

Membership  
Guide  
2015

**bestMed**

Better living. Better life.



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# 1. About Bestmed

## 1.1 Introducing Bestmed

After achieving the benchmark of celebrating our 50<sup>th</sup> anniversary in 2014, Bestmed is still raising the bar in the medical industry to the point where we have grown our Membership to reach the fifth overall position countrywide. Going forward Bestmed is also focused on serving our Members with the legendary Bestmed touch.

A self-administered scheme, Bestmed now has more than 92 000 principal Members and provides healthcare benefits to more than 193 000 lives. With our extensive experience and exceptional expertise, we can negotiate with our service providers to offer our Members benefits and services that are, Rand for Rand, the best value compared to other large open medical schemes.

## 1.2 We Live Our Values

We are constantly inspired by our company vision which states:

“Bestmed shall be trusted as the medical scheme of first choice to access value-for-money lifestyle and preventative care benefits, and a healthcare offering that is unique in the market we serve.”

This is the reason why we follow a principled approach, interacting with all stakeholders in a mutual spirit of partnership. It is our passion to surpass customer expectations and forge seamless partnerships, thus ensuring real benefits for our Members.

At Bestmed, we embrace the following critical values:

### Mutual

We believe in a shared experience that includes our Members. The spirit of partnership is evident in everything we do. We are proactive in our approach, we invest in the community, put people before profit and we are accountable for our actions. Simply put, we're all in this together.

### Seamless

Bestmed works closely with service providers to offer our Members a seamless experience in which the Members are never left wondering who they should ask. It's about closing the gaps, never playing the blame game, and equipping our staff with the comprehensive knowledge and understanding of all our products. It all adds up to service excellence.

### Principled

Family values are at the heart of everything we do. Warmth, care, openness and loyalty are the things we enshrine. This means when we make a promise, we honour it. Above all, we always act in the best interests of our more than 92 000 strong Member family.

## Passionate

We are driven by a love of what we do. It gives us the energy to stay proactive, innovative, inspired and committed to exceeding the Members' expectations. You see, it's not all about medical cover. It's about helping people. When you think about it like that, it's easy to believe in what you do.

## 1.3 The Relevant Legislation

Although some pieces of legislation in South Africa are applicable to Bestmed Medical Scheme, great care is taken to ensure that we comply with the rights, benefits, contributions and duties of Members.

Some of the major Acts are:

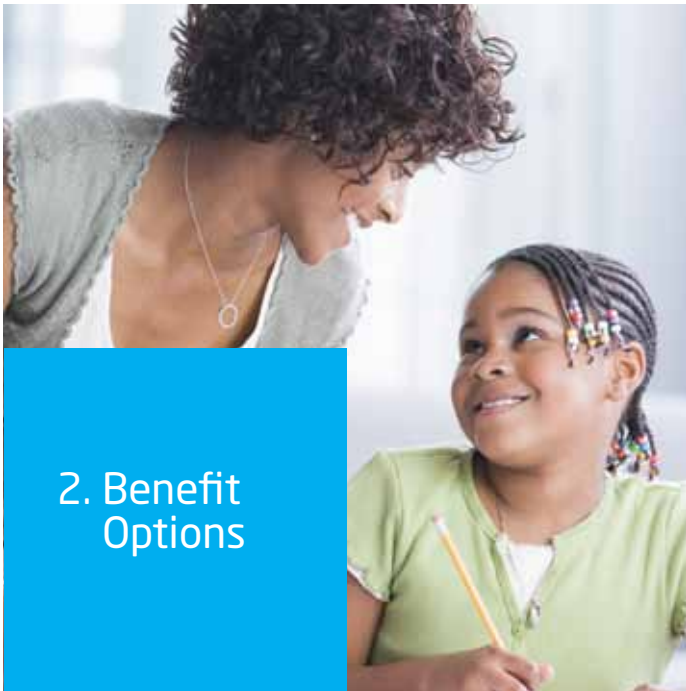
- Constitution of the Republic of South Africa, 1996 (Section 27)
- Medical Schemes Act 131 of 1998
- National Health Act 61 of 2003 (NHA)
- Health Charter
- Consumer Protection Act 68 of 2008
- Promotion of Access to Information Act 2 of 2000

## 1.4 Our Membership Growth

In 2014 Bestmed grew its Membership for, the 12<sup>th</sup> consecutive year of consistent growth. Bestmed has grown to be the fifth biggest open medical scheme in the industry, with 92 000 principal Members and 193 000 beneficiaries.

YEAR	PRINCIPAL MEMBERS	BENEFICIARIES
2008	36 669	85 478
2009	41 555	92 359
2010	64 201	141 759
2011	69 982	147 485
2012	73 181	152 889
2013	88 000	185 000
2014	92 000	193 000





## 2. Benefit Options

\*Please note: Consistent with the Scheme Rules, a word or expression used in this Guide in the masculine includes the feminine and a word used in the singular includes the plural, and vice versa.

### 2.1 Benefit Option Ranges

Bestmed recognises that Members' healthcare needs will vary depending on age, marital status and different responsibilities and priorities. So, to address our Members' desire for choice and flexibility, Bestmed has developed three benefit categories, differently structured to suit various healthcare needs. Bestmed's Beat, Pace and Pulse product offerings span the entire range from cover for hospital costs to a more comprehensive offering covering all healthcare requirements:

- **The Beat range** offers flexible hospital benefits on all Beat options with limited savings to pay for out-of-hospital expenses on some options such as Beat2 and Beat3 but extensive out-of-hospital cover on Beat4. As from 2015, the Beat range offers an efficiency discount option (N option). This is an option where the Scheme offers discounted contributions to Members who agree to sacrifice freedom of choice and make use of the Scheme-contracted Designated Service Providers (DSPs) for hospitals, specialists and medicine. Co-payments are applicable to the voluntary use of non-DSPs. The options in this category are Beat1, Beat2, Beat3 and Beat4.
- **The Pace range** offers more comprehensive hospital benefits, but with funds from the Scheme and more savings to cover out-of-hospital expenses. The options in this category are Pace1, Pace2, Pace3 and Pace4.
- **The Pulse range** offers full hospital benefits with out-of-hospital benefits provided by Designated Service Providers only. The options in this range are Pulse1 and Pulse2.

### 2.2 Benefit Option Guidelines

#### Beat1

#### Hospital Plan Option (Choice between Non-network/ Network Option)

You're young, single and ambitious. You keep healthy and care about your wellbeing, but you seek extensive in-hospital cover from your medical scheme, should anything happen to you and you are faced with exorbitant hospital costs. You also find value in benefits like flu vaccines, contraceptives etc. Beat1 is the option that perfectly suits your dynamic lifestyle.

#### THE BEAT1 OPTION IS FOR YOU, IF:

- You want an affordable option.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which include flu vaccines, oral contraceptives, back rehabilitation, etc.
- You realise that at any time you may be faced with expensive, unforeseen hospital costs.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Beat1 option in-hospital services are paid from Scheme risk benefit and out-of-hospital services will be for the Member's own account. Some preventative care services are available from Scheme risk benefit.

#### Beat2

#### Hospital Plan Option (Choice between Non-network/ Network Option)

You and your partner believe that prevention is better than cure and find value in preventative care such as flu vaccines, immunisations, contraceptives, preventative dentistry etc. However, you understand that life is unpredictable, so you are looking for extensive hospital cover. Beat2 provides the ideal cover for you.

#### THE BEAT2 OPTION IS FOR YOU, IF:

- You want an affordable option.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which include flu vaccines, paediatric immunisations, contraceptives, back rehabilitation, basic and preventative dentistry, etc.
- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You want to make provision for out-of-hospital medical expenses to be paid out of your medical savings account.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Beat2 option in-hospital services are paid from Scheme risk benefit and out-of-hospital services will be paid from the savings account. Some preventative care services are available from Scheme risk benefit.

\*See Understanding your Savings on page 13.

#### Beat3

#### Hospital Plan Option (Choice between Non-network/ Network Option)

You are planning to extend your family and need affordable medical cover with good maternity benefits. You also want a broad range of hospital benefits, preventative care benefits and cover for unforeseen chronic disease medicines. Beat3 comfortably fits in with your evolving life.

#### THE BEAT3 OPTION IS FOR YOU, IF:

- You want an affordable option.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which includes flu vaccines, paediatric immunisations, oral contraceptives, back rehabilitation, basic and preventative dentistry, etc.
- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You are planning to start a family and need cover for sonars and antenatal visits.

- You are in need of cover for chronic conditions.
- You want to make provision for out-of-hospital medical expenses to be paid out of your medical savings account.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Beat3 option in-hospital services are paid from Scheme risk benefit. Some day-to-day benefits are paid from the Scheme risk benefit and other services will be paid from your savings account. Some preventative care services available from Scheme risk benefit.

\*See Understanding your Savings on page 13.



You are planning to extend your family and need affordable medical cover with good maternity benefits. You also want a broad range of hospital benefits, preventative care benefits and cover for unforeseen chronic diseases. Beat4 comfortably fits in with your evolving lifestyle.

#### THE BEAT4 OPTION IS FOR YOU, IF:

- You require comprehensive day-to-day cover.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which includes flu vaccines, paediatric immunisations, oral contraceptives, back rehabilitation, basic and preventative dentistry, PAP smears, mammograms, etc.
- You realise that at any time you might be faced with expensive and unforeseen hospital costs.
- You are in need of cover for chronic conditions.
- You want to make provision for out-of-hospital medical expenses to be paid from your savings account.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Beat4 option in-hospital services are paid from Scheme risk benefit. Some out-of-hospital services are paid from the annual savings first and, once depleted, will be paid from the Scheme Risk benefit. Some preventative care available from Scheme risk benefit.

\*See Understanding your Savings on page 13.



You are a healthy, growing family and require excellent hospital benefits with extensive day-to-day cover. Being happy and healthy is important to you so you value good preventative care such as vaccinations and PAP smears. Chronic medicine cover is also of absolute importance to you. Pace1 will take care of you and your family.

#### THE PACE1 OPTION IS FOR YOU, IF:

- You require extensive day-to-day cover to meet your healthcare needs.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which includes flu vaccines, paediatric immunisations, oral contraceptives, back rehabilitation, basic and preventative dentistry, PAP smears, mammograms, etc.
- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You are in need of cover for chronic conditions.

- You prefer freedom of choice when it comes to visiting a healthcare service provider.
- You want to make provision for out-of-hospital medical expenses to be paid from your medical savings account.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Pace1 option in-hospital services are paid from Scheme risk benefit. Some out-of-hospital services are paid from your annual savings first and once depleted will be paid from Scheme risk benefit. Some preventative care benefits are available from Scheme risk benefit.

\*See Understanding your Savings on page 13.



You are an established family in need of extensive day-to-day cover with freedom of choice when it comes to hospitals, doctors and specialists. You also require extensive out-of-hospital benefits and the assurance that comes with a full-range of chronic benefit cover. Enjoy peace of mind in that Pace2 will take great care of you and your family's healthcare needs.

#### THE PACE2 OPTION IS FOR YOU, IF:

- You require comprehensive day-to-day cover.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which includes flu vaccines, paediatric immunisations, oral contraceptives, back rehabilitation, basic and preventative dentistry, PAP smears, mammograms, etc.
- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You are in need of cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Pace2 option in-hospital services are paid from Scheme risk benefit. Some out-of-hospital services are paid from your annual savings first and once depleted will be paid from Scheme risk benefit. Some preventative care benefits are available from Scheme risk benefit.

\*See Understanding your Savings on page 13.



You are a mature family with a diverse range of medical needs. As much as you live by the rule that prevention is better than cure, you still require comprehensive chronic benefits and excellent hospital cover. You can also access day-to-day medical benefits which are funded from your personal savings account. Once depleted, Scheme Risk benefits will apply.

With Pace3 you can rest assured that your family is well taken care of.

#### THE PACE3 OPTION IS FOR YOU, IF:

- You require comprehensive day-to-day cover.
- You live by the rule 'prevention is better than cure' - Pace3 offers a wide range of preventative care benefits which include flu vaccines, paediatric immunisations, oral contraceptives, back rehabilitation, prostate screening tests, basic and preventative dentistry, mammograms, PAP smears and bone densitometry tests, etc.

- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You are in need of cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Pace3 option in-hospital services are paid from Scheme risk benefits. Some out-of-hospital services are paid from your annual savings first and once depleted will be paid from Scheme risk benefit. Some preventative care benefits are available from Scheme risk benefit.

\*See Understanding your Savings on page 13.

### Pace4

#### Traditional Option

You are a discerning family who may have above average medical costs. You need the comfort of extensive benefits for preventative care (such as PSA, PAP smears, and bone densitometry), day-to-day medical care, maximum cover for chronic conditions and hospital expenses. In addition, a personal savings account, which offers further payment flexibility, is also available. With the exclusivity that Pace4 offers, you have the greatest cover with complete peace of mind.

#### THE PACE4 OPTION IS FOR YOU, IF:

- You require comprehensive day-to-day cover.
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which include flu vaccines, paediatric immunisations, oral contraceptives, back rehabilitation, basic and preventative dentistry, PAP smears, mammograms, prostate screening tests, etc.
- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You are in need of extensive cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Pace4 option in-hospital services, out-of-hospital services and preventative care are paid from Scheme risk benefit. Once out-of-hospital risk benefits are depleted, further claims will be paid from savings.

### Pulse1

#### Capitation Option

You are a young individual who prefers an affordable option such as Pulse1, where primary healthcare services are provided by a network of providers (CareCross) and private hospital cover by designated network hospitals. Additional Scheme benefits include travel cover and preventative care. With comprehensive benefits for hospitalisation and quality primary healthcare provided by CareCross network providers, you will have peace of mind about your health and wellbeing.

#### HOW THE PULSE1 OPTION WORKS:

Pulse1 is a network option. This means that Bestmed has contracted CareCross (an accredited managed care organisation) to provide all your primary healthcare services and designated network hospitals to provide hospital cover. You must therefore only use service providers who are part of CareCross' national network of service providers and hospitals from the designated network. All other benefits as explained in your option benefit guide are provided by Bestmed.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Pulse1 option in-hospital services are paid from Scheme risk benefit. The Designated Network Provider (DNP), CareCross receives a capitation fee to provide most out-of-hospital services. Some preventative care benefits are available from Scheme risk benefit.

Out-of-Network visits with GPs must be paid by the Member up-front and then claimed back from the available benefit with CareCross.

### Pulse2

#### Capitation Option

You are a healthy family with a concern for maintaining a healthy lifestyle and ensuring the provision of comprehensive healthcare when needed. Pulse2 is a value-for-money network option where primary healthcare services are provided by a network of providers (OneCare) and private hospital cover by designated hospitals. Additional day-to-day benefits include a range of preventative care benefits which include vaccinations, immunisations, the back rehabilitation programme and health screening tests to take care of you and your family.

#### THE PULSE2 OPTION IS FOR YOU, IF:

- You require comprehensive day-to-day benefits at a network facility (through the OneCare provider network).
- You live by the rule 'prevention is better than cure' - you have access to preventative care benefits which include flu vaccines, pneumonia or immunisation programme, paediatric immunisations and back rehabilitation.
- You realise that at any time you might be faced with expensive, unforeseen hospital costs.
- You are in need of cover for chronic conditions.

#### METHOD OF SCHEME BENEFIT PAYMENT

On the Pulse2 option in-hospital services are paid from Scheme risk benefit. The designated network provider OneCare receives a capitation fee to provide most out-of-hospital services. Some preventative care benefits are available from Scheme risk benefit.





### 3. Application Processes and Benefits

At Bestmed, we have always remained committed in our continued effort to uphold our core value offering which embraces customer satisfaction, affordable benefits that give good value-for-money and access to top quality healthcare. We have designed a convenient Benefit Summary that lists all benefits for each option.

At a glance you should be able to see what you are covered for in terms of in-hospital, out-of-hospital, medicine and preventative care benefits. It also contains your latest contributions. All of this is also available on [www.bestmed.co.za](http://www.bestmed.co.za)

In the sections below the additional benefits of your specific option that are not on your Benefit Summary are explained in greater detail as well as the various processes you need to follow.

#### 3.1 Chronic Benefit Programme

It is compulsory to register all the chronic condition/s in order to receive funding from the chronic medicine benefits. All it takes is three easy steps:

- The patient and the treating doctor, will be required to complete a chronic medicine application form. It's advisable that one presents the treating doctor with a copy of the medicine formulary as it applies to the specific Bestmed Scheme option and the specific chronic condition. An additional supporting questionnaire might also be required for certain conditions. The chronic medicine application form is available at [www.bestmed.co.za](http://www.bestmed.co.za).
- The completed and signed application documentation must be sent to the Chronic Medicine Department, by e-mail, fax or post (contact details appear on page 39), together with all supporting documentation as required for the condition/s applied for.
- Once received, processing of the application takes five to seven working days - whereafter the applicant will be notified of the outcome of the application in writing.

Once approved, you will only have to present the doctor's prescription at the pharmacy to have the approved chronic medicine dispensed and reimbursed from the chronic medicine benefit.

##### 3.1.1 Are there specific requirements when registering for CDL or non-CDL conditions?

Some of the CDL and non-CDL chronic conditions require additional clinical information in order to qualify for registration. Before Bestmed can process the application, it is necessary for them to receive a report from the appropriate treating Specialist, together with specific clinical information. The conditions where additional information is needed, with the specific information required for each chronic condition, are listed in the following table.

CONDITION	SPECIFIC REQUIREMENT
Acne	Prescription required from a dermatologist.
Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD)	Prescription required from a psychiatrist or paediatrician or neurologist.
Alzheimer's Disease	Mini-mental state examination (MMSE) initially required together with a prescription from the relevant specialist.
Chronic Obstructive Pulmonary Disease (COPD)	COPD questionnaire to be completed.
Diabetes	Diabetes questionnaire to be completed and submitted together with the HbA1c blood test results and/or fasting blood glucose results, pre-treatment values and current values.
Epilepsy	EEG report must be submitted together with the application, alternatively a prescription from the neurologist is required.
Eczema and Psoriasis	Prescription required from a dermatologist.
Hyperlipidaemia	Hyperlipidaemia questionnaire to be completed. Lipogram results (initial and most recent) to be submitted with the application.
Osteoporosis	Osteoporosis questionnaire to be completed. Bone densitometry test results to be submitted (initial and most recent).
Psychiatric conditions	Psychiatric questionnaire to be completed by a psychiatrist.
Rheumatoid arthritis	Rheumatoid arthritis questionnaire to be completed initially by a rheumatologist.

**Below are some additional questions and answers that you might find useful with regards to chronic medicine.**

##### 1. What is a formulary?

A formulary is a list of medicines we will cover, according to Scheme Rules, for the treatment of the listed chronic conditions per option.

##### 2. What is an ICD-10 code?

It is a diagnosis code indicating the sickness condition for which treatment is being received and is therefore compulsory on all medicine applications and prescriptions.

##### 3. What are the Chronic Disease List (CDL) conditions?

CDL is a list of chronic conditions for which a scheme MUST provide cover for the medicine and treatment.

##### 4. What is a non-CDL condition?

These are additional chronic conditions which may be covered by the Scheme depending on your chosen benefit option. It is NOT compulsory for the Scheme to fund treatment of these conditions. Refer to the Comparative Guide or our website at [www.bestmed.co.za](http://www.bestmed.co.za) for the list of conditions covered per option.

##### 5. What are Prescribed Minimum Benefits (PMBs)?

PMBs are a set of minimum benefits which, by law, must be provided to all medical scheme Members and include the provision of diagnosis, treatment and costs of ongoing care.

## 6. What treatment plans are available for approved CDL chronic conditions?

For every CDL chronic condition that is approved there is a basic treatment plan that is also available. The treatment plan differs from condition to condition and can include consultations, pathology and radiology. For each approved service there is a maximum allowed per year. Once this maximum has been reached, any further claims will be covered from the normal day-to-day/acute benefits. This maximum is refreshed on a yearly basis and new allocations are made, in January.

## 7. General waiting periods and exclusions

If a Member has a general 3 month waiting period, he is entitled to apply for CDL chronic benefits. If a Member has a 12 month condition-specific exclusion, then the Member cannot claim for any services related to that condition for a period of 12 months.

## 8. Is the chronic medicine benefit allocated automatically?

No. To access the chronic benefit, pre-authorisation is compulsory. Thus, it is the Member's responsibility to apply for chronic benefits.

## 9. How does one apply for chronic medicine benefits?

The patient and the treating doctor will be required to complete a chronic medicine application form. It is advisable that one presents the treating doctor with a copy of the medicine formulary as it applies to the specific Bestmed Scheme option and the specific chronic condition.

### For all Beat and Pace options:

Call +27 (0) 86 000 2378 or log onto [www.bestmed.co.za](http://www.bestmed.co.za) to obtain an application form. Completed application forms can be sent by fax to +27 (0) 12 472 6760 or e-mailed to [medicine@bestmed.co.za](mailto:medicine@bestmed.co.za)

### For Pulse1 and Pulse2 option:

Call +27 (0) 86 010 2182 or log onto [www.carecross.co.za](http://www.carecross.co.za) to obtain an application form. Completed application forms can be sent by fax to +27 (0) 21 673 1815 or e-mailed to [chronic@carecross.co.za](mailto:chronic@carecross.co.za)

## 10. What if I forget to send my chronic application in time for registration?

Benefits will only be granted from the date your application/prescription was received. No retrospective authorisations will be granted.

## 11. What are generic medicines?

A generic medicine is one that contains identical amounts of the same active ingredient in the same strength and in the same dosage form as the original medicine. Generic medicines are approved by the South African Medicines Control Council (MCC) and must have the same quality and produce an equivalent effect in the body as the original medicine. Benefits of using generic medicines:

- They are more affordable than the original product.
- They help extend one's acute and chronic medicine benefit through the year.
- They help to prevent one paying co-payments where generic alternatives are available for original medicine.
- They reduce the rand value of co-payments as they are usually less expensive.

## 12. What is reference pricing?

A generic reference price is a maximum set price a medical scheme is prepared to pay for a specific generic molecule for a specific dosage. Bestmed uses the Mediscor Reference Price (MRP) and Maximum Medical Aid Price (MMAP) as their reference. A Member can use the original medicine and pay the difference between the price of the chosen medicine and the applicable reference price (thus have a co-payment). Alternatively, the Member can use a generic alternative within the reference price range and have no co-payment. Reference pricing is applicable to all medicines, including formulary and non-formulary medicines.

## 13. What is a co-payment?

A co-payment is the portion of a claim payable by the Member directly to the service provider.

## 14. When do co-payments apply?

- When the medicine being used is not on the medicine formulary.
- If the medicine being used is more expensive than the reference price.
- When the provider charges a higher dispensing fee than what the Scheme reimburses.
- Non-CDL conditions have co-payments for non-formulary medicine.

## 15. Why do I still have a co-payment when I use generic medicine?

- Medicine prices differ and some generic medicines are more expensive than others.
- Some generics may be more expensive than the reference price.

## 16. Why does the co-payment differ from time-to-time?

The reference price is reviewed and updated on a regular basis and is dependent on the availability of generic medicines as well as new generics entering the market. Thus, the change in reference price can affect the co-payment amount.

## 17. What if I prefer not to use generic medicine?

Should you prefer to use the original product, Bestmed will only reimburse the claim up to the reference price amount. Thus, you will be responsible for the difference in price payable to the provider.

## 18. What should I do if my chronic prescription changes?

Refer to question 9.

## 19. What must I do if my medicine authorisation is about to expire?

A month prior to the date your medicine authorisation expires, you must submit a copy of your prescription. Please submit your renewed script timeously to ensure correct payment of claims as No retrospective authorisations will be granted.

## 20. How often should I submit a chronic prescription to Bestmed or CareCross?

You should only submit your prescription if your medicine has changed or if your authorisation is about to expire. However, your pharmacy will require a new repeat prescription every six months in order to dispense your medicine.

## 21. Why is my medicine rejected even though the condition is covered on my benefit option?

Bestmed applies protocols and funding guidelines in their authorisation process. Should your requested treatment fall outside of these funding guidelines, it will not be approved.

## 22. How often can I claim for my approved chronic medicine?

Chronic medicine claims can be submitted every 24 days.

## 23. What happens if I need an advance supply of my medicine?

Complete the application form for advanced medicine supply, which is available on our website at [www.bestmed.co.za](http://www.bestmed.co.za). Alternatively you can call +27 (0) 86 000 2378 to obtain the form.

## 24. Who are the Preferred Providers for medicine?

A preferred provider is a pharmacy recommended for Bestmed Members to obtain their medicine. Any pharmacy that charges a dispensing fee of not more than 33% with a maximum of R33 (excl. VAT), and charges no additional administration fees, can be regarded as a preferred provider. Bestmed has negotiated with more than 1 300 pharmacies and has compiled a list of these preferred providers who will charge a dispensing fee the same as, or lower than the Bestmed fee structure. You are advised to obtain your medicine from one of these preferred providers to avoid any dispensing fee co-payments. A complete list of these providers can be viewed on [www.bestmed.co.za](http://www.bestmed.co.za).

