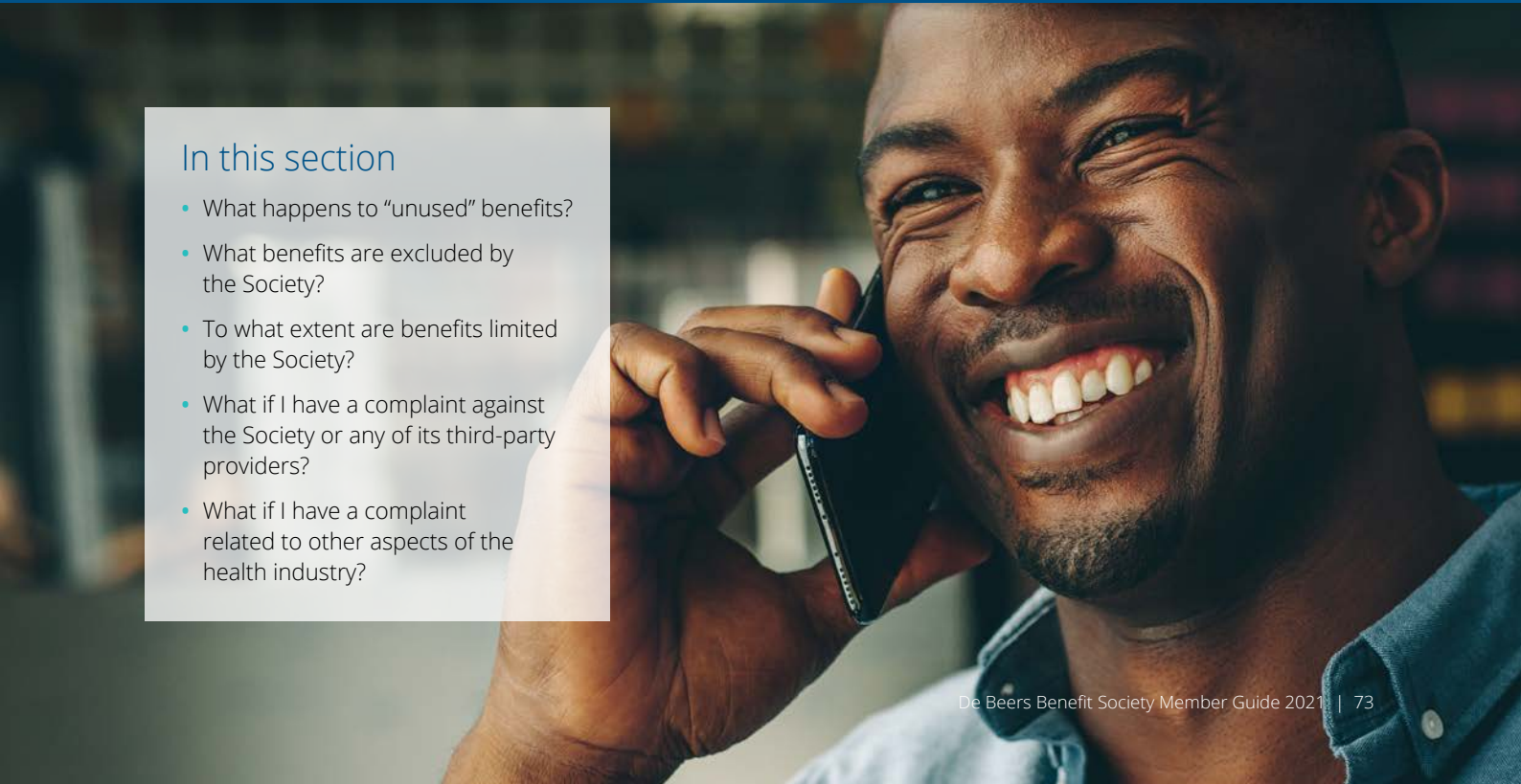
10 FREQUENTLY ASKED QUESTIONS



In this section

- What happens to “unused” benefits?
- What benefits are excluded by the Society?
- To what extent are benefits limited by the Society?
- What if I have a complaint against the Society or any of its third-party providers?
- What if I have a complaint related to other aspects of the health industry?

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.

