Member Guide 2023

bestMed

personally yours

Introduction

Over the years we have grown sustainably, enabling us to build a reputable name in the industry. Our core focus will always be to provide superior healthcare and exceptional client service to all our members. As a self-administered scheme, we provide healthcare benefits to over **100 000** principal members and care for over **210 000** beneficiaries. With our extensive experience and unparalleled expertise we offer an extensive network of FP's, specialists and other medical professionals.

In 2018 we instilled a set of *Personally Yours* principles throughout our organisation with the aim of refining our client service delivery and to encourage each Bestmed employee to actively implement our brand promise: Personally Yours. This internal initiative enabled us to grow and maintain our first place in the 2020 and 2022 Ask Afrika Orange Index's medical aid industry category. The South African Customer Satisfaction Index (SA-csi) results for the past three years (2020 to 2022) placed Bestmed at the forefront of customer experience in the South African medical scheme industry.

We see these achievements merely as benchmarks from where we can launch our client service to even greater heights in 2022 and beyond, always serving our members with the legendary Bestmed touch.

We live our values

We are **caring and principled** in everything we do and **passionate** about exceeding expectations.

We approach all partnerships with a focus on the **mutual** benefit for everyone involved, ensuring that we enhance our members' health and medical aid experience through a **seamless** integration of all operations.

Bestmed Tempo wellness programme

The Bestmed Tempo wellness programme is focused on supporting you on your path to improving your health and realising the rewards that come with it. To ensure you achieve this, you will have access to the following benefits:

Tempo Health Assessment (HA) for adults (beneficiaries 16 years and older) which includes one of each of the following per year per beneficiary:

- The Tempo lifestyle questionnaire
- Blood pressure check
- Cholesterol check
- Glucose check
- Height, weight and waist circumference

These assessments need to be done at a contracted pharmacy or on-site at participating employer groups.

THE BESTMED TEMPO JOURNEYS:

Get Active (Fitness) Journey (beneficiaries 16 years and older)

- 1 x (face-to-face) fitness assessment at a Tempo partner biokineticist
- 1 x follow-up (virtual or face-to-face) consult to obtain your personalised fitness/exercise plan from the Tempo partner biokineticist

These fitness benefits are intended to assist you on your Tempo Get Active Journey.

Nutritional Health Journey (beneficiaries 16 years and older)

- 1 x (face-to-face) nutrition assessment at a Tempo partner dietitian
- 1 x follow-up (virtual or face-to-face) consult to obtain your personalised healthy-eating plan from the Tempo partner dietitian

These nutrition benefits are intended to assist you on your Tempo Nutritional Health Journey.

Emotional Wellbeing Journey

This journey was developed by qualified psychologists and healthcare providers, and will assist you to identify and manage your emotions and the affect they have on your mental health. This Journey provides beneficiaries 21 years and older with access to (via the Bestmed App and website):

- Two questionnaires that assess whether the participant experiences symptoms of depression and/or anxiety (for beneficiaries 21 years and older).
- Access to the educational information, challenges, recordings, videos, and support group details that will assist them with self awareness and to cope with challenges (for beneficiaries 16 years and older).

Don't worry, be Appy!

The Bestmed App is just one more way that Bestmed is Personally Yours. It's user-friendly and has been designed to put all your essential medical information at your fingertips.

The app provides the following benefits:

- A digital version of your membership card
- Find a service provider
- Submit a claim
- Check your available benefits
- Email your membership card to service providers
- Check your Health Assessment results
- Update contact details for dependants 18 years and older
- Submit your chronic application/prescription
- Download the Bestmed App from your preferred provider

Google Play Store
Android devices

App Store
iOS devices

AppGallery
Huawei devices

Relevant legislation

We take great care to ensure that we comply with the rights, benefits, contributions and duties of members.

We'd like to highlight some of the major Acts:

- 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
- Protection of Personal Information Act 4 of 2013

HEALTHCARE OPTIONS

Our range of healthcare options

We recognise that people are different, and we all have different healthcare needs. To address a desire for choice and flexibility, we offer three main healthcare ranges, each with their own unique options to choose from. Each option is structured differently, so whether you essentially just want to cover hospital costs or require a more comprehensive offering, we have an option for you.

Our three healthcare ranges include: **Beat, Pace and Rhythm**.

- The **Beat range** offers offers flexible hospital benefits with savings on some options to pay for out-of-hospital expenses. Beat1, 2 and 3 also offer you the choice to lower your monthly contribution in the form of network options.
- The **Pace range** offers comprehensive in-hospital and out-of-hospital benefits. These options all have additional day-to-day benefits to cover extensive out-of-hospital expenses. This range is ideal for those seeking comprehensive cover.
- The **Rhythm** options are ideal for you if are seeking an income-based option, you are comfortable with making use of Designated Service Providers (DSPs) within the Rhythm network, and if you are looking for unlimited comprehensive hospital cover and the added benefit of preventative care.

An overview of each option

BEAT1/BEAT1 NETWORK - THE HOSPITAL PLAN OPTION

Our "hospital plan" option offers extensive in-hospital cover. You can choose to either have access to any hospital on Beat1 or opt for Beat1 N and make use of a specific list of hospitals and receive a discount on your contribution.

Is this option for you?

- You want an affordable option.
- You live by the motto that "prevention is better than cure" - receiving access to preventative care benefits, including flu vaccines, oral contraceptives, back and neck preventative programme, etc.
- You realise that at any time you may be faced with expensive, unforeseen hospital costs.

Method of Scheme benefit payment

In-hospital expenses are paid from Scheme risk and out-of-hospital expenses will have to be paid from your own pocket. Certain preventative care benefits are available from Scheme risk.

BEAT2/BEAT2 NETWORK - THE NEW GENERATION OPTION

Our superior "hospital plan" with a savings account to offer you flexibility. This option offers extensive in-hospital cover at private hospitals. Your medical savings account is available for any unforeseen day-to-day expenses. You can choose to either have access to any hospital on Beat2 or opt for Beat2 N and make use of a specific list of hospitals and receive a discount on your contribution.

Is this option for you?

- You want an affordable option.
- You live by the motto that "prevention is better than cure" - receiving access to preventative care benefits, including flu vaccines, contraceptives, back and neck preventative programme, basic and preventative dentistry, etc.
- You're planning to start a family and will require medical cover for sonars and antenatal visits.
- You need access to more out-of-hospital benefits than those paid from the savings account.

Method of Scheme benefit payment*

In-hospital expenses are paid from Scheme risk and out-of-hospital expenses are paid from your medical savings account. Some preventative care benefits are available from Scheme risk.

*Please consult page 15 in this guide should you have any questions about your medical savings account.

BEAT3/BEAT3 NETWORK - THE NEW GENERATION OPTION

Our value-for-money option offers generous maternity benefits and extensive in-hospital cover at private hospitals. You can choose to either have access to any hospital on Beat3 or opt for Beat3 N and make use of a specific list of hospitals and receive a discount on your contribution. This option offers additional chronic benefits, e.g. for allergic rhinitis and ADD/ADHD. It includes preventative care benefits such as immunisations and contraceptives.

Is this option for you?

- You want an affordable option.
- You live by the motto that "prevention is better than cure" - receiving access to preventative care benefits, including 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're planning to start a family and will require medical cover for sonars and antenatal visits.
- You need cover for some chronic additional conditions.
- You want to make provision for out-of-hospital expenses by utilising your medical savings account.

Method of Scheme benefit payment*

In-hospital expenses are paid from Scheme risk. Some day-to-day benefits are paid from Scheme risk and some from your medical savings account. Some preventative care benefits are available from Scheme risk.

*Please see page 15 in this guide should you have any questions about your medical savings account.

BEAT4 - THE HYBRID OPTION

Our superior option offers comprehensive in-hospital cover at private hospitals. A generous amount of day-to-day medical cover for consultations, dentistry, chronic medications and a range of preventative care screenings: mammograms, pap smears and dietitian counselling.

Is this option for you?

- You require comprehensive day-to-day cover.
- You live by the motto that "prevention is better than cure" - receiving access to preventative care benefits, including 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 need cover for chronic conditions.
- You need access to more out-of-hospital benefits than those paid from the savings account.

Method of Scheme benefit payment*

In-hospital expenses are paid from Scheme risk. Some out-of-hospital expenses are paid from your medical savings account first and, once depleted, are paid from your day-to-day benefit. Some preventative care benefits are available from Scheme risk.

*Please see page 15 in this guide should you have any questions about your medical savings account

PACE1 - THE HYBRID OPTION

This option is ideal for those seeking comprehensive in-hospital and out-of-hospital benefits as well as extensive day-to-day benefits to cover extensive out-of-hospital expenses.

Is this option for you?

- You require extensive day-to-day cover to meet your healthcare needs.
- You live by the motto that "prevention is better than cure" - you have access to preventative care benefits, including 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 need cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.
- You need access to more out-of-hospital benefits than those paid from the savings account.

Method of Scheme benefit payment*

In-hospital services are paid from Scheme risk. Some out-of-hospital services are paid from the annual savings first and, once depleted, paid from the day-to-day benefit. Once the day-to-day benefit is depleted, services can be paid from the available vested savings. Some preventative care services are available from Scheme risk.

*Please see page 15 in this guide should you have any questions about your medical savings account.

PACE2 - THE HYBRID OPTION

The perfect option for those seeking comprehensive in-hospital and out-of-hospital benefits as well as extensive day-to-day benefits to cover extensive out-of-hospital expenses and a full range of chronic benefit cover. This option also offers freedom of choice when it comes to hospitals, family practitioners and specialists.

Is this option for you?

- You require comprehensive day-to-day cover.
- You live by the motto that "prevention is better than cure" - receiving access to preventative care benefits, including 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 need cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.

Method of Scheme benefit payment*

In-hospital expenses are paid from Scheme risk. Some out-of-hospital expenses are paid from your medical savings account first and, once depleted, are paid from your day-to-day benefit. Once your day-to-day benefit is depleted, expenses can be paid from your available vested savings. Some preventative care benefits are available from Scheme risk.