## 25. What are the contact details for chronic medicine enquiries or information?

### For all Beat and Pace options:

Tel: +27 (0) 86 000 2378

Fax: +27 (0) 12 472 6760

E-mail: [medicine@bestmed.co.za](mailto:medicine@bestmed.co.za)

### For Pulse1 and Pulse2 options:

Call +27 (0) 86 010 2182 or log onto [www.carecross.co.za](http://www.carecross.co.za) to obtain an application form. Completed application forms can be sent by fax to +27 (0) 21 673 1815 or e-mailed to [chronic@carecross.co.za](mailto:chronic@carecross.co.za)

## 26. What are the contact details for information and enquiries about PMBs (in and out-of-hospital)?

Tel: +27 (0) 86 000 2378

Fax: +27 (0) 12 472 6760

E-mail: [pmb@bestmed.co.za](mailto:pmb@bestmed.co.za)

## 3.2 Prescribed Minimum Benefits

Prescribed Minimum Benefits (PMBs) are minimum benefits that, by law, must be provided to all medical scheme Members. This includes the provision of diagnosis, treatment and care costs for:

- A limited set of 270 conditions as specified in Annexure A of the Regulations to the Medical Schemes Act 131 of 1998.
- A list of 27 chronic conditions, which are also referred to as the Chronic Disease List (CDL).
- Any emergency condition.

Hence, based on the stipulations in the Medical Schemes Act and the Regulations of the Act, PMBs are funded from the Scheme's risk pool. Therefore, a structured PMB process that meets legislative requirements as well as supports cost containment has been implemented for Bestmed Members.

### 3.2.1 How does one apply for PMB benefits?

If a Member wants to apply for a specific service to be evaluated and approved from the PMB risk pool, the following must be kept in mind:

- Only qualifying PMB ICD-10 codes will be considered for PMB benefits.
- The Bestmed PMB application form has to be completed by the treating provider as well as the Member for this request to be considered for PMB benefits.
- If all the PMB criteria have been met, funding for PMBs firstly come from the available benefits and only thereafter the difference will be covered as a PMB.

The PMB application request form is available and can be requested by the Members and/or providers by contacting the Call Centre. This PMB application request form must be signed by both the Member and provider and if a dispute arises further information may be requested by the Scheme.

PMB benefits are authorised by means of retrospective application. Decision-making is based on the support of or made in accordance with the relevant treatment algorithms of the PMB regulations, Scheme protocols, Scheme Rules, formularies and other managed care initiatives.

Once a decision is made by the PMB Department, both the Member and provider will be informed of the outcome of the PMB application request via e-mail and/or telephone.

PMB applications and/or related PMB enquiries can be submitted by contacting Bestmed's Call Centre at +27 (0) 86 000 2378 or [service@bestmed.co.za](mailto:service@bestmed.co.za).

Completed application forms can also be e-mailed to [pmb@bestmed.co.za](mailto:pmb@bestmed.co.za), faxed to +27 (0) 12 472 6760 or posted to PO Box 2297, Pretoria, 0001.

### 3.2.2 How do I know that my application has been approved?

For any application received, an e-mail will be sent to the practice as well as the Member informing them of the decision that has been made by the PMB Department.

### 3.2.3 What happens once an application is approved?

If an application has been approved for retrospective services, Bestmed will arrange for the claim/s to be processed from the PMB benefit. Members will be able to view all corrections to claims on the e-mailed and/or posted claims statement.

### 3.2.4 What happens if an account was short paid and the account has now been approved as a PMB?

- Bestmed will arrange for the short payment to be made to the provider, or
- On receipt of proof of payment from the Member, make a payment into the Member's bank account so that the Member can settle the account with the service provider.

### 3.2.5 If I have GAP Cover, will it cover the shortfall on all my in-hospital accounts?

GAP Cover may provide cover for the shortfall of in-hospital accounts that are not valid PMB cases. If the hospitalisation was for a valid PMB, the practice or Member needs to apply directly to Bestmed to possibly approve the shortfall as PMB.

### 3.2.6 Where can the PMB application form be obtained?

The form is available from Bestmed's Call Centre at +27 (0) 86 000 2378, by e-mailing a request to [pmb@bestmed.co.za](mailto:pmb@bestmed.co.za) or sending a request by fax to +27 (0) 12 472 6760.

## 3.3 Oncology Benefit Management

The Bestmed Oncology Designated Service Provider Network in partnership with ICON has been functioning since April 2013. ICON is the Designated Service Provider for all newly registered oncology patients for all Bestmed's options except Pace3 and Pace4, which are dealt with by the South African Oncology Consortium (SAOC), as well as Pulse1 where State facilities have been appointed as the designated service provider.

The Oncology Programme provides affected Members with the following benefits:

- Access to additional benefits and services that form part of the treatment protocol.
- Oncology treatment that includes chemotherapy, radiation therapy, certain pathology, certain radiology and certain consultations.

Certain supportive medicines in the Bestmed oncology formulary may be funded from this benefit. Please note that preferred providers (including State facilities) may be appointed by Bestmed for specific benefit options.

To access the Oncology benefit one needs to register for the programme:

- All services must be pre-authorised by Bestmed.
- Services are rendered by the preferred providers that Bestmed has appointed.
- The services must fall within Bestmed's funding protocol.

If you would like to find out more about the Oncology benefit and programme, please visit our website on [www.bestmed.co.za](http://www.bestmed.co.za) and click on "Managed Care". Alternatively, you can contact us on +27 (0) 12 472 6254 and one of our Oncology Case Managers will gladly assist you.

**Below are some questions and answers that you might find useful with regards to Bestmed's oncology programme.**

**1. Is cancer a PMB?**

Not all cancers qualify for PMB benefits. The regulations of the Medical Schemes Act define cancers covered under the Bestmed oncology benefits as cancers that are contained in the organ of origin. This means that the cancer has not spread to adjacent organs or to distant parts of the body (metastasis). Certain types of cancers are not bound to organs such as cancers of the blood system. The oncology benefits may include limited cover for cancers that have already spread in order to provide better management of the patient.

**2. Which conditions are funded from the oncology benefit?**

Cancer (malignant tumours and malignant haematological/blood conditions) confirmed by a laboratory report will qualify for registration on the oncology programme. Normally a tissue sample is collected during a biopsy procedure and sent for evaluation by pathologists.

The findings of the diagnosis will be noted on a histology report. Benign tumours and pre-malignant conditions do not qualify for funding on the oncology programme. The diagnosis (ICD-10) code for cancer usually starts with a "C" and may be included in the oncology benefit. Codes for benign conditions mostly start with a "D" and are not funded from the oncology benefit as they are not cancerous.

**3. Why do I have a co-payment on my oncology medicine?**

The generic Mediscor Reference Price (MRP) is applicable to all medicines, including injectable and intravenous medicines. This means that if your doctor chooses to prescribe the original product, and a generic alternative is available, you will have to pay the difference between the price of the original medicine and that of the MRP.

**4. Why do I have a co-payment on my consultation/procedure?**

Oncology benefits are funded up to 100% of the Bestmed Scheme tariff. If a doctor charges more than the Scheme tariff, you will have to pay the difference.

**5. I visited my GP/specialist regarding my cancer. Will it be funded from the oncology benefit?**

As oncologists specialise in the treatment of cancer, the oncology benefit makes provision for funding of oncologist consultations. GP consultations are not funded from the oncology benefit. Certain specialist visits may be funded from the oncology benefit, depending on the type of cancer you are registered for. For example, urologists for bladder cancer, dermatologists for skin cancer, etc. Always confirm benefits before assuming that a consultation will be funded from the oncology benefit.

**6. What is ICON?**

ICON stands for the Independent Clinical Oncology Network, a South African multidisciplinary network of oncology specialists who are dedicated to widening local access to quality cancer care.

Bestmed has appointed ICON as Designated Service Provider (DSP) for all the benefit options, excluding Members on Pulse1, Pace3 and Pace4. Bestmed uses the Standard option of ICON for all Members.

**7. What is SAOC?**

The South African Oncology Consortium (SAOC) endeavours to enable access to cost-effective oncology treatment for South Africans. Members on Pace3 and Pace4 use the South African Oncology Consortium (SAOC) cancer treatment guidelines. Bestmed uses the SAOC "Tier 1" treatment guidelines and these guidelines form the basis of oncology funding for Pace3 and Pace4. "Tier 2" treatment protocols will only be considered as an extended benefit after "Tier 1" has failed and authorisation has been given.

**8. Will breast reconstruction or prosthesis after mastectomy be funded from the oncology benefit?**

A doctor's motivation and quotation may be sent to the Scheme. Only the prosthetic insert is funded and not the special bra. Depending on your benefit option, the prosthesis is funded either from the Medical Appliance Limit or

savings account. Benefit options with no Medical Appliance Limit or savings account do not make provision for this funding.

Non-cosmetic breast reconstruction may be considered for funding only after a breast cancer mastectomy, and is restricted to the cancerous breast only. Surgery on the healthy breast will not be funded. Hospital authorisation has to be obtained from the pre-authorisation department for approval from the high-risk Scheme benefits at 100% of Scheme tariff, subject to funding protocols and guidelines.

**9. Will wigs be funded from the oncology benefit?**

No. The oncology benefit does not make provision for funding of wigs and related items.

**10. Which scans and tests are funded from the oncology benefit?**

A group of specific services, directly related to the specific type of cancer, are authorised for payment from the oncology benefit. This may include basic radiology (such as sonars or black and white x-rays) or blood tests (such as liver function tests and full blood counts). Your doctor can confirm if the tariff codes for these scans and tests are funded from the oncology benefit before proceeding with these services. CT scans, PET scans and nuclear scans are not funded from the oncology benefit but are subject to your option's Specialised Radiology benefit.

**11. Is hospice or terminal care funded from the oncology benefit?**

Terminal care services are not funded from the oncology benefit. Accommodation in an old-age home or institution providing general care and nursing services to persons (e.g. the infirm, aged and chronically sick patients) or similar institutions, including home nursing visits, are a Scheme exclusion. Hospice authorisation may be considered for the last seven days of life only by the pre-authorisation department.

**12. If I go into remission, will I be removed from the oncology programme?**

No. You are registered for life on Bestmed's oncology programme. This means that you will be able to utilise the oncology benefit for services like annual oncologist consultations even when you are in remission.

**13. I need to go for physiotherapy or lymph drainage. Will it be funded from the oncology benefit?**

No. If your benefit option makes provision for supplementary services, all physiotherapy will be funded from that benefit on motivation.

**14. Why has my chemotherapy not been approved?**

Bestmed provides oncology benefits applying evidence-based medicine principles and considering affordability to the different benefit options. Treatment plans may not be approved for several different reasons, including the following:

- The treatment plan falls outside the scope of ICON/SAOC treatment protocols and guidelines.
- The medicine in the treatment plan is not registered with the South African Medicine Control Council for the treatment of the specific cancer.
- The medicine is not registered for use in the South African market by the Medicine Control Council (Section 21 medicine).
- The medicine in the treatment plan is not covered on your specific benefit option (biological and other high-cost medicine, etc.).

**15. I have a family history of cancer. Will precautionary measures and tests be paid from the oncology benefit?**

No. Oncology benefits are limited to Members who have already been diagnosed with cancer and are registered on the oncology programme.

**16. Will genetic testing be funded from the oncology benefit?**

No, genetic typing and testing is excluded from the oncology benefit.

### 17. Why isn't all the medicine I use due to cancer funded from the oncology benefit?

The oncology benefit is dedicated to funding of chemotherapy and radiotherapy. Bestmed makes use of a limited formulary for certain additional supportive medicines (for nausea, pain etc.). Medicines that are excluded from the oncology benefit include anti-depressants, certain anti-inflammatories and painkillers, proton pump inhibitors for acid reflux, sleeping tablets, anti-anxiety medicine etc.

### 18. Why do I need to receive cancer treatment in a State facility?

If you are registered on the Pulse1 benefit option, Bestmed has appointed State facilities as its Designated Service Provider. Pulse1 is a capitation option with limited oncology benefits and Members are referred to State facilities to receive treatment in accordance with the registered Scheme Rules and legislation. Newly diagnosed oncology patients may upgrade to a higher benefit option in order to access more comprehensive oncology benefits in private facilities.

### 19. Are there specific limits or exclusions in terms of benefits?

Certain services/procedures are excluded from Oncology benefits, including (but not limited to) the following:

- If a speciality medicine including biological's and other high cost medicine (only applicable to specific benefit options) is approved according to Scheme funding guidelines, an annual monetary limit is applicable. This limit is shown in the benefits and brochures of the various benefit options.
- Brachytherapy for prostate cancer will only be considered, where the funding criteria is met, for cover on the Pace2, Pace3, Pace4 and Pulse2 options. A global fee with a limit of R 91 000 (Ninety one thousand Rand) is applicable.
- Specialised radiology services, including CT scans, PET scans and nuclear scans, are excluded from the oncology benefit.
- Only benefits as stipulated and authorised by the Scheme will be funded in accordance with your specific benefit option.

## 3.4 HIV/AIDS Benefit

Bestmed covers counselling and testing of Members who suspect they may be HIV positive or who wish to know their status. Bestmed has contracted OneHealth to manage the HIV/AIDS benefit. The benefits for Members who are HIV positive, cover a spectrum of services, which include the following:

- Advice and counselling that are available during business hours from the HIV Helpline (see under Contact Details at the end of this Membership Guide).
- Regular blood tests to monitor the course of the disease and to measure the response to treatment
- Medicine and anti-retrovirals (medicine specifically used to fight the virus).

The treatment programme covered by the Scheme is based on the HIV/AIDS funding guideline and approved treatment depends on the clinical parameters of each individual. The stage of the disease and the results of blood tests determine what treatment will be covered and how the individual must be followed up.

Cover is provided for prevention of mother-to-child transmission during pregnancy and as post-exposure prophylaxis.

Further details can be obtained by contacting OneHealth on the numbers or e-mail address listed under contact details at the end of this Membership Guide.

## 3.5 Spinal Rehabilitation Programme

This is also called the DBC programme which stands for Documentation Based Care. This is a scientifically proven rehabilitation programme for spinal problems (back, neck and shoulders) that are rendered at specific centres where all the Programme relevant expertise and equipment are present. This benefit is aimed at offering a full evaluation of the clinical spinal problem by active measurements of the functional status of the patient's affected areas. It also aims to be a possible alternative to surgery or to structure a rehabilitation programme aimed at improving the Member's function and mobility and to decrease pain and discomfort.

This benefit is available to qualifying Members on all options except Pulse1. It is only available where DBC facilities are offered.

Apply as follows for this programme:

- Contact Bestmed at the numbers or e-mail address provided for more information and authorisation. Please keep in mind that a full clinical history including the latest X-rays and reports may be required.
- After obtaining pre-authorisation from the Scheme an assessment will be arranged at a DBC facility.
- The beneficiary's X-rays will be required by the staff at the DBC facility when visiting the facility for an assessment.

Once the assessment report has been evaluated and discussed, a rehabilitation treatment programme may be suggested. Bestmed will confirm with Members what services will be funded and for what period of time.

#### Contact details

Telephone number: +27 (0) 86 000 2378

Fax number: +27 (0) 12 472 6500

E-mail address: [service@bestmed.co.za](mailto:service@bestmed.co.za)

## 3.6 Ambulance and Evacuation Emergency Services (ER24)

Bestmed has contracted with ER24 to render quality access to emergency medical services and assistance with international travel cover at preferential tariffs with no penalties.

ER24 is available 24/7 at +27 (0) 84 124.

#### What to do in an emergency

- Call +27 (0) 84 124.
- If someone else is calling on your behalf, please tell him/her to call +27 (0) 84 124.
- Tell the ER24 operator that you are a Bestmed Member. They will guide you or the person calling on your behalf to obtain all the information they require to assist you.
- If you are unsure whether your condition can be classified as an emergency or what to do when a family Member is ill or injured, ask to speak to one of the friendly ER24 nurses, who will assist you.

#### Useful tips

- Teach your family Members to call +27 (0) 84 124 in case of an emergency.
- Please store the +27 (0) 84 124 number on your cell phone and in your medical file.
- In the event of an accident, take note of the street names and numbers as this will expedite the emergency response time.

#### Your car sticker

Please follow these basic guidelines to ensure maximum effectiveness of your Bestmed/ER24 vehicle sticker:

- Remove all other medical scheme or emergency provider stickers from your vehicle(s).
- You should only display the ER24 sticker to prevent confusion and possible costs in case of an emergency.
- Place the vehicle sticker on the right-hand side (driver's side) of the vehicle - either in the rear window or in the small window behind the rear passenger's window.
- Do not place the sticker on a window that can wind down.
- If your sticker becomes damaged or faded, please contact Bestmed on +27 (0) 86 000 2378 or [service@bestmed.co.za](mailto:service@bestmed.co.za) to request a new one.

#### Please note:

Bestmed's Rules stipulate that if a Member and/or his/her Dependant(s) voluntarily make use of another ambulance service the Scheme is not liable for the account.

## 3.7 International Travel Cover

If you are travelling overseas on holiday, you will enjoy the cover provided by the International Travel Cover benefit. Download the policy at [www.bestmed.co.za](http://www.bestmed.co.za) and keep it with you while you are away.

**Note:** You must contact ER24 on +27 (0) 11 319 6500 to take out additional insurance if:

- You will be travelling overseas for more than 90 days
- You will be taking part in hazardous activities while you are away

If you have a medical emergency while travelling, call +27 (0) 10 205 3100. Quote 'ER24 International Travel Extension' and your Bestmed policy number.

## 3.8 Pre-Authorisations

Regardless of your benefit option, Members need to obtain pre-authorization from Bestmed before going to hospital or having any surgery or diagnostic investigations. In the event of a life-threatening emergency admission after hours, on weekends or public holidays, you must obtain an authorisation number on the first working day after the hospital admission. If you do not pre-authorise a hospital visit, penalties will be imposed for late authorisation.

Pre-authorization helps to ensure that both Members and service providers are aware of what expenses will be covered by Bestmed. It also allows the Scheme to negotiate with hospitals and medical professionals on your behalf. The pre-authorization process includes the management of your stay and treatment in hospital.

To obtain authorisation, contact the authorisation centre with the following information ready:

- Membership number as printed on the Membership card
- Name of Member or beneficiary (Dependant) and date of birth
- Date of admission
- Date of the operation (if applicable)
- Name of the treating doctor and the practice number
- Name of the hospital and the practice number
- The reason for admission to hospital (for example, Tonsillectomy, chest pain or stroke)
- The ICD 10 code - this code indicates the specific diagnosis and can be obtained from the treating doctor
- If admitted for an operation, the procedure codes (tariff codes)

The authorisation number must be provided to the hospital and providers rendering in-patient services. It must appear on all claims as these cannot be processed and paid without this number. In an emergency, on public holidays or over weekends you must obtain an authorisation number on the first working day after admission to the hospital or clinic.

For more information visit our website at [www.bestmed.co.za](http://www.bestmed.co.za) and click on 'Managed Care' and then on 'Hospital Benefit Management'. Please note that pre-authorization does not guarantee payment of claims.

Pre-authorization contact number: +27 (0) 80 022 0106

## 3.9 Claims

### 3.9.1 How to submit a claim

Please submit your original claim directly to Bestmed if your service provider does not submit claims. The following details must appear on all claim documents:

- Name and contact details of Member
- Bestmed Membership number
- Name, contact details and practice number of the service provider

- Details of treatment, including applicable tariff and ICD-10 codes
- Details of patient
- Whether to pay the service provider or the Member

You must submit the claim with the necessary proof of payment, within 4 (four) months of the treatment. If your claim is not received within four months, it will be rejected and you will have to settle the account yourself. Claims are processed within 48 hours of receipt.

Bestmed has a claims payment run every Friday as well as a month-end payment run (three working days after the last day of the previous month). Money will be paid directly into your bank account within 7 (seven) working days of receipt of your claim. Please remember to attach your proof of payment and updated bank account details.

Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the Member and the healthcare service provider accordingly, within 30 days after receipt thereof. The Scheme shall state the reasons why such a claim is regarded as erroneous or unacceptable and afford such Member and provider the opportunity to resubmit a corrected claim to the Scheme within 60 days of the notice.

You will receive a mini statement via e-mail notifying you the day after a claim was processed - you can reply to the e-mail if you have any queries regarding the claim/s. A complete claims statement (remittance advice) will be sent to you via e-mail or post after each claims payment run. Please ensure that the details on the statement are correct.

### 3.9.2 Claims to be submitted as follows

- Scan and e-mail your claim to [claims@bestmed.co.za](mailto:claims@bestmed.co.za), or
- Post your claim to Bestmed Medical Scheme, PO Box 2297, Pretoria, 0001, or
- Deliver your claim to the Bestmed offices, Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria.

Please note that the Scheme tariff will apply to all non-PMB claims. The Member remains responsible for the payment of any excess. Please negotiate with your service provider for an affordable rate. It should also be noted that a Member will remain responsible for outstanding funds once limits have been reached.

### 3.9.3 How to submit a claim to CareCross

The CareCross benefit option makes provision for Members, who are registered on the Pulse1 option, to visit a non-contracted GP for an emergency or when travelling. The benefit for such visits is limited to a maximum of R1 000 per family per year.

Members will be required to pay for all treatment received at the point of service. The costs of these services may be claimed back from CareCross by completing a patient reimbursement form which can be downloaded from the CareCross website at [www.carecross.co.za](http://www.carecross.co.za) or obtained by calling CareCross. The reimbursement will be subject to CareCross protocols.

Members can also e-mail [bestmedpulse1@carecross.co.za](mailto:bestmedpulse1@carecross.co.za) or contact their call centre on +27 (0) 86 010 3491 for any further queries in this regard.

### 3.9.4 How to submit a claim to OneCare

Every family registered on the Pulse2 option qualifies for two out of network visits with a general practitioner per year which must be pre-authorized by OneCare. Each visit shall be limited to R1 000. The Member shall pay for the visit upfront and then claim back from OneCare.

#### Contact details

Telephone number: +27 (0) 86 010 3491

Fax number: +27 (0) 21 673 1811

E-mail address: [clientfocus@carecross.co.za](mailto:clientfocus@carecross.co.za)

### 3.9.5 Easy online services

All claims received by Bestmed are processed within 48 hours of receipt. Thereafter a Member can log on to the Bestmed website by using the Member number in order to determine the status of submitted claims.

The online service is a free enquiry facility provided to Members. This facility allows registered users to access their relevant scheme information, including personal details, claims history, the process status of submitted claims, online, in real time. You will also be able to view correspondence and statements, as well as scanned images of claims.

Members can register on the Bestmed website by entering <https://online.bestmed.co.za/enquiries/default.asp> in the address box, which will take you directly to the registration page. Alternatively, you can follow the steps set out on page 18 by means of the various print screens.

## 3.10 Designated Service and Preferred Providers

Bestmed focuses on the establishment of different preferred and Designated Service Provider (DSP) networks in collaboration with provider groups with the aim of making sustainable, high-quality healthcare services available to our Members at affordable premiums. The network providers have committed to charging Scheme tariffs for consultations and other medical services as well as lower dispensing fees and we anticipate that they will, therefore, accept minimal or no co-payments from you. A full list of all the Scheme's contracted DSPs is available from the Bestmed website, [www.bestmed.co.za](http://www.bestmed.co.za) (after registering) or through the Scheme's Call Centre, who will provide full details on request.

### 3.10.1 General Practitioners

The Bestmed General Practitioners Preferred Provider Network has been functioning since January 2013. These general practitioners have committed to charging the Scheme tariff with no co-payments to the Member. An updated list of contracted general practitioners is available on our website.

### 3.10.2 Pharmacies

The Bestmed Pharmacy Preferred Provider Network has been functioning since February 2013. These pharmacies have committed to providing cost-effective medicines at competitive dispensing fees. Their dispensing fees are capped at a much lower level than that non-network pharmacies charge. In addition, they have also committed to not charging co-payments over and above their contracted rates. These pharmacies are Dis-Chem pharmacies with Courier PLS, MediRite (in Checkers and Shoprite stores), Pick n Pay, ScriptSavers, Optipharm, Pharmacy Direct, Clicks, Medicross and S Buys with Courier Script-Wise. An updated list of contracted pharmacies is available on our website.

### 3.10.3 Ancillary Groups

From January 2014 Bestmed implemented, an Ancillary Preferred Provider Network formed by seven different ancillary groups, namely the Physiotherapists, Occupational Therapists, Dieticians, Biokineticists, Psychologists as well as Speech Therapists and Audiologists. These groups each have their own Bestmed Preferred Provider Network and have committed to charging scheme tariff with no co-payments to the Member. The lists of all contracted ancillary provider groups is available on the Bestmed website ([www.bestmed.co.za](http://www.bestmed.co.za))

### 3.10.4 Rehabilitation Services

In addition, a Bestmed Drug and Alcohol Rehabilitation Designated Service Provider Network was implemented in January 2014. Providers in the network are Stabilis Treatment Centre, Elim Clinic and SANCA centres who will render Designated Service Provider services to the Scheme. A list of the contracted Drug and Alcohol Rehabilitation clinics with their locations across the country is available on our website.

