols apply.



TESTS

Pathology	• Network Admissions will be paid at Scheme Rate. • Non-Network Admissions will be paid at SRPL rate. • Subject to a request by a medical practitioner.
Radiology (other than CT and MRI Scans)	• Network Admissions will be paid at Scheme Rate. • Non-Network Admissions will be paid at SRPL rate. • Subject to a request by a medical practitioner.
CT and MRI Scans	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department. • Paid at 100% of SRPL rate. • Limited to 3 scans. • Managed-care protocols apply.



MEDICINE

Hospital medicines

- Paid at 100% of Single Exit Price (SEP).
- TTO medicine up to a maximum of 7 days' supply on discharge.



MATERNITY

Home confinement or natural birth delivery

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Paid at 100% of SRPL rate.
- Limited to the in-hospital maternity benefit costs.
- Managed-care protocols apply.

Delivery in hospital

- **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department.
- Network Admissions – The treating providers will be paid at Scheme Rate and the hospital at negotiated rates.
- Non-Network Admissions – The treating providers and the hospital will be paid at SRPL rate.
- Limited to 2 days' hospitalisation for normal delivery and 3 days' hospitalisation for a caesarean delivery.
- Managed-care protocols apply.

 EYE CARE

Corneal transplants	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department. • Network Admissions – The treating providers will be paid at Scheme Rate and the hospital at negotiated rates. • Non-Network Admissions – The treating providers and the hospital will be paid at SRPL rate. • Graft benefit limited to R13 480. • Harvesting cost limited to a maximum of R17 530. • Managed-care protocols apply.
Cataract removal	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department. • Paid at 100% of the cost as approved by the Society. • The Society will pay for one post-operative cataract consultation per year. • If an optometrist refers a beneficiary for a cataract examination by an ophthalmologist, the prescription may not be completed until the outcome of the referral is known. Should the optometrist prescribe and dispense spectacles before any surgery that may subsequently be performed, then the beneficiary will not qualify for additional optical benefits post-surgery within the 24-month optical benefit cycle. • Preferred providers contracted specifically for cataract procedures should be first choice. Should a preferred provider not be accessible, then a DSP Network hospital is to be used. • Managed-care protocols apply.



EYE CARE *(Continued)*

Intra-ocular lenses	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department. • Network Admissions (including day clinics and sub-acute facilities) – The treating providers will be paid at Scheme Rate and the hospital at negotiated rates. • Non-Network Admissions – The treating providers and the hospital will be paid at SRPL rate. • This is limited to single vision lenses to a maximum of R3 730 per lens. • Managed-care protocols apply.
Refractive surgery	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department. • Network Admissions – The treating providers will be paid at 50% of Scheme Rate and the hospital at 50% of the negotiated rates. • Non-Network Admissions – The treating providers and the hospital will be paid at 50% of SRPL rate. • Limited to one procedure per eye per lifetime. • Lenses limited to single vision lenses. • Including but not limited to Excimer Laser and eye surgery required for astigmatism, hypermetropia, presbyopia, myopia and hypermyopia. • Managed-care protocols apply.



ORAL SURGERY

Maxillofacial and oral surgery

- **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department.
- Network Admissions (including in-rooms procedures) – The treating providers will be paid at Scheme Rate and the hospital at negotiated rates.
- Non-Network Admissions – The treating providers and the hospital will be paid at SRPL rate.
- This excludes surgery in preparation for osseo-integrated implants and orthognathic surgery.
- Managed-care protocols apply.



NURSING

Private nursing

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Paid at 90% of SRPL rate.
- Limited to **R12 250**.
- The provider must be registered with the Board of Healthcare Funders.

Wound care

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Paid at 90% of SRPL rate.
- Limited to **R12 250**.

Hospice care

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Subject to PMB.
- Pre-authorisation of treatment plan is required.