*Please see page 15 in this guide should you have any questions about your medical savings account.

PACE3 - THE HYBRID OPTION

This option offers excellent in-hospital cover and comprehensive chronic cover. In addition, you are able to access a generous range of preventative care benefits such as pap smears, mammograms, immunisations and dietitian counselling.

Is this option for you?

- You require comprehensive day-to-day cover.
- You live by the motto that "prevention is better than cure" - you have access to preventative care benefits, including flu vaccines, paediatric immunisations, oral contraceptives, 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 need cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.

Method of Scheme benefit payment*

In-hospital services are paid from Scheme risk. Some out-of-hospital expenses are paid from your medical savings account first and, once depleted, are paid from your day-to-day benefit. Once your day-to-day benefit is depleted, expenses can be paid from your available vested savings. Some preventative care benefits are available from Scheme risk.

*Please see page 15 in this guide should you have any questions about your medical savings account.

PACE4 - THE TRADITIONAL OPTION

Our top-of-the-range, premium option designed for those who rely on their medical aid to cater for all their healthcare needs. It has the most comprehensive in-hospital cover and all-encompassing benefits for chronic medicine. In addition, you can access a generous range of preventative care benefits such as mammograms, pap smears and prostate screening. The option has a substantial savings account for added flexibility and freedom of choice.

Is this option for you?

- You require comprehensive day-to-day cover.
- You live by the motto that "prevention is better than cure" - you have access to preventative care benefits, including 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 need extensive cover for chronic conditions.
- You prefer freedom of choice when it comes to visiting a healthcare service provider.

Method of Scheme benefit payment*

In-hospital services, out-of-hospital services and preventative care are paid from Scheme risk. Once out-of-hospital risk benefits are depleted, further claims will be paid from the savings account.

*Please see page 15 in this guide should you have any questions about your medical savings account.

RHYTHM1/RHYTHM2 - THE NETWORK OPTIONS

This option is ideal for those seeking a benefit option that is suited to their income, and offers unlimited primary care benefits that can be obtained from a network of designated service providers.

Is this option for you?

- You are seeking a medical aid option that is based on your income.
- You are comfortable with making use of designated service providers (DSPs) within our Rhythm network.
- You are looking for unlimited primary care, for example FP visits, acute medicine, and preventative care benefits.
- You require quality hospital cover at private hospitals.

Method of Scheme benefit payment

In-hospital services, some preventative care services and some out-of-hospital services are paid from Scheme risk. Only Rhythm specialist DSP networks will apply.

We embrace member satisfaction through affordable benefits which offer value for money and access to top-quality healthcare. For additional information please visit the **plans and options** as well as the **benefits and cover** sections on our website **www.bestmed.co.za** to view the full range of available benefits.

BENEFIT MANAGEMENT

Chronic medicine benefit

It's compulsory to register your chronic condition(s) with Bestmed to qualify for the chronic medicine benefit.

How to register for this benefit?

1. The member and the treating doctor will be required to complete a chronic medicine application form. It's advisable to present the treating doctor with a copy of the medicine formulary as it applies to the specific Bestmed benefit option and the specific chronic condition. The chronic medicine application form and formularies are available on our website: www.bestmed.co.za.
2. Email the completed and signed application form, and include any additional supporting documentation as required to medicine@bestmed.co.za.
3. Once received, processing the application takes two to three working days. The member will be notified of the outcome of the application via e-mail/post.
4. If approved, the member will then be able to submit their treating doctor's prescription at a pharmacy to have their approved chronic medicine dispensed and reimbursed from the chronic medicine benefit.

Specific requirements for registration

Some of the chronic conditions require additional clinical information to qualify for registration.

The following table outlines the chronic conditions where additional information will be required, as well as the specific information that's necessary for each of these chronic conditions.

CONDITION	SPECIFIC REQUIREMENT
Addison's disease	Prescription required from endocrinologist or physician
Ankylosing spondylitis	Prescription required from a rheumatologist or physician
Anaemia	Most recent laboratory report required
Attention deficit disorder (ADD) Attention deficit hyperactivity disorder (ADHD)	Prescription required from a psychiatrist, paediatrician or neurologist
Alzheimer's disease	Mini-mental state examination (MMSE) required together with a prescription
Autism	Prescription required from a paeditrician, paediatric neurologist or child psychiatrist
Blepharospasm	Prescription required from a neurologist together with a motivation
Bronchiectasis, cystic fibrosis and pulmonary interstitial fibrosis	Prescription required from a pulmonologist or physician, or a paediatrician (in the case of a child)
Cerebral palsy	Prescription required from a neurosurgeon, neurologist, paediatric neurologist or paediatrician. Attach supporting clinical diagnostic report
Collagen disease/scleroderma and Paget's disease	Prescription required from a physician
Crohn's disease and ulcerative colitis	Prescription required from a gastroenterologist or physician with motivation and supporting documentation

CONDITION	SPECIFIC REQUIREMENT
Chronic obstructive pulmonary disease (COPD)	Lung function test (LFT) report is required, which includes the FEV1/FVC and FEV1 post-bronchodilator use.
Chronic renal disease	Application form must be completed by a nephrologist or physician. Attach supporting laboratory reports
Diabetes mellitus (Types 2)	Submit HbA1c blood test results and/or fasting blood glucose results, pre-treatment value and current values
Diabetes insipidus	Application form must be completed by an endocrinologist or physician
Epilepsy	EEG report must be submitted with the application, or a prescription from the neurologist is required or a paediatrician (in the case of a child)
Haemophilia	Prescription required from physician For initial applications: attach a laboratory report reflecting factor VIII or IX levels For medicine fill release: dosing chart is required
Hyperlipidaemia	Submit initial and most recent Lipogram results Lipogram results required
Multiple sclerosis	Prescription required from a neurologist with supporting scans for initial applications. Attach a report from a neurologist for applications for biologicals indicating: a. Relapsing – remitting history b. Extended disability status score (EDSS)
Osteoporosis	Most recent Bone Mineral Density (BMD) test results required
Polyarteritis nodosa/psoriatic arthritis and Sjögren's syndrome	Application form must be completed by a rheumatologist or physician
Psychiatric conditions	Prescription is required from a psychiatrist. A family practitioner may prescribe the following active ingredients: fluoxetine, citalopram, escitalopram and tricyclic anti-depressants
Rheumatoid arthritis	Prescription required from a rheumatologist. A family practitioner may also submit a prescription along with the pathology report

CHRONIC MEDICINE – ADDITIONAL INFORMATION

What is a formulary?

A formulary is a pre-determined list of medicines that will be covered for the CDL, non-CDL and PMB conditions. These lists of covered medicines vary from option to option. Bestmed makes use of formularies for each condition. These formularies are compiled and maintained by a team of professionals on the basis of evidence-based medicine, considering cost effectiveness and affordability.

Bestmed allows flexibility in terms of every member and dependant's choice of medicine. If a member chooses to make use of a product that is not on the formulary, a co-payment will be applicable. This co-payment varies between the different benefit options, and forms part of Bestmed's Scheme Rules.

What is an ICD-10 code?

An ICD-10 code is a diagnosis code, indicating the illness condition for which treatment is being received and is, therefore, compulsory on all medicine applications and prescriptions.

What is the CDL- and PMB-lists?

Chronic Disease List (CDL) and Prescribed Minimum Benefit (PMB) are lists of chronic conditions for which Bestmed must provide cover for both the medicine and treatment of the condition. Note: Option specific inclusions/ exclusions apply.

What is a non-CDL condition?

These are additional chronic conditions which may be covered by Bestmed, depending on your selected option. It's NOT compulsory for Bestmed to fund treatment of these conditions. Refer to our website at www.bestmed.co.za for the list of conditions covered per option.

What are PMBs?

Prescribed Minimum Benefits (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.

What is a treatment plan?

For every CDL and PMB chronic condition, where medicine is approved, there is a basic treatment plan that is also loaded. The treatment plan differs from condition to condition and can include consultations, pathology and radiology. These services are paid from Scheme benefits and not from the savings account. For each approved service, there is a maximum allowed per year.

How are claims paid for a treatment plan?

- On options that have a day-to-day limit (Beat4, Pace1, Pace2, Pace3 and Pace4), all services on the treatment plan are first pay from that limit and log to the applicable limit. For example, a claim for a consultation will first be paid from the day-to-day consultations limit. Once this limit is depleted, further claims against the treatment plan will be paid from Scheme risk with no monetary value limit, but the quantity limit on the treatment plan will still apply.
- Once the maximum on the treatment plan 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, from January, the new allocations are made.

General waiting periods and exclusions

If a member has a general three-month waiting period indicated by GEN on the membership certificate, the member is entitled to apply for CDL and PMB chronic benefits.

If a member has a 12-month condition specific waiting period, the member cannot apply for any services relating to that condition for a period of 12 months. The member can also not claim for CDL and PMB benefits if it relates to the specific condition.

Is the chronic medicine benefit allocated automatically?

No. To access the chronic benefit, pre-authorisation is compulsory. It's the member's own responsibility to apply for chronic benefits.

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.

What are generic medicines?

A generic medicine 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 Health Products Regulatory Authority (SAHPRA) 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 from 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.

What is the Mediscor Reference Price (MRP)?

The Mediscor Reference Price (MRP) is a reference pricing model applicable to all medicines with generic equivalents or biosimilars. MRP sets the maximum reimbursable price for generically similar or biosimilar products. This means that if you opt to use a medicine above MRP, you will have to pay the difference between the selected medicine and that of MRP. Reference pricing is applicable to all medicines, including formulary and non-formulary chronic medicines, as well as acute and over-the-counter (OTC) medicines.

What is a co-payment?

A co-payment is the portion of a claim payable by the member directly to the service provider. This co-payment cannot be paid automatically from the available savings account or vested savings account.

When do co-payments apply?