#### Contact details

Our contact details for information on all the above networks are as follows:  
Telephone number: +27 (0) 12 818 9080  
E-mail address: [providers@bestmed.co.za](mailto:providers@bestmed.co.za)

### 3.10.5 Oncology

The Bestmed Oncology Designated Service Provider Network in partnership with ICON has been functioning since April 2013. ICON is the Designated Service Provider for all newly registered oncology patients for all Bestmed's options except Pace3 and Pace4, which are dealt with by the South African Oncology Consortium (SAOC). Members who are currently registered for oncology will not experience any changes. An updated list of contracted oncologists is available on our website.

### 3.10.6 Specialists

We have also previously communicated on the Bestmed Specialist Designated Service Provider Network which has been implemented as from January 2014. The main objective of the network is to offer sustainable high-quality specialist healthcare services at Scheme tariffs with minimal or no co-payments, especially for treatment of the diseases listed under Prescribed Minimum Benefits for which schemes are obliged to pay at cost. These diseases are listed as 200+ conditions that include emergencies, almost all the cancers as well as some chronic conditions.

Members are encouraged to use the services of specialists in the Bestmed Specialist Designated Service Provider Network. An updated list of contracted specialists will be available on our website ([www.bestmed.co.za](http://www.bestmed.co.za)) as from January 2015. It will for the time being remain your choice which specialist you wish to use, but please note that if you opt for a specialist who is not part of our network (as is your right), you may be expected to make a co-payment to the particular out-of-network specialist. Alternatively, you may also negotiate with the out-of-network specialist to charge Scheme tariff. Service providers in our Bestmed Specialist Designated Service Provider Network have agreed not to charge any co-payments or to apply split-billing<sup>1</sup>.

Regarding hospital utilisation, you have freedom of choice and may generally use any private hospital for treatment (except for Pulse1 and Pulse2 Members, who are required to use Netcare as their designated hospital service provider). Members who are on any of the Beat Network options should make use of the designated hospital. If a hospital out of the network is used, a penalty of R5 000 will be payable by the Member.

<sup>1</sup> \* **Split-billing:** This method of billing is **illegal**. A provider submits **two different accounts**; one to the patient and another to the patient's medical scheme. **Balance-billing** is a **legal method** of billing. In this case a provider submits **one account** to the patient and the same account to the patient's medical scheme.



### 3.11 Health Check

To complement its preventative care programme, Bestmed encourages Members to live a more preventive, meaningful and productive life through our various programmes which will now be referred to as health check programmes. We are here to assist you to become a better version of yourself through choosing a healthier lifestyle. Bestmed's wellness philosophy is based on the five basic pillars. We encourage our Members simply to:

- **Be Active:** Incorporate exercise as part of your daily schedule to ensure positive change.
- **Be Safe:** Make responsible lifestyle choices to prevent adverse consequences.
- **Be Nutri-wise:** Balanced nutrition is important to maintain a healthy body and mind.
- **Be Happy:** Create and maintain a balance between work, life and home.
- **Be Fin-Wise:** Making informed financial decisions in life will ensure financial independence.



### 3.12 BestBaby

This programme has been designed as a supporting forum for Bestmed's pregnant mothers. The programme offers telephonic interaction throughout the pregnancy and also has a dedicated 24-hour emergency line with trained medical personnel to guide Members through those sudden and often unexpected occurrences during pregnancy.

If a mother is regarded as a high clinical risk, she will be monitored more closely. This programme also offers additional benefits such as free gifts to all Members registered on the programme.

All Bestmed registered Members confirmed as pregnant, with a pregnancy duration of 12 weeks and onwards, can register.

Once the Scheme starts receiving pregnancy related claims, we will inform the BestBaby programme staff and they will contact the Member. Members can also register by using the contact details provided.

#### Contact details

Telephone number: +27 (0) 86 111 1936

E-mail address: info@babyhealth.co.za

### 3.13 Preventative Care Benefit

All Bestmed Members and Dependants older than ten years can access Biometric screenings from selected pharmacies (Dis-Chem, Clicks, MediRite, Script Savers and Pick n Pay). Biometric screenings will be reimbursed from the Scheme risk benefit and will not have an impact on your day-to-day benefits.

Bestmed provides cover for preventative care benefits on all of its benefit options. The table below indicates the different benefits covered on each option.

For further information on preventative care benefits, visit our website [www.bestmed.co.za](http://www.bestmed.co.za).



BENEFIT	BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	PULSE1	PULSE2
Flu Vaccines	X	X	X	X	X	X	X	X	X	X
Pneumonia Vaccines	X	X	X	X	X	X	X	X	X	X
Paediatric immunisations	X	X	X	X	X	X	X	X	X	X
DBC programme	X	X	X	X	X	X	X	X		X
Female Contraceptives	X	X	X	X	X	X	X	X		X
Preventative dentistry		X	X	X	X	X	X	X		
HIB Titre immunisation				X	X	X	X	X		
Mammogram				X	X	X	X	X		
PAP smear			X	X	X	X	X	X		
PSA test						X	X	X		
Bone density test							X	X		
Biometric screening	X	X	X	X	X	X	X	X	X	X
Dietician counselling session				X		X	X	X		
HPV vaccinations				X	X	X	X	X		

### 3.14 Understanding Your Savings

Understanding your medical savings will help you plan the use of your Scheme benefits more effectively so that you do not exhaust these services when you might need them most. Through better planning and budgeting, you could very well ensure that you and your loved ones have access to your medical benefits throughout the year.

Because we believe that our Members are unique and special, medical savings are structured differently for our various benefit options. Our capitated/network options, like the Pulse range, however, do not have any savings.

#### PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA): ANNUAL

Beat2	Beat3	Beat4	Pace1	Pace2	Pace3
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A savings amount equal to a specific percentage of your total annual contribution, as per your selected benefit option, is made available in advance at the beginning of the benefit year in your Personal Medical Savings Account.

Medical expenses for services rendered out-of- hospital/day-to-day are paid from your medical savings account. Please refer to your benefit summary for more detail.

When your Medical Savings Account has been depleted during a financial year, then you will have to pay for out-of-hospital expenses yourself or you will qualify for specific day-to-day benefits as per option-specific rules.

Any unused funds that accumulate in your medical savings account at the end of a benefit year will be carried over to the next year to your credit, into your Personal Medical Savings Account or Bonus/Vested Savings Account (See explanation below).

Should you resign from the Scheme in the duration of a financial year, the unused funds in your medical savings account or Vested Savings Account will be refunded to you after a period of 5 (five) months or be transferred on a compulsory basis to the savings account of the new medical scheme option where you enrol as a Member.

Should you, in the above instance, on a pro rata basis have exceeded the amount in your Savings Account, then you will have to refund the Scheme.

Pace4
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On the Pace4 option in-hospital services, out-of-hospital services and preventative care are paid from Scheme risk benefit. Once out-of-hospital risk benefits are depleted, further claims will be paid from savings.

#### BONUS / VESTED MEDICAL SAVINGS ACCOUNT

Beat4	Pace1	Pace2	Pace3
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If you do not use all your monthly medical savings amounts, these funds will be transferred into a Bonus/Vested Account in your name after a period of five months, depending on the benefit option you are on.

Any vested credit in your Bonus/Vested Account may be used to pay for any out-of-hospital expenses that are not covered by the Scheme or should you, for instance, have reached your out-of-hospital/day-to-day overall annual limit or the sub-limits as indicated in your benefit summary.

Unused funds in your Bonus/Vested Account at the end of a financial year will be carried over to the credit of your Bonus/Vested Account for the next year.

Members registered on the Pace1 and Pace2 options until 31 December 2014, will have their last monthly savings transferred into their Bonus/Vested account in May 2015 should there be funds available from the previous months.

#### 3.14.1 What if my day-to-day Benefits are depleted?

Depending on your benefit option, medical expenses are paid from your medical savings account, as stipulated per your selected option. A Personal Medical Savings Account (PMSA) is where the Scheme holds a portion of your contributions to pay for day-to-day medical expenses. When your medical savings account has been exhausted, you will pay for out-of-hospital expenses yourself. Any unused funds in your medical savings account at the end of a benefit year will be carried over to the next year. Should you resign from the Scheme during a benefit year; the funds in your medical savings account will be paid back to you after a period of 5 (five) months.

**Please note:** The percentage of savings will vary per benefit option.

#### 3.14.2 Conditions for Personal Medical Savings Account (PMSA) Payments

- The PMSA is used solely for medical expenses related to day-to-day benefits, subject to the exclusions referred to in Annexure C to the Scheme Rules (Scheme Rules and Annexures are available at [www.bestmed.co.za](http://www.bestmed.co.za)).
- On admission to the Scheme, an PMSA, held by the Scheme, is established in the name of the Member concerned into which the contributions payable in respect of the PMSA component shall be credited and benefits in respect thereof, shall be debited.
- No cross-subsidisation between Members will apply in respect of the PMSA. There are different saving percentages applicable to different options.
- Subject to sufficient funds being available at the date on which a claim is processed, Members shall be entitled to claim for all healthcare services provided for in the Scheme Rules at 100% of the cost as well as any co-payments or shortfalls the Member is responsible for.
- Any balance in the PMSA at the end of a financial year remains the property of the Member and accumulates in his name.
- Upon the death of a Member, the balance due to the Member will be transferred to his registered Dependents who continue Membership on the Scheme or paid into his estate in the absence of such Dependents.
- On transfer to another option of the Scheme, which does not provide for such an account, any balance in the PMSA will be refunded to the Member, 5 (five) months after such transfer and subject to applicable laws.
- Should a Member terminate Membership of the Scheme and not be admitted as a Member of another medical scheme or be admitted to Membership of another medical scheme which does not provide for an PMSA, the balance due to the Member will be refunded to the Member 5 (five) months after termination of Membership, and subject to applicable laws.
- Should a Member be admitted to Membership of another medical scheme, which provides for a similar account, the balance due to the Member will be transferred to such scheme within 5 (five) months after termination of Membership.
- The decision to grant the funds in the PMSA annually to the Member as an interest free loan in advance up to the end of the financial year, shall vest at the discretion of the Scheme.
- Any debit balance in the PMSA arising during or at the end of the financial year remains the Member's liability and is repayable to the Scheme upon Membership termination. A debit balance arises when the monetary savings amount used exceeds the total monetary amount refunded by the Member to the Scheme on a monthly basis.



## 3.15 Rights and Responsibilities of Members

### 3.15.1 New Member

As a Member of Bestmed Medical Scheme you need to ensure that all your contact details registered with us such as your telephone or cell number, address and e-mail are correct. So if we need to communicate with you or send you a replacement Member card, it reaches the right person. Please also inform the Scheme if these details, your health profile or those of your Dependants should change.

Our commitment to the environment means that we would love to reduce our reliance on printed materials for all our communication with Members. If you also think that trees are important and cutting down on paper products will help, then please ensure that we have an e-mail address for you (if you have not done so already) and activate your internet access with the Scheme.

Please check your statements regularly as it is the responsibility of the Member to ensure that they have sufficient cover when accessing benefits. You could then also notify the Scheme if we have not captured information on these statements correctly.

Bestmed provides healthcare cover and service to individual Members as well as to groups of Members such as from employer groups. If you joined the Scheme through a broker or directly through Bestmed, then you are an individual Member with access to all ten benefit options.

Corporate Members would most likely have joined through their Human Resources department and might only be subsidised on particular benefit options.

### 3.15.2 Changing benefit options

You are allowed to change your option in January each year. You can change your benefit option by completing the relevant Benefit Option Choice form which is available on [www.bestmed.co.za](http://www.bestmed.co.za) or by contacting Bestmed at:

Telephone number: +27 (0) 86 000 2378

Fax number: +27 (0) 12 472 6500

E-mail address: [membership@bestmed.co.za](mailto:membership@bestmed.co.za)

If you are an employee of a participating employer group at Bestmed, your option change request should first be submitted to your Human Resources department to update their payroll system. Individual Members may send the option changes directly to Bestmed.

It should be noted that a Member retains their Membership of the Scheme with the registered Dependants, if any, in the event of retirement, employment being terminated by their employer on account of age, ill health or other physical or mental disability.

### 3.15.3 Your responsibility as a Member

Familiarise yourself with the registered Bestmed Rules to ensure that you know your rights, responsibilities and benefit entitlement. The Scheme Rules are available in this guide and the complete Rules and Annexures are published on our website at [www.bestmed.co.za](http://www.bestmed.co.za). Your benefits may change annually and it is therefore important to keep track of changes before the beginning of each calendar year.

Please ensure that you promptly update your personal information, bank details and status of beneficiaries when changes occur. Contact details are used when Bestmed communicates to Members on a frequent basis and bank detail changes are important for monthly contribution deductions and claims payment.

Bestmed may request any treatment, care and diagnosis information that will assist with pre-authorisation of hospital admittances and access of high cost treatment or medicine. You will be informed of such requirements once access is required.

A Member or Dependant may only belong to one scheme or have membership of one scheme at any given time.

Please refer to the Registered Rules of Bestmed and the Medical Schemes Act 131 of 1998 for more responsibilities of Members.

### 3.15.4 Dependants

Bestmed recognises the following people as Dependants:

- The Member's spouse or partner, adult contributions are payable.
- A child older than 21 if the child is dependent on the Member due to a mental or physical disability, adult contributions are payable.
- A child older than 21, but not older than 26, who is studying and dependent on the Member, child contributions are payable subject to proof of registration at a registered tertiary institution/ or other educational institution.
- A child older than 21, but not older than 26, who is unemployed and not studying, but is dependent on the Member, adult contributions are payable.
- Immediate family for whom the Member is legally liable to provide family care and support. This refers to the Member's mother, father, brother or sister. In respect of the mentioned registration, underwriting or late joiner penalties may apply subject to proof of dependency, adult contributions are payable.

How do I proceed to apply for registration of our new baby as a Dependant?

- Corporate Members: Complete the Bestmed Application For Registration Of Dependant form (available from your personnel practitioner) within 30 days after birth and send it, with a copy of the birth certificate to your HR Department.
- Individual Members: Send a copy of the birth certificate with a covering letter to [Membership@bestmed.co.za](mailto:Membership@bestmed.co.za) or fax it to +27 (0) 12 472 6500.

Should I pass away, would my Dependants retain their Membership of Bestmed?

The Dependants of a deceased Member, who are registered with the Scheme as his Dependants at the time of such Member's death, shall be entitled to retain Membership of the Scheme without any new restrictions, limitations or waiting periods.

Should my wife and I pass away, what would happen with my Child Dependants?

If child Dependants are orphaned, the eldest child may be deemed the principal Member, and any younger siblings as child Dependant(s).

What should I do if my Dependent Child no longer qualifies as a Child Dependant?

You must notify Bestmed via your personnel practitioner (or directly in case of individual Members) within 30 days of the occurrence of any such event. A Member who fails to inform the Scheme shall not be entitled to a refund of contributions. The Scheme may claim reimbursement from the Member for benefits paid on behalf of such Dependant and costs incurred after he ceased to be a Dependant in terms of the Rules.

My wife and I are divorced and live together. May she retain Membership?

A person with whom the Member has a sustained committed, serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party, may be registered as the Member's adult Dependant. Should your contributions be subsidised by your employer, you will have to confirm whether such an arrangement can be accommodated.

### 3.15.5 Pro rata Benefits

If you join Bestmed after 1 January in any year, you will receive pro rata benefits. This means that we will reduce your annual limits in proportion to the number of months remaining in that year. Bestmed benefits are calculated for a period of 12 (twelve) months from 1 January to 31 December. If a Member joins during the year, e.g. in May, the benefits will be calculated according to the number of months remaining in the year.

### 3.15.6 Calculating Late-joiner Penalties

Late-joiner penalties can be imposed on new Members over the age of 35. Depending on the number of years during which the Member did not belong to a medical scheme, a late-joiner penalty will be added to the Member's monthly high-risk contribution. The penalty is calculated on a sliding scale as shown in

the table below, based on the total number of years from age 35, effective as from 1 April 2001, where a Member did not belong to medical scheme. Remember that the late-joiner penalty is only calculated on risk and not the PMSA.

NUMBER OF YEARS SINCE AGE 35 WHERE APPLICANT WAS NOT A MEMBER OF A MEDICAL SCHEME	PENALTY
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

**Example:** If your high risk premium is R900 with a savings of R135, your total premium adds up to R1 035. Thus, if you have not been a Member of another medical scheme for the past 6 years, we need to apply a penalty of 0.25, i.e.  $R900 \times 0.25 = R225$  (the penalty payable).

The calculation of your new premium would then be as follows: High risk premium + Penalty + Savings = New premium  $R900 + R225 + R135 = R1\ 260$ .

### 3.15.7 Contribution Fees

#### Total Monthly Contributions

The total monthly contributions payable to the Scheme by or in respect of a Member are as stipulated in Annexure A to the Scheme Rules, provided that contributions shall be determined on the basis of income or the number of Dependants or both income and number of Dependants, and provided further that premium penalties for persons joining late in life may be applied in accordance with the provisions of the Act (Scheme Rules and Annexures are available at [www.bestmed.co.za](http://www.bestmed.co.za)).

#### Due date for Contributions

Contributions shall be due monthly in advance as follows:

- On the 20<sup>th</sup> (twentieth); or
- On the 25<sup>th</sup> (twenty-fifth); or
- On the 1<sup>st</sup> (first); or
- Monthly in arrears as agreed upon between the Scheme and an Employer, and be payable by not later than the 3<sup>rd</sup> (third) day after each respective due date of each month.

Where subscriptions owing to the Scheme have not been paid on or before the due date as indicated in the Scheme rules respectively, the Scheme shall notify the Member and Employer, where applicable, and suspend the Membership due to non-payment or partial payment of subscriptions, with effect from the 1<sup>st</sup> (first) day of the month for which subscriptions are due and not received. A written confirmation of suspension will be issued to the Members involved.

If payments are not brought up to date within 3 (three) months from the date the amount was due, the Scheme shall terminate the Membership, with retrospective effect. Contributions shall be due monthly in advance or monthly in arrears as agreed upon between the Scheme and a participating employer and be payable by not later than the 3<sup>rd</sup> day of each month.

### 3.15.8 Waiting Periods

The Medical Schemes Act allows medical schemes such as Bestmed to impose a waiting period on benefits under certain circumstances. This means that you will not be able to access a particular benefit for a specified period of time. There are two types of waiting periods:

1. Condition-specific waiting period - this refers to a specified period of time during which a beneficiary cannot claim benefits for up to 12 months. This is limited to conditions for which he received medical advice, diagnosis, care or treatment during the 12 months before he applied to join Bestmed.
2. General waiting period - this is a specified period of time during which a beneficiary is not entitled to claim any benefits for the first 3 (three) months.

If you are on chronic medicine, you may be able to claim for certain treatments or chronic medicine covered under the Prescribed Minimum Benefits.

However, if you were not a Member or Dependant of a registered medical scheme for longer than 90 days before joining Bestmed, you will not be able to claim for certain treatments or chronic medicine covered under the Prescribed Minimum Benefits.

### 3.15.9 Termination of Membership

#### Resignation

Members are allowed to resign from the Scheme at any time during the year by submitting a one calendar month written notice, starting on the first day of any calendar month. A Member serving a notice period is still entitled to receive full benefit cover until the last day of the notice period. A Membership certificate will be issued within 30 days of termination of Membership or at any time of request.

Balances in your Personal Medical Savings Account (PMSA) will be transferred to the other medical scheme if it has a similar account, or we will refund you if the other scheme does not have a similar account. The transfer will be done within 5 (five) months of your termination of Membership.

Please note that if you resign during the course of a financial year and you have used more than the amount available for the year so far from your savings account, the Scheme will debit you with the difference between the amount used and the pro rata amount available on the day of resignation.

The Member remains liable for payment of contributions to Bestmed irrespective whether he receives financial assistance from an employer. An employer subsidy remains a matter between the Member and the employer.

#### Cancellation of Membership

Bestmed may cancel or suspend Membership on the following conditions:

- Non-disclosure of material information such as if you failed to inform the Scheme about a certain medical condition.
- Failure to pay contributions as stated in the Rules.
- Submission of fraudulent claims or committing of any fraudulent activity.

### 3.15.10 Third-Party Claims

If you are involved in a motor vehicle accident Bestmed will pay for medical expenses relating to the accident. You need to inform Bestmed if you choose to claim compensation from the Road Accident Fund (RAF) to ensure that a refund is made to Bestmed for medical expenses paid.

Please note that there is a principle in common law called subrogation which indicates that a person cannot enrich themselves unjustly by receiving a double compensation for the same health event.



**Below are some more questions and answers that you might find useful with regards to Membership.**

1. How may a Member from time-to-time ascertain what his obligations to the Scheme are and what his rights, benefits, contributions and limitations are?

A Member is entitled on request, to copies of the Scheme's Rules, financial statements and annual reports upon payment of a reasonable fee for such documents. On admission to Membership medical schemes are obliged to furnish Members with a summary of the registered Rules which comprise reciprocal rights and obligations of both the scheme and Members and all benefit options and relevant contributions.

2. How do I know which benefit option to select?

Ensure that you understand how the benefit options operate and elect according to your healthcare needs and what you can afford. The registered rules of medical schemes fully disclose detailed information regarding the relevant benefits and contributions. It is essential that you obtain the Scheme Rules or a summary thereof to verify all information relevant to enable you to make an informed choice.

3. What is a co-payment?

It is a portion of the cost for which you are responsible.

4. Can I belong to more than one medical scheme at the same time?

No. It is illegal.

5. Can a minor become a Member?

Yes, with the assistance of his parents or guardian, provided that the relevant contributions are paid by him or on behalf of him.

6. Must a prospective Member apply for Membership of a medical scheme through a broker?

No. There is no such provision in the Act. One can apply directly to the Scheme or choose to use the services of a broker (intermediary).

7. If a Member passes away, will his registered Dependants still be covered?

Yes, without any break in Membership and provided contributions are paid. It is important to inform the Scheme if one chooses not to continue.



8. Must I give notice to the Scheme in the event that I wish to terminate Membership?

Yes, the notice period stipulated in the Rules must be complied with.

9. Am I entitled to benefits while serving notice of termination?

Yes, until the last day of Membership provided contributions are being paid.

10. What role does my employer play in my relationship with my scheme?

The employer may determine whether or not the employees are entitled to belong to a specified scheme or whether the employees have total freedom of choice of scheme. The employer also determines, generally within the framework of conditions of service, negotiations with the workforce and organised labour, such as trade unions/staff organisations, what level of subsidies will apply to different categories of employees or in general. Therefore, employers are not admitted to Membership but they play an important role in collecting contributions and ensuring payment thereof to the scheme concerned.

11. If I do not claim from my medical scheme, may I receive a no-claim bonus or rebate?

No. The Act prohibits the payment of bonuses, rebates or re-funding of any portion of contributions other than in respect of savings accounts in certain circumstances.

12. May my medical scheme call upon me for increased contributions with retrospective effect?

No. In terms of the Act a medical scheme must give Members advance written notice of any change in contributions and benefits or any other condition affecting their Membership.

13. May a medical scheme request pre-authorisation or second opinions in respect of certain benefits?

Yes, except in an emergency where pre-authorisation should be obtained as stipulated in the Rules.

14. What can I do if I am not satisfied with my current benefit option?

Instead of changing schemes and be faced with waiting periods, a Member can either buy up in order to get better benefits or buy down for less contributions.

15. What are Prescribed Minimum Benefits (PMBs)?

The benefits in respect of relevant health services prescribed by the regulations under the Act, and rendered by State hospitals or designated service providers according to clinical protocols and criteria.

16. What is a Designated Service Provider (DSP)?

A healthcare provider or group of providers selected by the scheme as the preferred provider or providers to provide to its Members diagnosis, treatment and care in respect of one or more Prescribed Minimum Benefit conditions.

17. To what extent are the prescribed minimum benefits restricted?

No restrictions, co-payments, waiting periods or exclusions may be applied to any person in respect of the Prescribed Minimum Benefits if the services are rendered by State hospitals or DSPs. In instances where services are voluntarily obtained from a non-DSP, co-payments may apply or waiting periods may be imposed only on those applicants who have never belonged to a medical scheme, or have not been beneficiaries for the preceding 90 days.

18. What constitutes the involuntary obtaining of services in respect of the PMBs from non-DSPs?

Involuntarily obtained means:

1. The service was not available from the designated service provider or would not be provided without unreasonable delay;
2. Immediate medical or surgical treatment for prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

3. There was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

### 19. What are the types of waiting periods?

There are two kinds of waiting periods i.e.:

1. A general waiting period of up to three months.
2. A condition-specific waiting period of up to 12 months.

### 20. What does a waiting period mean?

A period during which contributions are payable without the Member being entitled to benefits.

### 21. When do waiting periods not apply?

Waiting periods do not apply in respect of:

1. Prescribed minimum benefits.
2. A child Dependant born during the period of Membership.
3. A Member moving between benefit options unless he has to complete the remaining period of previously imposed waiting periods.
4. When an individual has to involuntarily transfer to another scheme due to a change of employment.
5. In instances where an employer changes the medical scheme of his employees with effect from the beginning of the financial year.

### 22. What is a late-joiner penalty?

It is a penalty by way of additional contributions, imposed on persons joining a scheme late in life, i.e. an applicant who is 35 years of age or older who was not a Member of one or more medical schemes as from a date preceding 1 April 2001 without a break in coverage exceeding 3 (three) consecutive months since 01 April 2001.

