6.1 CONDITIONS

(a) BESTmed's benefits on accounts properly lodged in terms of rule 15 shall be granted as shown in each paragraph hereunder, and the member shall be liable for the difference between BESTmed’s benefits and the full amount of the account.

(b) No benefits shall be granted on accounts reaching BESTmed after the last day of the fourth month following the date on which the service was rendered.

(c) A member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.

(d) Benefits shall be based on the Scheme tariff or contracted fee as agreed by BESTmed and the supplier of service, whichever is applicable.

(e) BESTmed’s financial year shall run from 1 January to 31 December.

(f) The benefits of the option shall be divided into two parts, namely:

♦ Scheme Benefits
♦ Individual Medical Savings Account

(g) No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained previously or, in an emergency, on the first working day after admission to a hospital, by BESTmed or its proxy.

(h) No benefits in a private hospital shall be granted if an authorisation number has not been obtained previously (in the case of planned major operations and dental procedures – preferably 14 days in advance) or, in an emergency, on the first working day after admission to a hospital, by BESTmed or its proxy.

(i) If a member or his dependants receive treatment in a private hospital without an authorisation number having first been obtained (whether because prior application was not made or because a prior application was refused), a R500 surcharge per
admission shall be imposed whenever an application is approved with retrospective effect.

(j) If an authorisation number has been obtained for treatment in a **private** hospital but the treatment exceeds the authorised benefits, only the benefits of the authorised treatment shall be granted and the member shall be liable for payment of the excess to the service provider.

(k) A member shall qualify for the extent and level of minimum benefits provided for in regulation 8 in terms of the Medical Schemes Act (No. 131 of 1998), without co-payment or the use of deductibles.

### 6.2 **SCHEME BENEFITS**

(i) Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.

(ii) Full cross subsidisation between members shall apply.

(iii) Granting of benefits under the Scheme Benefits shall be subject to treatment protocols, preferred providers and medicine formulary accepted by BESTmed.

(iv) Joint replacement surgery (for example hip- and knee replacements) will be excluded from benefits except for PMB conditions. The following sub-limits will apply to the prosthesis if pre-authorised by BESTmed or its proxy:

   (i) Hip prosthesis shall be limited to R17 500
   (ii) Knee prostheses shall be limited to R22 000

(v) A co-payment of R1 000 will be applicable on all endoscopic investigations. No co-payment shall apply where procedures are performed out of hospital (in doctor’s rooms).

### 6.2.1 **Hospitals: contracted providers**

Accommodation in a **general** ward, intensive-care and high-care unit, theatre, medicine (including seven calendar days’ supply of medicine, which are related to the sickness condition for which the patient was hospitalised, to take home) and material – 100% of the contracted fee.
6.2.2 Hospitals: non-contracted providers

Accommodation in a *general* ward, intensive-care and high-care unit, theatre, medicine (including seven calendar days’ supply of medicine, which are related to the sickness condition for which the patient was hospitalised, to take home) and material – 100% of the Scheme tariff.

6.2.3 Mental health clinics: contracted providers

Accommodation and treatment of psychological and psychiatric conditions – 100% of the contracted fee: Provided that benefits are subject to the following:

(i) The length of stay shall be limited to 21 days per beneficiary per financial year.

6.2.4 Mental health clinics: non-contracted providers

Accommodation and treatment of psychological and psychiatric conditions – 100% of the Scheme tariff: Provided that benefits are subject to the following:

(i) The length of stay shall be limited to 21 days per beneficiary per financial year.

6.2.5 Registered institutions for the treatment of chemical and substance dependence/abuse

Accommodation and treatment for chemical and substance dependence/abuse – 100% of the Scheme tariff: Provided that benefits are subject to the following:

(i) The length of stay shall be limited to 21 days per beneficiary per financial year.

(ii) Benefits shall be limited to R14 500 per beneficiary per financial year.

6.2.6 Consultations and visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation

Consultations and visits, operations, surgical procedures and anaesthetics during surgical procedures and operations by general practitioners and specialists during hospitalisation – 100% of the Scheme tariff or contracted fee.
6.2.7 Confinements

Benefits shall be paid even if the child dies before registration.

(i) Medical practitioners – 100% of the Scheme tariff.
(ii) Nursing home and hospital fees in accordance with the provisions of paragraphs 6.2.1 to 6.2.2.
(iii) Home confinement by a midwife – 100% of the Scheme tariff for midwives.
(iv) Confinement by a midwife during hospitalisation – Two thirds (66.67%) of the cost for a confinement by general practitioners in the Scheme tariff.

