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Benefit Beat

Your Society – there for you when you need it most

Each year the Society experiences many high-cost cases, such as premature babies, fractured necks and respiratory failure, where claims in respect of hospitals and associated service providers for a member or one of his/her registered dependants can run into hundreds of thousands and in some cases over a million rand.

This is where the true benefit of a medical scheme lies. It is virtually impossible for most members to cover major medical expenses from their own pocket when they are hospitalised for major surgery and/or for an extended period.

Your membership of the Society should give you great peace of mind: you are provided with competitive medical benefits to cover you and your loved ones for medical emergencies, in addition to which you enjoy very competitive day-to-day out-of-hospital benefits. It should also be comforting to members to know that their average out-of-pocket medical expenses, as recorded by the Society, are below 10%, whilst the industry average is 18.6% (CMS 2015/16 Annual Report).




7.9%

CONTRIBUTION INCREASE

Contributions for 2017

The Society's increase in contributions for 2017 will be **7.9%**. This brings the Society's adult and child contributions for 2017 to **R 2 872** and **R 773** respectively. Open schemes such as Bonitas, Momentum, Bestmed, Medihelp and Discovery are increasing their contributions by between **9.9%** and **17.0%** for 2017. The Society's increase is well below the general industry increases. This again demonstrates the focus of the Trustees on ensuring that the Society continues to provide you with value for money for your contributions – with competitive and quality medical cover at a reasonable price, given the level and extent of benefits provided. Society members also play a significant role in containing costs by using benefits in a responsible manner and supporting initiatives implemented to contain costs.



How the Society works for you

NOT PROFIT-DRIVEN

- As a not-for-profit, self-administered restricted medical scheme for De Beers' employees and pensioners, the Society has only one focus – to provide members with good value for money with no profit incentive. In the end, we as members benefit in that almost 100% of our contributions are available to provide our members with medical benefits.
- Open medical schemes and medical schemes that are not self-administered are administered by administrators that have to show a profit from their operations. This profit is funded out of member contributions. In addition, VAT is payable on fees payable for outsourced administration.
- Open medical schemes are marketed by brokers who earn significant ongoing commissions from these schemes, which are also funded from member contributions.

COMPETITIVE CONTRIBUTION INCREASES AND MINIMISED ADMINISTRATION COSTS

- The Society's average annual contribution increase over the past five years has been 7.7%, compared with the average industry increase of 9.0% over the same period (*CMS 2015/16 Annual Report*).
- The Society's administration cost also compares favourably to that of the industry. The Society's administration cost over the past five years as a percentage of contributions averages about 7.0%, whilst the industry average is above 10% (*CMS 2015/16 Annual Report*).
- Furthermore, the Society's level of reserves allows it to fund the majority of its administration costs from investment income. This means that almost 100% of member contributions received is used to pay for medical benefits (claims) on behalf of our members.
- Recently, the extent of trustee remuneration has enjoyed much publicity. The Society only remunerates member

elected Trustees (4 out of 8) at a rate per meeting attended as agreed at each AGM. The extent of the conservative total remuneration per member elected Trustee is recorded in the Society's published Annual Financial Statements. The total remuneration paid to all Trustees during 2015 is less than that quoted in the press for an individual Trustee of some of the open medical schemes.

VERY STABLE AND FINANCIALLY SOUND

- The Society has been in existence since 1889, making it the oldest registered medical scheme in South Africa. It has always managed to put members' interests first, to adapt to changing conditions and to position itself to provide quality medical benefits at competitive contribution levels.
- The Society's accumulated funds (reserves) as a percentage of annual contributions is 149%. This is significantly higher than the industry average of 33% and the minimum of 25% required by law. This provides significant protection to the Society against unpredictably high claims. As mentioned above, the investment returns earned on these reserves fund the administrative costs of the Society. The added benefit of the significant size of the Society's reserves is that, unlike some open schemes that are close to or below the required legal reserve level of 25%, the Society does not have to access member contributions or increase such contributions to achieve and maintain the 25% reserve level required by law.

INDIVIDUAL COVER FOR MAJOR MEDICAL EVENTS AND DAY-TO-DAY EXPENSES

- The Society operates on the same principles as an insurance company, but without any profit motive – it undertakes liability on behalf of members in return for contributions, to provide you with medical cover on a day-to-day basis and – importantly – when you need it most.

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How the Society works for you *CONTINUED*

- Hospitalisation benefits in network hospitals are reimbursed at 100%.
- For additional peace of mind, the Society offers a host of very competitive out-of-hospital day-to-day benefits. Each benefit has its own limit and each beneficiary has access to these benefits. The list of benefits include, but are not limited to: GP and specialist consultations, physiotherapy, medicines, dental benefits, optical benefits, mental health benefits, radiology, pathology, scans, oncology benefits, hearings aids and wheelchairs.
- The Society offers each beneficiary his or her own set of individual benefits. There are no family benefit limits as is often the case with open schemes and which can result in one family member depleting all the benefits available.