- Where a medicine is chosen for the treatment of a CDL, non-CDL or PMB condition that is not on the formulary.
- When the chosen medicine is above the MRP.
- When the provider charges a higher dispensing fee than that which the Scheme reimburses.
- Non-CDL conditions have standard co-payments for formulary medicine (except on Pace4).

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.

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.

What if I prefer not to use generic medicine?

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

What should I do if my chronic prescription changes?

Please send a copy of the prescription (please ensure the diagnosis codes are included on the prescription) to Bestmed at **medicine@bestmed.co.za** or fax **012 472 6760.**

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

One month prior to the date your medicine authorization expires, you must submit a copy of your latest prescription, including the ICD-10 code, with your member number to **medicine@bestmed.co.za** or fax **012 472 6760**.

Please submit your renewed script timeously to Bestmed to ensure correct payment of claims as no retrospective authorisations will be granted.

How often should I submit a chronic prescription to Bestmed?

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.

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.

How often can I claim for my approved chronic medicine?

Chronic medicine claims can be submitted every 24 days.

I'm travelling and need an advanced supply of my medicine?

Approval conditions

Bestmed can grant approval for a member to claim for an advanced supply of medicine in the following instances:

- If the member is going to a destination across the local border
- If the member is going overseas
- If the member is going to a destination where there is no pharmacy in the nearby vicinity (e.g., Kruger National Park)

Please note that Bestmed will not grant approval for an advanced supply of medicine when members are travelling within the borders of South Africa.

Approval process

The process for approval for takes up to five working days to complete. Please ensure that all required documentation is received together and timeously before the requested collection date

Please attach the following to the completed form:

- A copy of the flight ticket or travel document
- A copy of the prescription for the medicine required for collection
- This information can be emailed to **medicine@bestmed.co.za** or faxed to **012 472 6760.**

Who are the preferred providers for medicine?

These are pharmacies that have committed to providing cost-effective medicines at competitive dispensing fees which are capped at a lower level than non-network pharmacies. 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 providers, which 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.

Please visit **https://bestmed.co.za/content/medicine-and-chronic-benefits** for a list of the Bestmed Network Pharmacies. Alternatively, download the Bestmed App to find a pharmacy near you.

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 271 conditions as specified in Annexure A of the Regulations to the Medical Schemes Act 131 of 1998.
- A list of 26 chronic conditions which are also referred to as the Chronic Disease List (CDL).
- An emergency medical condition refers to the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment.

Please note: 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, which meets legislative requirements and supports cost containment, has been implemented for Bestmed members.

How do I 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 and signed by the treating provider as well as the member.
- If all the PMB criteria have been met and approval granted, funding a PMBs will first be paid from the day-to-day risk benefits and only thereafter the difference will be covered as a PMB.

Where can the PMB application form be obtained?

The form is available online and from Bestmed's Client Service Department at **086 000 2378** or by e-mailing a request to **pmb@bestmed.co.za**. Upon application submission, additional information may be requested from the member/provider(s).

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(s) will be informed of the outcome of the PMB application request via e-mail. PMB applications and/or related PMB enquiries can be submitted by contacting Bestmed's Client Service Department at **086 000 2378** or **service@bestmed.co.za.**

Completed application forms can also be e-mailed to **pmb@bestmed.co.za,** faxed to **012 472 6760** or posted to PO Box 2297, Pretoria, 0001.

PRESCRIBED MINIMUM BENEFITS - ADDITIONAL INFORMATION

How do I know that my application has been approved?

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

What happens once an application is approved?

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

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.

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 which are not listed PMB cases. If the hospitalisation was for a listed PMB, the practice or member needs to apply directly to Bestmed to possibly approve the shortfall as a PMB.

Making use of a designated service provider (DSP)

Making use of DSPs may ensure that claims are paid in full. Exceptions are made in case of emergencies, where no DSP is available or where a member cannot be accommodated within a reasonable time. Members have the choice to voluntarily use non-network providers. However, they may be charged with higher fees or co-payments for the member's own account.

Ambulance and emergency evacuation benefits

ER24 is contracted as the emergency response provider for Bestmed. ER24 provides paramedic services and ambulance transportation in the event of an emergency via a nationwide emergency number: 084 124. The cost of the service will be covered at 100% Scheme tariff if obtained and authorised from ER24 and is determined to be an emergency. **Where any ambulance is called for a non-emergency situation, the member will be responsible for all costs. ER24 is a Designated Service Provider (DSP), and if another service provider is called the cost will not be covered and be for the member's own account.**

When you require assistance, follow these steps:

Step1:

Call **084 124 or 010 205 3000,** the dispatcher will require:

- Your name.
- The nature of the emergency.
- The address of the emergency. Please ensure that the address is clearly stated including the province, suburb, street name and number, building/complex name and number. If possible, please provide the nearest landmark.
- Please inform security, if required, as to where the emergency is.
- Your contact number where you can be reached.

Step 2:

You will receive an SMS verifying the address of the emergency. The SMS will also provide a reference number for any future communication. Please check the SMS to confirm that the address has been correctly captured.

Step 3:

ER24 will dispatch a vehicle to the scene of the emergency. It may be an ER24 vehicle, or a service provider contracted to ER24, if there is no ER24 vehicle immediately available in the nearby vicinity.

Step 4:

Please inform the ambulance crew of a nearby Bestmed Designated Service Provider (DSP) hospital if possible. Depending on the nature of your emergency, the ambulance may be obliged to take you to the nearest medical facility.

What happens if I do not use ER24 in an emergency?

If you or a family member make voluntary use of a service other than ER24 for transportation, you will be liable for the cost of the service.

What does this benefit cover?

- Medical transportation in the event of an emergency by road or air ambulance, whichever is considered medically necessary by ER24, to the nearest appropriate medical facility.
- An upgrade in care from a medical facility, which does not have the appropriate care available to manage the patient's medical condition, to a facility that can manage the condition using the most appropriate ambulance transportation (road or air) as determined by ER24.
- One way transportation per hospital admission from one medical facility to another for the purpose of a diagnostic test for example a CT scan.
- Transportation from a registered medical facility to an oncology treatment centre. Up to a maximum of 3 times per admission.
- Transfer from a registered medical facility to a registered rehabilitation/step down facility, where there is authorisation in place from Bestmed.
- A call out fee if the ambulance crew are able to successfully treat the patient on scene and negate the need for a hospital visit e.g. asthmatics requiring nebulisation or diabetics requiring glucose administration.

What is not covered by this benefit

- Any ambulance transportation for conditions that are not a result of a medical emergency, whereby the service is used purely as a means of transportation. This includes transportation when a member is pregnant and is in normal term labour with no complications during the pregnancy.
- Any transportation to a home address or an old age home with no authorisation from Bestmed.
- Any transportation to a doctor's room for an appointment or for the purpose of an X-ray where no medical emergency exists, or for any procedure that could be done in the current medical facility.
- Any transportation from a home address or step down for any booked procedures or doctor's visit including dialysis or oncology treatment.
- Any transportation for any other reason other than that the referring medical facility is unable to manage the patient.
- Where an ambulance is dispatched, and the member is not transported due to personal reasons or the presenting condition not being a medical emergency.
- Ambulances called for the sole purpose of declaration of death.

COVID-19

Due to the increased volumes during the pandemic, members may experience longer waiting times for ambulances.

Members who have mild symptoms are advised to contact their local Family Practitioner instead of calling an ambulance.

Ambulances called for the assessment of a patient with COVID-19 symptoms or for the purpose of commencing an intravenous line will not be covered under the Bestmed benefit.

ER24 also provides other non-emergency services Bestmed members has access to. These can be accessed by phoning 084 124 and includes:

"Ask the nurse" medical information line can assist members with common queries such as:

- What to do to treat a fever.
- First aid for minor cuts, grazes, sprains, nosebleed.
- Do they need to go to a pharmacy, a Family Practitioner or go to hospital.
- Medication queries.

International Travel benefit

What does the International Travel Policy Cover?

The benefit covers you and your family for Medical Emergencies when you travel outside of South Africa.

The International travel insurance for Emergency Medical Conditions covers unforeseen and unexpected illnesses or accidental injuries (includes pre-existing medical conditions up to R250 000).

The cover provided is not a comprehensive medical scheme option and does not cover medical procedures that can be done in South Africa.

What is the benefit limit?

Leisure Travel: Emergency Medical & Related Expenses

Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 90 days, with R3 million for a family i.e. member and dependants.

Business Travel: emergency Medical & Related Expenses

Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 45 days, with R3 million for a family i.e. member and dependants.

What is covered?

- Emergency medical and related expenses
- Hospitalisation: outpatient and in-patient
- Emergency optical and dental expenses
- Medical repatriation, evacuation and transportation

Limits, excesses, terms and conditions apply. These are outlined in the policy wording and documents.

What is not covered (excluded)?

- Vaccines
- Traveling on a one-way airline ticket
- Cover for winter sports, adventure, and/or hazardous activities
- Cover not activated before you leave South Africa
- A child born whilst on the journey
- Treatment that the medical advisors are aware of will arise during the international journey or where a medical advisor has advised against travel
- Investigatory treatment that is not specified by the medical practitioner appointed by the insurer as immediately necessary
- Elective surgery, procedures or medical appointments, and travel specifically to obtain treatment abroad
- The benefits will not cover you if you intend to emigrate
- Expenses incurred in obtaining or replacing medication
- Additional costs arising from single or private room accommodation
- Treatment of services provided by a health spa, convalescent or nursing home, or any rehabilitation center unless agreed by the Emergency Assistance Service
- Any costs incurred by you to visit another person in hospital
- Any expenses incurred after you have returned to your home
- Any expenses incurred after the date we exercise our rights under this section to move you from one hospital to another and/or arrange your repatriation, but you decide not to be moved or repatriated
- Business travel undertaking manual labour

How to make sure you are covered before your departure

Call **0861 838 333** or email **bestmed-assist@linkham.com** to activate the international travel benefit when you are planning to travel out of the country. To be eligible to receive the benefits included in the international travel insurance policy, your premiums must be up to date and the travel insurance policy must be issued before your date of departure from the country of residence.