ONCOLOGY

Treatment in and out of hospital	• PRE-AUTHORISATION REQUIRED • For <i>in-hospital treatment</i>, from the Society's Hospital pre-authorisation department. • For <i>out-of-hospital treatment</i>, from the Society's Managed-care department. • Benefit is according to the ICON Advanced Option. • Limited to R337 240. • Should an ICON provider not be used, the consultation and treatment will be limited to 80% of the SPRL rate and accrue to the Oncology benefit. • If you do not obtain your oncology medicine from one of the Society's DSPs, a 30% out-of-network co-payment will be applied. • All parenteral medicine for oncology treatment must be obtained from Dis-Chem Direct and comply with normal MRP and Formulary rules. • 6 follow-up visits are provided for at an ICON provider. • ICON protocols apply.
All Biologicals	• Limited to R271 380 (combined sub-limit for Chronic medicine and Oncology). • Subject to available limit for oncology treatment. • Managed care protocols apply.
PET and related CT planning scans	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department. • Paid at 100% of SRPL rate. • Subject to available limit for oncology treatment. • ICON protocols apply.



PROSTHESIS/TRANSPLANTS

Internal prosthesis	• PRE-AUTHORISATION REQUIRED From the Society's Hospital pre-authorisation department. • Paid at the cost as approved by the Society. • Limited to an overall benefit of R59 450 (inclusive of bone cement, cages, screws, plates, coronary and vascular stents, pacemakers, aortic and valve replacements). • The overall annual limit is cumulative for all the sub-limits below: - Joint replacements – R59 450 - Spinal prosthesis – R59 450 - Coronary & vascular stents, pacemakers, aortic & mitral valve replacements – R59 450 - Mesh (Gortex slings and Permacol®) – R16 950 • Managed-care protocols apply.
Artificial limbs (including prosthetic eyes)	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department. • Paid at 90% of the cost as approved by the Society. • Limited to R59 500. • Repairs and maintenance are included in the limit, to a sub-limit of 15% of the limit. • The benefit applies over a five-year cycle (starting from 1 January 2021). • Managed-care protocols apply.
Renal dialysis (applicable to PMB-confirmed cases only)	• PRE-AUTHORISATION REQUIRED From the Society's Managed-care department. • Paid at 100% of DSP Rate in and out of hospital. • Managed-care protocols apply.



PROSTHESIS/TRANSPLANTS *(Continued)*

Organ transplants
(applicable to PMB-confirmed cases only)

- **PRE-AUTHORISATION REQUIRED** From the Society's Managed-care department.
- Paid at SRPL or Scheme Rate.
- Managed-care protocols apply.



MENTAL HEALTH

Psychiatric hospitalisation for mental disorders and alcohol and/or drug dependency in-hospital rehabilitation

- **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department.
- Network or Registered Psychiatric Admissions – The treating providers will be paid at Scheme Rate and the hospital at negotiated rates.
- Non-Network Admissions – The treating providers and the hospital will be paid at SRPL rate.
- Managed-care protocols apply.
- **Psychiatric Hospital Admissions:** Limited to 21 days per year, provided that the treatment of PMB conditions are limited as per Annexure A of the Regulations made in terms of the Act.
- **Alcohol and Drug Dependency Admissions:** Limited to 24 days provided that the treatment of PMB conditions are limited as per Annexure A of the Regulations made in terms of the Act.



HEARING

Cochlear implants

- **PRE-AUTHORISATION REQUIRED** From the Society's Hospital pre-authorisation department.
- Paid at SRPL or Scheme Rate.
- Device limit of **R309 100** for internal and external components only, per lifetime.
- Replacement & repair of the external processing system will be paid from the Hearing Aid benefit, of which the limit applies over a five-year cycle starting from 1 January 2021 (see page 26 for more information).
- Managed-care protocols apply.



OTHER

Blood transfusion

- Paid at SRPL rates.
- Unlimited.



7

BENEFITS:

EMERGENCY TRANSPORT



In this section

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

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

RSA residents simply call
084 124

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

What must I do in an emergency?

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

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

Please note that a beneficiary will only receive an ambulance benefit if the transportation is authorised by ER24.

What qualifies as an emergency?

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

Here are some examples:

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

When should I call an ambulance, and when not?

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

- Where you or your family are well enough to go in a car, bus or taxi to see your doctor or go to the hospital as an outpatient;

- If you do not require urgent medical attention for a life-threatening condition;
- Transport home from hospital when you are well enough to be discharged;
- When you are pregnant, with no complications and starting with labour; or
- When you need to be admitted for a pre-planned operation or procedure.