‘OUR PEOPLE’ - MANAGING AND STAFFING THE SOCIETY

- The Society's Board of Trustees (which includes Trustees elected by you as members) is made up of individuals who

are committed to serve the Society and its members in a professional and efficient manner. The Trustees are supported by a professional management and administration team based in Kimberley, as well as Board Committees and professional advisers who are industry leaders in their respective fields.

- Society staff members are committed to superior levels of personalised service to all members and stakeholders. They understand our members and their needs (often knowing members by name) and are therefore ideally placed to provide unparalleled levels of personal service.

COMMITTED TO CORPORATE GOVERNANCE

- The Society is committed to the highest levels of corporate governance. The Board of Trustees maintains a firm focus on upholding high standards of corporate governance and it proactively monitors and manages the risks and challenges that the Society faces. The Society also obtains regular assurance from internal and external auditors regarding the efficiency of its governance structures and risk-management functions.

Benefit improvements for 2017

The benefit limits for 2017 have, on average, been increased by 6%. Member co-payments have not been increased contrary to what has happened elsewhere in the industry in an attempt to contain contribution increases. In addition, no benefits have been reduced, except for the introduction of a generous “soft” limit of R 4 800 per beneficiary, as a cost control measure, in respect of out-of-hospital pathology benefits. This limit may still be exceeded, subject to motivation by the treating provider. Member choice in terms of treating service provider selection also remains unchanged for 2017.

The Society has also made some enhancements to the benefit structure. These include:

- Acute medication now includes benefits for contraceptive preparations and devices.
- A number of benefits have been added (see the 2017 Member Guide for more details):
 - Laparoscopic Incisional / Ventral Hernia repair procedures, capped at R37 200;
 - A Robotic Assisted Laparoscopic Procedure (RALP) for a radical prostatectomy capped at R70 000 for the hospital procedure only. This includes the anaesthetic theatre time limited to a maximum of 3 hours. All the associated service providers (surgeon, anaesthetist, etc.) are capped at a combined total of R40 000 for the RALP;
 - Home confinement / Natural birth delivery, capped at the normal delivery total cost of R15 800;

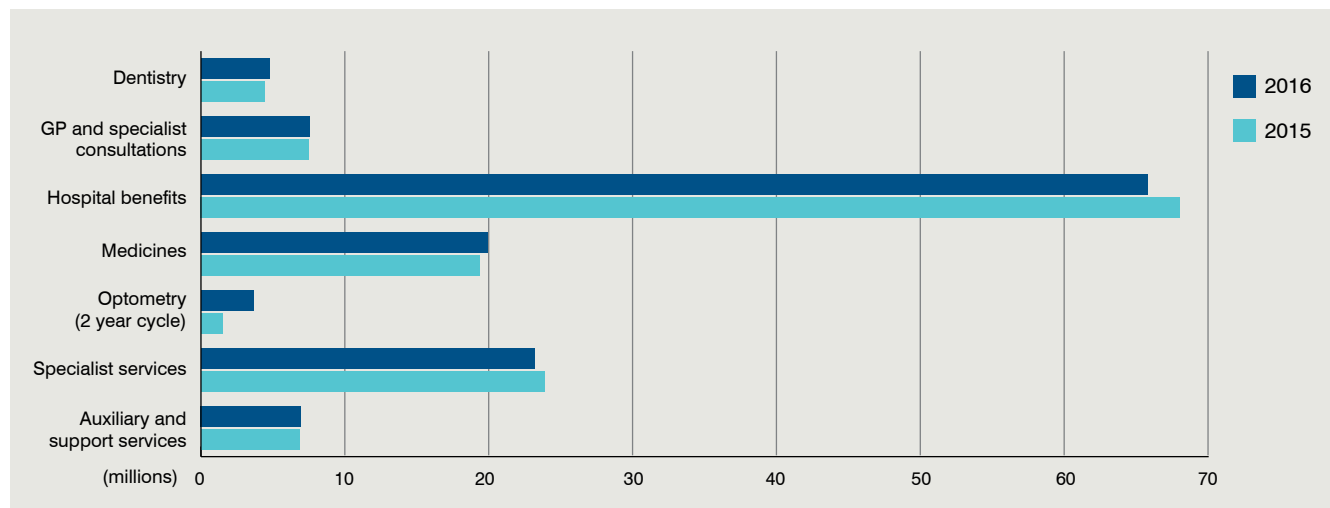


- The addition of continuous glucose monitoring devices to the aids and appliances benefit;
- Social Workers' fees, which will accrue to the mental health benefit; and
- Occupational and speech therapy and dietician services in-hospital, which will no longer deplete the out-of-hospital benefit limit.