### 23. What restrictions may a medical scheme impose on an applicant?

1. Late-joiner penalty
2. Waiting periods

### 24. Can a medical scheme impose a condition-specific waiting period on pregnancy?

Yes, in those instances where the person was a beneficiary of a medical scheme for up to 9 (nine) months.

### 25. Within what period of time must my account for services or claims reach my medical scheme?

The account must be submitted not later than the last day of the fourth month following the month in which the service was rendered.

### 26. May credit balances in my Personal Savings Account be withdrawn in cash?

Only when you terminate your Membership of the Scheme or a benefit option, without joining another medical scheme or benefit option with a savings component.

### 27. May contributions be paid out of my savings account?

No, except on termination of Membership. Funds in the PMSA may be used by the Scheme to offset any debt owed by the Member, which would include contributions.

### 28. How do I know whether or not my scheme has paid and what amount has been paid in respect of a claim?

Payment of claims is regulated by the Act, which includes the dispatch to a Member of a statement containing full particulars of the transaction, including the amount charged for every service and the amount of the benefit awarded for each service to a Member.



### 29. Within what period of time must the Scheme pay my claim?

If the account or claim is correct and acceptable for payment, it should be paid within 30 days of receipt of the claim.

### 30. Who manages the affairs of a medical scheme?

A Board of Trustees of which at least 50% must be elected or appointed from the ranks of Members. These persons must be fit and proper to perform their duties, ensure that the interests of Members are protected and that the scheme is properly administered. If they are guilty of misconduct, or reckless trading, they may be held accountable for losses incurred.

### 31. How do medical schemes function?

Contributions are pooled for the benefit of Members. Schemes are not-for-profit organisations and belong to the Members. Therefore, any surplus made remains in the scheme on the trust principle, for the benefit of Members and their Dependants.

### 32. May I participate in the operation of my scheme?

Yes, in terms of the Act, a medical scheme must provide for Annual General Meetings (AGMs) where Members may voice their views and present motions. They may also hold meetings at different venues for the benefit of Members or regional meetings to maximise Member participation.

### 33. Can a medical scheme change its rules and thereby move the goal post?

Yes, there is provision in the Act and in the rules of every medical scheme on how the Board of Trustees may amend rules. All rule amendments must, however, be approved and registered by the Registrar of Medical Schemes as required by the Act. The scheme will still notify Members of such changes as they are entitled to it.

### 34. When may my scheme terminate or suspend my Membership?

Only on the grounds of failure to pay Membership fees timeously or other debts owing to the scheme, submission of fraudulent claims, committing other fraudulent acts, or the non-disclosure of material information.

### 3.16 How do we Communicate?

At Bestmed we communicate in a Member's preferred language, i.e. English as well as Afrikaans. On request, our Call Centre can assist a Member in any one of South Africa's 11 official languages.

#### 3.16.1 Easy online services

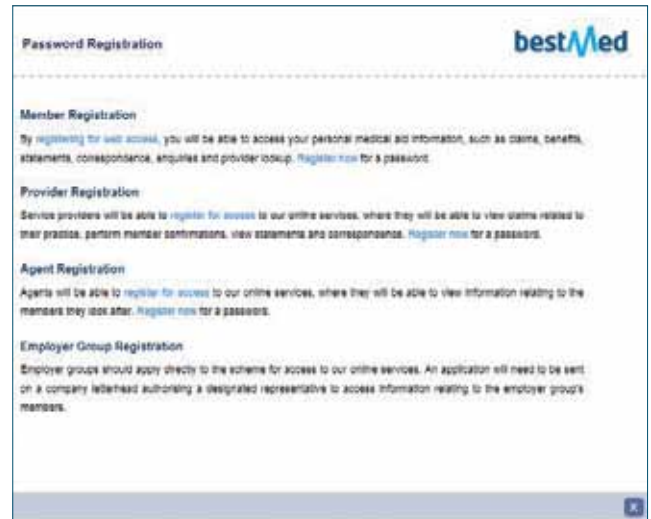
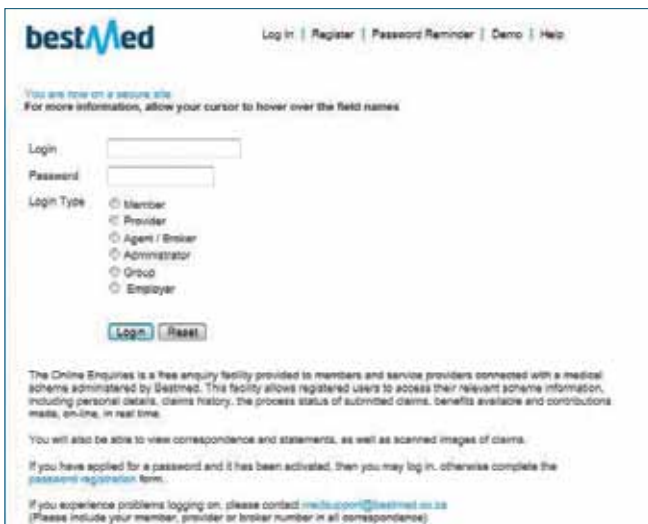
All claims received by Bestmed are processed within 48 hours of receipt. Thereafter a Member can log on to the Bestmed website using the Member number in order to determine the status of claims.

The online service is a free enquiry facility provided to Members. This facility allows registered users to access their relevant scheme information, including personal details, claims history, the process status of submitted claims, online, in real time. You will also be able to view correspondence and statements, as well as scanned images of claims. Members can register on the Bestmed website by entering <https://online.bestmed.co.za/enquiries/default.asp> in the address box, which will take you directly to the registration page. Alternatively, you can follow the steps set out below.

1. Go to the Bestmed website and click on "Login/Register" in the top right-hand corner.



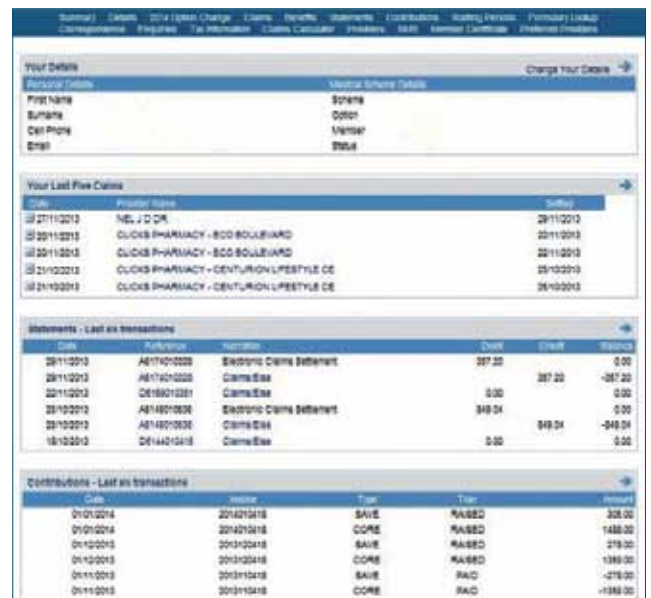
2. You can log on with your Member number or register using the "Password Registration" screen which will pop up when you click on "Register".



3. Members have three options to register on the online registrations. They can register on line, call the Call Centre or they can complete an activation request by printing it, signing it and sending it back to Bestmed.



4. Once Members have been successfully registered they can log on with their details and access their claims. When they log on, the screen below will appear, showing a summary of all Members' details and recent activities.



- The Member then has the option of clicking on claims and will be able to see all the claims on his medical aid and the current status of a claim. For detailed information the Member can click on the specific claim.

Date	Process No	Service Name	Status
20110209	160321	NEJLO DR	20110209
20110209	160322	CLICK PHARMACY	20110209
20110209	160323	CLICK PHARMACY	20110209
20110209	160324	CLICK PHARMACY	20110209
20110209	160325	CLICK PHARMACY	20110209
20110209	160326	NEJLO DR	20110209
20110209	160327	NEJLO DR	20110209
20110209	160328	NEJLO DR	20110209
20110209	160329	NEJLO DR	20110209
20110209	160330	NEJLO DR	20110209
20110209	160331	NEJLO DR	20110209
20110209	160332	NEJLO DR	20110209
20110209	160333	NEJLO DR	20110209
20110209	160334	NEJLO DR	20110209
20110209	160335	NEJLO DR	20110209
20110209	160336	NEJLO DR	20110209
20110209	160337	NEJLO DR	20110209
20110209	160338	NEJLO DR	20110209
20110209	160339	NEJLO DR	20110209
20110209	160340	NEJLO DR	20110209
20110209	160341	NEJLO DR	20110209
20110209	160342	NEJLO DR	20110209
20110209	160343	NEJLO DR	20110209
20110209	160344	NEJLO DR	20110209
20110209	160345	NEJLO DR	20110209
20110209	160346	NEJLO DR	20110209
20110209	160347	NEJLO DR	20110209
20110209	160348	NEJLO DR	20110209
20110209	160349	NEJLO DR	20110209
20110209	160350	NEJLO DR	20110209
20110209	160351	NEJLO DR	20110209
20110209	160352	NEJLO DR	20110209
20110209	160353	NEJLO DR	20110209
20110209	160354	NEJLO DR	20110209
20110209	160355	NEJLO DR	20110209
20110209	160356	NEJLO DR	20110209
20110209	160357	NEJLO DR	20110209
20110209	160358	NEJLO DR	20110209
20110209	160359	NEJLO DR	20110209
20110209	160360	NEJLO DR	20110209
20110209	160361	NEJLO DR	20110209
20110209	160362	NEJLO DR	20110209
20110209	160363	NEJLO DR	20110209
20110209	160364	NEJLO DR	20110209
20110209	160365	NEJLO DR	20110209
20110209	160366	NEJLO DR	20110209
20110209	160367	NEJLO DR	20110209
20110209	160368	NEJLO DR	20110209
20110209	160369	NEJLO DR	20110209
20110209	160370	NEJLO DR	20110209
20110209	160371	NEJLO DR	20110209
20110209	160372	NEJLO DR	20110209
20110209	160373	NEJLO DR	20110209
20110209	160374	NEJLO DR	20110209
20110209	160375	NEJLO DR	20110209
20110209	160376	NEJLO DR	20110209
20110209	160377	NEJLO DR	20110209
20110209	160378	NEJLO DR	20110209
20110209	160379	NEJLO DR	20110209
20110209	160380	NEJLO DR	20110209
20110209	160381	NEJLO DR	20110209
20110209	160382	NEJLO DR	20110209
20110209	160383	NEJLO DR	20110209
20110209	160384	NEJLO DR	20110209
20110209	160385	NEJLO DR	20110209
20110209	160386	NEJLO DR	20110209
20110209	160387	NEJLO DR	20110209
20110209	160388	NEJLO DR	20110209
20110209	160389	NEJLO DR	20110209
20110209	160390	NEJLO DR	20110209
20110209	160391	NEJLO DR	20110209
20110209	160392	NEJLO DR	20110209
20110209	160393	NEJLO DR	20110209
20110209	160394	NEJLO DR	20110209
20110209	160395	NEJLO DR	20110209
20110209	160396	NEJLO DR	20110209
20110209	160397	NEJLO DR	20110209
20110209	160398	NEJLO DR	20110209
20110209	160399	NEJLO DR	20110209
20110209	160400	NEJLO DR	20110209

### 3.16.2 Connecting with Bestmed

Because we are committed to client service excellence, Bestmed has introduced a variety of channels to access the Scheme as well as making it more convenient for Members to retrieve their information.

#### The Contact Centre

The Bestmed Contact Centre is easily accessible by telephone, fax, e-mail or as a walk-in facility. This is to make it convenient for Members to directly speak to a consultant with regards to benefit options, claims, queries or even complaints.

Our Contact Centre can be reached on the following share call number: +27 (0) 86 000 2378 or by e-mail at [service@bestmed.co.za](mailto:service@bestmed.co.za), and the office hours are from 08:00 to 16:00.

For those who prefer to speak to a consultant face-to-face, we have a walk-in facility at our head office in Pretoria, situated in Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria.

Members will be assisted in English, Afrikaans and the other official languages. Bestmed aims to provide a one-stop service for Members at the Contact Centre, but it may also be necessary for an agent to refer clinical enquiries to specific departments.

If a Member is not satisfied with a response, then you may choose to escalate the process. This is set out in section 4.3 below under the heading "Escalation of Queries".

#### The Website

Bestmed's user-friendly website [www.bestmed.co.za](http://www.bestmed.co.za), is designed to not only provide Members with the latest information on various programmes and benefit options, it is also a dedicated portal for Members and other stakeholders.

To register for online access:

- Go to [www.bestmed.co.za](http://www.bestmed.co.za)
- Click on "Member Login"
- Click on the "Register" button
- In the dialogue box that appears, click on "Registering for web access" or on "Register now" under "Member Registration"

You now have three options to activate your registration:

#### Option 1 ("Register Online"):

Register online immediately by completing this password registration form. You will be required to enter certain personal details. If this matches the information we have on record, a password will be generated and sent to you immediately.

#### Option 2 ("Call our Contact Centre"):

Alternatively, you may register for web access by calling the Bestmed Call Centre on +27 (0) 86 000 2378 during office hours (08:00 - 16:00). A password will be generated and sent to you either by e-mail or SMS.

#### Option 3 ("Activation Request"):

If you do not wish to register via either Option 1 or Option 2, you may complete an activation request online. You will be required to print and sign the activation request, and fax this to Bestmed for activation.

The online service provides Members access to:

- Personal details
- Claims history
- Process status of submitted claims
- Benefits available
- Contributions paid



## Webmail

The webmail service gives Members a summary of their chronic medicine and condition/s as registered; personal details; as well as the three most recent claims received and assessed via e-mail. To access this service, just send a blank e-mail to [webmail@bestmed.co.za](mailto:webmail@bestmed.co.za) and you will receive the information from us via e-mail. Please ensure that Bestmed has your correct e-mail address.

## SMS

If Members would like to receive their Bestmed information directly to their cell phones, depending on the information required, one could simply SMS either A, B or C to 31416.

A = Personal details

B = Summary of benefits available

C = Confirmation of three most recent claims

## eMagazine

To keep Members informed of all Scheme developments, competitions and interesting yet informative articles, Bestmed publishes Top Living, our complimentary electronic magazine. Members receive this through their e-mail addresses and can view this exciting magazine online by clicking on the button "Top Living Digi Mag". On a regular basis the Scheme sends e-mailers to Members regarding new developments in Bestmed or the healthcare industry.

## Social Media

Bestmed is also available on social media networks where Members share their stories and the Scheme keep fans informed of the latest Bestmed events. The Scheme appears on Facebook as Bestmed Medical Scheme. For those with limited access to the Internet, Bestmed also sends Member statements, informational postcards on industry and new Scheme developments via the post.

## Annual Report

To coincide with its annual general meeting that are open to all Bestmed Members, the Scheme produces its annual report. Amongst other things, this report outlines:

- Regulatory challenges
- Key sustainability issues that impact on our strategy
- Risks pertaining to the regulatory environment
- Report of the chairperson and the principal officer
- A variety of other reports such as corporate governance, administration, managed healthcare and marketing
- Annual financial statements

Bestmed produces an integrated annual report which is the latest in best practice in organisational reporting. Integrated reporting gives a comprehensive view of the Scheme by placing its performance and strategy in the context of its relevant social and environmental issues.

Our latest annual report is available on our website at [www.bestmed.co.za](http://www.bestmed.co.za) or call +27 (0) 86 000 2378 for a printed copy.



## 4. Regulations, Regulatory Bodies and Compliance

### 4.1 Council for Medical Schemes

The Council for Medical Schemes (CMS) is a statutory body established by the Medical Schemes Act 131 of 1998 to provide regulatory supervision of private health financing through medical schemes. One of their strategic objectives is to ensure an appropriate level of protection for the beneficiaries or Members of medical schemes. Bestmed is a not-for-profit entity that collects set contributions from Members and facilitates payment of medical expenditure incurred whilst accessing health care services in line with the Medical Schemes Act. The Rules of Bestmed are registered at the Council for Medical Schemes and any changes to the Rules must first be approved by them.

### 4.2 Financial Services Board

The Financial Services Board (FSB) is responsible for the regulation of non-banking financial services such as medical schemes. The FSB assists clients with legislative related complaints dealing with the manner in which the regulated companies conduct themselves and any contravention of the acts by which they are governed. The FSB cannot assist with claim disputes and contractual disagreements. For this you would need to consult the relevant Ombudsman or Pension Funds Adjudicator. The FAIS Ombudsman deals with complaints from clients against Financial Services Providers (FSP) in relation to the specific services rendered by FSPs as prescribed by the FAIS Act 37 of 2002.

#### Contact details

Tel: +27 (0) 12 470 9080 / +27 (0) 12 470 9099

Fax: +27 (0) 12 348 3447 / +27 (0) 86 032 4766

Web: [www.faisombud.co.za](http://www.faisombud.co.za)

E-mail: [info@faisombud.co.za](mailto:info@faisombud.co.za)

### 4.3 Escalation of Queries

With regard to Member complaints, the Council for Medical Schemes advises that:

*Any complaint must first be lodged with the scheme concerned. Written complaints would certainly be preferable, but all schemes should also have dedicated telephone lines to handle everyday complaints and enquiries. All schemes are also required to have independent disputes committees where Members' disputes may be settled. Members and/or their legal representatives may be present at disputes committee meetings to present their arguments. Legal representation is not obligatory. Should all efforts fail to resolve an issue with your scheme, you can submit your complaint to the Council for Medical Schemes Complaints Unit by either posting, faxing, e-mailing or submit online by going to the following website address: [http://www.medicalschemes.com/Consumer\\_Assistance/CMain](http://www.medicalschemes.com/Consumer_Assistance/CMain)*

Bestmed continually strives to offer the best with value-for-money products supported by superior client service to make your dealings with Bestmed efficient and to your satisfaction. If you are not satisfied with Bestmed's service, e-mail your complaint to [toservice@bestmed.co.za](mailto:toservice@bestmed.co.za) (Subject box: Manager, escalated query) or write to us at PO Box 2297, Pretoria 0001. Bestmed has a dedicated division that handles escalated queries. For everyday complaints and queries you can contact our Call Centre on +27 (0) 86 000 2378.

If you are still unhappy with the Scheme's response, then you could escalate your complaint to the Council for Medical Schemes (CMS).

## 4.4 Escalation to CMS

To escalate a complaint to the CMS, you may send an e-mail to [complaints@medicalschemes.com](mailto:complaints@medicalschemes.com)

Who can complain to the Registrar's Office?

- Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.
- It is, however, very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme before approaching the Council for assistance.
- Complaints can be submitted by any reasonable means such as a letter, fax, e-mail or in person at the CMS offices from Mondays to Fridays from 08:00 to 17:00.

Fax Complaints: +27 (0) 12 431 0608

E-mail Complaints: [complaints@medicalschemes.com](mailto: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

## 4.5 Confidentiality

Bestmed assures Members of confidentiality of information and no information will be provided to any third party except when legally required. Please note that cardholder information (as reflected on your Membership card) will be provided to electronic switching houses in order for pharmacy claims and electronic claims to be submitted to the Scheme.

## 4.6 Bestmed Hotline

Bestmed has decided to act pro-actively in addressing unethical behaviour, theft, fraud or related activity and has thus joined forces with KPMG to fight such practices. Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed employees, service providers or even Bestmed Members, please report this anonymously to KPMG.

The Bestmed Hotline operates as an independent conduit where callers are guaranteed anonymity. The call centre is secure and the public does not know the location thereof. Furthermore, Bestmed cannot demand that the identity of the caller be revealed.

**To contact the Bestmed Hotline, please follow the steps below:**

1. Dial +27 (0) 80 111 0210, toll free from any Telkom line.
2. You may remain anonymous. Provide full detail in respect of the fraudulent, corrupt or unethical practice to the call operator.

Such details may include:

- Who is involved or doing what?
- What has happened?
- How is it done and how often is it done?
- Where is it done - exact location or place?
- When was the incident observed, dates and times
- Value involved - estimated monetary value?

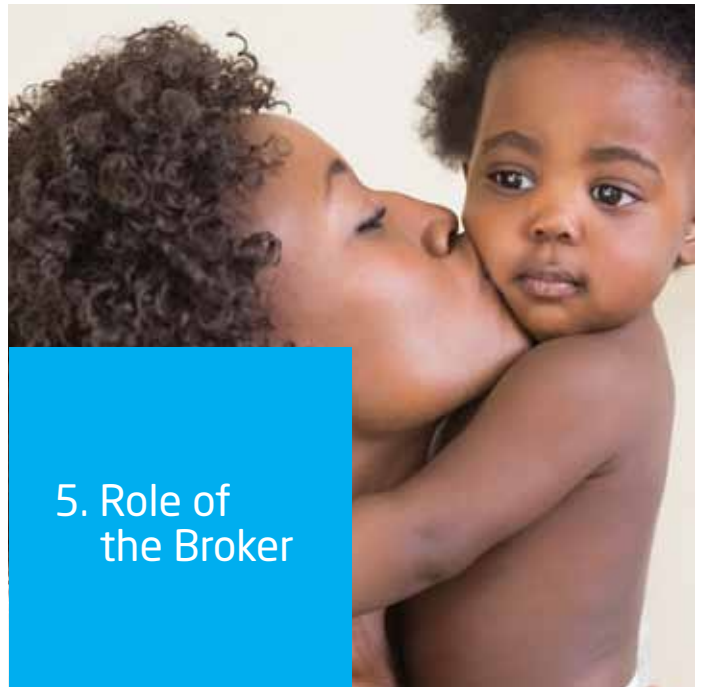
3. You will be given a reference number. Keep this confidential as you will need this number if you make a follow-up call (call at a later date to add additional information to the original report) or a feedback call (call at a later date to request feedback on the original call).

You may also fax details anonymously to a confidential fax line (also operated by KPMG). Should you wish to use this method, please include as much detail as possible including that the report is in respect of Bestmed. This detail may be faxed to +27 (0) 80 020 0796.

In addition, details can be posted free-of-charge to the KPMG Ethics Line at the following address:

KPMG Hotpost, BNT371, PO Box 14671, Sinoville 0129

Information can also be e-mailed through to the hotline anonymously at the following address: [fraud@kpmg.co.za](mailto:fraud@kpmg.co.za)



## 5. Role of the Broker

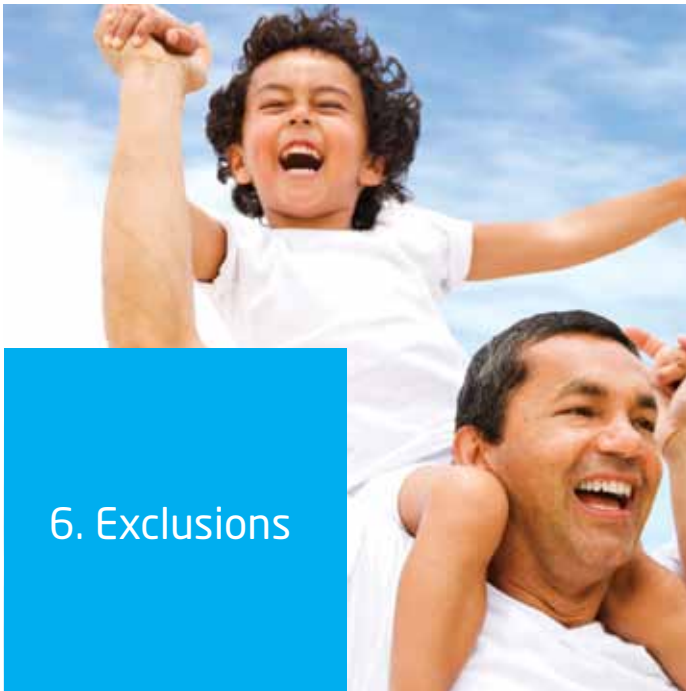
In instances where a broker completes a form on behalf of the Member and material information is not disclosed as directed by the Member, the Member will be liable since Members are legally required to read, understand and be made aware of the information disclosed in the application form.

A broker needs to provide you as Member with adequate information and explain all necessary terminology. Please note that brokers are not in a position to make any commitments to clients in which he binds or attempts to bind the Scheme in any matter where a discretionary power resides with the Scheme such as the application of waiting periods or late joiner penalties.

### 5.1 Health Risk Analysis

You should remember that with increased age comes an increased prevalence of hypertension, heart disease, diabetes, arthritis, cancer, stroke and other chronic conditions. Your present benefit option may not necessarily make provision for all these health care expenses and might result in you having to pay for these from your own pocket.

It might well be that you or your Dependant/s' healthcare needs have already begun to change. If that is the case, we encourage you to have a needs analysis done to ensure that you are on the appropriate benefit option. A health risk analysis can be organised through your broker or dial +27 (0) 86 000 2378 for assistance. You can also visit [www.bestmed.co.za](http://www.bestmed.co.za) to consider other, more comprehensive benefit options.