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

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

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

What if a non-ER24 service provider is dispatched?

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

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

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

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

Will an emergency admission to any hospital be covered?

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

The Society retains the right to move a patient admitted as a result of an emergency to an appropriate Network Hospital once the patient has been stabilised if additional treatment and care is required.

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

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

8

PRESCRIBED MINIMUM BENEFITS

In this section

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

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What are PMBs?

PMBs are prescribed minimum benefits which by law must be provided by all medical schemes for:

- any emergency medical condition as defined*;
- a set of 270 medical conditions (called the DTPs**, listed in the Regulations to the Act; and
- The 26 chronic disease conditions listed on page 30.

Medical schemes must cover the costs related to the diagnosis, treatment and care of these conditions, where the following requirements are met:

- The medical condition must qualify as a PMB (either an emergency, DTP or CDL).
- The treatment needed must match the treatment included in the defined benefits. This includes standard treatments, procedures, consultations and medicine lists. (Full details available from the CMS www.medicalschemes.co.za).

- The Society's DSP must be used where a DSP exists for the service.

PMBs may be affected by waiting periods where applicable.

How do I access my PMB benefits?

- Members or service providers may contact the Society's Claims Department on 053 807 3111 (Option 5) and inform the agent of their request to register for a PMB condition.
- The Society's agent will then e-mail the PMB application form to the service provider for completion.
- The completed form must be returned by e-mail to benefitpost@dbbs.co.za.
- The Society will then inform the service provider of the outcome of their application.
- If your query is not satisfactorily resolved within 15 working days, you may follow the Complaints Process detailed on page 81.

* 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 working 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.

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

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

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

The Society's DSPs are:

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

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

The following circumstances may leave you with no choice but to obtain medical treatment from a non-DSP for the treatment of a PMB condition:

- 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 Society's Rules.

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

ICD-10 codes provide accurate and specific information regarding the condition that you have been diagnosed with and/or treated for and needs to be provided by your service provider on the account. These codes enable the Society to determine what benefits you are entitled to receive and how these benefits must be paid. This becomes very important when you are claiming for the treatment of a PMB condition, as the ICD-10 codes allow the Society to accurately identify the PMB condition.

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.co.za as well as regular publications and updates on this subject. A link to the Council for Medical Schemes website is available on the Society's website www.dbbs.co.za.

9

MEMBERSHIP

In this section

- Who may join the Society?
- Who qualifies as dependants?
- When will the child rate apply to a child dependant?
- When will the adult dependant rate start to apply to a child dependant?
- What happens to my membership when I retire or am retrenched?
- What happens to dependants' membership if the member passes away?
- Can I or any of my dependants belong to more than one medical scheme at the same time?
- What waiting periods apply to new members and dependants?
- What if a beneficiary has not been a member of a medical aid before?
- When will my membership of the Society end?
- Under what circumstances can I terminate my membership or de-register a dependant?

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Who may join the Society?

The Society is a restricted medical scheme as defined by the Act and as such has specific qualifying criteria for who may join the Society. These criteria are defined in the Society's Rules.

Only persons employed by the Employer (De Beers Group Services (Pty) Ltd) and Associated Employers, and such persons' eligible dependants, can join the Society. The employee who joins the Society is regarded as the main or principal member and is referred to as the "member." Persons added to such membership, at the request of the member, are referred to as "dependants".

Who qualifies as dependants?

- a member's spouse or life partner;
- a member's (natural, step or legally adopted) child who is dependent on the member; and/or
- a member's immediate family for whom the member is liable for family care and support and is thus dependent on the member, restricted to:
 - siblings (brothers and sisters)
 - siblings 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, provided that such siblings were registered as a dependant of the deceased member at the time of the death of the member.

The criteria to prove dependency in terms of Ruling 9 (dependants other than a member's spouse/partner or a child under the age of 21) of the Society is:

- The dependant should not have a regular monthly income of more than twice the latest published minimum monthly wage of a Shop Assistant in the Retail Industry Area A as published by the Department of Labour;
- The dependant should be able to demonstrate that the dependant is reliant on monetary assistance provided by the member to the dependant to meet reasonable day-to-day living expenses; and /or
- The dependant should be able to demonstrate that the member assists in providing accommodation for the dependant.