Please note that the turnaround time for receipt of the policy document is 24 business hours.
Please read the policy document carefully to ensure that you understand all the terms and conditions.

What information is required when requesting cover for an international trip?

- Member medical aid and plan
- Membership number
- Full names and surname as reflected in the passport
- ID number
- Contact numbers
- Departure date and date of arrival back in South Africa
- Destinations
- Are you traveling for business or leisure?
- Will you be participating in any hazardous pursuits of adventure sports?
- Do you have any pre-existing conditions?
- Email address to where the policy should be emailed
- Physical Address

If you require emergency assistance abroad

Emergency medical assistance is available 24 hours a day, 7 days a week. Call **0861 838 333** or email **assist@europassistance.co.za** as soon as possible if you need assistance. Reverse call charges are also accepted.

What must you do?

- Read the Policy Wording and Schedule of Benefits to familiarise yourself with what is covered and not covered
- Obtain your family's travel insurance policies before they leave on the trip
- Be fit and healthy to travel

In the event of an incident, it is your duty to contact the Emergency Assistance Services.

All hospital admissions, treatment and/or medical care need to be pre-authorised by Europ Assistance via telephone on **0861 838 333** or **email assist@europassistance.co.za**. Should pre-authorisation not have been obtained from Europ Assistance, they reserve the right to refuse reimbursement of your claim.

How to claim travel insurance?

- Visit **schengen.eclaims.europassistance.com** to get your Schengen travel insurance reimbursement quickly
- Click on "Online Processing"
- Attach the documents that serve as evidence of the cause for your claim, as well as the relevant invoices or documents

Europ Assistance will handle your request as soon as possible. You will be notified of any updates on your claim's status.

You will receive the payment within a few days once your request has been accepted. If you do not receive the payment within the given timeframe, send an email to **claimsschengen@roleurope.com**

Managed Care programmes and their benefits

In addition to the prescribed minimum benefits (PMBs). Bestmed offers Managed Care programmes that members can register for to receive additional support.

Our Managed Care programmes have specifically been developed to care for members by providing additional benefits to treat and manage the specific conditions with appropriate treatment in a cost-effective manner.
These programmes include:

- Oncology care
- Back and neck preventative care
- HIV/AIDS care
- Dialysis care
- Diabetes care
- Alcohol and substance abuse care
- Wound care
- Stoma care
- Maternity care
- Preventative care

For detailed information on each of these programmes, please download the Managed Care Guide 2023 available on the Bestmed website: **https://www.bestmed.co.za/resources/documents**

Preferred & designated service providers

Bestmed focuses on the establishment of different preferred and designated service provider (DSP) networks with the aim of making sustainable, high-quality healthcare services available to our members at affordable premiums. The network providers have committed to charging agreed network 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.

HEALTHCARE PROVIDER NETWORKS

Family practitioner (FP) network

These family practitioners (FPs) have committed to charging Scheme tariffs with no or minimum co-payments to the member.

Pharmacy network

These pharmacies have committed to providing cost-effective medicines at competitive dispensing fees. Their dispensing fees are capped at a lower level than non-network pharmacies. In addition, they have also committed to not charge co-payments over and above their contracted rates. Kindly visit the Bestmed website for a list of all our network pharmacies - **www.bestmed.co.za.**

Specialist network

Bestmed has a demographically representative, established specialist healthcare provider network. The main objective of the network is to offer sustainable high-quality specialist healthcare services at agreed network 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 which include emergencies, almost all of the cancers as well as some chronic conditions.

Members are encouraged to use the services of specialists in the Bestmed specialist designated service provider (DSP) network. By making use of a DSP, members will have no or minimum co-payments.

DSP network for PMBs

The specialist network, which includes all the major specialist disciplines, is a DSP network. Currently, there are 2 800 specialists on the network who are located across South Africa with rooms in, or have access to many general private hospitals. The coverage of this network also continues to grow with more and more providers joining each month. Bestmed members should, therefore, be able to easily access the specialists on the network.

Members are required to use a specialist from the DSP network for services related to their PMB conditions. Such services will be charged and paid for at the agreed DSP rate.

Should a member voluntarily choose not to use a specialist from the DSP network for a PMB, the Scheme will only pay up to the Scheme rate and any charges above this rate will be for the member's account.

Dental network

Bestmed has an extensive dental network which includes dentists, dental therapists and dental technicians. These providers have committed to charge Scheme tariff and the members can expect no or minimum co-payments.

Ancillary groups

The ancillary preferred provider network includes physiotherapists, occupational therapists, dietitians,

biokineticists, psychologists, speech therapists, audiologists, hearing aid acousticians, podiatrists, counsellors, registered nurses, midwives and clinical technologists. These groups each have their own Bestmed preferred provider network and have committed to charging Scheme tariff with no co-payments to the member.

Product supply networks

Bestmed established product supply networks with the following who have products available within the relevant option limits. These include: oxygen, drug-eluting stents and pacemakers, hip, knee, shoulder and spinal prosthesis and stoma.

SERVICE NETWORKS

Rehabilitation services

In addition, a Bestmed drug and alcohol rehabilitation designated service provider network was implemented as from January 2014. A list of the contracted drug and alcohol rehabilitation clinics with their locations across the country is available on our website.

Renal care for chronic dialysis

National Renal Care is contracted as the designated service provider for chronic dialysis. Please visit the National Renal Care website to search for a NRC - **www.nrc.co.za.**

Hearing aid devices supply and service networks

Bestmed has contracted individual audiologists and hearing aid acousticians, as well as Kind2Hearing and the Ear Institute. Both of these services offer contracted services in addition to cost-effective solutions.

Bestmed Service Provider Department Contact details

Telephone number **012 472 6343** or e-mail address **providers@bestmed.co.za**

*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.

Pre-authorisations

Regardless of their benefit option, members need to obtain pre-authorisation from Bestmed at least 14 (fourteen) days before going to hospital or having any elective surgery or specialised diagnostic imaging.

Granting of hospital authorisation shall be subject to, but not limited to, treatment protocols, funding guidelines, preferred providers, designated service providers (DSP) and network option services. Benefits shall be subject to the exclusions referred to in Annexure C of the registered Rules.

No benefits in a private hospital or day clinic shall be granted by the Scheme or its proxy if pre-authorisation and an authorisation number have not been obtained in advance:

- In the event of planned major operations and dental procedures at least 14 (fourteen) days before the event or shorter period where clinically indicated; or
- In the event of a life-threatening emergency admission after hours, over a weekend or on a public holiday, an authorisation number must be obtained on the first working day after the hospital admission. If the admission is not pre-authorised, members may have to pay the hospital expenses incurred.

Pre-authorisation helps to ensure that, with the information provided, 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-authorisation process includes the management of your stay and treatment in hospital. To obtain pre-authorisation, members must contact the authorisation centre with the following information ready:

- Membership number as printed on the membership card.
- The name of the patient, member or dependant(s) and their date of birth.
- Date of the operation (if applicable).
- The name and practice number of the treating doctor.
- The name and practice number of the hospital.
- 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.

For more information, visit our website at **www.bestmed.co.za** and follow the links on our website (Benefits > Benefit Management > Hospital Benefit Management). Please note that pre-authorisation does not guarantee payment of claims. For pre-authorisation contact **080 022 0106** or email **authorisations@bestmed.co.za.**

Claims

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 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.

Claim payments commence twice per week. Payment will reflect in your bank account the next day after the payment run. Please remember to attach your proof of payment and inform Bestmed of any changes to your 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 confirmation via e-mail once your claim was received and indexed. Should you have any queries, you can send an e-mail to **service@bestmed.co.za**. 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.

The claims process

- Scan and e-mail your claim to 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.
- Make use of the Bestmed App.

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.

Claims - 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. Members will also be able to view correspondence and statements, as well as scanned images of claims.

Members can register on the Bestmed website **www.bestmed.co.za**. Alternatively members can follow the steps set out on page 18 by means of the various print screens.

Medical savings account

Understanding your personal medical savings account (PMSA) will help you plan the use of your savings more effectively, and to avoid exhausting your PMSA before you might need it most. Through better planning and budgeting, you can ensure that you and your loved ones have access to medical services throughout the entire year.

We're always cognisant that each member's needs vary. Therefore, we have structured the medical savings differently for our various healthcare options.

Please note: Hospital plans like Beat1 and Beat1 Network, and the Rhythm range don't have any medical savings.

PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA): ANNUAL

Beat2/Beat2 Network	Beat3/Beat3 Network	Beat4	Pace1	Pace2	Pace3
16%	15%	14%	19%	14%	14%

Bestmed allows a certain percentage of the total annual contribution, in accordance with your selection of the abovementioned benefit options, towards a personal medical savings account (PMSA), also referred to as a medical savings account, and avails it in advance at the beginning of a benefit year or prorated if you joined during the year. The funds in your PMSA shouldn't be used to pay the costs pertaining to PMB services or offset contributions.

Medical expenses for services rendered out-of-hospital - e.g. day-to-day benefits, during the year - are paid from that year's annual savings account first. Please refer to your benefit summary for more detail.

Once your medical savings account has been depleted during a financial year, you will have to pay for out-of-hospital expenses yourself or you'll qualify for specific day-to-day benefits as per option-specific rules.

Any unused funds which accumulate in your medical savings account at the end of the year, will be carried over to the next year to your credit into your medical savings account or 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 will be refunded to you after a period of five months or be transferred on a compulsory basis to the savings account of the new medical scheme option or where you enrol as a member.

Should you, in the above instance, have exceeded the amount in your medical savings account, you'll have to refund this to the Scheme.

Active members will be liable for any debit balance in the PMSA arising during or at the end of the financial year, and this balance is repayable to the Scheme. 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, e.g. due to option changes during the financial year and/or the termination of a dependant(s). The Scheme may also use the funds in the PMSA of the following year to settle the debt.