6.2.8 Surgical dentistry

Maxillo-facial and Oral surgery strictly related to:

(i) severe trauma (soft tissue injuries, fractures of jaws and facial bones);
(ii) cleft lip and palate;
(iii) Crouzon’s disease;
(iv) malunited craniomaxillary disjunction;
(v) post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);
(vi) internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);
(vii) salivary gland surgery (removal of gland or salivary stone);
(viii) life threatening sepsis (Ludwig’s angina);
(ix) confirmed oral cancer.

100% of the Scheme tariff with a maximum of R6 600 for the member with his dependants per financial year.

6.2.9 Radiation and Chemotherapy

100% of the Scheme tariff subject to registration on the oncology programme. Provided that:

♦ the services shall be pre-authorised by BESTmed;
♦ preferred providers may be appointed by BESTmed;
♦ the services fall within BESTmed’s protocol criteria.
6.2.10 Pathology and radiology during hospitalisation

100% of the Scheme tariff: Provided that benefits in respect of MRI scans and computer tomographic studies (CAT scans) shall be subject to the following:

Pre-authorisation by BESTmed.

6.2.11 Blood transfusions

Blood, operators’ fees and apparatus – 100% of the fees charged by the South African Blood Transfusion Services. Blood transport charges are excluded from benefits.

6.2.12 Prosthesis

(i) Prosthesis surgically implanted during operations/hospitalisation

Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of R40 000 per prosthesis per family per financial year: Provided that benefits will not be pro-rated, further that benefits are subject to the following conditions, sub-limits and prescribed minimum benefits (PMB's):

(a) Pre-authorisation by BESTmed
(b) Preferred providers may be appointed by BESTmed
(c) Vascular prosthesis shall be limited to R15 500
(d) Spinal prosthesis shall be limited to R15 500
(e) Artificial disk – no benefit
(f) Drug eluting stent – no benefit
(g) Mesh shall be limited to R5 500
(h) Gynaecology/Urology prosthesis shall be limited to R4 500
(i) Lens implant shall be limited to R3 500 per lens.

(ii) External prosthesis after operations

Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of R10 000 per prosthesis per sickness condition: Provided that benefits are subject to the following:

(a) Pre-approval by BESTmed.
(b) Two quotations may be required.
(c) Preferred providers may be appointed by BESTmed.
(d) Artificial limbs are limited to one limb per 60 months.

6.2.13 Heart pacemakers

100% of the cost after discount for the member with his dependants per financial year: Provided that benefits shall be subject to pre-authorisation by BESTmed.

6.2.14 Services rendered by clinical technologists during hospitalisation

100% of the Scheme tariff.

6.2.15 Ambulance and emergency evacuation services

100% of the cost of ambulance services without a limit: Provided that the service has previously or, in an emergency, on the first working day after evacuation been approved as clinically necessary by BESTmed’s preferred provider for ambulance services and that this preferred provider shall arrange the service. If this preferred provider does not render the service, no benefits shall be payable by BESTmed.

6.2.16 Haemodialysis

Benefits are subject to the Prescribed Minimum Benefits.

6.2.17 Organ transplants

PMB conditions only. 100% of cost.

6.2.18 Alternatives to hospitalisation

Services rendered by step-down facilities approved by BESTmed, registered private nurses and hospices – 100% of the fees approved by BESTmed with a maximum of R10 000 for the member and his dependants per financial year: Provided that benefits shall be approved in advance by BESTmed or its proxy.

6.2.19 Physiotherapy and biokinetics inside hospital

Physiotherapy prescribed beforehand by a medical practitioner – 100% of the Scheme tariff.
6.2.20 Prescribed Minimum Benefits for Chronic Disease List (CDL)

A member shall apply on BESTmed’s prescribed application form to qualify for the Chronic Disease List benefits provided for in Annexure A of the Regulations in terms of the Medical Schemes Act (no 131 of 1998). The benefits are subject to the following:

(i) Pre-authorisation
(ii) Formulary medicine

BESTmed’s medicine benefits for CDL medicines, prescribed by a medical practitioner are subject to a formulary (medicine list). Medicines on the formulary will be reimbursed without a co-payment. If a member, however, opts to use a non-formulary medicine, the Scheme will reimburse that product at 65% and the member will have a 35% co-payment. A member shall apply (obtain pre-authorisation) on BESTmed’s prescribed application form to qualify for these medicines on the CDL benefit. A member shall qualify for benefits from the date on which the medicine is approved by BESTmed or its proxy.

6.2.21 HIV/AIDS test subject to prescribed minimum benefits

The cost of HIV/AIDS test per beneficiary per financial year – 100% of cost.