## 6. Exclusions

For the full version of the Scheme Rules and Exclusions, including the relevant Annexures, please visit the Bestmed website at [www.bestmed.co.za](http://www.bestmed.co.za)

### 6.1 General Exclusions applicable to all Benefit Options

- 6.1.1 All travel expenses for doctors and patients.
- 6.1.2 Medical aids, orthopaedic, surgical and medical appliances, except for those defined in Annexure B.1 to B.10 including any sub-benefit option registered.
- 6.1.3 Reports, examinations and tests requested for emigration, immigration, visas, insurance policies, employment, admission to schools and universities, court medical reports, muscle-function tests, fitness examinations and tests, adoption of children and retirement because of ill health.
- 6.1.4 Any operations, treatment and procedures for non-functional or cosmetic purposes.
- 6.1.5 Accounts for services rendered by persons not registered with the Health Professions Council of South Africa, Associated Health Service Professions Board or any other similar Healthcare body in the country where the service was rendered.
- 6.1.6 Accounts in respect of:
  - 6.1.6.1 All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party is liable. The member is however entitled to such benefits as would have applied under normal conditions, provided that on receipt of payment in respect of medical expenses, the member will reimburse the Scheme any money paid out in respect of this benefit by the Scheme.
  - 6.1.6.2 Obesity.
  - 6.1.6.3 Appliances and medication to prevent injuries during sports and recreational activities.
  - 6.1.6.4 Injuries arising from illegal actions on the basis of which the member or his dependants took part in a criminal offence.
  - 6.1.6.5 Appointments not kept by members.
- 6.1.7 Accommodation in an old-age home or institution providing general care and nursing services to persons, e.g. the infirm aged and chronically sick patients, or similar institutions.
- 6.1.8 Examinations, tests and treatment of impotence and of infertility or artificial insemination or artificial fertilisation of a person within or outside the human body as defined in the National Health Act (Act 61 of 2003)(NHA) and more specifically the Regulations: general control of human bodies, tissue, blood, blood products and gametes, issued in terms of the NHA. In the case of artificial insemination, Bestmed shall not make any contribution in respect of the preparatory expenses, i.e. pre-insemination expenses or insemination outside the female body.
- 6.1.9 Costs in excess of the annual maximum benefits to which the member is entitled under Bestmed's rules.
- 6.1.10 Any costs in respect of conditions specifically excluded from benefits because of a waiting period at admission or registration of the member and his dependants with Bestmed.
- 6.1.11 The costs of holidays for recuperation purposes, accommodation in spa's, health resorts and places of rest even if prescribed by a treating provider.
- 6.1.12 HIV, Aids and other sexually contagious diseases: Provided that-
  - 6.1.12.1 Services in a public hospital shall be paid, limited to the minimum benefits provided for in regulation 8 of the regulations in terms of the Medical Schemes Act (No. 131 of 1998) and Annexure D1 of these Rules; and
  - 6.1.12.2 The member or his dependants shall furnish clinical evidence of their HIV/AIDS status to the Medical Advisor of Bestmed.
- 6.1.13 Costs arising from a person's association with the official armed forces for which he is covered by the Government.
- 6.1.14 Benefits not referred to in this Schedule or services not rendered in terms of accepted protocol or are not aimed at the treatment of an actual or supposed condition or deficiency, disadvantaging or endangering essential bodily functions.
- 6.1.15 Mammary surgery except where this is related to carcinoma, tumours and abscesses.
- 6.1.16 Refractive surgery for Pulse1. On all other benefit options where -
  - 6.1.16.1 Hyperopia is measured greater than +3; or
  - 6.1.16.2 Myopia is measured more negative than -5; or
  - 6.1.16.3 Astigmatism is measured greater than -2.5; and
  - 6.1.16.4 Pre-Authorisation shall apply.
- 6.1.17 Any cost charged by a service provider for medical motivations or prior motivations as stipulated by these Rules, unless the Scheme has requested such aforesaid medical motivations.
- 6.1.18 Costs arising from lost or damaged devices, apparatus, spectacles or contact lenses.
- 6.1.19 Psychometric tests.
- 6.1.20 Injuries during participation in riots, civil unrest or public disorder, war, invasion, any act of foreign enemies, hostilities, warlike operations or civil war.
- 6.1.21 The following exclusions relating to oral and dental benefits:
  - 6.1.21.1 The cost of gold, metal or other inlays in a denture and/or crown.
  - 6.1.21.2 Bleaching of vital teeth.
  - 6.1.21.3 Lingual orthodontics.
- 6.1.22 Procedures considered by Bestmed as cosmetic or of a cosmetic approach where alternative procedures exist.
- 6.1.23 Items indicated in the Dental Schedule as "by arrangement" or "N/A".
- 6.1.24 Procedures requiring prior authorisation for which no authorisation was applied for.
- 6.1.25 Sunglasses.
- 6.1.26 Ambulance and emergency evacuation from a hospital to a patient's home or from a patient's home to a consulting room of any medical practitioner.

6.1.27 Transport fees, renting of birth pools, hospital facility fees, medical disposables and medication, antenatal consultations, doulas and breastfeeding support for home confinements by a midwife and midwife assisted births in an Active Hospital Birth Unit.

## 6.2 The following benefits are not applicable to certain options according to the design of such an option:

- 6.2.1 Any out of hospital services for Beat1 members (day-to-day benefits), including non-CDL chronic medicine, acute medicine and over-the-counter medicine.
- 6.2.2 Biological or other high cost medicine, meaning any medicinal product manufactured in or extracted from biological sources, or other high cost speciality medicines, including rational designed medicines are excluded from the Beat1, Beat2, Beat3, Beat4, Pulse1 and Pace1 benefit options.
- 6.2.3 Surgical dentistry for Pulse1.
- 6.2.4 External prosthesis for Pulse1.
- 6.2.5 Specialised dentistry for Pulse1.
- 6.2.6 Supplementary services out of hospital for Pulse1.
- 6.2.7 Rehabilitation after trauma for Pulse1, Pulse2, and Beat1.
- 6.2.8 Orthopaedic and surgical appliances during hospitalisation for Beat1.
- 6.2.9 Non PMB complications for breast reduction for Pace4.
- 6.2.10 Facility fee as part of out-of-network visits for Pulse1.
- 6.2.11 Specialised diagnostic imaging (MRI, Cat scans, PET scans, angiography, etc.) for Pulse1.
- 6.2.12 Radiology tests requested by Specialists not listed on the radiology tariff list for Pulse1.
- 6.2.13 Contact lenses, contact lens solutions, mirror or other graded tinted lenses, accessories or enhancements for glasses for Pulse1.
- 6.2.14 Refractive surgery for Pulse1.
- 6.2.15 The following dental exclusions for Pulse2:
  - 6.2.15.1 Orthodontic therapy for patients older than 18 years old;
  - 6.2.15.2 Complications with removable dentures; and
  - 6.2.15.3 MRI and CT scans for any dento-alveolar procedure.

## 6.3 The following is a list of exclusions as applied by CareCross and will therefore be applicable to the Pulse1 benefit option. These exclusions might be in addition to the exclusions indicated in Annexure C1.

- 6.3.1 Any services obtained from a non-CareCross supplier other than those covered under the "Out of Network" benefit.
- 6.3.2 Travel expenses.
- 6.3.3 Cosmetic treatment, operations, procedures and applicators, toilet preparations, etc.
- 6.3.4 Reports, examinations and tests for insurance policies, legal reasons.
- 6.3.5 Injuries arising from or appliances for professional sport, bungee or parachute jumps.
- 6.3.6 Accommodation in an old age home, general care institutions, spa's, health or holiday resorts.
- 6.3.7 HIV, Aids treatment except for the general health management services as provided for in the Capitation agreement between CareCross and the Scheme.
- 6.3.8 Treatment for obesity, alcohol or drug abuse.

- 6.3.9 Treatment and operations of choice and non-essential medical items.
- 6.3.10 Acupuncture, biokenetics, chiropractors, herbalists, nature and homeopaths.
- 6.3.11 Chronic psychiatric conditions and mental disorders except for CDL conditions.
- 6.3.12 Treatment and medication in respect of Tuberculosis other than general health management at general practitioner level.
- 6.3.13 Injuries sustained during participation in strikes, illegal picketing, riots or physical struggle.
- 6.3.14 Nutritional supplements, tonics, stimulants, vitamins, minerals.
- 6.3.15 Contraceptives and devices to prevent pregnancy.
- 6.3.16 Stimulant laxatives.
- 6.3.17 Treatment for infertility and sexual dysfunction.
- 6.3.18 Root canal treatment and other advanced dentistry.
- 6.3.19 Services in respect of the treatment of any sickness condition or injury sustained by a beneficiary for which any other party may be liable.
- 6.3.20 Biologics not forming part of the care-out drug list.

## 6.4 Other limitations of benefits

Benefits in respect of medicines obtained on prescription of a designated service provider are limited to the prescribed quantities, but in any event to not more than one month's supply thereof.

## 6.5 Voluntary use of a non-DSP

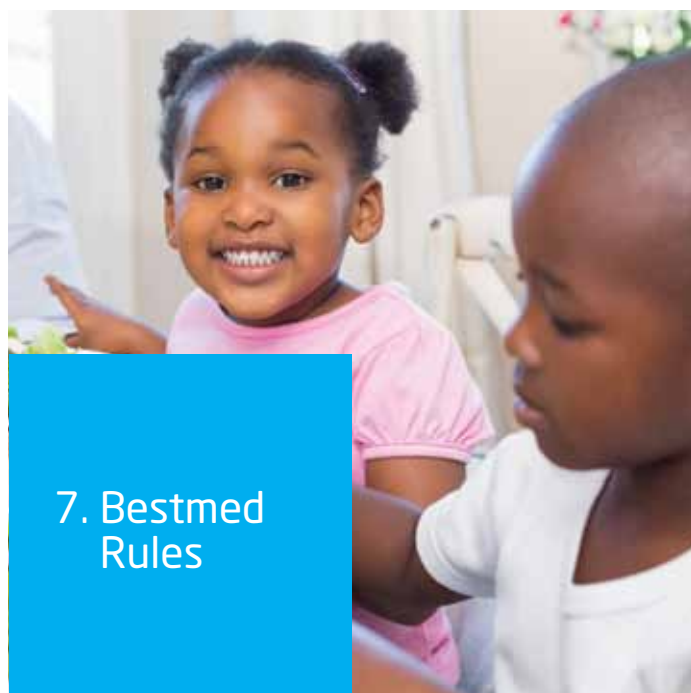
Should a beneficiary voluntarily choose not to make use of a Hospital DSP on the Pulse1, Pulse2 and the efficiency-discount sub-options from Beat1 up to Beat4 benefit options, a maximum co-payment of R5 000-00 will apply.

## 6.6 Medicine exclusions

- 6.6.1 Preparations for the specific treatment of obesity, including dietary supplements.
- 6.6.2 Patent and household remedies.
- 6.6.3 Nutritional supplements (including patent and baby foods).
- 6.6.4 Medicines used specifically to treat infertility.
- 6.6.5 Aphrodisiacs,
- 6.6.6 Sun-screening agents (medicated or otherwise).
- 6.6.7 All soaps and shampoos (medicated or otherwise).
- 6.6.8 Cosmetic substances.
- 6.6.9 Anti habit substances.
- 6.6.10 Anabolic steroids.
- 6.6.11 Tonics, stimulants, biological substances, vitamins, minerals and vitamin/mineral combinations unless proven medical indications can be submitted: Provided that Bestmed will contribute for prenatal medicine.
- 6.6.12 Unregistered medicines will not be considered for benefits until such time that it is registered by the Medicines Control Council.
- 6.6.13 Unregistered indications or "off label" use of medicines will not be considered for benefits.
- 6.6.14 Haematinics i.e. Erythropoietin for Pulse1.
- 6.6.15 Biological and Biotechnological substances for Pulse1.

## 6.7 Limitations of benefits

- 6.7.1 The maximum benefits to which a member and his dependants are entitled in any financial year are limited as set out in Annexure B1 to B10 including any sub-benefit options registered.
- 6.7.2 Members admitted during the course of a financial year are entitled to the benefits adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.
- 6.7.3 Unless otherwise decided by the Board of Trustees, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof.
- 6.7.4 of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof.



## 7. Bestmed Rules

(Adopted by the Board of Trustees on 11 September 2014 and approved in terms of CMS Circular 59 Of 2014, which also confirms the pending exemption in respect of the efficiency-discounted sub-options (EDOs)

### 1. NAME

The name of the Scheme is Bestmed Medical Scheme, hereinafter referred to as the "Scheme". The abbreviated name is Bestmed.

### 2. LEGAL PERSONA

The Scheme is a body corporate, capable in its own name of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act, 1998, the Regulations there under and these Rules.

### 3. REGISTERED OFFICE

The registered office of the Scheme is situated at Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

### 4. DEFINITIONS

In these Rules, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context:

- A word or expression in the masculine gender includes the feminine and vice versa; and
- A word in the singular number includes the plural, and vice versa; and
- The following expressions have the following meanings:

- 4.1 "Administrator" means any person who has been accredited by the Council in terms of section 58, and shall, where any obligation has been placed on the Scheme in terms of the Act, also mean a medical scheme;
- 4.2 "Approval" means prior written approval;
- 4.3 "Auditor" means an auditor registered in terms of the Public Accountants' and Auditors' Act, 1991, (Act No. 80 of 1991);
- 4.4 "Beneficiary" means a Member or a person admitted as a Dependant of a Member;
- 4.5 "Benefits" mean the benefits to which a Member is entitled as set out in Rule 16 and in terms of the schedule of the Scheme option in which he participates, subject to the restrictions imposed by these Rules;
- 4.6 "Biological or other high cost medicine" means any medicinal product manufactured in or extracted from biological sources, and other high cost speciality medicines, including rational designed medicines are either excluded from the Scheme option or are limited to an annual rand value;
- 4.7 "Board" means the Board of Trustees constituted in terms of Rule 18 to govern the Scheme in terms of the Act and these Rules;
- 4.8 "Board Of Trustees" means the board of trustees charged with the governance of the affairs of this Scheme, and which has been elected or appointed under these Rules;
- 4.9 "Bonus Account/Vested Medical Savings Account" means an account to which unused medical savings are transferred after a period of 4 (four) calendar months or at the beginning of the financial year, according to the benefit option, and that could be used for out-of-hospital expenses. Any interest earned shall accrue to the Bonus Account/Vested Medical Savings Account balance. No cross subsidisation applies to the Bonus Account/Vested Medical Savings Account;
- 4.10 "Broker" means a person whose business, or part thereof, entails providing broker services, but does not include:
- 4.10.1 An employer or employer representative who provides service or advice exclusively to the employees of that employer;
- 4.10.2 A trade union or trade union representative who provides service or advice exclusively to Members of that trade union; or
- 4.10.3 A person who provides service or advice exclusively for the purposes of performing his or her normal functions as a trustee, principal officer, employee or administrator of the Scheme, unless a person referred to in this paragraph elects to be accredited as a broker, or actively markets or canvasses for membership of this Scheme;
- 4.11 "Broker Services" means:
- 4.11.1 The provision of services or advice in respect of the introduction or admission of Members to this Scheme; or
- 4.11.2 The on-going provision of service or advice in respect of access to, or benefits or services offered by, this Scheme;
- 4.12 "Business of a Medical Scheme" means the business of undertaking, in return for a premium or contribution, the liability associated with one or more of the following activities:
- 4.12.1 Providing for the obtaining of any relevant health service;
- 4.12.2 Granting assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; or
- 4.12.3 Rendering a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with the Scheme;
- 4.13 "Child" means a Member's natural child, or a stepchild or legally adopted child or a child who has in accordance with the law been placed in the custody of the Member or his spouse or partner;
- 4.14 "Chronic Disease List (CDL)" means a list of chronic conditions where the Scheme will provide and pay for medication and the treatment of the chronic condition as listed in the Act;
- 4.15 "Claim" means an itemised statement of services and costs from a health care provider or facility submitted to the Scheme for payment where the Member and or his beneficiary(ies) applies for benefit pay out for relevant health service(s) utilised or the amount which a Member demands of the Scheme in respect of expenditure incurred by him in connection with a relevant health service in respect of which he and/or his Dependants are entitled to in terms of Rule 16 and Annexure B of these Rules, in the benefit option which he participates in;

- 4.16 "Condition-specific Waiting Period" means 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 twelve-month period ending on the date on which an application for membership was made;
- 4.17 "Continuation/Retired/Widowed/Orphaned Member" means:
- 4.17.1 An employee of a participating employer who retains his membership of the Scheme upon retirement; or
- 4.17.2 Due to death of a Member, his registered Dependant(s) become(s) a Member of the Scheme in terms of Rule 6.3;
- 4.18 "Contracted Fee" means the fee determined in terms of an agreement between the Scheme and a service provider or group of service providers in respect of the payment for relevant health services;
- 4.19 "Complaint" means a complaint against any person required to be registered or accredited in terms of the Act or any person whose professional activities are regulated by the Act and these Rules, and alleging that such person has:
- 4.19.1 Acted, or failed to act, in contravention of this Act and these Rules; or
- 4.19.2 Acted improperly in relation of any matter which falls within the jurisdiction of the Council;
- 4.20 "Co-Payment" means that portion of a claim or medical expense that a Member must pay out of pocket for relevant health services for which he claims, that is paid by the Member to the service provider or, on request that will be paid from the available funds in the Member's medical savings account;
- 4.21 "Cost" means, in relation to a benefit, the net amount charged in respect of a relevant health service;
- 4.22 "Council" means the Council for Medical Schemes established by section 3 of the Act;
- 4.23 "Creditable Coverage" means any period during which a late joiner was:
- 4.23.1 A Member or a Dependant of a medical scheme;
- 4.23.2 A Member or a Dependant of an entity doing the business of a medical scheme which, at the time of his membership of such entity, was exempt from the provisions of the Act;
- 4.23.3 A uniformed employee of the South African National Defence Force, or a Dependant of such employee, who received medical benefits for the South African National Defence force; or
- 4.23.4 A Member or a dependent of the Permanent Force Continuation Fund, but excluding any period of coverage as a Dependant under the age of 21 (twenty-one) years;
- 4.24 "Date Of Service" means
- 4.24.1 In the case of consultations, visits or treatments by a health practitioner, the date on which each consultation, visit or treatment took place, whether it was for the same illness or not;
- 4.24.2 In the case of operations, procedures or confinements, the date on which the operation, procedure or confinement took place;
- 4.24.3 In the case of hospitalisation, the date of each discharge from a hospital or nursing home alternatively the date on which membership is terminated, whichever date is the earlier;
- 4.24.4 In the case of any other benefit, the date on which the service was rendered or the benefit or item was obtained; and
- 4.24.5 In the case of an accident, event or injury referred to in Rule 15.5, the date of final ruling;
- 4.25 "Dependant" means
- 4.25.1 A Member's spouse or partner who is not a Member or a registered Dependant of a Member of another scheme;
- 4.25.2 A Member's dependent child who is under the age of 21 (twenty-one) years and not a Member or a registered Dependant of a Member of another Scheme;
- 4.25.3 A parent, brother or sister of a Member in respect of whom a duty of support and family care rests on the Member, and for whom subscriptions as for adult Dependants are payable, if such Dependant is older than 21 (twenty-one) years of age;
- 4.25.4 A child Dependant of a Member who is 21 (twenty-one) years or older who has not reached the age of 26 (twenty-six) years and who is a student at a school or other educational institution recognised and accepted as such by the Board: Provided that;
- 4.25.4.1 proof acceptable to the Board is submitted to the effect that the child is a registered student at the institution in question; and
- 4.25.4.2 the child is not enrolled as a Member or a Dependant of a Member of another scheme.
- 4.25.5 An adult Dependant of a Member who is 21 (twenty-one) years or older who, because of a mental or physical handicap or for any similar reason, has been recognised and accepted as such by the Board;
- 4.25.6 Subject to the provisions of Rules 4.25.4 and 4.25.5, a child of the Member, above the age of 21 (twenty-one) years and who is dependent on the Member, but in respect of whom subscriptions for adult Dependants are payable; and
- 4.25.7 A Member's parent, brother or sister who is not in receipt of a regular income of more than the maximum social pension per month; or a child due to a mental or physical disability is dependent upon the Member;
- 4.25.8 Any other person who is recognised by the Board as a Dependant for purposes of these Rules.
- 4.26 "Designated Service Provider" means a health care provider or group of providers selected by the Scheme as the preferred provider or providers to provide to the Members diagnosis, treatment and care in respect of one or more prescribed minimum benefit condition at a contract fee rate;
- 4.27 "Dispensing Fee" means the fee a pharmacist charges for dispensing medicine;
- 4.28 "Emergency Medical Condition" means the sudden and at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy;
- 4.29 "Employee" means a person in the employ of a participating employer;
- 4.30 "Employer" means a participating employer who has contracted with the Scheme for purposes of admission of its employees or part thereof as Members of the Scheme;
- 4.31 "Endoscopic Investigation" means looking inside the body for medical reasons using an instrument called an endoscope, to examine the interior of a hollow organ or cavity of the body;
- 4.32 "Financial Year" means a period from the 1st (first) day of January to the 31<sup>st</sup> (thirty-first) day of December of that year, both days included;
- 4.33 "Formulary" means a list of medicines that the Scheme will pay for to treat the chronic conditions as per the benefit option the Member selected;
- 4.34 "General Waiting Period" means a period in which a beneficiary is not entitled to claim any benefits;
- 4.35 "Income" means for the purposes of calculating contributions in respect of —
- 4.35.1 A Member who is an employee of a participating employer – basic salary;
- 4.35.2 An individual Member - gross monthly income;
- 4.35.3 A Member who registers a spouse or partner as a Dependant — the higher of the Member's or spouse's gross monthly income; and
- 4.35.4 A continuation Member - gross monthly income;
- 4.36 "Health Practitioner" means any person, including a student, registered with the Council in a profession registrable in terms of the Health Professions Act, No. 56 Of 1974;
- 4.37 "Individual Member" means a Member that obtained membership of the Scheme by joining on his/her own and not through a participating employer organisation.
- 4.38 "Late Joiner" means an applicant or the adult Dependant of an applicant who, at the date of application for membership or admission as a Dependant, as the case may be, is 35 (thirty-five) years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical Schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 (three) consecutive months since 1 April 2001;
- 4.39 "Late Joiner Penalty" means a penalty payable for a late joiner that will be added to the Member's monthly contribution. The penalty is applied only to the portion of the contribution related to the Member or adult Dependant who qualifies for late joiner penalties and as such is calculated on the bands as prescribed by the Act;

- 4.40 "Managed Health Care" means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rule-based and clinical management-based programmes;
- 4.41 "Maxillofacial Surgery" means surgery to the jaw or face;
- 4.42 "Maximum Benefits" means the total benefits which may accrue to a Member and his Dependants in terms of these Rules for the financial year;
- 4.43 "Medical Savings Account" means a benefit account established in the name of the Member concerned into which an amount that may not exceed 25% (twenty-five percent) of the total gross contribution made in respect of the Member during the financial year concerned is payable as indicated by the specific benefit option chosen by the Member. Funds deposited in a Member's personal medical savings account, where applicable, shall be available for the exclusive benefit of the Member and his or her Dependants and will not be used to offset the Member's contributions, provided that the Scheme may use funds in a Member's personal medical savings account to offset debt owed by the Member to the Scheme following that Member's termination of membership of the Scheme. Any interest earned shall be accrued to the medical savings account balance. No cross subsidisation applies to the medical savings account;
- 4.44 "Medical Scheme" means any medical scheme registered under section 24 of the Act.
- 4.45 "Mediscor Reference Price (MRP)" means a reference list of generic medicines that cost less than original brand name medicines. The MRP sets a maximum reimbursement price for each generic product. A change in the MRP, as and when it is received from Mediscor, will affect the co-payment amount payable by the Member if he elects to receive the original brand medicines;
- 4.46 "Member" means a person who has been enrolled or admitted as a Member of the Scheme in terms of these Rules;
- 4.47 "Network Option Services" means an arrangement entered into between the Scheme and an accredited managed care organisation whereby the Scheme pays to such an accredited managed care organisation a prenegotiated fixed fee in return for the delivery or arrangement of the delivery of specified benefits to some or all of the Members of the Scheme;
- 4.48 "Non-CDL Condition" means other chronic conditions which do not form part of the Chronic Disease List. Payment shall depend on non-CDL benefits specified per benefit option, as determined by the Scheme, at its sole, discretion, in accordance with each individual benefit option;
- 4.49 "Officer" means any Member of the Board of Trustees, any manager, the Principal Officer, treasurer, clerk or other employee of the Scheme, but does not include the auditor of the Scheme;
- 4.50 "Partner" means a person with whom the Member has a sustained committed, serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party;
- 4.51 "Practice Number" means the number allocated to a supplier of services as a practice number by registered authorities;
- 4.52 "Pre-Authorisation" means the formal approval by the Scheme for payment of a requested procedure before it occurs;
- 4.53 "Pre-Existing Sickness Condition" means a sickness condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 (twelve) month period ending on the date on which an application for membership was made;
- 4.54 "Preferred Provider Network" means a health care provider or group of providers selected by the Scheme as the preferred provider or providers to provide to the Members of the Scheme diagnosis, treatments and care in respect of one or more conditions at a prenegotiated rate;
- 4.55 "Prescribed Minimum Benefits" means the benefits contemplated in section 29 (1) (o) of the Act and consist of the provision of the diagnosis, treatment and care costs of:
- 4.55.1 The Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, as amended from time to time, subject to any limitations specified therein; and
- 4.55.2 Any emergency medical condition.
- 4.56 "Prescribed Minimum Condition" means a condition contemplated in the Diagnosis and Treatment Pairs or any emergency medical condition in terms of Annexure A of the Regulations, as amended from time to time;
- 4.57 "Prescribed" means prescribed by regulation;
- 4.58 "Preventative Care" means pro-actively identifying a health risk or the management thereof, aimed at preventing disease, payable by the Scheme for specifically defined benefits;
- 4.59 "Principal Officer" means the principal officer appointed in terms of section 57 (4) (a) of the Act;
- 4.60 "Prosthesis" means an artificial part supplied to remedy a deficiency;
- 4.61 "Protocols" means clinical guidelines, compiled by experts in the field of a specific medical condition, which specify how a condition should be treated, based on best practice principles;
- 4.62 "Registrar" means the Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of section 18 of the Act;
- 4.63 "Relevant Health Service" means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object:
- 4.63.1 The physical or mental examination of that person;
- 4.63.2 The diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- 4.63.3 The giving of advice in relation to any such defect, illness or deficiency;
- 4.63.4 The giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
- 4.63.5 The prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
- 4.63.6 Nursing or midwifery,
- and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;
- 4.64 "Rules" means the Rules of a medical scheme and include:
- 4.64.1 The provisions of the law, charter, deed of settlement, memorandum of association or other document by which the Scheme is constituted;
- 4.64.2 The articles of association or other Rules for the conduct of the business of the Scheme; and
- 4.64.3 The provisions relating to the benefits which may be granted by and the contributions which may become payable to the Scheme;
- 4.65 "Scheme Tariff" means an annual fixed tariff determined by the Scheme for the payment of benefits in accordance with the provisions of Rule 16.6;
- 4.66 "Single Exit Price" means a single exit price included in a transparent pricing system contemplated in section 22G(2)(a) of the Medicines And Related Substances Act No. 101 Of 1965, which is published as prescribed, and such price shall be the only price at which manufacturers shall sell medicines and scheduled substances to any person other than the State;
- 4.67 "Social Pension" means the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (Act no 59 of 1992);
- 4.68 "Spouse" means the person to whom the Member is married in terms of any law or custom recognised by Law;
- 4.69 "Subscription /Contribution/ Premium" means, in relation to a Member, the gross amount, including amounts for his savings account, paid by or in respect of the Member and his registered Dependents, if any, as membership fees;
- 4.70 "the Act" means the Medical Schemes Act (ACT 131 OF 1998) and includes the Regulations and sections referred to herein.
- 5. MISSION AND BUSINESS OF THE SCHEME**
- 5.1 Mission**
- The mission of the Scheme is to operate a medical scheme in terms of the Act in a financially responsible manner for the defrayal of its Members' healthcare expenses by means of:
- 5.1.1 The optimal appropriation of Members' contributions and other income;
- 5.1.2 The operation and administration of one or more benefit option(s) and/or Scheme(s);

- 5.1.3 The striving for balanced growth in membership;
- 5.1.4 The rendering of relevant health services; and
- 5.1.5 Negotiations with providers of relevant health services for the supply of quality and cost effective services.