IMPORTANT: Dependants who wish to be registered with the Society may not remain a member of another medical scheme or a registered dependant of a member of another medical scheme.

When will the child rate apply to a child dependant?

A dependant child will qualify for the child rate if they are:

- under the age of 21; or
- over the age of 21 but under the age of 26 and can prove their dependency as provided for in Ruling 9 of the Society; or
- over the age of 21 but under the age of 26 but due to mental or physical disability is not independent.

When will the adult dependant rate start to apply to a child dependant?

A financially dependant child aged 26 and older may remain a registered dependant, but adult dependant rates will apply.

Yearly eligibility review of dependants (Ruling 9)

In terms of the Society's Rules, membership of dependants aged 21 and over will automatically be terminated at the end of their birth month.

In the case of dependants over the age of 21, the member must provide the Society with annual proof of eligibility for these dependants (except in the case of a mentally or physically disabled dependant who has registered their disability with the Society). The necessary forms to determine the eligibility are to be completed and submitted to the Society before the dependant's birthday.

Eligibility review for dependants		
Age	Rate to be paid	Review Period
From 21 to 25 years of age	Child Rate	Yearly, 60 days before the end of the dependant's birth month
26 years and older	Adult Rate	Yearly, 60 days before the end of dependant's birth month

What happens to my membership when I retire or am retrenched?

Retirement

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

Retrenchment

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;
- the Society may terminate the membership of such member if they secure permanent employment with any employer, other than the Employer or Associated Employer, entitling them to membership of another

medical scheme by virtue of such permanent employment; and

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

What happens to dependants' membership if the member passes away?

In the event of the member's death the dependants of such a deceased member (and who are registered with the Society as dependants at the time of the member's death) shall be entitled to continuation membership of the Society. The Society will inform dependants of their right to membership and of the contributions payable in respect thereof.

Unless such dependants inform the Society in writing of their intention to not become members, they will be admitted as members of the Society. Such dependants' membership terminates if they become a member or a dependant of a member of another medical scheme.

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.

What waiting periods apply to new members and dependants?

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

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

recommended or received within the 12 month period before application for membership was made.

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

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

Break between medical schemes of up to 89 days

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

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

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

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

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

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

When will my membership to the Society end?

Your membership to the Society will end/terminate if you resign from the employment of the Employer or if your employment contract is terminated for other reasons than retirement or retrenchment. A member who ceases to be an employee of the Employer during a calendar month will be entitled to retain his/her membership to the last day of such calendar month.

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

A member who is not required in terms of his/her conditions of employment to be a member, may terminate his/her membership to the Society by giving one month's written notice to the Society.

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

For example: if a member gives notice on the 5th of July, the calendar month will apply from 1 August to 31 August. The member will be liable for the contribution for August and will receive benefits until 31 August.

A member may de-register a dependant by giving 30 days written notice to the Society. Such a member will remain liable for the full contributions for the whole notice period, even where immediate termination of membership is requested. The dependant's rights to benefits shall cease after the last day of the calendar month during which such notice expires.

Important note:

A member must give the Society at least 30 days prior written notice of the occurrence of any event of which the member is aware that will result in any one of his/her dependants no longer satisfying the conditions in terms of which he may continue to be registered as a dependant; e.g. divorce or a child dependant no longer being dependant on the member.

9

CO-PAYMENTS

In this section

- What is a co-payment?
- How are co-payments calculated?

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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 by the service provider and the benefit provided in terms of the Society's Rules and benefit structure.

The co-payment will be collected via your salary, pension or debit order, provided you have sufficient credit limit. If you do not have sufficient credit limit the co-payment needs to be paid directly by yourself to the service provider. 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.

What is a penalty co-payment?