6.2.22 Preventative treatment

(i) 100% of the cost for:

<table>
<thead>
<tr>
<th>Preventative Care Benefit</th>
<th>Gender and Age Group</th>
<th>Quantity and Frequency</th>
<th>Benefit Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Vaccine</td>
<td>All ages</td>
<td>One per beneficiary per year</td>
<td>Applicable to all active members and beneficiaries</td>
</tr>
<tr>
<td>Pneumonia Programme</td>
<td>Children &lt; 2yrs</td>
<td>Once in 5yrs</td>
<td>Funding for children &lt; 2yrs: Parents to contact BESTmed in advance to pre-arrange funding prior to obtaining the vaccine Funding for adults: BESTmed will identify certain high risk individuals who will be invited to be immunized</td>
</tr>
<tr>
<td></td>
<td>High risk adult group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td>Funding for all pediatric vaccines according to the State recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>Programme for babies and children</td>
<td></td>
<td></td>
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<tr>
<td>---------------</td>
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</tr>
<tr>
<td>Oral contraceptives</td>
<td>All females of child bearing age</td>
<td>Monthly fills up to the maximum allowed amount</td>
<td>Limited to R1 200 per family for the year. Includes all items classified in category of oral contraceptives</td>
</tr>
<tr>
<td>DBC programme (Document Based Care)</td>
<td>All ages</td>
<td>When required</td>
<td>Applicable to beneficiaries that have serious spinal or back problems and may require surgery. BESTmed identifies appropriate participants for evaluation at the DBC centre. Based on the outcomes of the evaluation, a rehabilitation treatment plan is drawn up and initiated which lasts approx 6 weeks.</td>
</tr>
<tr>
<td>HIV test</td>
<td>All ages</td>
<td>One test per beneficiary per year</td>
<td>One ELISA diagnostic test per beneficiary. Western Blot diagnostic tests excluded from this benefit.</td>
</tr>
</tbody>
</table>

(ii) 100% of the Scheme tariff for basic preventative dentistry:

<table>
<thead>
<tr>
<th>DESCRIPTION OF SERVICE</th>
<th>AGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>General full mouth examination by a general dentist</td>
<td>Above 12 years</td>
<td>Once a year</td>
</tr>
<tr>
<td></td>
<td>Under 12 years</td>
<td>Twice a year</td>
</tr>
<tr>
<td>Full mouth intra-oral radiographs</td>
<td>All ages</td>
<td>Once every 3 years</td>
</tr>
<tr>
<td>Intra-oral radiograph</td>
<td>All ages</td>
<td>2 x photos per year</td>
</tr>
<tr>
<td>Scaling and/or polishing</td>
<td>All ages</td>
<td>Twice a year</td>
</tr>
<tr>
<td>Fluoride treatment</td>
<td>All ages</td>
<td>Twice a year</td>
</tr>
<tr>
<td>Fissure sealing</td>
<td>Up to and including 21 years</td>
<td>In accordance with accepted protocol</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>During primary and mixed denture stage</td>
<td>Once per space</td>
</tr>
</tbody>
</table>
Over and above the provisions for foreign claims, referred to in Rule 16.12, members and their dependants qualify for the following additional benefit:

100% for the cost of services for worldwide international emergency medical cover: Provided that benefits are subject to the following:

(i) The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs.
(ii) Beneficiaries have access to 90 days cover per trip, limited to 180 days per annum.
(iii) A member has to notify the preferred provider at least 48 hours in advance when he and or his dependants are travelling overseas. Failure to notify the preferred provider will result in claims not entertained.
(iv) Out of hospital medical expenses, medicine and elective planned procedures incurred outside of South Africa are not covered.

6.3 **INDIVIDUAL MEDICAL SAVINGS ACCOUNT (IMSA)**

(i) On admission to BESTmed, an IMSA, held by BESTmed is established in the name of the member concerned into which the contributions payable in respect of the IMSA component shall be credited and benefits in respect thereof, shall be debited.
(ii) No cross subsidisation between members will apply in respect of the IMSA. The size of the IMSA is limited to 15% of gross annual contributions.
(iii) Subject to sufficient funds being available at the date on which a claim is processed, members shall be entitled to claim for all health care services provided for under paragraph 6.3 at 100% of the cost as well as any co-payments or shortfalls the member is responsible for.
(iv) Any balance in the IMSA at the end of a financial year remains the property of the member and accumulates in his name.
(v) Upon the death of the member, the balance due to the member will be transferred to his registered dependants who continue membership of BESTmed or paid into his estate in the absence of such dependants.
(vi) On transfer to another option of BESTmed, which does not provide for such an account, any balance in the IMSA will be refunded to the member, 5 (five) months after such transfer and subject to applicable laws.
(vii) Should a member terminate membership of BESTmed 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 IMSA, the balance due to the member must be refunded to the member 5 (five) months after termination of membership, and subject to applicable laws.