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

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

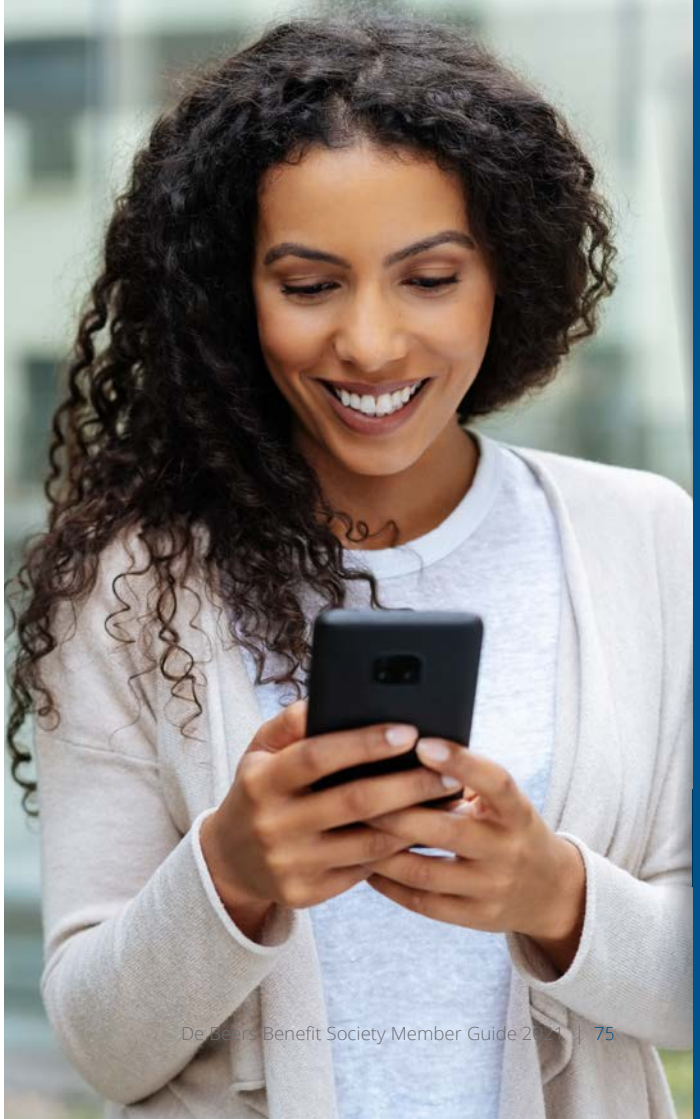
Based on the outcome of the above, the Trustees aim to set the contributions at a level that will cover the cost of the estimated benefits to be provided. If a situation occurs where too much or too little is collected from members, this has an influence on the solvency level of the Society and the outcome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

What benefits are excluded by the Society?

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

EXCLUSIONS

1. Expenses and medicines arising from examinations, treatment and/or operations for cosmetic purposes (the Society in its sole discretion may decide if any procedure is deemed to be cosmetic based on the motivation provided), infertility, artificial insemination, impotency and erectile dysfunction, gender reassignment, treatment of an experimental nature or treatment that does not constitute the prevailing medical or surgical diagnostic and treatment practice in the South African Public Sector (unless specifically authorised by the Society subject to such conditions as it may impose), and any complication that may arise from such examinations or treatment with the exception of any PMB.
2. Expenses (including expenses relating to any PMB) incurred outside the Area of operation.
3. Expenses in respect of the treatment of any learning, marital, social or family problems.
4. Expenses relating to the purchase of:



i. any medicine not registered by the Medicines Control Council or similar authority (except for Homeopathic Medicines); or

ii. medicines not registered for treatment of the condition for which such medicines are obtained and any patent and household remedies.

5. Expenses relating to services that do not relate to any sickness condition, including but not limited to examinations for insurance, employment, visas, pilot and driving licenses and school readiness tests.
6. Expenses relating to any recuperative or convalescent holidays.
7. Expenses relating to travel.
8. Expenses relating to any diagnostic preparations and instruments, orthopaedic beds, soaps, shampoos, and other topical applications (of a cosmetic nature), medicated or otherwise but excluding those intended for treatment of lice, scabies and other parasitic or fungal infections.
9. Expenses relating to any anti-addiction and anti-habit agents not covered under PMB code 182T.
10. Expenses relating to any cosmetic items inclusive of hair-restorers.
11. Expenses relating to any sun screening and sun-tanning agents except those intended for the treatment of PMB skin disorders.
12. Expenses relating to any homeopathic and herbal medicines and remedies not prescribed by a registered homeopath.
13. Expenses relating to any food supplements except those required for use when approved as part of a discharge plan for a PMB condition, including all patent and baby foods and special milk preparations.
14. Expenses relating to any household bandages, dressings and diapers.
15. Expenses relating to any syringes and needles except those required for use in the treatment of diabetes or when approved as part of a discharge plan.
16. Expenses relating to any vitamins, mineral supplements, growth hormones, tonics and stimulants. However, benefits will be granted for the following:

    i. Pre-natal vitamins; and

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

17. Appointments not kept by you.
18. Expenses relating to any telephone prescriptions, other than for repeat prescriptions.
19. Expenses relating to any telephonic consultations.
20. Expenses relating to accommodation and services rendered in convalescent or old age homes or similar institutions catering for the aged or chronically ill other than specifically provided for in the rules.
21. Expenses relating to any contact lens preparations.
22. Expenses relating to all non-prescription sunglasses.
23. Expenses relating to lost or damaged devices, apparatus, spectacles or contact lenses.
24. Expenses relating to sleep therapy.
25. Expenses relating to ambulance transportation from a hospital to your home or from your home to a consulting room of any medical practitioner or hospital, unless deemed clinically necessary and pre-authorised.
26. Expenses incurred without a pre-authorisation as required by the rules.
27. Expenses relating to:
    i. 3D and 4D gestational sonars
    ii. Angioseal and similar closure devices when performing coronary angiograms where the patient is not considered a high risk for vascular complications, such high risk including but not limited to patients known to have peripheral vascular disease, advanced age, liver disease, coagulopathy, immunosuppression, post valve replacement and renal dysfunction.
    iii. Artificial Discs unless used in the treatment of a PMB condition at a PMB level of care.
    iv. Mammoplasty, including breast augmentation and reductions, which includes all costs for the operation, medicine and treatment of cosmetic or elective procedures. The only exception will be for PMB and PMB related conditions.
    v. Motorised carts/tricycles, other than motorised wheelchairs in appropriate cases.
    vi. Magnetic Resonance Imaging (MRI) of the breast is not considered to be a standard screening tool unless used in the treatment of staging a diagnosed

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

vii. Orthodontic treatment of beneficiaries older than 18 years.