Penalty co-payments are levied when a member does not follow the Society's required processes and procedures, as provided for in the Society's Rules and approved by the CMS. Examples of penalty co-payments would be a voluntary admission to a non-Network Hospital for a non-emergency procedure, consulting with a non-ICON oncologist, obtaining chronic medicine (including for oncology) from a non-DSP pharmacy, or obtaining optometry benefits from a non-PPN provider. The good news is that these set penalty co-payments can be avoided by using the Society's DSPs and making sure hospital admissions are pre-authorised.

Note: The examples on the next pages do not represent all co-payments that could be incurred for services received from a 3rd party and are just for explanatory purposes.

What is a credit limit?

The Society aims to minimise members' having to pay co-payments at point of sale or point of service, such as when they are purchasing acute medicine or consulting a doctor. Where members have sufficient monthly income and are paid by the Employer or Associated Employers (in the case of working members) or the De Beers Pension Fund (in the case of pensioners receiving a pension from the Fund), this is done automatically through a deduction from their salary or pension. For example, if you obtain acute medicine to the value of R200 – the Society will pay the full R200 to the service provider and deduct the 30% co-payment (the Society's benefit for acute medicine is 70%) of R60 from your monthly salary/pension.

If your monthly income (salary/pension) is too small you may not qualify for a credit limit and will be required to settle any amounts owed to service providers, directly with those service providers as this will not be administered by the Society. For example, if you obtain acute medicine to the value of R200 – the Society will pay the service provider R140 and the 30% co-payment (the Society's benefit for acute medicine is 70%) of R60 must be paid by yourself directly to the service provider. If you are unsure about your specific credit limit, please contact the Society on tel 053 807 3111.



How are co-payments calculated?



Consultations

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



After-hours consultation

If you...	...you will have to pay	What you can do to avoid additional costs:
consult with a service provider unscheduled* or after-hours for a non-emergency, your claims will be covered at SRPL rate, and <i>* Most practices charge an after-hours consultation fee for consultations conducted after normal working hours and during weekends. Please note that, if you phone your doctor during normal working hours and they fit you in on that specific day without an official pre-booked appointment, you will be charged for an unscheduled consultation.</i>	the difference between what you are charged by the service provider and SRPL rate, PLUS the after-hours or unscheduled* consultation fee. Example: GP claimed R628.00 (normal consult) GP claimed R229.30 (after-hours consult) SRPL rate is R509.00 (normal consult) The member is liable for R50.90 (10% co-payment of R509) plus the provider overcharge of R119 (R628 – R509) Total member liability = R50.90 plus R119.00 plus R229.30 = R399.20 (The after-hours or unscheduled* consultation fee will be rejected and the member will be liable to settle this charge directly to the provider.)	• Confirm the normal operating hours of the service provider. • You may provide written motivation of circumstances, should it be considered to have been an emergency as defined on page 53, to the Society by emailing benefitpost@dbbs.co.za.



Hospital (Network) – associated provider overcharge

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



Hospital (Network) – no pre-authorisation

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



Hospital (non-Network)

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



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

If you...	...you will have to pay	What you can do to avoid additional costs:
are admitted to a Network Hospital for a non-emergency major surgery involving: • internal prosthesis; or • laparoscopic procedures, your claims will be covered at Scheme Rate, but sub-limits will apply, and	the difference between what you are charged by the service provider and the Society's Benefit Limit. Example: Hospital claimed R24 437.42 Hospital paid in full at Negotiated rate Prosthesis cost R116 023.90 Limit is R59 450 Prosthesis costs are R56 573.90 more than the limit. Total co-payment = R56 573.90	• Ensure the relevant authorisation department has negotiated the prosthesis cost if the quote is above limit. • Speak to your service provider about the options available to you.



Oncology – non-DSP (ICON not used)

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

10 FREQUENTLY ASKED QUESTIONS

In this section

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

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What happens to “unused” benefits?

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

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

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



the benefit structure and any changes to it;



past claims experience;



projected future increases in the cost of various medical services;



developments in the medical industry;



the changing demographics of the Society's membership and projected benefit utilisation versus contribution income; 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.

How much time do I have to submit a claim?

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

What benefits are excluded by the Society?