Pace4
3%

On the Pace4 option, a savings amount equal to 3% of your total annual contribution is made available in advance at the beginning of the benefit year. The savings can be used to pay for valid claims when the day-to-day risk benefits are depleted.

VESTED MEDICAL SAVINGS ACCOUNT (VMSA)

Beat4	Pace1	Pace2	Pace3

Unused funds which accumulate in your medical savings account at the end of a benefit year will be carried over to the credit of your VMSA account after a period of five months.

Any vested credit in your VMSA may be used to pay for out-of-hospital expenses, e.g. day-to-day benefits which have been paid at Scheme tariff 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 VMSA at the end of a financial year will be carried over to the credit of your VMSA for the next year.

A member may claim, upon his/her request, for any co-payments or shortfalls for which he/she is liable, except in respect of PMB services, membership contributions and the self-payment gap, and shall be entitled to claim for all healthcare services as provided for in Annexure B.4 of the Scheme Rules at Scheme tariff, subject to the availability of sufficient funds at the date when a claim is processed.

Should you resign from the Scheme in the duration a benefit year, the funds in your VMSA will be refunded to you after a period of 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.

What if my savings account is depleted?

Depending on your healthcare option, certain out-of-hospital medical expenses are paid from your PMSA. Once the allocated funds have been depleted, you'll pay for out-of-hospital expenses yourself or from the VMSA.

What is a VMSA?

A VMSA is an account to which unused medical savings are transferred after a period of 5 months or at the beginning of the financial year, according to the healthcare option's structure. The VMSA could be used for out-of-hospital expenses. Any interest earned shall accrue to the VMSA balance. No cross-subsidisation applies to the VMSA.

Conditions for payments from your PMSA

- Your PMSA is used solely for medical expenses pertaining to day-to-day benefits, subject to the exclusions referred to in Annexure C of the Scheme Rules (Scheme Rules and Annexures are available at **www.bestmed.co.za**.
- The funds in your PMSA shouldn't be used to pay the costs pertaining to PMB services or offset contributions.
- On admission to the Scheme a 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 Scheme tariff.
- 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 dependants who continue membership of the Scheme or paid into his estate in the absence of such dependants.
- On transfer to another option of the Scheme, which doesn't provide for such an account, any balance in the PMSA will be refunded to the member 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 a PMSA, the balance due to the member will be refunded to the member 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 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. On termination of membership, funds in the member's PMSA may be used to offset any debt owed by the member, including outstanding contributions.
- On active membership, 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. 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, e.g. due to option changes during the financial year and/or the termination of a Dependant(s). The Scheme may also use the funds in the PMSA of the following year to settle the debt.

Rights and responsibilities

New members

Please provide the Scheme with your most recent contact details, e.g. telephone number, cell phone number, residential and postal address, and email address. This will ensure that all Scheme communication and/or other items you may have requested, e.g. a replacement membership card, are delivered to you. Please be on the look out of communication to confirm the address for the delivery of your card.

Remember to download the Bestmed App to your smart device from the **Apple App store**, **Google Play** or **Huawei App Gallery**. The App enables you to:

- Access to your digital membership card
- Find a service provider
- Submit a claim
- Check your available benefits
- Email your membership card to service providers
- Check your Health Assessment results
- Update contact details for dependants 18 years and older
- Submit your chronic application/prescription.

Bestmed provides healthcare cover and related service to individual members, as well as employer groups.

Please note: Underwriting will be applied according to the approved underwriting policy. Applicants will be notified of any applicable underwriting.

Dependants

Bestmed recognises the following people as dependants:

- A member's spouse or partner who is not a member or a registered dependant of a member of another scheme;
- A member's dependent child who is under the age of 24 years and not a member or a registered dependant of a member of another scheme;
- A parent, brother or sister of a member in respect of whom the member is liable for family care and support, and
- for whom adult Dependants contributions shall be payable, if such dependant is older than 24 years of age;
- A member's child who is 24 years or older, registered as a student at a school or other educational institution recognised and accepted as such by the Board, and has not reached the age of 26 years for whom child dependant's contributions shall be payable, provided that:
  - Proof acceptable to the Board is submitted to the effect that the child is a registered student at the institution in question; and

- The child is not enrolled as a member or a dependant of a member of another scheme.

- A member's child who is 24 years or older in respect of whom the member is liable for family care and support, or because of a mental/physical handicap or for any similar reason is dependent on the member and an adult dependant's contribution shall be payable.

How to register a new dependant

Please visit our website www.bestmed.co.za, or contact your Human Resources (HR) Department, if applicable, to complete the relevant application forms.

Changing your healthcare option

You're allowed to change options at the end of the year to be effective from January. You can change your benefit option by completing the relevant Benefit Option Choice form which is available at www.bestmed.co.za or by contacting Bestmed to ensure that you make an informed decision.

Telephone number: 086 000 2378
Fax number: 012 472 6500
E-mail address: membership@bestmed.co.za

If you're 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 (if applicable). Individual members may send the option changes directly to Bestmed.

Changes to benefit options are permitted to all members from the beginning of a financial year in accordance with the provisions of the registered Rules. However, should you wish to apply to the Scheme to change your benefit option as a special concession during a financial year, due to a newly diagnosed life-threatening medical condition, this will be at the full discretion of the Scheme. In the event that the request is approved by the Scheme, for example from October 2023, then the option change will be valid for the 2024 financial year as well. Therefore, you will only be able to change your option again to be effective from January 2025.

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 Annexures are published on our website at www.bestmed.co.za. Your benefits may change annually and it's, 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 (if applicable) and claims refunds.

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

A member shall notify the Scheme, and his employer, where applicable, in writing within 30 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.

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

Pro rata benefits

If you join Bestmed after 1 January in any year, you'll receive pro rata benefits. This means that we'll reduce your annual limits in proportion to the number of months remaining in that year. Bestmed benefits are calculated for a period of 12 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. If you change your status during a year and your savings balance is negatively impacted, you will be expected to settle the outstanding amount immediately. A negative amount on your claims statement is confirmation of the expenditure amount.

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 didn't 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 didn't belong to a medical scheme. Remember that the late-joiner penalty is only calculated on risk contribution and not the PMSA.

NUMBER OF YEARS SINCE AGE 35 WHEN APPLICANT WASN'T 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. If you haven't been a member of another medical scheme for the past 6 years, we need to apply a penalty of 0.25, i.e. R900 x 0.25 = R225 (the penalty payable).

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

MEMBERSHIP CONTRIBUTIONS

Total monthly contributions

The total monthly contributions payable to the Scheme by or in respect of a member are as stipulated in Annexure A of 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).

Due date for contributions

Contributions shall be due monthly in advance or in arrears as shall be determined and approved by the Scheme, on the following dates:

- On the 20th; or
- On the 25th; or
- On the 1st; or
- As agreed upon between the Scheme and an employer, and be payable by not later than the third day after each respective due date of each month.

Where subscriptions owing to the Scheme haven't 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 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 three months from the date the amount was due, the Scheme shall terminate the membership with retrospective effect.

If you are a corporate member, in other words your employer deducts the monthly contribution from your salary and pays the amount on your behalf, it remains your responsibility to ensure that the correct deductions are deducted. Bestmed will inform you directly if there are any outstanding balances older than 90 days. Please contact your Payroll representative(s) should you have any queries.

Waiting periods

The Medical Schemes Act allows medical schemes 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:

- **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/she received medical advice, diagnosis, care or treatment during the 12 months before he/she applied to join Bestmed.
- **General waiting period –** this is a specified period of time during which a beneficiary isn't entitled to claim any benefits for the first 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.

TERMINATION OF MEMBERSHIP

Voluntary resignation

Members are allowed to terminate their membership with 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 on request.

Positive balances in your PMSA will be transferred to the new medical scheme if it has a similar account or we will refund you upon receipt of a copy of your ID and confirmation of your bank details, if the new scheme does not have a similar account. The transfer will be done within 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 of whether he/she receives financial assistance from an employer. An employer subsidy remains a matter between the member and the employer.

Cancellation of membership by the Scheme

Bestmed may cancel or suspend membership on the following conditions:

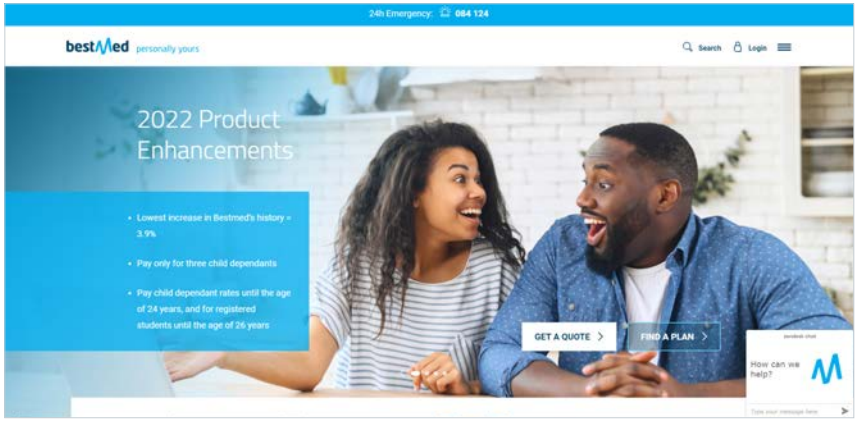
- Non-disclosure of material information such as if you failed to inform the Scheme about a certain medical condition.
- Failure to pay contributions as stated in the rules.
- Submission of fraudulent claims or committing of any fraudulent activity.

Please note: Bestmed will be in contact with members during the cancellation process to allow for the opportunity to make the necessary arrangements.