## 5.2 Business of the Scheme

The business of the Scheme is to undertake, within its financial means and subject to the provisions of the Act and these Rules;

- 5.2.1 Liability in respect of its Members and their Dependants, in return for a contribution by a Member;
- 5.2.2 To make provision for the obtaining of any relevant health service;
- 5.2.3 To grant assistance in defraying expenditure incurred in connection with the rendering of any health service; and
- 5.2.4 To render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme.

## 6. MEMBERSHIP

### 6.1 Individual Members

- 6.1.1 Any person who is self-employed or financially independent and who is neither an Employee nor a continuation Member of a Participating Employer may apply to become a Member of the Scheme.
- 6.1.2 The provisions of Rules 6.2 and 6.3 are mutatis mutandis (the necessary changes having been made) applicable to Individual Members who retire as well as the Dependants of deceased individual Members.

### 6.2 Retirees

- 6.2.1 A Member shall retain his/her membership of the Scheme as a Continuation Member together with his registered Dependants, if any, in the event of his retiring on pension from the service of his employer or his employment being terminated by his employer on account of age, ill-health or other physical or mental disability, and will remain on his current benefit option until the end of that financial year, where after he may elect to change from benefit option in accordance with the registered Rules.
- 6.2.2 The Scheme shall inform the Member of his right to continue his membership and of the contribution payable by himself or on his behalf from the date of retirement or termination of his employment within a reasonable time. Unless such Member informs the Scheme in writing of his desire to terminate his membership, he shall continue to be a Member of the Scheme, and the Scheme will be entitled to collect all contributions in terms of his membership in terms of his current benefit option until the end of that financial year, where after he may elect to change from benefit option in accordance with the registered Rules.

### 6.3 Dependants of deceased Members

- 6.3.1 The Dependants of a deceased Member who are registered with the Scheme as his Dependants at the time of such Member's death shall be entitled to retain membership of the Scheme as Continuation Members without any new restrictions, limitations or waiting periods.
- 6.3.2 The Scheme shall inform the Dependant of his right to membership and of the contributions payable in respect thereof within a reasonable time. Unless such person informs the Scheme in writing of his intention not to become a Member within 30 (thirty) days from the date of the deceased Member's death, he shall be admitted as a Member of the Scheme and the Scheme will be entitled to collect all contributions in terms of his membership.
- 6.3.3 Such a Member's membership shall automatically terminate if he becomes a Member or a Dependant of a Member of another medical scheme. The Scheme must be informed in writing of another membership before the beginning of any calendar month, failing which the Member shall be held liable for that specific month's contribution.
- 6.3.4 Where a child Dependant has been orphaned, the eldest child may be deemed to be the Member, and any younger sibling as a child Dependant.

## 7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

### 7.1 Registration of Dependants

- 7.1.1 A Member may apply for the registration of his Dependants at the time that he applies for membership in terms of Rule 8.

- 7.1.2 If a Member applies to register a new-born or newly adopted child or a stepchild within 30 (thirty) days of the date of birth or adoption or it becoming a stepchild of the Member, such child shall be registered by the Scheme as a Dependant: Provided that contributions in respect of such a child shall be due as from the first day of the month following the month of birth or adoption or becoming a stepchild of the Member, and benefits will accrue as from the date of birth or adoption or the date of the child becoming a stepchild.

- 7.1.3 If a Member, who marries subsequent to joining the Scheme, applies within 30 (thirty) days of the date of such marriage to register his Spouse as a Dependant, his Spouse shall thereupon be registered by the Scheme as a Dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of marriage: Provided that the Spouse shall not qualify for benefits until such time as the Member himself qualifies for benefits.

- 7.1.4 In the event of any person becoming eligible for registration as a Dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the Member may apply to the Scheme for the registration of such person as a Dependant, whereupon the provisions of Rule 8 shall apply mutatis mutandis (the necessary changes having been made).

- 7.1.5 The provisions of Rule 8.6 in respect of subscriptions and accrual of benefits apply in all cases not specifically provided for above.

### 7.2 De-registration of Dependants

- 7.2.1 A Member shall inform the Scheme and his Employer where applicable in writing within 30 (thirty) days of the occurrence of any event which results in any one of his Dependants no longer satisfying the conditions in terms of which he may be considered to be a Dependant. A Member who fails to inform the Scheme shall not be entitled to a refund of contributions or subscriptions received by the Scheme as from the date of the occurrence of any event which results in any one of his Dependants no longer satisfying the conditions in terms of which he may be considered to be a Dependant, until the aforesaid Dependant(s) has been de-registered by the Scheme as the Member's Dependant.
- 7.2.2 When a Dependant ceases to be eligible to be a Dependant, he shall no longer be deemed to be registered as such for the purpose of these Rules or be entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise: Notwithstanding anything to the contrary, and subject to the provisions of the Act, the Scheme may claim reimbursement from the Member for benefits paid on behalf of such Dependant and costs incurred after he ceased to be a Dependant in terms of these Rules.

## 8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

### 8.1 Minors

A minor may become a Member with the written consent of his parent or guardian.

### 8.2 Membership of one Scheme only

No person shall:

- 8.2.1 Be a Member of more than one medical scheme;
- 8.2.2 Be admitted as a Dependant of –
  - 8.2.2.1 more than one Member of a particular medical scheme; or
  - 8.2.2.2 Members of different medical schemes; or
- 8.2.3 Claim or accept benefits in respect of himself or any of his Dependants from any scheme other than the scheme of which he is a Member.

### 8.3 Application form and information required

- 8.3.1 Prospective Members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence in respect of himself and his Dependants, of age, income, state of health and of any prior membership or admission as a Dependant of a Member of any other medical scheme.
- 8.3.2 The Scheme may require an applicant to provide the Scheme with a medical report in respect of him or of his proposed beneficiary (ies) in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12- (twelve-) month period ending on the date on which an application for membership was made. The cost of medical tests or examinations required and requested by the Scheme will be paid for by the Scheme. The Scheme may, however, at its sole discretion, appoint a Preferred Service Provider to perform such tests or examinations.
- 8.3.3 The non-disclosure of material information shall result in the action of cancellation or suspension of membership of the Member or that of any of his Dependents.

## 8.4 Waiting periods

- 8.4.1 The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a Dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application:
- 8.4.1.1 A general waiting period of up to 3 (three) months;
- 8.4.1.2 A condition-specific waiting period of up to 12 (twelve) months.
- 8.4.2 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application:
- 8.4.2.1 A condition-specific waiting period of up to 12 (twelve) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits; or
- 8.4.2.2 In respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.
- 8.4.3 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application, a general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

## 8.5 Non-applicability of waiting periods

No waiting periods may be imposed on:

- 8.5.1 A person in respect of whom application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 (ninety) days immediately prior to the date of application, where the transfer of membership is required as a result of-
- 8.5.1.1 Change of employment; or
- 8.5.1.2 An employer changing or terminating the medical scheme of its employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the scheme to which an application is made for such transfer to occur at the beginning of the financial year; where the former medical scheme had imposed a general or condition-specific waiting period in respect of persons referred to in this Rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.
- 8.5.2 A beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied.
- 8.5.3 A child Dependant born during the period of membership.

## 8.6 Payment of subscriptions and accrual of benefits

Subject to the provisions of Rules 7.1.2 and 7.1.3 subscriptions become due in respect of and benefits accrue to Members and their Dependants on the 1<sup>st</sup> (first) day of the month following acceptance of their applications for membership, or, in exceptional circumstances on such other day as the Scheme may decide, in its sole discretion. Failure to pay in full the membership fees required in the Rules, within the time allowed in these Rules, will result in cancellation or suspension of membership of the Member or that of any of his Dependants.

## 8.7 Re-establishment of membership

The Scheme may, after reasonable consideration and upon the Member being satisfactorily rehabilitated, re-establish membership of a Member whose membership has been terminated in terms of Rule 12.7.

## 8.8 Dependants in same option as Member

The registered Dependants of a Member must participate in the same benefit option as the Member.

## 8.9 Binding force of these Rules

Members and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming, are bound by these Rules as amended from time to time.

## 9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

If the Members of a medical scheme who are Members of that scheme by virtue of their employment by a particular employer, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Scheme will admit as a Member, without a waiting period, any Member of such first-mentioned scheme who is a continuation Member by virtue of his past employment by the particular employer and admit any person who has been a registered Dependant of such Member, as a Dependant.

## 10. MEMBERSHIP CARD AND MEMBERSHIP CERTIFICATE

- 10.1 Every Member will, on admission to membership, receive a detailed summary of these Rules, specifying the Member's rights and obligations, which shall include contributions, benefits and limitations. The Scheme, our Members and their Dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.
- 10.2 Every Member shall be furnished with a Membership card containing such particulars as may be prescribed by the Act. This card must be exhibited to the supplier of a relevant health service on request. It shall remain the property of the Scheme and shall be returned forthwith to the Scheme on termination of membership.
- 10.3 The utilisation of a membership card by any person other than the Member or his registered Dependants, with the knowledge or consent of the Member or his Dependants, is not permitted and shall constitute a breach of the Rules of the Scheme in terms of Rule 12.7.
- 10.4 On termination of membership or on de-registration of a Dependant, the Scheme shall, within 30 (thirty) days of such termination or at any time on request, furnish such person with a certificate of membership and cover, containing such particulars as prescribed by the Act.

## 11. CHANGE OF ADDRESS AND MEMBER STATUS

- 11.1 A Member shall notify the Scheme, and his employer, where applicable, in writing within 30 (thirty) days on the required forms of any change of address, contact details as well as any change in the circumstances that may bring about an amendment in the subscriptions payable or the membership status.
- 11.2 The Scheme shall not be held liable if a Member's rights are prejudiced or forfeited as a result of the Member's failure to comply with this Rule.

## 12. TERMINATION OF MEMBERSHIP

### 12.1 Resignation from service of participating employer

A Member who resigns from the service of the Employer (Participating Employer) shall, on the date of such resignation, be eligible for individual membership of the Scheme if he so chooses without the imposition of any new restrictions that did not exist at the time of his resignation.

### 12.2 Voluntary termination of membership

- 12.2.1 A Member may terminate his membership of the Scheme by furnishing 1 (one) month's written notice starting on the first day of any calendar month. All rights to benefits shall cease following the last day of membership.
- 12.2.2 A Member who, in terms of his conditions of employment, is required to be a Member of the Scheme, may not terminate his membership while he remains an Employee without the prior written consent of his Employer, where after such consent must accompany the Member's written notice of membership termination in terms of Rule 12.2.1.
- 12.2.3 An Employer (participating employer) or such part of the Employer as communicated to the Scheme, may terminate its participation with the Scheme by giving 2 (two) calendar months' written notice to that effect, stating if the Employer as a whole or partly terminates its relationship with the Scheme, starting on the first day of any calendar month. All rights to benefits cease following the last day of membership. The Employer shall be responsible to provide notice of the termination to his Employees, Continuation, Retired, Widowed, and Orphaned Members who obtained membership of the Scheme by virtue of their current and/or past employment or relationship with the Employer. The Employer shall provide, on request by the Scheme, proof of notification to the stated Employees, Continuation, Retired, Widowed, and Orphaned Members, which notice must contain the date on which the aforesaid membership will terminate.

12.2.4 The Scheme's entitlement to the notice period referred to in Rules 12.2.1 and 12.2.3 may be waived in substantiated cases where membership of another medical scheme becomes compulsory for the Members as a result of a condition of employment.

### 12.3 Membership whilst abroad

A Member who proceeds on leave outside the Republic of South Africa or is required to temporarily leave the Republic of South Africa on official duty, may either apply to have his membership suspended during such period of absence, subject to the Scheme's approval or may elect to continue to receive the benefits in accordance with the benefit option of his choice: Provided further that contributions are paid by or on behalf of such Member and that the benefits thus received shall not exceed the amount that would have applied in the Republic of South Africa.

### 12.4 Death

Membership shall terminate upon the death of that Member: Provided that the surviving spouse and Dependants of a deceased Member may continue to be Members subject to the terms and conditions contained in Rule 6.3.

### 12.5 Cessation of benefits

The right to benefits of the Member and of any Dependants of a Member, whose membership has been terminated, shall cease after the last day of membership.

### 12.6 Failure to pay amounts due to the Scheme

If a Member and/or his Employer, as the case may be, fails and/or refuses and/or neglects to pay any amount, and/or any debt, due to the Scheme as set out in the Rules:

12.6.1 The Member and/or his Employer, where applicable, must be informed that the Member is in default.

12.6.2 If payments are not brought up to date, within a stipulated time period the Scheme may, at its sole discretion:

12.6.2.1 Suspend all benefit payments which have accrued to such Member and his Dependants, irrespective of when the claim for such benefits arose; and/or

12.6.2.2 Pay to or on behalf of the Member any benefits less the relevant amount owed by or in respect of the Member to the Scheme; and/or

12.6.2.3 Deduct from any moneys owing to the Member by the Scheme, any relevant outstanding amount; and/or

12.6.2.4 Terminate the Member's membership and institute any action to recover any losses and outstanding amounts as well as all legal costs incurred on attorney and own client scale.

### 12.7 Contravention of the Rules of the Scheme

12.7.1 The Scheme may exclude from benefits, suspend or terminate the membership of a Member or a Dependant who –

12.7.1.1 Contravenes any provision of these Rules or fails to comply therewith;

12.7.1.2 Submits fraudulent claims:- submits or causes to be submitted any claim for the payment of any benefit allegedly due in terms of these Rules, knowing such claim to be false;

12.7.1.3 Commits any fraudulent act:- knowingly makes or causes to be made a false representation of any material fact to the Scheme, for use in determining any right to any benefit allegedly due in terms of the Rules of the Scheme;

12.7.1.4 Fails to disclosure of material information:- having knowledge of any fact or the occurrence of any event affecting his right to receive any benefit in terms of these Rules, and who fails to disclose such fact or event to the Scheme with the intent to obtain a benefit to which he is not entitled or a larger benefit than that to which he is entitled.

12.7.2 The Member may make written representations in respect of a decision enforced in terms of Rule 12.7.1 to the Disputes Committee of the Scheme, constituted and functioning in terms of Rule 28, within 14 days from notification of the relevant decision.

12.7.3 The Member may appeal to the Council of Medical Schemes in terms of Chapter 10 of the Act against a decision of the Disputes Committee.

## 13. SUBSCRIPTIONS

### 13.1 Total monthly subscriptions

The total monthly subscriptions payable to the Scheme by or in respect of a Member are as stipulated in Annexure A of these Rules, as amended from time to time: Provided that subscriptions shall be determined on the basis of income or the number of Dependants or both income and number of Dependants: Provided further that contribution penalties for persons joining late in life may be applied in accordance with the provisions of the Act.

### 13.2 Due date for subscriptions

13.2.1 Subscriptions shall be due monthly in advance as follows:

13.2.1.1 On the 20<sup>th</sup> (twentieth); or

13.2.1.2 On the 25<sup>th</sup> (twenty-fifth); or

13.2.1.3 On the 1<sup>st</sup> (first); or

13.2.1.4 Monthly in arrears as agreed upon between the Scheme and an Employer,

and be payable by not later than the 3<sup>rd</sup> (third) day after each respective due date of each month.

13.2.2 Where subscriptions owing to the Scheme have not been paid on or before the due date as indicated in 13.2.1 respectively, the Scheme shall notify the Member and Employer, where applicable, and suspend the membership due to non-payment or partial payment of subscriptions, with effect from the 1<sup>st</sup> (first) day of the month for which subscriptions are due and not received. A written confirmation of suspension will be issued to the Members involved.

13.2.3 If payments are not brought up to date within three (3) months from the date the amount was due, the Scheme shall terminate the membership, with retrospective effect.

### 13.3 Reinstatement of membership and benefits

The membership and benefits shall be reinstated without any break in continuity only–

13.3.1 In the event that payments are brought up to date subsequent to the Scheme's decision in terms of Rules 12.6 and/or 12.7, as the case may be;

13.3.2 If a Member applies for reinstatement within three (3) months of the date of termination, all outstanding debt has been paid in full, should that be the reason for termination, and provided that such application shall be accompanied by a declaration of health to determine underwriting for the Member and his Dependants;

13.3.3 If a Member requests to be reinstated after the three (3) months period, the Member shall reapply for new membership by completing an application form, after which underwriting will apply.

Reinstatement is subject to the right of the Scheme to recover reasonable expenses associated with the default and to recover interest at the prime overdraft rate of the Scheme's bankers: Provided that a levy as determined by the Scheme from time to time to cover expenses associated with such default shall be payable to the Scheme by a Member or Employer in all cases where a debit order demand is refused.

### 13.4 No refund of subscriptions

Unless specifically provided for in these Rules in respect of savings accounts, no refund of any assets of the Scheme or any portion of a subscription shall be paid to any person where such Member's membership or cover in respect of any Dependant terminates during the course of a month or where the Member has failed to notify the Scheme of a change in membership status in accordance with Rule 11.

### 13.5 Balance of savings account

The balance standing to the credit of a Member in terms of any option which provides for personal medical savings accounts shall be for the exclusive benefit of the Member and his Dependants: Provided that such savings account:

13.5.1 May not be used to offset contributions: Provided that the Scheme may use such funds to offset debt owed by the Member to the Scheme following the Member's termination of membership;

13.5.2 Shall be transferred to another medical Scheme or benefit option with a savings account when such Member changes medical schemes or benefit options within 5 (five) months calculated from the date following the last day of membership or last date of the Member's previous benefit option, as the case may be;

- 13.5.3 Must be taken as a cash benefit, subject to applicable taxation laws, when the Member terminates his membership and does not join another medical scheme or an option with a savings account; and
- 13.5.4 Shall not be used to pay for the costs of prescribed minimum benefits.

## 14. LIABILITIES OF EMPLOYER AND MEMBER (RESPECTIVELY)

### 14.1 Liability of Employer

The liability of an Employer towards the Scheme is limited to any amounts payable in terms of any agreement between the Employer and the Scheme. An employer shall be held liable for and pay the monthly subscription of each Member in his employ and continuation Members to the Scheme on the basis agreed upon.

### 14.2 Liability of Member to Scheme

The liability of a Member to the Scheme is limited to the amount of his unpaid subscriptions together with any sum disbursed by the Scheme on his behalf or on behalf of his Dependants which has not been repaid to the Scheme. If a Member fails to refund within 30 (thirty) days from the due date, any amounts owing by him to the Scheme in respect of himself or his Dependants, the Scheme may act in accordance with Rule 12.6.

### 14.3 Amounts owing on cessation of membership

In the event of a Member ceasing to be a Member, any amount still owing by such Member shall be a debt due to the Scheme and recoverable by the Scheme.

### 14.4 Recovery of amounts owed to the Scheme

The Scheme is competent to deduct from any moneys owing to the Member by the Scheme, any amount outstanding on a loan to the Member and/or the Member's share of any account for which the Member is responsible in terms of these Rules; or to request a Member's Employer to recover from a Member, any amount owing to the Scheme, by the Member, from any moneys payable to the Member.

## 15. CLAIMS PROCEDURE

### 15.1 Information on accounts

Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement as prescribed. An account for relevant health services rendered must contain the following:

- 15.1.1 The surname and initials of the Member;
- 15.1.2 The surname, first name and other initials, if any and the date of birth of the patient;
- 15.1.3 The name of the Scheme;
- 15.1.4 The membership number of the Member;
- 15.1.5 The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if and where applicable, and name and address of the provider of the relevant health service;
- 15.1.6 The date on which each relevant health service was rendered;
- 15.1.7 The relevant diagnostic (ICD 10 code) and such other item code numbers, as stipulated by the Department of Health or required by law from time to time, that relate to such health services;
- 15.1.8 The nature and cost of each relevant health service rendered, including the supply of medicine to the Member concerned or to a Dependant of that Member; and the name, NAPPI code, quantity and dosage of and net amount charged by the provider of the relevant health service in respect of the medicine and payable by the Member;
- 15.1.9 Where a pharmacist supplies medicine according to a prescription to a Member or to a Dependant of a Member of the Scheme, a copy of the original prescription or a certified copy of such prescription, if the Scheme requires or requests it;
- 15.1.10 If the account is a photocopy of the original, certification on the photocopy by the supplier by means of a rubber stamp or signature, declaring same to be a true reflection of the original;
- 15.1.11 A statement whether the account is in accordance with the Scheme tariff, or any other applicable tariff;
- 15.1.12 The name of the referring medical practitioner or dentist, where applicable; and

- 15.1.13 The signature of the Member or of the patient where the Member himself submits the claim.

- 15.1.14 Where mention is made in such account or statement of the use of a theatre:

- 15.1.14.1 The name and relevant practice number and provider number contemplated in Rule 15.1.5 of the medical practitioner or dentist who performed the operation;

- 15.1.14.2 The name or names and the relevant practice number and provider number contemplated in Rule 15.1.5 of every medical practitioner or dentist who assisted in the performance of the operation; and

- 15.1.14.3 All procedures carried out together with the relevant item code number contemplated in paragraph 15.1.7;

- 15.1.15 In the case of a first account or statement in respect of orthodontic treatment or other advanced or specialised dentistry, a treatment plan indicating:

- 15.1.15.1 The expected total amount in respect of the treatment;

- 15.1.15.2 The expected duration of the treatment;

- 15.1.15.3 The initial amount payable; and

- 15.1.15.4 The monthly amount payable.

### 15.2 Confirmation of payment by Scheme

If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme shall, in addition to the payment contemplated in Section 59 (2) of the Act, despatch to the Member a statement containing at least the following particulars –

- 15.2.1 The name and the membership number of the Member;

- 15.2.2 The name of the supplier of relevant health service;

- 15.2.3 The final date of service rendered by the supplier of the relevant health service on the account or statement which is covered by the payment;

- 15.2.4 The total amount charged for the service concerned; and

- 15.2.5 The amount of the benefit awarded for such relevant health service.

### 15.3 Claims to be submitted within 4 (four) months

- 15.3.1 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct by a Member and must be submitted to the Scheme not later than the last day of the 4<sup>th</sup> (fourth) month following the month in which the relevant health service was rendered.