(viii) Should a member be admitted to membership of another medical scheme, which provides for a similar account, the balance due to the member must be transferred to such scheme within 5 (five) months after termination of membership.

(ix) The member himself is responsible for managing his IMSA and no cross subsidisation between members shall apply here.

(x) The decision to grant the funds in the IMSA annually to the member as an interest free loan in advance up to the end of the financial year, shall vest in the discretion of BESTmed.

(xi) Any debit balance in the IMSA 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.

6.3.1 Consultations, visits, injections and treatments

Consultations, diagnostic examinations, visits, injections and treatments by general practitioners, specialists, chiropractors, homoeopaths, naturopaths, osteopaths and herbalists - 100% of the cost.

6.3.2 Supplementary services

(i) Physiotherapy prescribed beforehand by a medical practitioner - 100% of cost.

(ii) Treatments and/or tests for occupational therapy, speech therapy, audiology, chiropody, biokinetics and dietary services - 100% of the cost.

(iii) Psychiatric treatment by medical doctors, clinical, educational and counselling psychologists and social workers - 100% of the cost.

6.3.3 Dental services

100% of the cost on all dental services categorized as “B” Basic, “I” Intermediary dentistry as well as “A” Advanced dentistry in the South African Dental Association (SADA) codes and terminologies. This includes all dental services and services rendered by dental technicians in terms of the T-codes, as well as orthodontic, periodontic, prosthodontic services and implants, whether the procedures are surgical or not, i.e. orthognatic, para-orthodontic and preprosthetic surgery shall also fall under the Individual Medical Savings Account: Provided that
(i) items referred to in subparagraph 6.2.8 fall under Scheme Benefits.

6.3.4 Acute medicine

(i) 100% of the cost of medicine prescribed outside a hospital by a medical practitioner or dentist or a person authorised thereto by law.
(ii) Medicine over the counter – 100% of the cost.
(iii) Benefits in respect of medicine obtained on a prescription from a dentist or a person authorised thereto by law and administered during a stay in a hospital or nursing home, whether or not such medicine has been supplied by the hospital itself or whether part of the medicine was used after discharge from the hospital, shall be in accordance with the provisions of paragraphs 2.2.1 and 2.2.2(iv).

6.3.5 Optical services rendered by ophthalmologists, optometrists and optical dispensers registered with the Health Professions Council of South Africa

100% of the cost: Provided that no benefits shall be considered or granted for sunglasses.

6.3.6 Private nursing (excluding home-aid services) prescribed by a medical practitioner

100% of the cost: Provided that services be rendered by a registered nurse or an enrolled nursing assistant registered by the SA Nursing Council.

6.3.7 Orthopaedic, surgical and medical appliances

100% of the cost on the following items:
(i) Hearing aid.
(ii) Back, leg, arm and neck supports.
(iii) Wheel chairs.
(iv) Surgical footwear.
(v) Crutches.
(vi) Speech appliances.
(vii) Elastic stockings.
(viii) Medical apparatus.

6.3.8 Oxygen, diabetic and stoma aids
100% of the cost after discount on items which are continually essential for the medical treatment of the patient: Provided that benefits are subject to the following:

(i) Oxygen must be approved by BESTmed beforehand.
(ii) Certain insulin needles and syringes for insulin dependant diabetics are included in the Formulary medicine benefit under High Risk benefits, if applied for by the member and approved as such by BESTmed.
(iii) Certain glucose test strips for insulin dependant diabetics are included in the Formulary medicine benefit under High Risk benefits, if applied for by the member and approved as such by BESTmed.

6.3.9 Ambulance services: non-preferred providers

100% of the cost.

6.3.10 Pathology and basic (black and white) radiology outside hospital

100% of the cost

6.3.11 Advanced radiology outside hospital

MRI scans, computer tomographic studies and isotope studies – 100% of cost.

6.3.12 Rehabilitation after trauma

100% of cost.

6.3.13 Medicine for non-CDL chronic conditions

100% of cost.

6.4 MAXIMUM BENEFITS

Where a maximum amount of benefits has been imposed per financial year, the benefits shall be calculated at the maximum for the financial year in which the service was rendered. Where maximum benefits apply to a financial year, the maximum benefits for which a member and his dependants qualify shall be determined in accordance with the actual membership status at the date on which the service is rendered. Benefit maxima for members shall be calculated pro-rata for the financial year in which they join BESTmed as referred to in paragraph 6.1(c).