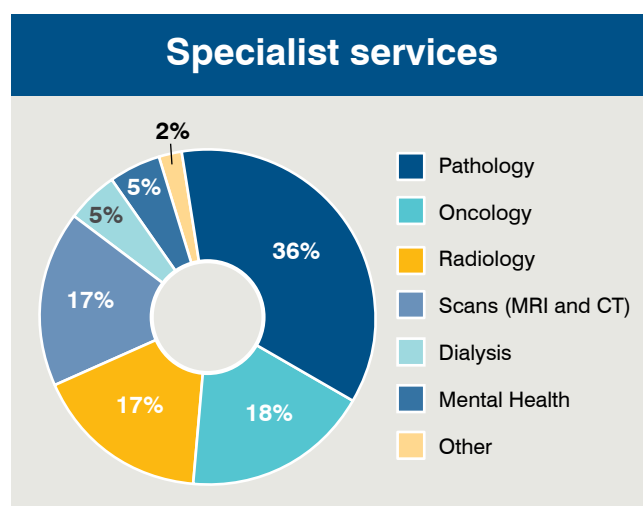
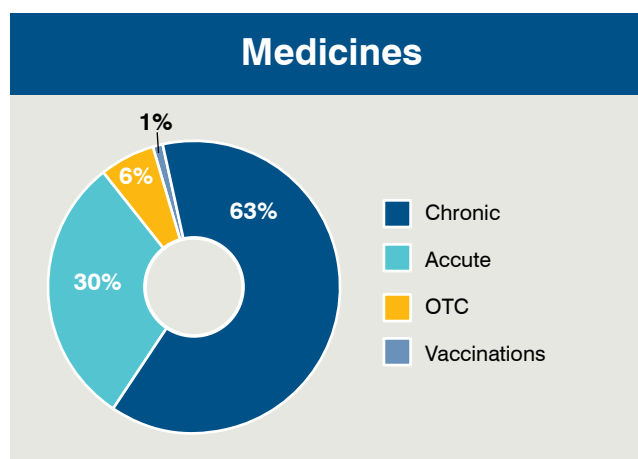
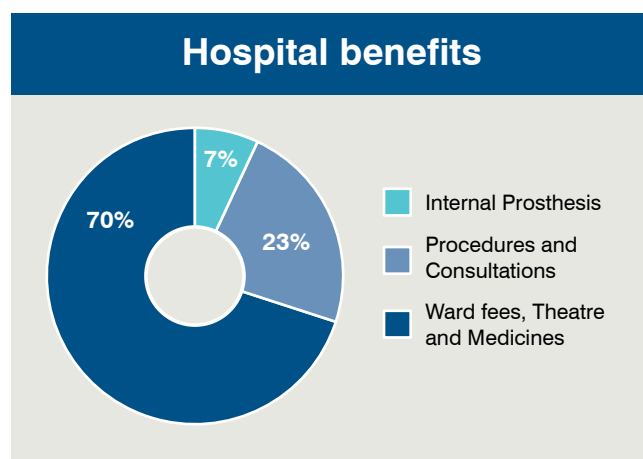
Members are encouraged to study the Society's Member Guide for 2017 (distributed together with this issue of Benefit Beat) and to contact the Society's call centre on 053 807 3111 (option 5) if any clarity regarding the benefits available for 2017 is required.

Where do member contributions go?

For the period January to June 2016 (half a benefit year) the Society spent a total of R149.9 million in benefits for members. The major claims paid are shown below:



The following graphs provide a breakdown of the most costly categories:



'Medical savings accounts' – the full story



The Society offers a traditional benefit structure with defined in-hospital, chronic and extensive out-of-hospital day-to-day benefits. Unlike the more modern open schemes, the Society does not offer a medical savings account facility; a fact that is sometimes met with some dissatisfaction. However, the Trustees firmly believe that the current benefit structure is far more beneficial to the average beneficiary, and this is why:

- In terms of the Society's traditional benefit structure, each registered beneficiary qualifies to receive his/her own set of benefits (as opposed to benefit limits set per family), as provided for in the rules and detailed in the annual Member Guide. The risk of all benefits being used in full in a single year is low and in general members' out-of-pocket medical expenses are limited.
- In a 'new generation' medical scheme with a medical savings account, members' contributions are split, with a portion being paid to provide for risk benefits (major medical events, such as hospitalisation and chronic medicine benefits) and a relatively small portion being allocated to a medical savings account from which out-of-hospital day-to-day claims such as acute medicines, GP visits, physiotherapy, dentistry, pathology tests and optical benefits for all beneficiaries need to be paid. Whilst a medical savings account has the theoretical benefit that unused funds can be carried over from one year to the next, the disadvantage is that medical savings accounts invariably offer much lower benefit limits than traditional benefits. The reason for this is that traditional benefits allow the Society to cross-subsidise, effectively using unclaimed benefits of low-claiming beneficiaries in any year to support high-claiming beneficiaries in the same year.