EXCLUSIONS

1. Expenses and medicines arising from:
 - i. 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);
 - ii. infertility, artificial insemination, impotency and erectile dysfunction;
 - iii. gender reassignment;
 - iv. 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
 - v. any complication that may arise from such examinations or treatment with the exception of any PMB.
2. Expenses (including expenses relating to any PMB) incurred outside the area of operation.
3. Expenses in respect of the treatment of any learning, marital, social or family problems.
4. Expenses relating to the purchase of:
 - i. any medicine not registered by the Medicines Control Council or similar authority (except for Homeopathic Medicines); or
 - ii. medicines not registered for treatment of the condition for which such medicines are obtained and any patent and household remedies.
5. Expenses relating to services that do not relate to any sickness condition, including but not limited to examinations for insurance, employment, visas, pilot and driving licenses and school readiness tests.
6. Expenses relating to any recuperative or convalescent holidays.
7. Expenses relating to travel for beneficiaries.
8. Expenses relating to any diagnostic preparations and instruments, 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; including all patient and baby foods and special milk preparations (except those required for use when approved as part of a discharge plan for a PMB condition).
14. Expenses relating to any household bandages, dressings and diapers.
15. Expenses relating to any syringes and needles except those required for use in the treatment of diabetes or when approved as part of a discharge plan.
16. Expenses relating to any vitamins, mineral supplements, growth hormones, tonics and stimulants. However, benefits will be granted for the following:

- i. Pre-natal vitamins; and
 - ii. Calcium supplements when prescribed and approved for the treatment of osteoporosis.
17. Appointments not kept.
 18. Expenses relating to any telephone prescriptions, other than for repeat prescriptions.
 19. Expenses relating to accommodation and services rendered in convalescent or old age homes or similar institutions catering for the aged or chronically ill other than specifically provided for in the Society's Rules.
 20. Expenses relating to any contact lens preparations.
 21. Expenses relating to all non-prescription sunglasses.
 22. Expenses relating to lost or damaged devices, apparatus, spectacles or contact lenses.
 23. Expenses relating to sleep therapy.
 24. Expenses relating to ambulance transportation from a hospital to home or from home to a consulting room of any medical practitioner or hospital, unless deemed clinically necessary and pre-authorised.
 25. Expenses incurred without a pre-authorisation as required by the Society's Rules.

26. Expenses relating to:

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

Radiologist or where the mammogram does not yield conclusive results.

vii. Orthodontic treatment of beneficiaries older than 18 years.

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

ix. Vasovasostomy.

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

i. Genetic or biomarker tests.

ii. Oncotype tests.

iii. Gynaecomastia and mammary surgery. The only exception will be for PMB and PMB related conditions.

iv. Kyphoplasty.

28. Expenses relating to services which are regarded as not being medically necessary, cost efficient and affordable, provided that a treatment, procedure, supply, medicine, hospital or specialised centre stay (or part of a hospital or specialised centre stay) shall be regarded as medically necessary if:

i. The treatment is required to restore the normal function of an affected limb, organ or system;

ii. The treatment is generally accepted as optimal and necessary for the specific condition and is supplied at an appropriate level to render safe and adequate care;

iii. The treatment is not rendered for the convenience of the relevant beneficiary or service provider;

iv. Outcome studies are available and acceptable to the Society; and

v. No alternative exists that has a better outcome, is more cost effective and has a lower risk.

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

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

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

Members may lodge complaints in writing to the Society via e-mail (complaints@dbbs.co.za) or courier such to Kimberley House, 84 DuToitspan Road, Kimberley, 8301 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 Chairperson of the Board, will be binding in terms of the Society's 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.co.za or contact them as per the contact details below.

CMS Contact details

Customer Care Service Center
086 112 3267 / 086 112 3 cms
General Enquiries
Email Enquiries: information@medicalschemes.co.za
Reception
Telephone: 012 431 0500 Fax: 086 206 8260
Complaints
Fax Complaints: 086 673 2466 Email Complaints: complaints@medicalschemes.co.za
Address
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.co.za

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)



The information in this member guide is subject to the registered Rules of the De Beers Benefit Society. The Society's Rules 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), a copy may be obtained from your HR department, or from the Society's website at www.dbbs.co.za or members may request that a printed copy be posted to them.

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