- 15.3.2 It remains the Member's responsibility to submit claims timeously. If a Member is unable to obtain an account for services rendered or where he has in fact received an account but because of special circumstances beyond his control is unable to lodge the account within 4 (four) months as required, the Scheme may in its sole discretion extend this period, on condition that a written application for extension is received by the Principal Officer before the expiration of the period named in Rule 15.3.1.

- 15.3.3 All accounts of Members whose membership has been terminated in terms of Rule 12.6 and 12.7 respectively shall, together with the Member's contribution, reach the Scheme in terms of the provisions of Rule 15.3.1 and failure to comply with this requirement shall relieve the Scheme of any obligation for the payment of its contribution in terms of the Schedule of the Scheme option in which the Member participates: Provided that where the membership of a Member is terminated by his death, the executor in his estate may, in the discretion of the Scheme, be granted additional time to submit to the Principal Officer the accounts as well as written proof that all outstanding amounts inclusive of any outstanding contributions owing by the deceased Member to the Scheme, has been settled in full.

- 15.3.4 Accounts paid by Members

Where a Member has paid an account, he shall, in support of his claim, submit a receipt of the net amount paid after any discount.

### 15.4 Erroneous and unacceptable accounts

Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the Member and the healthcare service provider accordingly, within 30 (thirty) days after receipt thereof. The Scheme shall state the reasons why such account, statement or claim is regarded as erroneous or unacceptable and afford such Member and provider the opportunity to correct or resubmit such account, statement or claim to the Scheme within 60 (sixty) days following the date from which the aforesaid account was returned for correction.

## 15.5 Personal injury claims against third parties

In the event of the Scheme paying benefits to or on behalf of a Member or Dependant in respect of personal injuries suffered by the Member or Dependant in consequence of an accident, incident or event caused by a third party, under circumstances which give rise to a legally enforceable claim by the Member or Dependant against such third party, then the Member shall be obliged to:

- 15.5.1 Take all reasonable steps in order to timeously lodge a claim and/or institute an action for the recovery of compensation in respect of the aforesaid personal injuries (including past and future medical, hospital and allied expenses) against the third party concerned before the claim prescribes or becomes unenforceable;
- 15.5.2 Diligently and reasonably prosecute such claim to its final conclusion or settlement;
- 15.5.3 Pay, or cause to be paid, to the Scheme the amount or amounts awarded or received by the Member or Dependant in respect of the benefits paid by the Scheme, including amounts received under a written undertaking furnished by the Road Accident Fund or Compensation Commissioner to the Member or Dependant.

## 15.6 Evaluation of claims for medical applicability

The Scheme reserves the right to evaluate or have evaluated any claim for benefits for relevant health services to determine the clinical applicability, cost effectiveness and quality of the services. After consulting its clinical advisers, the Scheme may intervene to revise or adjust the use of such services on a future, simultaneous or retrospective basis.

## 15.7 Prolonged indisposition and/or hospitalisation

- 15.7.1 In the case of a prolonged indisposition of a Member or a registered Dependant of a Member, the Scheme may require such Member or Dependant to consult a particular preferred provider forming part of the Scheme's Preferred Provider Network nominated by the Scheme after consulting the treating doctor, and if the advice of the preferred provider(s) is not followed, the Scheme may decide not to grant any further benefits for the indisposition in question.
- 15.7.2 In cases of prolonged hospitalisation for any medical condition of a Member or a registered Dependant of a Member, the Scheme may require such Member or Dependant to consult a preferred provider forming part of the Scheme's Preferred Provider Network nominated by the Scheme to obtain a second opinion regarding the clinical prognosis, management and level of care of such Member or Dependant. If in the light of the opinion(s) expressed by the nominated preferred provider(s), it is clear that the Member or a Dependant suffers from a terminal condition which is not a PMB, and furthermore, the financial impact of granting further benefits for such hospitalisation would constitute a substantial threat to the continued financial viability of the option selected by the Member, then the Board of Trustees of the Scheme may decide, after having duly considered the relevant facts, to grant benefits for such hospitalisation to an appropriate level of care given the clinical circumstances of the Member or Dependant. The Scheme remains liable for all costs where a decision taken by the Board of Trustees requires that a beneficiary be transferred to another provider considered affordable.

## 15.8 Consultation of specialists without referral

Whenever a specialist, except an ophthalmologist, is consulted without being referred by a general practitioner, the benefit granted by the Scheme may be restricted to the amount that would have been paid to a general practitioner for the same service.

## 15.9 Disease management programmes

Where the Scheme provides benefits by means of disease management programmes, the Member and/or his Dependents shall be obliged to register on such programme and provide the Scheme with any relevant information requested: Provided that beneficiaries will only qualify for benefits in respect of services provided for in the programme if the Scheme's requirements are complied with.

## 15.10 Designated Service Provider

- 15.10.1 The Scheme has selected, and as such contracted with various health care providers, pharmacists and hospitals to provide diagnosis, treatment and/or care in respect of one or more Prescribed Minimum Benefit condition(s) at an agreed rate.
- 15.10.2 Prescribed minimum benefits (PMBs) are defined by law. They are the minimum level of diagnosis, treatment, and care that the Scheme will cover from the risk pool in full.
- 15.10.3 The Scheme will pay in full for the diagnosis, treatment and care costs of a prescribed minimum benefit condition if those services are obtained from the selected designated service provider in respect of that condition. A full list of

all the Scheme's contracted DSP's are available from the Scheme's website or through the Scheme's Call Centre, who will provide full details on request.

- 15.10.4 Members making voluntary use of providers outside of the designated service provider network will be liable for funding the difference of any claims exceeding the contracted designated service provider rates, provided that no co-payment or deductible is payable by a Member if the service was involuntarily obtained from a provider other than a designated service provider.
- 15.10.5 For the purposes of clarification to 15.10.4, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if
  - 15.10.5.1 The service was not available from the designated service provider or would not be provided without unreasonable delay;
  - 15.10.5.2 Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
  - 15.10.5.3 There was no designated service provider within a 50 (fifty) kilometre radius to the beneficiary's ordinary place of business or personal residence.

## 16. BENEFITS

### 16.1 Choice of benefits and options

Members are entitled to benefits during a Financial Year, as per Annexure B of these Rules, and such benefits extend through the Member to his registered Dependents. A Member shall, on admission as a Member elect in writing to participate in any one of the available options, detailed in Annexure B of these Rules.

### 16.2 Change from one option to another

A Member is entitled to change from one benefit option to another benefit option subject to the following conditions:

- 16.2.1 The change may be made only with effect from 1 January of any financial year. The Scheme may, in its absolute discretion, permit a Member to change from one benefit option to another benefit option on any other date.
- 16.2.2 Application to change from one benefit option to another must be in writing and lodged with the Scheme by not later than 31 December prior to the year upon which it is intended that the change will take place.
- 16.2.3 A Member may, within 3 (three) months of joining, exercise his final choice of one of the possible benefit options in writing, including the accompanying correction in membership and benefits accrued where applicable. If the Member does not notify the Scheme in writing of his final choice on or before the last day on which the period of 3 (three) months expires, such a Member shall remain on the benefit option originally chosen, after which a change of benefit options will be exercised in accordance with the provisions on Rules 16.2.1 and 16.2.2 respectively.

### 16.3 Payment to Member or supplier

Subject to the respective provisions of Rules 12.7, 17.2 and 17.4, the Scheme shall, where an account has been correctly rendered, pay any benefit that is due to a Member, either to that Member or to the supplier of the relevant health service who rendered the account, within 30 (thirty) days after the date of receipt of the claim pertaining to such benefit.

### 16.4 Transfer of claims and rights

A Member may not cede, transfer, pledge or hypothecate or make over to any third party, any claim, or part of a claim or any right to a benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a Member is entitled under these Rules, or any right in respect of such benefit or payment of such benefit to such Member, if a Member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.

### 16.5 Payment for prescribed minimum benefits

All benefit options offered in Annexure B of these Rules, cover in full the cost of Prescribed Minimum Benefits subject to the provisions of Rule 15.10 read with Annexure D.1 of these Rules: Provided that the funds in a Member's medical savings account shall not be used to pay for the costs of a Prescribed Minimum Benefit.

### 16.6 Scheme tariff

All benefits shall be paid according to the Scheme tariff or contracted fees, as the case may be. The Scheme tariff shall be determined by the Board of Trustees before the end of every financial year.

## 16.7 Exclusion of services from benefits

The Scheme may exclude services from benefits as set out in Annexure C of these Rules.

## 16.8 Guidelines or protocols for services

Where the Scheme has funding guidelines or protocols in respect of any covered services or supplies, beneficiaries will only qualify for benefits in respect of those services and supplies if the guidelines or protocols have been complied with.

## 16.9 Requirements for benefits without protocols

Where the Scheme does not have funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme acknowledges them as medically necessary. "Medically necessary" refers to services or supplies that meet all the following requirements:

- 16.9.1 It is required to restore function of an affected limb, organ, or system;
- 16.9.2 No alternative exists that has a better outcome, is more cost-effective, and has a lower risk;
- 16.9.3 It is accepted by the relevant service-provider group as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;
- 16.9.4 It is not rendered for the convenience of the relevant beneficiary or service provider;
- 16.9.5 For which outcome studies are available and acceptable to the Scheme; and
- 16.9.6 Evidence based medicine as published in peer review journals.

## 16.10 Clinical data required for recognition of new medicine, technology, procedures and interventions

No benefits are payable in respect of any new technology, investigational procedures/interventions, and service or supply, including newly registered medicine, until such time that the Scheme has been satisfied through the submission of clinical data of the acceptability of all of the following aspects relating to that service or supply:

- 16.10.1 Therapeutic role in clinical medicine;
- 16.10.2 Cost-efficiency;
- 16.10.3 Value relative to existing services or supplies;
- 16.10.4 Local indications, application, and outcome studies; and
- 16.10.5 A Funding Guideline or Protocol has been drawn up. The Scheme may, at its discretion structure projects with specific providers around new technology, in order to gauge results and/or finalise its funding guidelines.

## 16.11 Exclusion of service or supply due to lack of clinical data

- 16.11.1 If the Scheme is not satisfied in respect of a particular new service or supply as contemplated in Rule 16.10, the Scheme may exclude or limit that service or supply from benefits until sufficient clinical data has been submitted, alternatively submitted clinical data has been properly reviewed and accepted by the Scheme.
- 16.11.2 An exclusion of one or more years may be required by the Scheme, at its sole discretion, to assess the local indications, application and outcome data on all new medicines/technology/procedures or any instance where evidence is lacking or still under review before it can be considered for benefits.

## 16.12 Foreign claims

Benefits for foreign claims shall be based on the Scheme tariffs or other tariffs applicable to similar services/items in the Republic of South Africa: Provided that

- 16.12.1 Medical claims incurred in foreign countries must be paid in full by the Member and proof of payment must accompany the claim;
- 16.12.2 Fully specified accounts must be submitted to the Scheme within the prescribed period of four months under cover of the Scheme's special claim form for foreign claims;
- 16.12.3 Accounts must be translated into English if rendered in a foreign language;
- 16.12.4 Where a claim exceeds R5 000 in South African currency, certified copies of the passport and travelling tickets of the patient are required by the Scheme to qualify for benefits; and

- 16.12.5 Benefits for elective and planned surgery or procedures abroad shall be subject to pre-authorisation, Scheme protocols and Scheme tariff. Each case shall be evaluated individually, on the clinical information available.

## 16.13 Medicine supply

Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to 1 (one) month's supply for every prescription or repeat thereof.

## 16.14 Interest on Personal Medical Savings Account (PMSA)/ Bonus Account (Vested Medical Savings Account)

- 16.14.1 Any balance in the PMSA/ Bonus Account (Vested Medical Savings) at the end of a financial year remains the property of the Member and accumulates to his credit until such time comes that savings funds are paid to the Guardians Fund. No cross subsidisation applies to the PMSA/ Bonus Account (Vested Medical Savings).
- 16.14.2 Any funds standing to the credit of the PMSA/ Bonus Account (Vested Medical Savings) shall be invested within 7 (seven) days of receipt thereof in a Savings trust account according to specifications of item 1a of Annexure B to the Medical Schemes Act. These trust accounts held by the Scheme are current and money market accounts.
- 16.14.3 Should a Member terminate membership of the Scheme and not be admitted as a Member of another medical scheme or be admitted to membership of another medical scheme which does not provide for an PMSA/ Bonus Account (Vested Medical Savings), the balance due to the Member, including interest earned, must be refunded to the Member five (5) months after termination of membership, and subject to applicable laws.
- 16.14.4 Interest income to the PMSA/ Bonus Account (Vested Medical Savings) balance shall be allocated on credit balances on the month-end savings balance on a pro-rata basis at month-end and shall accrue to the PMSA/ Bonus Account (Vested Medical Savings) balance of all active and resigned Members. The interest allocated is netto interest income minus bank charges on the trust accounts.
- 16.14.5 Unclaimed balances, where the Member cannot be traced within 5 (five) years after termination of membership and after all reasonable attempts at tracing the Member have been pursued, the unclaimed savings balance of the particular Member will be paid to the Guardians Fund. Interest will not be accrued once the savings balance was paid over to the Guardians Fund.

## 17. PAYMENT OF ACCOUNTS

### 17.1 Payment restricted to maximum of benefit option

Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected.

### 17.2 Suppliers may be paid directly

Notwithstanding Rule 16.3, the Scheme may, whether by agreement or not with any supplier or group of suppliers of a relevant health service, pay the benefit to which the Member is entitled, directly to the supplier who rendered the service.

### 17.3 Recovery of overpayments

Where the Scheme has paid an account or portion of an account or any benefit to which a Member is not entitled, whether payment is made to the Member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme in terms of Section 59(3) of the Act.

### 17.4 Scheme may pay Members directly

Notwithstanding the provisions of these Rules, the Scheme shall be entitled within its absolute discretion to pay any benefit directly to the Member concerned.

### 17.5 Claims from outside South Africa

A claim from a Member on official duty outside the Republic of South Africa will be dealt with on its merits by the Board as contemplated in Rule 16.10 and benefits shall not exceed the amount that would have applied for the service in the Republic of South Africa.

## 18. GOVERNANCE

### 18.1 Constitution of the Board of Trustees

The affairs of the Scheme shall be managed according to these Rules and the applicable legislation by a Board of Trustees consisting of not more than 12 (twelve) persons, excluding the persons referred to in Rule 18.1.3, who are fit and proper to be trustees, and who shall be constituted as follows:

- 18.1.1 Member representatives
- 18.1.1.1 3 (three) Employee Members of the Scheme who are nominated for election by the Employee Members and thereafter elected by all Members of the Scheme;
- 18.1.1.2 2 (two) Individual Members of the Scheme who are nominated for election by the individual Members and thereafter elected by all Members of the Scheme;
- 18.1.1.3 1 (one) Continuation/Retired/Widowed Member of the Scheme who is nominated for election by Continuation/Retired/Widowed Members and thereafter elected by all Members of the Scheme;
- 18.1.2 Appointed trustees
- 6 (six) persons, who need not be Members of the Scheme, appointed by the Board;
- 18.1.3 Partner representatives
- A maximum of 3 (three) persons from a scheme/or schemes which amalgamates with Bestmed, may be appointed by the Board of Bestmed after consultation with the board of such scheme; Provided that not less than half of such appointed Members shall be persons elected to the board of such scheme by the Members of that scheme.
- 18.2 Eligibility of candidates for election**
- 18.2.1 The following persons are not eligible to serve as Members of the Board:
- 18.2.1.1 A person under the age of 21 (twenty-one) years;
- 18.2.1.2 An employee, director, officer, consultant or contractor of any administrator of the Scheme or of any holding company, subsidiary, joint venture or associate of that administrator;
- 18.2.1.3 A broker;
- 18.2.1.4 The Principal Officer of the Scheme; and
- 18.2.1.5 The auditor of the Scheme.
- 18.2.2 Retiring Members of the Board are eligible for re-election and re-appointment.
- 18.2.3 Not more than 1 (one) representative within each group referred to in Rule 18.1.1 may be an Employee of the same Employer: Provided that should it, after the counting of the votes, appear that such Employees constitute more than the prescribed number, only the candidate with the most votes in the relevant group will be declared duly elected: Provided that all voting Members may only cast a vote for 1 (one) candidate of a particular Employer group. The other such candidates will be disqualified and replaced by candidates from that particular membership group who are not such employees who received the next most votes.
- 18.3 Election of Member representatives**
- 18.3.1 Not later than 1 November of the year before a vacancy is due to occur the Scheme's Principal Officer shall request each Member in each different membership group referred to in Rule 18.1.1 to nominate not more than 1 (one) candidate from that group, on the relevant nomination form approved by the Board, for election to the Board. These nominations should reach the Principal Officer on or before 31 January of the following year.
- 18.3.2 Each nomination must be seconded by another Member of the particular membership category and the nominee must accept the nomination in writing for a nomination to be valid: Provided that an independent nomination of the same nominee by another Member shall be regarded as a secondment of the nominee.
- 18.3.3 If only the numbers of candidates for whom there are vacancies are so nominated, they shall be declared duly elected at the annual general meeting, subject to the provisions of Rule 18.2.3.
- 18.3.4 If more candidates than the number for which there are vacancies in a membership category are so nominated, the Principal Officer shall provide all the Members of the Scheme on or before 28 February of the year in which the election takes place with ballot papers approved by the Board for this purpose, containing the names of all the nominated candidates in each membership category. All the Members of the Scheme shall then elect, by means of such ballot papers, the number of candidates for which there are vacancies. Completed ballot papers shall reach the principal officer on or before 7 April of such year.
- 18.3.5 The number of candidates for which there are vacancies in each membership category and who receive the majority vote in this manner shall be declared duly elected at the annual general meeting subject to the provisions of Rule 18.2.3: Provided that in the event of an equal number of votes for candidates in the same group, it shall be decided by the lot which candidate is elected.
- 18.3.6 If fewer candidates than the number for which there are vacancies in the membership category are so nominated, additional Members shall be elected by all the Members present at the annual general meeting.
- 18.3.7 The term of office of elected Member representatives is 4 (four) years from the first Board meeting after the annual general meeting in the year of election.
- 18.4 Appointment of Trustees referred to in Rule 18.1.2**
- 18.4.1 At the last scheduled Board meeting before the annual general meeting in which a vacancy is due to occur, a maximum of 6 (six) persons referred to in Rule 18.1.2, who need not be Members of the Scheme, shall be appointed by the other Members of the Board as Trustees. The names of the Members appointed shall be made known at the annual general meeting.
- 18.4.2 The term of office of such a Member is 4 (four) years from the first Board meeting after the annual general meeting in his year of appointment.
- 18.5 Co-option of additional Members**
- 18.5.1 The Board may co-opt 1 (one) or more knowledgeable person(s) who are Members of the Scheme to assist with its deliberations: Provided that such person shall not have a vote at meetings of the Board.
- 18.5.2 Where such co-opted Member is appointed or elected to any committee, he shall have the right to vote in such committee.
- 18.5.3 The term of office of co-opted Members shall be 1 (one) year.
- 18.6 Filling of vacancies of the Board**
- When a Member of the Board resigns, is disqualified from service or dies, the Board must, by majority vote of the remaining Members of the Board, fill such vacancy for the unexpired period of office of the vacant seat of the Board; or in the event of the vacancy arising from an elected seat on the Board, at the sole discretion of the Board, have an election.
- 18.7 Disqualification and resignation from the Board**
- 18.7.1 A Member of the Board may resign at any time by giving notice in writing to the Board.
- 18.7.2 A Member of the Board ceases to hold office if;
- 18.7.2.1 He becomes mentally ill or incapable of managing his affairs;
- 18.7.2.2 He is declared insolvent or has surrendered his estate for the benefit of his creditors;
- 18.7.2.3 He is convicted, whether in the Republic of South Africa or elsewhere, of any serious criminal offence;
- 18.7.2.4 He is removed by a court of law from any office of trust on account of misconduct;
- 18.7.2.5 He is disqualified under any law from carrying on his profession;
- 18.7.2.6 Being a Board Member elected by Members of the Scheme, he ceases to be a Member of the Scheme;
- 18.7.2.7 He absents himself from 2 (two) consecutive meetings of the Board without the permission of the Board;
- 18.7.2.8 He is removed from office by the Council in terms of Section 46 of the Act; or
- 18.7.2.9 He is removed from office by a 2/3 (two-thirds) majority of the Board present at a meeting, in terms of the provisions of the terms of reference of the Disciplinary Committee of the Board.
- 18.8 Reimbursement of expenses and remuneration of Board**
- 18.8.1 Members of the Board shall in respect of the execution of their official duties be entitled to remuneration as provided for in the Trustee remuneration policy or, where no such provision is made, to a reasonable remuneration.
- 18.8.2 Notwithstanding 18.8.1, Members of the Board are entitled to the following reasonable remuneration:
- 18.8.2.1 Disbursements, including but not limited to:
- 18.8.2.1.1 Travelling and other expenses for attendance of meetings or conferences;
- 18.8.2.1.2 Accommodation and meals; and
- 18.8.2.1.3 Telephone expenses for business purposes;

- 18.8.2.2 Fees for attendance of meetings of the board or committees of the board;
- 18.8.2.3 Fees due for holding particular office on the board or committees of the board;

## 18.9 Procedure at meetings

- 18.9.1 The Board shall meet at least 3 (three) times per year on such dates as are approved by the executive committee.
- 18.9.2 The agenda for a meeting must reach the Members at least 5 (five) days before the scheduled date for a meeting.
- 18.9.3 Members of the Board wishing to place matters on the agenda should submit them to the Principal Officer at least 15 (fifteen) days before the scheduled date of the meeting: Provided that, with the approval of the meeting, matters of an urgent nature may be submitted at the meeting.
- 18.9.4 The presence of ½ (half) of the voting Members plus one during the course of a meeting shall constitute a quorum for that meeting; and
- 18.9.5 Should the required quorum not be obtained during the course of a meeting, such meeting shall be adjourned to a date not less than 3 (three) days from the date on which all Members of the Board have been informed of the date to which the meeting has been adjourned: Provided that at such adjourned meeting the voting Members of the Board present will constitute a quorum.
- 18.9.6 The Board must elect from its number a chairperson and a vice-chairperson, who shall also be the chairperson and vice-chairperson of the executive committee of the Board: Provided that in the absence of the chairperson the vice-chairperson shall act as chairperson, and in the absence of both the chairperson and the vice-chairperson the meeting shall elect a chairperson for the purposes of that meeting;
- 18.9.7 The election of the chairperson, vice-chairperson, executive committee and audit committee shall take place biennially at the first Board meeting after the relevant annual general meeting: Provided that the previous incumbents shall remain in office until the commencement of such Board meeting: Provided further that other committees of the Board, save the Disputes Committee shall elect their own office bearers where such officers have not been appointed by the Board; and
- 18.9.8 Nominations and voting for office bearers and executive committee Members of the Board shall be by way of closed ballot papers: Provided that 2 (two) or more nominations of a given person by voting Members of the Board shall be necessary for a valid nomination.
- 18.9.9 A proposer of a motion or amendment may amend or withdraw the proposal or amendment with the approval of the meeting;
- 18.9.10 A Member of the Board who raises a point of order is entitled to be heard immediately on raising the point of order.
- 18.9.11 The ruling of the chairperson on a point of order is not open for discussion: Provided that a Member of the Board may object to the ruling and the ruling is then immediately voted on by voting Members of the Board at the meeting, and the decision of the meeting is final.
- 18.9.12 Decisions at Board meetings shall be taken by a majority vote, and in the event of an equality of votes, the chairperson has a casting vote in addition to his deliberative vote: Provided that in urgent cases and without holding a meeting, the Board may take a decision by postal, telephonic, telegraphic or any other technological means, if ¾ (three-quarters) of all voting Board Members vote in favour of such decision: Provided further that, no decision of the Board shall be invalid because of any vacancy in the membership of the Board.
- 18.9.13 A voting Member of the Board may appoint another voting Member of the Board as a proxy to speak and vote on his behalf at a Board meeting, and where such proxy also represents other Board Members, he shall be entitled to act for all Board Members whom he represents at the Board meeting. A proxy shall be in writing and signed by the grantor, and shall:
  - 18.9.13.1 Be in such form as is approved by or acceptable to the Board;
  - 18.9.13.2 Be deposited at the registered office of the Scheme not less than 24 (twenty-four) hours before the scheduled time for the Board meeting;
  - 18.9.13.3 Except insofar as specifically provided otherwise, be deemed to confer the power generally to act at the Board meeting in question, subject to any specific direction contained in the proxy; and
  - 18.9.13.4 Be valid for a specific Board meeting and at every resumption of an adjourned Board meeting to which it relates, unless it has been withdrawn in writing by the grantor not less than 24 (twenty-four) hours before such Board meeting, or the grantor attends such Board meeting himself and acts on his own accord.

18.9.14 The chairperson or in his absence the vice-chairperson may convene a special Board meeting should the necessity arise and shall convene such Board meeting when any 3 (three) or more voting Members of the Board in writing request the chairperson to convene a special Board meeting, stating the matters to be discussed at such Board meeting.

18.9.15 No matters except those for which the special Board meeting was called may be dealt with at the special Board meeting: Provided that other matters may be dealt with if an unopposed motion to that effect is unanimously adopted by the voting Members of the Board present at the Board meeting.