Member communication channels

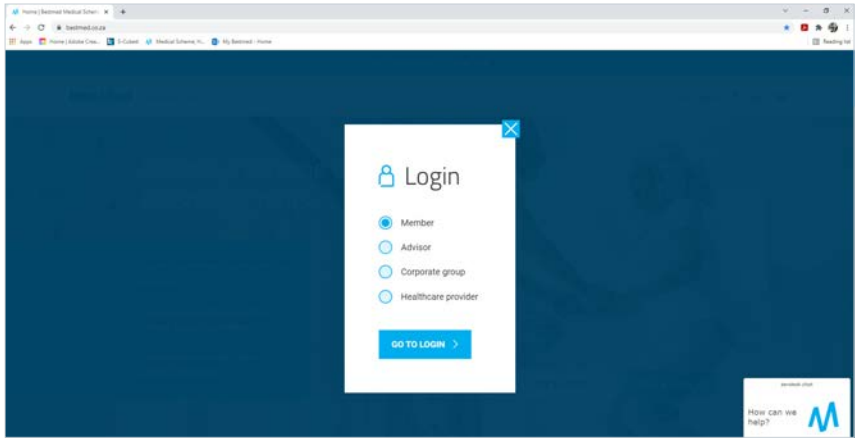
At Bestmed, our official language of communication is English. On specific request, our Client Service Department can assist a member in any of South Africa's 11 official languages.

1



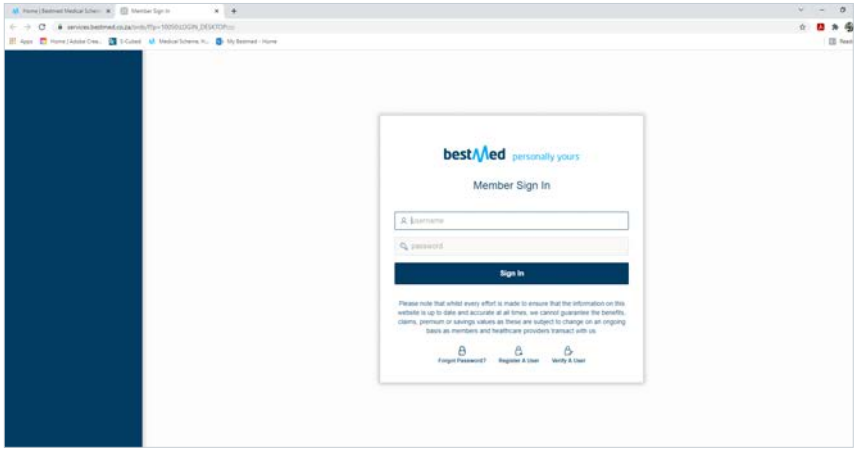
Click top right on "Login" to gain access to the member portal.

2



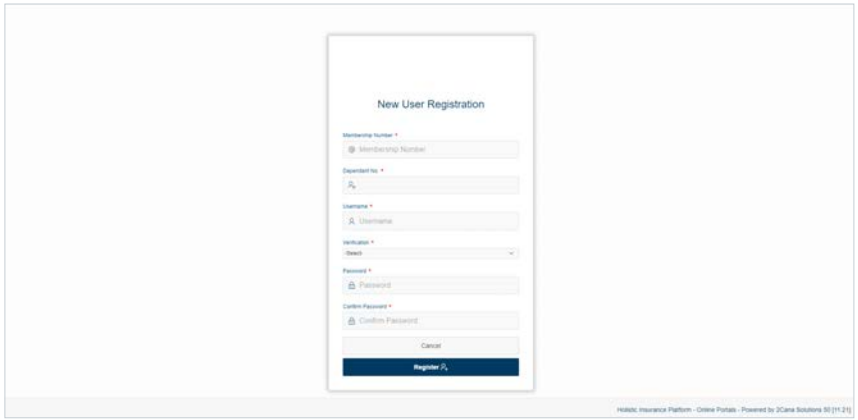
Select the "Member" option and click on "Go to Login".

3



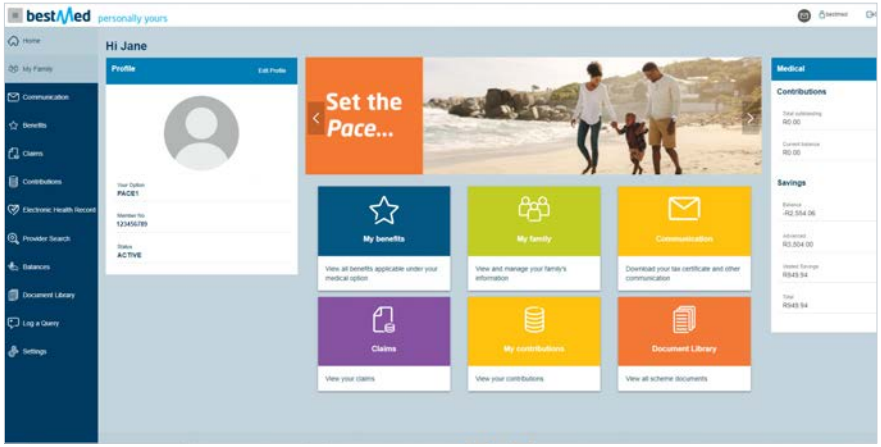
If you've registered previously, log in by entering your username and password. If you haven't yet registered, click on "Register a User" to register.

4



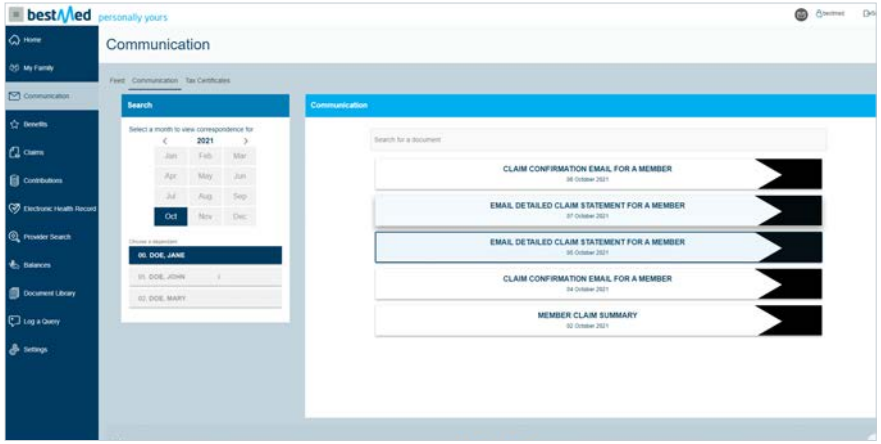
When you register as a new user, you will be asked to confirm your contact details (e.g. an e-mail address or a mobile number). A one-time pin will be sent to you via your chosen contact method.

5



Once you have logged in, this screen will appear. You can view your claims and any other correspondence sent to you from Bestmed here. All the calls/queries you've logged, as well as the outcomes, are found here.

6



Click on the correspondence link to access your required information.

EASY ONLINE SERVICES

Connecting with Bestmed

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

The Client Service Department

Members will be assisted in English, Afrikaans and the other official languages. Bestmed aims to provide a one-stop service for members at the Client Service Department but it may also be necessary for a consultant to refer clinical enquiries to specific departments.

If a member is not satisfied with a response, then he/she may choose to escalate the process. This is set out under the heading "Escalation of Queries" on page 22 of this guide.

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

Our Client Service Department can be reached on 086 000 2378 or by e-mailing at service@bestmed.co.za. Office hours are from Monday to Friday 08:00 - 17:00, Saturday 08:00 - 13:00.

Walk-in facility

For those who prefer to speak to a consultant face to face, we have a walk-in facility at our head office, situated in Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria. In addition to the walk-in facility, we have regional offices in five (5) provinces - please see page 26 for contact details.

The website

Bestmed's user-friendly website, www.bestmed.co.za, is designed not only to provide members with the latest information on various programmes and benefit options, it's also a dedicated portal for individual members, corporate members, corporate administrators and other stakeholders.

The Bestmed News

The Scheme sends Bestmed News, the member newsletter, to members monthly. The newsletter contains information regarding the latest developments in Bestmed and/or the healthcare industry, and tips for healthy living.

Social media

Bestmed is also available on social media networks where members share their stories and the Scheme keeps followers 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.

Bestmed App

Bestmed launched its App in 2015. Today, we've just made it appreciably better! So, if you haven't already downloaded the Bestmed App onto your smartphone, there's no better time to do it than right now.

CHATNOW

ChatNow is an instant messaging service which allows members and healthcare service providers to communicate in real time with a Bestmed consultant via a multimedia device. ChatNow enables us to provide immediate support via instant messaging as an additional channel of communication. ChatNow is designed for low to moderate queries to enable fast responses.

How to use the ChatNow functionality

- Visit **www.bestmed.co.za.**
- Click onto ChatNow pop-up tab on the bottom right-hand side of our website's home page.
- A pop-up will appear requesting your name, member number (optional), e-mail address and the nature of your question. You will be required to select the relevant department to deal with your query from a drop-down list.
- Once you have submitted the details, the name of the consultant you're connected to will appear on the screen.
- Your conversation will begin from there.

ANNUAL REPORT

To coincide with its Annual General Meeting that's open to all Bestmed members, the Scheme produces its annual report. Amongst other things, this report outlines:

- Regulatory challenges.
- Key sustainability issues which 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.

Role of the advisor

Advisors adhere to the values of best practice, offering their clients the opportunity to make a decision from only the best medical scheme benefit options.

Members have the option of joining any medical scheme directly, without the assistance of an advisor. However, the assistance of an advisor can be instrumental in assisting you to make the best possible choice when it comes to selecting a healthcare option that best suits your personal needs.

In instances where an advisor 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.

An advisor needs to provide you as member with adequate information and explain all necessary terminology.

Please note: Advisors are not in a position to make any commitments to clients in which they bind or attempt 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.

REGULATORY BODIES AND COMPLIANCE

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. Some of the strategic objectives of the CMS are to ensure an appropriate level of protection for the beneficiaries (members and their registered dependants) of medical schemes and to ensure that all entities conducting the business of medical schemes comply with the Medical Schemes Act.

