

DE BEERS BENEFIT SOCIETY
ANNEXURE C
EXCLUSIONS AND LIMITATIONS

The scheme will pay in full, without co-payment or use of deductibles, for the diagnosis, treatment and care costs of the prescribed minimum benefits as per Regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, the scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

1. EXCLUSIONS

- 1.1. Expenses and medicines arising from examinations, treatment and/or operations for cosmetic purposes (the SOCIETY in its sole discretion may decide if any procedure is deemed to be cosmetic based on the motivation provided), infertility, artificial insemination, impotency and erectile dysfunction, gender reassignment, treatment of an experimental nature or treatment that does not constitute the prevailing medical or surgical diagnostic and treatment practice in the South African Public Sector (unless specifically authorised by the SOCIETY subject to such conditions as it may impose), and any complication that may arise from such examinations or treatment with the exception of any PMB.
- 1.2. Expenses (including expenses relating to any PRESCRIBED MINIMUM BENEFIT) incurred outside the AREA OF OPERATION.
- 1.3. Expenses in respect of the treatment of any learning, marital, social or family problems.
- 1.4. Expenses relating to the purchase of:
 - 1.4.1. any medicine not registered by the Medicines Control Council or similar authority (with the exception of Homeopathic Medicines); or

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- 1.4.2. medicines not registered for treatment of the condition for which such medicines are obtained and any patent and household remedies.
- 1.5. 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.
- 1.6. Expenses relating to any recuperative or convalescent holidays.
- 1.7. Expenses relating to travel for BENEFICIARIES.
- 1.8. Expenses relating to any diagnostic preparations and instruments, orthopaedic beds, soaps, shampoos and other topical applications (of a cosmetic nature), medicated or otherwise but excluding those intended for treatment of lice, scabies and other parasitic or fungal infections.
- 1.9. Expenses relating to any anti-addiction and anti-habit agents not covered under PMB code 182T.
- 1.10. Expenses relating to any cosmetic items inclusive of hair-restorers.
- 1.11. Expenses relating to any sun screening and sun-tanning agents .
- 1.12. Expenses relating to any homeopathic and herbal medicines and remedies not prescribed by a registered homeopath.
- 1.13. Expenses relating to any food supplements, including all patent and baby foods and special milk preparations.
- 1.14. Expenses relating to any household bandages, dressings and diapers.
- 1.15. 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.

- 1.16. Expenses relating to any vitamins, mineral supplements, growth hormones, tonics and stimulants. However, benefits will be granted for the following:

1.16.1. Pre-natal vitamins; and

1.16.2. Calcium supplements when prescribed and approved for the treatment of osteoporosis.

- 1.17. Appointments not kept by BENEFICIARIES.

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- 1.18. Expenses relating to any telephone prescriptions, other than for repeat prescriptions.

- 1.19. Expenses relating to accommodation and nursing services rendered in convalescent or old age homes or similar institutions catering for the aged or chronically ill other than specifically provided for in the rules.

- 1.20. Expenses relating to any contact lens preparations.

- 1.21. Expenses relating to all non-prescription sunglasses.

- 1.22. Expenses relating to lost or damaged devices, apparatus, spectacles or contact lenses.

- 1.23. Expenses relating to sleep therapy.

- 1.24. Expenses relating to ambulance transportation from a hospital to a BENEFICIARY'S home or from a BENEFICIARY'S home to a consulting room of any medical practitioner or hospital, unless deemed clinically necessary and pre-authorised.



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

1.26. Expenses relating to:

1.26.1. 3D and 4D gestational sonars

1.26.2. Angioseal and similar closure devices when performing coronary angiograms will be excluded 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.

1.26.3. Artificial Discs .

1.26.4. Mammoplasty, including breast augmentation and reductions, which includes all costs for the operation, medicine and treatment of cosmetic or elective procedures.

1.26.5. Motorised carts/tricycles, other than motorised wheelchairs in appropriate cases.

1.26.6. 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.

1.26.7. Orthodontic treatment of beneficiaries older than 18 years.

1.26.8. Orthognathic surgery.

1.26.9. Vasovasostomy

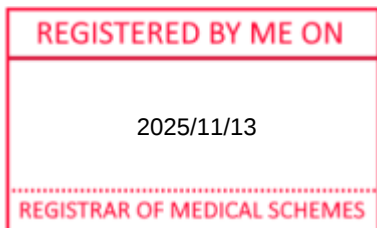
1.27. Expenses relating to the following services unless authorised by the Society;

1.27.1. Genetic or Biomarker tests.

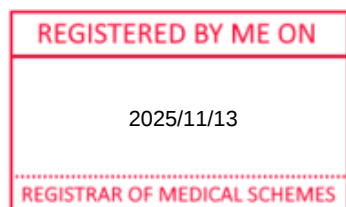
1.27.2. Oncotype tests.

1.27.3. Gynaecomastia and Mammary surgery.

1.27.4. Kyphoplasty.



1.28. 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 taking into account the above requirements. The fact that a provider has prescribed, recommended, approved or provided a treatment, service, supply or confinement shall not in itself be regarded as proof that such service was medically necessary. The SOCIETY may refer cases to a medical specialist for an opinion, or a second opinion. The decision of the SOCIETY on the issue of medical necessity following the advice of such specialist shall be final.

1.29. Expenses (including expenses in respect of the PRESCRIBED MINIMUM BENEFITS) 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 the PRESCRIBED MINIMUM BENEFITS in which case the SOCIETY shall be



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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 BENEFICIARY as the case may be.

- 1.30. Expenses arising from the treatment of obesity, for example, but not limited to Bariatric surgery.
- 1.31. Expenses for healthcare services rendered during any waiting periods applied.
- 1.32. Expenses for healthcare services that do not meet the SOCIETY's clinical protocols.
- 1.33. 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.

2. LIMITATIONS

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



average cost as determined by the Society for the standard procedure approved in terms of the managed care protocols of the SOCIETY, including all the associated provider costs and any prosthesis and / or device costs.

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