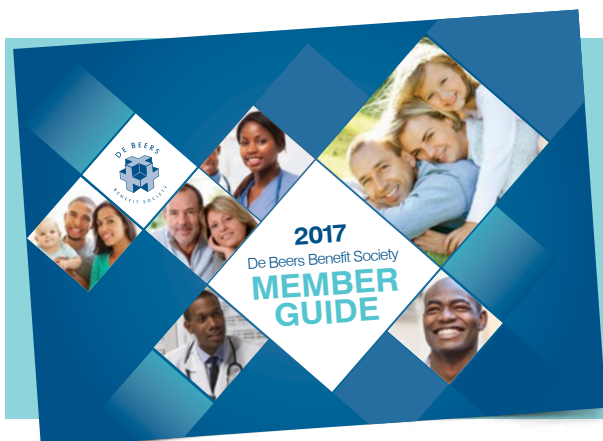
The main risk associated with medical savings accounts is that these accounts are prone to run dry before the end of the benefit year, or can possibly be used up by a single beneficiary from a family resulting in no further cover being available for out-of-hospital day-to-day benefits for any of the remaining family members. The extent of contributions channelled to medical savings accounts are also reduced in some cases to contain the overall contribution increases.

The majority of schemes market their medical savings account functionality as a benefit, whilst in reality a medical savings account is funded in full by the member who then effectively has to pay for a large portion of his/her benefits from and within the limits of this account.

For example...

Let's assume a member (plus his wife and two children) belongs to a medical scheme that has a medical savings account. His total monthly contribution is R8 380 per month, of which R2 090 goes towards his savings account. The out-of-hospital day-to-day cover for his entire family for the full benefit year is therefore $R2\,090 \times 12 = R25\,080$.

Had this member belonged to the Society, all the registered dependents of his family would have had access to out-of-hospital day-to-day benefits far in excess of R25 080. (All you need to do to confirm this is to add up the value of all the out-of-hospital benefits offered by the Society per beneficiary.)



Member Guide for 2017

Enclosed please find your DBBS Member Guide for 2017. Please read the Guide carefully and contact the Society's call centre on 053 807 3111 (option 5) if you have any queries or require any clarity regarding the benefits for 2017.

Stretching member contributions

The majority of service providers such as GPs, dentists and physiotherapists are reimbursed on a fee-for-service basis. This unfortunately creates incentives for some service providers to over-supply and charge excessive fees, ultimately impacting on member contribution levels. The Society therefore has to employ various mechanisms and initiatives to control this environment in the best interest of its members and to limit contribution increases as far as possible.

The Society has introduced the following mechanisms and initiatives over the years to help manage medical expenses, to ensure the maintenance of an acceptable overall benefit structure and to minimise contribution increases:

- **Pre-authorising** hospital admission requests and other major medical events and case managing hospital admissions;
- Introducing a well-defined, effective benefit structure with clearly defined **benefit limits, exclusions, member co-payments and penalties**, where applicable;
- Introducing **Network Hospitals**, which offer more favourable rates;
- Introducing a **medicine formulary** and **generic reference pricing** for chronic medicines;



- Appointing **Designated Service Providers**, such as Dischem, for the supply of chronic and acute medicines at more favourable dispensing rates;
- Appointing **ER 24** to provide emergency transport services at more favourable rates;
- Appointing **PPN** to provide and manage the Society's optical benefits through their contracted network at more favourable rates and with more limited potential for fraud; and
- Using **ICON's** protocols and provider network for all oncology-related consultation and treatment at more favourable rates.



Letter of appreciation

Dear De Beers Benefit Society staff members, hope to find you all well.

Dad passed away on Friday, the 13th of May 2016. A very, very big thank you from my side to all the staff members who, over the years, had with so much patience and extra effort, assisted my Dad with all his telephone calls, requests and issues regarding his medication.

For the friendly voices always - I've also phoned a few times and you're the best' nothing is too much trouble for you guys. You are truly angels and I thank you from the bottom of my heart.

Keep up the good work and be blessed.

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DISCLAIMER: Please note that while every effort has been made to ensure the accuracy of the information contained in this newsletter, the De Beers Benefit Society will not accept any responsibility for any inaccuracy or omission. In case of any dispute, the registered rules of the Society will apply. The rules are available from the Society and are also published on the Society's website. Should 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 this website for easy access to all your personal medical information online, provided you have registered to use this facility.