The CMS also ensures that complaints raised by members are handled appropriately and speedily. In order to facilitate this process, the CMS advises the following:

Escalation of queries

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 isn't obligatory.

Bestmed continually strives to offer the best value-for-money products supported by superior client service to make your dealings with Bestmed efficient and to your satisfaction. If you're not satisfied with Bestmed's service, e-mail your complaint to **escalations@bestmed.co.za** (Subject box: Manager, escalated query) or write to us at PO Box 2297, Pretoria, 0001. Bestmed has a dedicated division which handles escalated queries. For everyday complaints and queries you can contact our Client Service Department on **086 000 2378**.

Escalation to CMS

Should all efforts fail to resolve an issue with your scheme, you can escalate your complaint to the CMS' Complaints Unit.

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's, 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 16:30.

Fax Complaints: 086 673 2466.

E-mail Complaints: complaints@medicalschemes.co.za

Postal Address: Private Bag X34, Hatfield, 0028.

Physical Address: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157.

Financial Sector Conduct Authority (FSCA)

The Financial Advisory and Intermediary Services Act, 37 of 2002 (FAIS Act), came into operation on 30 September 2004. The purpose of the FAIS Act is to protect consumers of financial services and to professionalise the financial services industry. To achieve this, the FAIS Act imposes certain requirements on providers of financial services to ensure that consumers receive proper financial advice, that they are provided with sufficient information to make informed investment decisions and that they are dealing with fit and proper advisors and intermediaries.

The FAIS Act requires that any person who gives advice and/or renders an intermediary service in respect of a financial product must be authorised as a financial services provider, also referred to as an FSP, or must be appointed as a representative of an authorised financial services provider.

The Financial Sector Conduct Authority (FSCA) is responsible for market conduct regulation and supervision. They aim to enhance and support the efficiency and integrity of financial markets and to protect financial customers by promoting the fair treatment by financial institutions.

	FSCA	
Contact centre	0800 20 37 22	
Switchboard	012 428 8000	
Enquiries	enquiries@fsca.co.za	
Complaints	complaints@fsca.co.za	
Information centre	library@fsca.co.za	
Anonymous fraud and ethics	fsca@behonest.co.za	
Tip-offs:	0800 313 626	
Web:	www.fsca.co.za	
Address:	41 Matroosberg Road, Ashlea Gardens, Pretoria, 0002	PO Box 35655, Menlo Park, 0102

The information Regulator (South Africa)

The Protection of Personal Information Act, 2013 (POPIA) empowers the Information Regulator (South Africa), among other things, to monitor and enforce compliance with the provisions of POPIA by public and private bodies. The Information Regulator is also responsible for the regulatory mandate functions relating to the Promotion of Access to Information Act (PAIA) 2000.

PROTECTION OF PERSONAL INFORMATION

What is POPIA?

POPIA stands for the Protection of Personal Information Act, 4 of 2013. It seeks to protect the personal information of all citizens, while striking a balance between the right to privacy and the need for the free flow and access to information, in order to regulate how personal information is processed.

POPIA is applicable to anyone who keeps any type of records relating to information of a personal nature. It sets the minimum standards for the protection of personal information. It also regulates the processing of personal information. Processing includes collecting, receiving, recording, organising, retrieving, using, and dissemination of such information. As a member, you are protected in terms of POPIA.

You are encouraged to familiarise yourself with Bestmed's Data Protection and Privacy Policy, which deals with the manner in which we process your personal information. You may access the policy by visiting **https://www.bestmed.co.za/content/privacy-policy** or by logging on to **www.bestmed.co.za.**

PROMOTION OF ACCESS TO INFORMATION

What is PAIA?

PAIA stands for the Promotion of Access to Information Act (PAIA) 2000. It seeks to promote transparency, accountability and effective governance of all public and private bodies, as well as to assist members of the public to effectively scrutinize and participate in decision making by public bodies.

PAIA also encourages openness and is there to establish mechanisms or procedures which give effect to the right of access to information in a speedy, inexpensive, and easy manner.

We encourage you to familiarise yourself with Bestmed's PAIA Manual, which explains, among other things, how to make a request for access to records held by Bestmed, the costs involved and lists the categories of records held by Bestmed which are available without a person having to submit a formal PAIA request. You may access the PAIA Manual policy by logging on to **www.bestmed.co.za.**

At Bestmed, we place a high premium on the privacy of our members, and we acknowledge the importance of ensuring that your personal information is handled with care.

In the event that you are of the view that we are not complying with POPIA or PAIA, you can notify us by emailing us at **service@bestmed.co.za** or by calling us on **086 000 2378.**

You have the right to lodge a complaint with the Information Regulator. We however implore you to address any concerns with us first and we will try our outmost best to address any concerns raised.

The contact details of the Information Regulator are as follows:

Physical address: House 27 Stiemens Street, Braamfontein, Johannesburg 2001

Postal address: PO Box 31533, Braamfontein, Johannesburg, 2107

E-mail: **enquiries@inforegulator.org.za -** for general enquiries

PAIAComplaints@inforegulator.org.za - should your PAIA request be denied or there is no response from a public or private bodies for access to records you may use this email address to lodge a complaint.

POPIAComplaints@inforegulator.org.za – should you feel that your personal information has been violated, you may use this e-mail address to lodge a complaint.

Bestmed hotline

Bestmed has decided to act proactively 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 doesn't know the location thereof. Furthermore, Bestmed cannot demand that the identity of the caller be revealed.

How to contact the Bestmed hotline

1. Dial 0801 11 02 10 toll free from any Telkom telephone
   Email the hotline anonymously at: **fraud@kpmg.co.za**
   Fax details anonymously to **0800 200 796.**
   Details can be posted free of charge to the following address:
   KPMG Hotpost, BNT371, PO Box 14671, Sinoville, 0129.
2. You may remain anonymous. Provide full details in respect of the fraudulent, corrupt or unethical practice to the call operator including that the report is in respect of Bestmed. 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).

ABBREVIATIONS	
DBC	Documentation Based Care (back rehabilitation programme)
DSP	Designated Service Provider
FP	Family Practitioner
HPV	Human Papilloma Virus
M	Member
M1+	Member and Family
MRI/CT Scans	Magnetic Resonance Imaging/Computed Tomography Scans
NPWT	Negative Pressure Wound Therapy
PET Scan	Positron Emission Tomography Scan
PMB	Prescribed Minimum Benefits
PPN	Preferred Provider Negotiators
PSA	Prostate Specific Antigen

GLOSSARY

Scheme tariff

The negotiated rate for hospitals and designated or preferred service providers. For all other service providers, 100% of the National Health Reference Price List (NHRPL) for health care services published in 2006 plus percentage indicated in the rules as approved by the Board of Trustees annually.

Scheme risk

Contributions paid by members which are pooled by the Scheme for the benefit of all members and their dependants. Unused funds not used by a member are not carried over to the next year. The funds in a member's savings accounts do not form part of the risk pool and are used for the exclusive benefit of the member and his/her dependants.

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. An additional 18 conditions are covered as Prescribed Minimum Benefits (PMB), where the medical management and medicines are also covered from Scheme benefits. Non-CDL chronic conditions are those additional conditions that Bestmed provides chronic medicine cover for. Authorisation for CDL, PMB and non-CDL chronic medicines is subject to clinical funding guidelines and protocols, formularies and Designated Service Providers (DSPs) where applicable. Approved CDL and PMB chronic medicines are covered without an annual financial limit while non-CDL chronic medicines are subject to an annual financial limit. Below is the list of CDL, PMB and non-CDL conditions that Bestmed covers on the various benefit options.

	BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
Number of non-CDL conditions	0	0	5	9	7	20	20	29	0
Reimbursement for CDL & PMB	100% of Scheme tariff								
Reimbursement for non-CDL	N/A	N/A	80%	90%	90%	90%	90%	100%	N/A
Non-formulary co-payment for CDL and PMB conditions	30%	30%	30%	20%	25%	20%	15%	10%	30%
Formulary co-payment for non-CDL conditions	N/A	N/A	20%	10%	10%	10%	10%	0%	N/A
Non-formulary co-payment for non-CDL conditions	N/A	N/A	30%	20%	25%	20%	15%	10%	N/A

CDL									
CDL 1	Addison's disease	√	√	√	√	√	√	√	√	√
CDL 2	Asthma	√	√	√	√	√	√	√	√	√
CDL 3	Bipolar mood disorder	√	√	√	√	√	√	√	√	√
CDL 4	Bronchiectasis	√	√	√	√	√	√	√	√	√
CDL 5	Cardiac failure	√	√	√	√	√	√	√	√	√
CDL 6	Cardiomyopathy	√	√	√	√	√	√	√	√	√
CDL 7	Chronic obstructive pulmonary disease (COPD)	√	√	√	√	√	√	√	√	√
CDL 8	Chronic renal disease	√	√	√	√	√	√	√	√	√
CDL 9	Coronary artery disease	√	√	√	√	√	√	√	√	√
CDL 10	Crohn's disease	√	√	√	√	√	√	√	√	√
CDL 11	Diabetes insipidus	√	√	√	√	√	√	√	√	√
CDL 12	Diabetes mellitus type 1	√	√	√	√	√	√	√	√	√
CDL 13	Diabetes mellitus type 2	√	√	√	√	√	√	√	√	√
CDL 14	Dysrhythmias	√	√	√	√	√	√	√	√	√
CDL 15	Epilepsy	√	√	√	√	√	√	√	√	√
CDL 16	Glaucoma	√	√	√	√	√	√	√	√	√
CDL 17	Haemophilia	√	√	√	√	√	√	√	√	√
CDL 18	HIV/AIDS	√	√	√	√	√	√	√	√	√
CDL 19	Hyperlipidaemia	√	√	√	√	√	√	√	√	√
CDL 20	Hypertension	√	√	√	√	√	√	√	√	√
CDL 21	Hypothyroidism	√	√	√	√	√	√	√	√	√
CDL 22	Multiple sclerosis	√	√	√	√	√	√	√	√	√
CDL 23	Parkinson's disease	√	√	√	√	√	√	√	√	√