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

ix. Vasovasostomy

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

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.

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

To what extent are benefits limited by the Society?

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

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

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

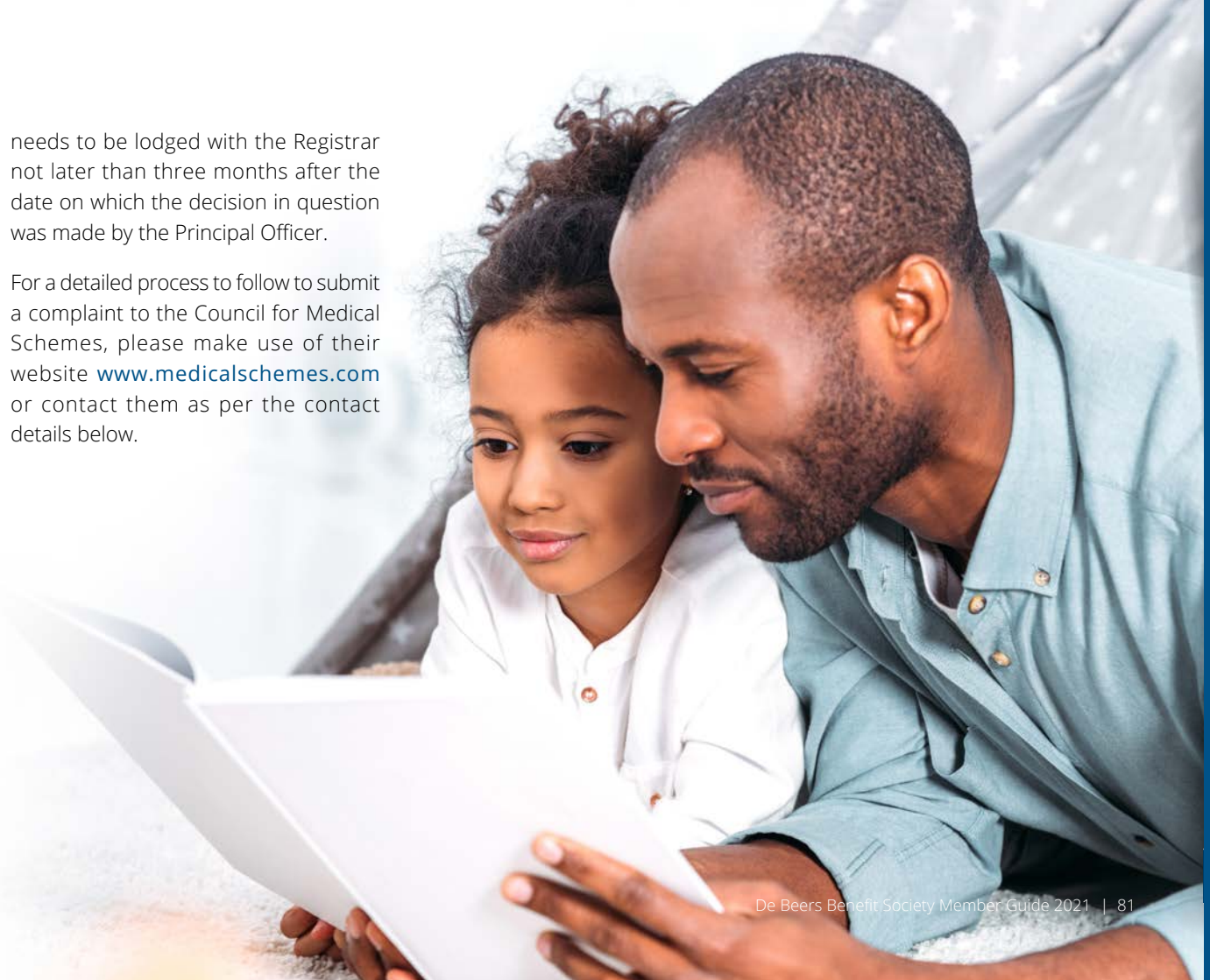
All complaints received in writing will be responded to by the Society, in writing, within **30 days** of receipt thereof.

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

Any member has the right to submit a complaint to the Council for Medical Schemes against the decision of the Principal Officer. Such complaint submitted to the Council

needs to be lodged with the Registrar not later than three months after the date on which the decision in question was made by the Principal Officer.

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



CMS Contact details

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

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

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

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

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