18.9.16 The Board may invite non-Board Members to attend a meeting of the Board or part thereof as observers and to participate in the discussions: Provided that such observers shall not have the right to vote on any matter.

## 19. DUTIES OF BOARD OF TRUSTEES

The duties of the Board of Trustees are as follows:

- 19.1 The Board shall be responsible for the proper and sound management of the Scheme, in terms of these Rules and in accordance with the Act.
- 19.2 The Board shall act with due care, diligence, skill and in good faith as is further detailed in the Scheme's Trustee Guidelines.
- 19.3 Members of the Board shall avoid conflicts of interests, and shall declare any interest they may have in any particular matter serving before the Board.
- 19.4 The Board shall, to the best of its ability, apply sound business principles and endeavour to ensure the financial soundness of the Scheme.
- 19.5 The Board shall appoint a principal officer who is a fit and proper person to hold such office and shall within 30 (thirty) days of such appointment give notice thereof in writing to the Registrar of the Council for Medical Schemes. The Principal Officer and other staff required for the proper execution of the business of the Scheme shall be appointed by the Board on such conditions of service as it may determine from time to time;
- 19.6 The Board shall have the power to take all the steps and to sign and execute all the documents to ensure and secure the due fulfilment of the Scheme's obligations under such appointments.
- 19.7 The Board shall have the power to cause the termination of the services of any employee of the Scheme in line with labour laws of South Africa: Provided that the termination of the services of the Principal Officer of the Scheme shall be approved by at least 2/3 (two thirds) of the full Board.
- 19.8 The Board shall take steps to ensure that the interests of beneficiaries are protected, and act with impartiality in respect of all beneficiaries.
- 19.9 The Board shall keep all minutes, accounts, entries, registers and records that are considered essential for the proper functioning of the Scheme.
- 19.10 The Board shall ensure that proper control systems are employed by and on behalf of the Scheme.
- 19.11 The Board shall ensure that adequate and appropriate information be communicated to the Members regarding their rights, benefits, contributions and duties in terms of these Rules.
- 19.12 The Board shall take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and these Rules.
- 19.13 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.
- 19.14 The Board shall obtain expert advice on legal, accounting and business matters as may be required, or on any other matter regarding which the Members of the Board may lack sufficient expertise.
- 19.15 The Board shall ensure that these Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.
- 19.16 The Board shall take all reasonable steps to protect the confidentiality of medical records concerning any Member or Dependant's state of health.
- 19.17 The Board shall approve all disbursements and exercise financial control over the affairs of the Scheme.
- 19.18 The Board shall cause to be kept in safe custody, in a safe or strong-room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme.

- 19.19 The Board shall make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.
- 19.20 The Board shall disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme.
- 20. POWERS OF BOARD**
- The Board has the power-
- 20.1 Subject to the provisions of paragraph 19.7, to cause the termination of the services of any employee of the Scheme: Provided in so doing it shall comply fully with all legal requirements;
- 20.2 To take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations;
- 20.3 To appoint 1 (one) or more committees consisting of Board Members and other experts as it may deem appropriate and necessary and may invest such committees or an official of the Scheme with all or any of its powers and duties: Provided that any committee so constituted shall comply with all these Rules and instructions of the Board: Provided further that the Board shall not be divested of any power with which it may invest such a committee or official;
- 20.4 To appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme; the terms and conditions of such appointment shall be contained in a written contract, which shall comply with the requirements of the Act;
- 20.5 To appoint, compensate and contract with any accredited broker for the introduction or admission of a Member to the Scheme;
- 20.6 To enter into any contract with a managed healthcare organisation or to provide such a service itself, subject to the provisions of the Act;
- 20.7 To purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it;
- 20.8 To let or hire movable or immovable property;
- 20.9 In respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such monies and to realise, re invest or otherwise deal with such monies and investments;
- 20.10 With the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers for the purpose of bridging a temporary shortage and to the extent necessary, encumber the Scheme's assets as security;
- 20.11 Subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any natural or juristic person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the Members of the Scheme;
- 20.12 To make a donation to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interest of all or any of the beneficiaries;
- 20.13 To grant repayable loans to Members or to make ex gratia payments on behalf of Members in order to assist such Members to meet commitments in regard to any matter specified in these Rules;
- 20.14 To contribute to any fund conducted for the benefit of employees of the Scheme;
- 20.15 To reinsure obligations in terms of the benefits provided for in these Rules;
- 20.16 To authorise the Principal Officer and /or such Member(s) of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;
- 20.17 To contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes; and
- 20.18 In general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.
- 21. DUTIES OF PRINCIPAL OFFICER AND STAFF**
- 21.1 The staff of the Scheme shall ensure the confidentiality of all information regarding its Members subject to disclosure of such information as is reasonable to the Scheme's medical advisers, any managed healthcare organisation, reinsurers, or as consented to by any Member.
- 21.2 The Principal Officer is the executive officer of the Scheme and as such shall ensure that:
- 21.2.1 The decisions and instructions of the Board be executed without unnecessary delay;
- 21.2.2 Where necessary, there is proper and appropriate communication between the Scheme and those parties affected by the decisions and instructions of the Board;
- 21.2.3 The Board be sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;
- 21.2.4 The Board be sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of section 57(6) of the Act; and
- 21.2.5 He does not take any major policy decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.
- 21.3 The Principal Officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all monies received and payments authorised by and made on behalf of the Scheme.
- 21.4 The Principal Officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall (unless he is indisposed or prevented by other circumstances beyond his control) attend all meetings of the Board, and any other duly appointed committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.
- 21.5 The Principal Officer shall be responsible for the appointment of staff and the supervision of staff employed by the Scheme unless the Board decides otherwise.
- 21.6 The Principal Officer shall keep full and proper records of all monies received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.
- 21.7 The Principal Officer shall prepare annual financial statements or cause such statements to be prepared and shall ensure compliance with all statutory requirements pertaining thereto.
- 21.8 The following persons are not eligible to be a Principal Officer:
- 21.8.1 An employee, director, officer, consultant or contractor of the administrator, if any, of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator; or
- 21.8.2 A broker.
- 22. INDEMNIFICATION AND FIDELITY GUARANTEE**
- 22.1 The Board and any officer of the Scheme shall be indemnified by the Scheme against all legal proceedings, costs and expenses incurred by reason of any claim against or legal proceedings brought against the Board, any of its Members or such officer in connection with the Scheme, not arising from their negligence, dishonesty or fraud.
- 22.2 The Board must ensure that the Scheme be adequately insured against loss resulting from the dishonesty or fraud of any of its officers (including Members of the Board) having the receipt or charge of moneys or securities belonging to the Scheme.
- 23. FINANCIAL YEAR OF THE SCHEME**
- The financial year of the Scheme shall run from 1 January to 31 December of that year.
- 24. BANK ACCOUNT**
- The Scheme shall maintain a bank account with a registered commercial bank. All monies received must be deposited to the credit of such account and all payments must be made either by electronic transfer, tape exchange or by cheque under the joint signature of not less than two persons duly authorised by the Board.
- 25. AUDITOR AND AUDIT COMMITTEE**
- 25.1 An auditor (who must be approved in terms of section 36 of the Act) shall be appointed by resolution at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.
- 25.2 The following persons are not eligible to serve as auditor of the Scheme
- 25.2.1 A Member of the Board;

<p>25.2.2 An employee, officer or contractor of the Scheme;</p> <p>25.2.3 An employee, director, officer or contractor of the Scheme's administrator, if any, of the Scheme or of the holding company, subsidiary joint venture or associate of the administrator;</p> <p>25.2.4 A person not engaged in public practice as an auditor; or</p> <p>25.2.5 A person who is disqualified from acting as an auditor in terms of the Companies Act, Act 71 of 2008.</p> <p>25.3 Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board shall within 30 (thirty) days appoint another auditor to fill the vacancy for the unexpired period.</p> <p>25.4 If the Members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this Rule, the Board shall within 30 (thirty) days make such appointment, and if it fails to do so, the Registrar may at any time do so.</p> <p>25.5 The auditor of the Scheme shall at all times have a right of access to the books, records, accounts, documents and other effects of the Scheme, and shall be entitled to require from the Board and the other officers of the Scheme such information and explanations as he may deem necessary for the due performance of his duties.</p> <p>25.6 The auditor must report to the Members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in general meeting.</p> <p>25.7 The Board must appoint an Audit Committee, with the objectives referred to in Section 36(1.2) of the Act, of at least 5 (five) Members of whom at least 2 (two) must be Members of the Board and the majority, including the chairperson of the Audit Committee, may not be officers of the Scheme.</p>	<p>26.2.3 Notice</p> <p>The notice convening the special general meeting together with the agenda and any documents shall be issued to all employers for their information as well as that of their employees who are Members and other Members who are not employer-based, not less than 2 (two) weeks before the date of the meeting. Copies of the said documents shall simultaneously be forwarded to all Members. Non receipt of such notice shall not invalidate the proceedings of the meeting.</p> <p>26.2.4 Quorum</p> <p>25 (twenty-five) Members shall constitute a quorum and Rules 26.1.4, 27.1 and 27.2 shall apply mutatis mutandis (the necessary changes having been made); Provided, however, that if a quorum is not present at the meeting convened at the request of Members after the lapse of ½ (half) an hour from the time fixed for the commencement of the meeting, the meeting shall be regarded as cancelled.</p>
<p><b>26. GENERAL MEETINGS</b></p> <p><b>26.1 Annual general meeting</b></p> <p>The annual general meeting of Members shall be held not later than 30 June of each year.</p> <p>26.1.1 Notice</p> <p>The notice convening the annual general meeting, together with the agenda, financial highlights and proposed amendments to these Rules shall be made available electronically or otherwise, to all Members for their information not less than two (2) weeks before the date of the meeting. A Member who requires a full set of financial statements may apply to the Scheme therefore or may inspect it and make extracts there from at the registered office of the Scheme. Non receipt of such notice shall not invalidate the proceedings at the meeting.</p> <p>26.1.2 Reports and statements</p> <p>The reports and statements referred to in Rule 26.1.1 shall be submitted to the annual general meeting together with any notice of proposal received by the Principal Officer on or before 31 January.</p> <p>26.1.3 Quorum</p> <p>25 (twenty-five) Members shall constitute a quorum. If a quorum is not present within ½ (half) an hour from the time laid down for the commencement of the meeting, the meeting shall be postponed for a further 30 (thirty) minutes and the Members then present shall constitute a quorum at the annual general meeting.</p> <p>26.1.4 Motions at annual general meeting</p> <p>Notices of motions to be placed before the annual general meeting must reach the Principal Officer not later than 7 (seven) days prior to the date of the meeting; Provided that each motion must be seconded by 2 (two) other Members of the Scheme.</p>	<p><b>27. VOTING AT MEETINGS</b></p> <p>27.1 Each Member present at the annual general meeting of the Scheme may vote and shall have 1 (one) vote on all matters: Provided that voting shall be by show of hands or by ballot paper if not less than 10 (ten) of the representatives present insist that voting shall be by ballot paper. The Chairperson shall nominate 3 (three) or more representatives to collect, check and count the votes.</p> <p>27.2 The Chairperson, if he is a Member of the Scheme, shall have a deliberative vote in addition to a casting vote whenever a vote is taken.</p>
<p><b>26.2 Special general meeting</b></p> <p>26.2.1 Meeting called by Board</p> <p>A special general meeting of Members may be called at any time by the Board.</p> <p>26.2.2 Meeting called by Members</p> <p>On receipt of a written request signed by at least 10% (ten percent) of the Members of the Scheme the Principal Officer shall call a special general meeting to be held within 30 (thirty) days after receipt of such request. Only matters specified in the request shall be discussed at such a meeting.</p>	<p><b>28. COMPLAINTS AND DISPUTES BY MEMBERS</b></p> <p>28.1 A Member may lodge a complaint, in writing, to the Scheme.</p> <p>28.2 Any complaints received in writing will be responded to by the Principal Officer of the Scheme in writing within 30 (thirty) days of receipt thereof.</p> <p>28.3 A Disputes Committee of the Scheme consisting of 3 (three) Members, who may not be Members of the Board or officers of the Scheme, shall be appointed by the Board to serve a term of office of 3 (three) years. At least one of such Members shall be a person with legal expertise.</p> <p>28.4 Any dispute about a ruling by the Principal Officer in terms of Rule 28.2, which may arise between a Member, prospective Member, former Member or a person claiming by virtue of such Member and the Scheme or an officer of the Scheme, must be referred by the Principal Officer to the Disputes Committee for adjudication.</p> <p>28.5 On receipt of a request in terms of this Rule, the Principal Officer must convene a meeting of the Disputes Committee by giving not less than 21 (twenty-one) days' notice in writing to the complainant and all the Members of the Disputes Committee, stating the date, time, and venue of the meeting and particulars of the dispute.</p> <p>28.6 The Disputes Committee shall determine the procedure to be followed: Provided that:</p> <p>28.6.1 The parties to any dispute shall have the right to be heard at the proceedings, either in person or through a representative;</p> <p>28.6.2 The parties may question each other on the evidence presented; and</p> <p>28.6.3 The parties may address the Disputes Committee after all evidence has been heard.</p> <p>28.7 The Disputes Committee shall give a ruling within 10 (ten) days of the meeting and immediately inform the parties in writing thereof.</p> <p>28.8 An aggrieved party has the right to appeal to the Council for Medical Schemes against the decision of the Disputes Committee. Such appeal must be in the form of an affidavit directed to the Council and shall be furnished to the Registrar not later than 3 (three) months after the date on which the decision concerned was made. A copy of the submitted affidavit must be provided simultaneously to the Scheme.</p> <p>28.9 A Member may appeal to the Council against a decision of a review panel established in terms of Chapter 10 under the Act.</p>
	<p><b>29. TERMINATION OR DISSOLUTION</b></p> <p>29.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution in accordance with the provisions of the Act and any other applicable law.</p> <p>29.2 Members in general meeting may resolve that the Scheme shall for the reasons stated in such resolution be dissolved, in which event the Board must arrange for all Members to decide by ballot whether the Scheme is to be liquidated.</p>

Unless the majority of Members resolve that the Scheme shall continue, the Scheme shall be liquidated in terms of section 64 of the Act.

29.3 Pursuant to a decision by Members taken in terms of Rule 29.2 the Principal Officer must, in consultation with the Registrar, furnish to every Member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

29.4 Every Member must be requested to return his ballot paper duly completed before a set date. If at least 75% (seventy-five percent) of the returned ballots of the Members is in favour of the dissolution of the Scheme, the Board shall ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

### 30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical Scheme or person.

30.1.1 The Board of Trustees shall investigate and may approve a proposed amalgamation or transfer of up to 15 000 (fifteen thousand) Members within a single transaction.

30.1.2 The Board shall arrange for all existing Members to decide by ballot whether a proposed amalgamation or transfer of more than 15 000 (fifteen thousand) Members within a single transaction should be proceeded with or not.

30.1.3 If at least 50% (fifty percent) plus 1 (one) of the returned ballots of the Members are in favour of the amalgamation or transfer as indicated in Rule 30.1.2 then, subject to section 63 of the Act, the amalgamation or transfer may be concluded.

### 31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any beneficiary must on request and on payment of a fee of R50, be supplied by the Scheme with a copy of the following documents:

31.1.1 The Rules of the Scheme;

31.1.2 The latest audited annual financial statements, returns, Trustees reports and auditor report of the Scheme; or

31.1.3 The management accounts in respect of the Scheme and all its benefit options.

31.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 31.1 and to make extracts there from.

31.3 A beneficiary's right of access to information in terms of the Promotion of Access to Information Act is not limited by the provisions of Rule 31.

### 32. AMENDMENT OF THESE RULES

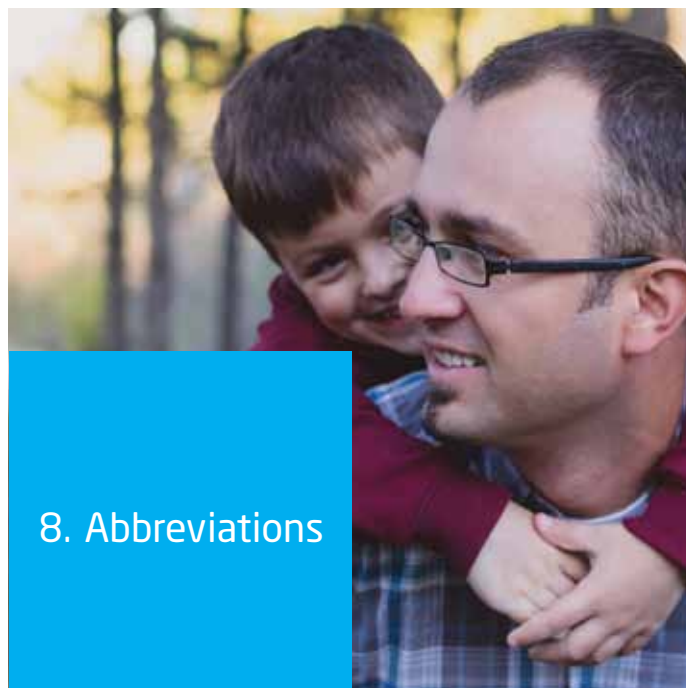
32.1 The Board shall be entitled to amend or rescind any Rule or annexure or to make any additional Rule or annexure.

32.2 No alteration, rescission or addition which affects the objects of the Scheme in terms of the Act, shall be valid unless it has been approved by a majority of Members present at a general meeting or a special meeting or by ballot.

32.3 Members shall be furnished with a copy of such amendment within a reasonable time after registration thereof. Provided that should a Member's rights, obligations, contributions or benefits be amended, he shall be given 30 (thirty) days' advance notice of such change.

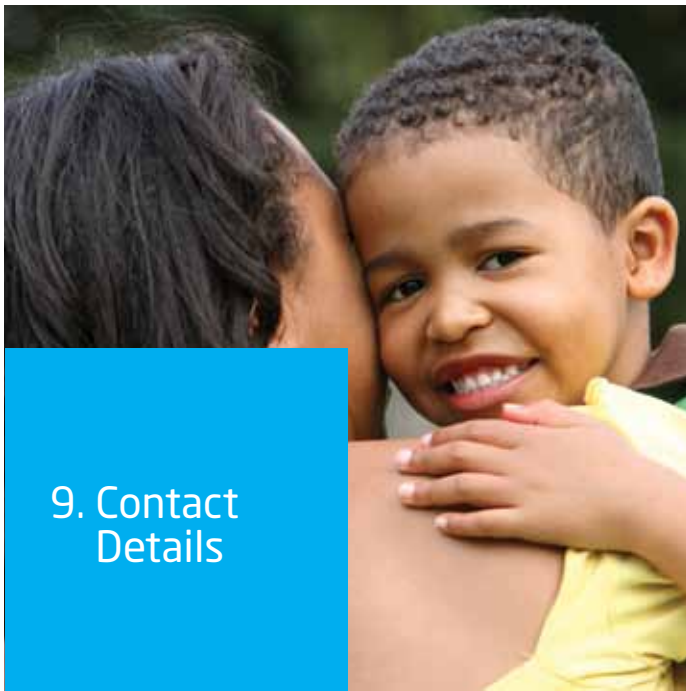
32.4 Notwithstanding the provisions of Rule 32.1 above, the Board shall, on the request and to the satisfaction of the Registrar, amend any Rule that is inconsistent with the provisions of the Act.

32.5 No alteration, rescission or addition shall be valid unless it has been approved and registered by the Registrar in terms of the Act.



## 8. Abbreviations

ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
CDL	Chronic Disease List
COPD	Chronic Obstructive Pulmonary Disease
DBC	Documentation Based Care (back rehabilitation programme)
DSP	Designated Service Provider
GORD	Gastro Oesophageal Reflux Disease
GP	General Practitioner or Doctor
HPV	Human Papilloma Virus
M	Member
M1+	Member and family
MMAP	Maximum Medical Aid Price
MRI/CT Scans	Magnetic Resonance Imaging/Computed Tomography Scans
MRP	Mediscor Reference Price
NPWT	Negative Pressure Wound Therapy
OCD	Obsessive Compulsive Disorder
PET Scan	Positron Emission Tomography Scan
PCOD	Polycystic Ovarian Disease
PMB	Prescribed Minimum Benefits
PPN	Preferred Provider Networks
PSA	Prostate Specific Antigen



## 9. Contact Details

### Client Services

Tel: +27 (0) 86 000 2378  
E-mail: [service@bestmed.co.za](mailto:service@bestmed.co.za)  
Fax: +27 (0) 12 472 6500

### Walk-in Facility

Block A, Glenfield Office Park, 361 Oberon Avenue,  
Faerie Glen, Pretoria, Gauteng, 0081, RSA

Postal address: PO Box 2297, Arcadia, Pretoria, Gauteng, 0001, RSA

### Enquiries and Claims

Tel: +27 (0) 86 000 2378  
E-mail: [claims@bestmed.co.za](mailto:claims@bestmed.co.za)

### SMS

SMS the corresponding letter A, B or C to 31416

A = Personal details  
B = Benefits available  
C = Last 3 claims

### Hospital Authorisation

Tel: +27 (0) 80 022 0106  
E-mail: [authorisations@bestmed.co.za](mailto:authorisations@bestmed.co.za)

### Chronic Medication

Tel: +27 (0) 86 000 2378  
E-mail: [medicine@bestmed.co.za](mailto:medicine@bestmed.co.za)  
Fax: +27 (0) 12 472 6760

### ER24 and International Travel Cover

Tel: +27 (0) 84 124

### BestBaby

Tel: +27 (0) 86 111 1936  
E-mail: [info@babyhealth.co.za](mailto:info@babyhealth.co.za)

### HIV/AIDS Programme

Tel: +27 (0) 11 251 9400  
Fax: +27 (0) 86 500 9822  
E-mail: [mhc@bestmed.co.za](mailto:mhc@bestmed.co.za)

### Oncology Programme

Tel: +27 (0) 12 472 6254  
Fax: +27 (0) 12 472 6770  
E-mail: [diseasemanagement@bestmed.co.za](mailto:diseasemanagement@bestmed.co.za)

### Online Service Access and Queries

E-mail: [service@bestmed.co.za](mailto:service@bestmed.co.za)

### Webmail Facility

E-mail: [webmail@bestmed.co.za](mailto:webmail@bestmed.co.za)

### Website technical issues

E-mail: [webmaster@bestmed.co.za](mailto:webmaster@bestmed.co.za)

### Complaints

If you are not satisfied with Bestmed's service:

Tel: +27 (0) 86 000 2378  
E-mail: [service@bestmed.co.za](mailto:service@bestmed.co.za) (Subject box: Manager, escalated query)  
Postal address: PO Box 2297, Arcadia, Pretoria 0001

### CareCross

Call Centre: +27 (0) 86 010 3491  
E-mail: [bestmedpulse1@carecross.co.za](mailto:bestmedpulse1@carecross.co.za)  
Website: [www.carecross.co.za](http://www.carecross.co.za)

### ONECARE

Call centre: +27 (0) 86 010 1159  
E-mail: [bestmed@onecarehealth.co.za](mailto:bestmed@onecarehealth.co.za)  
Fax: +27 (0) 21 673 1811  
Website: [www.carecross.co.za](http://www.carecross.co.za)

### KPMG Fraud Hotline

Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed employees, service providers or even Bestmed Members, please report this anonymously to KPMG.

Tel: +27 (0) 80 111 0210  
Fax: +27 (0) 80 020 0796

Details can be posted free-of-charge to KPMG Ethics Line at the following address:

Postal address: KPMG Hotpost  
BNT 371  
PO Box 14671  
Sinoville 0129

Information can also be e-mailed through to the hotline anonymously at the following address:

E-mail: [fraud@kpmg.co.za](mailto:fraud@kpmg.co.za)

## 10. Chronic Disease List

The Chronic Disease List (CDL) provides cover for the 27 listed chronic conditions for which medical schemes must cover the diagnosis, medical management and medicines as published by the Council for Medical Schemes. Non-CDL chronic conditions are those additional conditions that Bestmed provides chronic medicine cover for. Authorisation for CDL and non-CDL chronic medicines is subject to clinical funding guidelines and protocols, formularies and Designated Service Providers (DSPs) where applicable. Below is the list of CDL and non-CDL conditions that Bestmed covers on the various benefit options.

Reimbursement for CDL	100% of Scheme tariff									
	Beat1	Beat2	Beat3	Beat4	Pace1	Pace2	Pace3	Pace4	Pulse1	Pulse2
Reimbursement for non-CDL	N/A	N/A	85% of Scheme tariff	85% of Scheme tariff	85% of Scheme tariff	85% of Scheme tariff	85% of Scheme tariff	85% of Scheme tariff	N/A	100% of Scheme tariff
Non-formulary co-payment for CDL and non-CDL	35%	35%	35%	30%	35%	30%	25%	20%	35% for non-formulary medicines prescribed by a specialist	25%
No. of non-CDL conditions	0	0	5	16	10	31	31	45	N/A	25
CDL 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 13	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 15	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 16	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 17	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 18	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 19	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 20	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 21	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 22	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 23	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 24	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 25	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 26	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDL 27	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
non-CDL 1			✓	✓	✓	✓	✓	✓	✓	✓
Acne - Severe										



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