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
CDL 24	Rheumatoid arthritis	√	√	√	√	√	√	√	√	√
CDL 25	Schizophrenia	√	√	√	√	√	√	√	√	√
CDL 26	Systemic lupus erythematosus (SLE)	√	√	√	√	√	√	√	√	√
CDL 27	Ulcerative colitis	√	√	√	√	√	√	√	√	√
NON-CDL										
non-CDL 1	Acne - severe			√	√	√	√	√	√	
non-CDL 2	Allergic rhinitis			√	√	√	√	√	√	
non-CDL 3	Alzheimer's disease						√	√	√	
non-CDL 4	Ankylosing spondylitis						√	√	√	
non-CDL 5	Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ADHD)			√	√	√	√	√	√	
non-CDL 6	Autism						√	√	√	
non-CDL 7	Blepharospasm								√	
non-CDL 8	Collagen diseases						√	√	√	
non-CDL 9	Dermatomyositis						√	√	√	
non-CDL 10	Dystonia								√	
non-CDL 11	Eczema			√	√	√	√	√	√	
non-CDL 12	Gastro-oesophageal reflux disease (GORD)				√		√	√	√	
non-CDL 13	Gout prophylaxis				√	√	√	√	√	
non-CDL 14	Hypopituitarism								√	
non-CDL 15	Major depression*				√	√	√	√	√	
non-CDL 16	Migraine prophylaxis			√	√	√	√	√	√	
non-CDL 17	Motor neuron disease								√	
non-CDL 18	Neuropathy						√	√	√	
non-CDL 19	Obsessive compulsive disorder				√		√	√	√	
non-CDL 20	Osteoarthritis						√	√	√	
non-CDL 21	Osteoporosis						√	√	√	
non-CDL 22	Paget's disease						√	√	√	
non-CDL 23	Polyarteritis nodosa								√	
non-CDL 24	Psoriatic arthritis								√	
non-CDL 25	Psoriasis						√	√	√	
non-CDL 26	Urinary incontinence						√	√	√	
non-CDL 27	Scleroderma								√	
non-CDL 28	Sjogren's disease								√	
non-CDL 29	Trigeminal neuralgia								√	

* Approved medicine claims will continue to be paid from Scheme risk once the non-CDL limit is depleted.

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
PMB										
PMB 1	Aplastic anaemia	√	√	√	√	√	√	√	√	√
PMB 2	Benign prostatic hypertrophy	√	√	√	√	√	√	√	√	√
PMB 3	Cerebral palsy	√	√	√	√	√	√	√	√	√
PMB 4	Chronic anaemia	√	√	√	√	√	√	√	√	√
PMB 5	COVID-19	√	√	√	√	√	√	√	√	√
PMB 6	Cushing's disease	√	√	√	√	√	√	√	√	√
PMB 7	Cystic fibrosis	√	√	√	√	√	√	√	√	√
PMB 8	Endometriosis	√	√	√	√	√	√	√	√	√
PMB 9	Female menopause	√	√	√	√	√	√	√	√	√
PMB 10	Fibrosing alveolitis	√	√	√	√	√	√	√	√	√
PMB 11	Graves' disease	√	√	√	√	√	√	√	√	√
PMB 12	Hyperthyroidism	√	√	√	√	√	√	√	√	√
PMB 13	Hypophyseal adenoma	√	√	√	√	√	√	√	√	√
PMB 14	Idiopathic trombocytopenic purpura	√	√	√	√	√	√	√	√	√
PMB 15	Paraplegia/Quadriplegia	√	√	√	√	√	√	√	√	√
PMB 16	Polycystic ovarian syndrome	√	√	√	√	√	√	√	√	√
PMB 17	Pulmonary embolism	√	√	√	√	√	√	√	√	√
PMB 18	Stroke	√	√	√	√	√	√	√	√	√

CLIENT SERVICES
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Fax: +27 (0)12 472 6500

HIV/AIDS CARE PROGRAMME
Tel: +27 (0)12 472 6235/6249
Email: mhc@bestmed.co.za
Fax: +27 (0)12 472 6780

BESTMED HIV/AIDS MANAGED CARE ORGANISATION
LIFESENSE

Tel: +27 (0)86 050 6080
Email: enquiry@lifesense.co.za
Fax: +27 (0)86 080 4960

BESTMED DSP PHARMACIES
Please refer to the Bestmed website, www.bestmed.co.za, for network pharmacies in your area.

ONCOLOGY CARE PROGRAMME
Tel: +27 (0)12 472 6254/6234/6353
Email: oncology@bestmed.co.za
Fax: +27 (0)12 472 6770

ESCALATIONS
Tel: +27 (0)86 000 2378
Email: escalations@bestmed.co.za or e-mail the Executive of Corporate Services and Wellness at: Elmarie.Jooste@bestmed.co.za (Subject box: Manager, escalated query)
Postal address:
PO Box 2297,
Pretoria, Gauteng, 0001

CMS ESCALATIONS
Should an issue remain unresolved with the Scheme, members can escalate to the Registrar's office:

Fax Complaints: 086 673 2466.

Email Complaints: complaints@medicalschemes.co.za

Postal Address:
Private Bag X34, Hatfield, 0028

Physical Address:
Block A, Eco Glades 2 Office Park,
420 Witch-Hazel Avenue, Eco Park,
Centurion, 0157

REGIONAL OFFICES

Pretoria (Head Office)
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Glenfield Office Park,
361 Oberon Avenue,
Faerie Glen, Pretoria, 0081

Cape Town
Tel: +27 (0)21 202 8808
Email: service@bestmed.co.za
Eagle House, 92 Edward Street,
3rd Floor, Office 302,
Tygervalley, 7530

Durban
Tel: +27 (0)31 279 5420
Email: service@bestmed.co.za
21 Lighthouse Road,
Beacon Rock, Suite 117,
Entrance 5, Umhlanga, 4319

Gqeberha (Port Elizabeth)
Tel: +27 (0)41 363 8921
Email: service@bestmed.co.za
142 Cape Road, Mill Park,
Gqeberha, 6001

Nelspruit
Tel: +27 (0)13 101 0280
Email: service@bestmed.co.za
Crossing Office Block,
Level 1, Block E,
Crossing Shopping Centre,
Nelspruit, 1200.

Polokwane
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Unit 3 Tobara Place,
9 Watermelon Street,
Platinum Park, Bendor,
Polokwane, 0699

086 000 2378

service@bestmed.co.za

068 376 7212

012 472 6500

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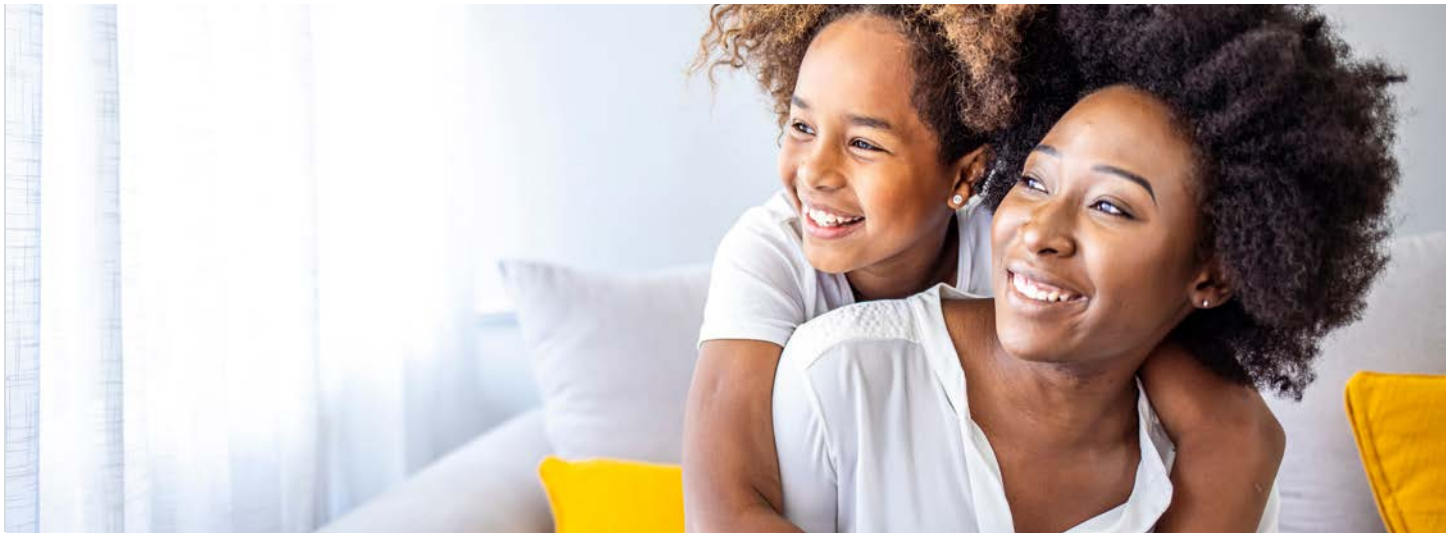

HOSPITAL AUTHORISATION
Tel: 080 022 0106
Email: authorisations@bestmed.co.za

CHRONIC MEDICINE
Tel: 086 000 2378
Email: medicine@bestmed.co.za
Fax: 012 472 6760

CLAIMS
Tel: 086 000 2378
Email: service@bestmed.co.za (queries)
claims@bestmed.co.za (claim submissions)

WALK-IN FACILITY
Block A, Glenfield Office Park,
361 Oberon Avenue, Faerie Glen,
Pretoria, 0081, South Africa

POSTAL ADDRESS
PO Box 2297, Arcadia,
Pretoria, 0001, South Africa

INTERNATIONAL TRAVEL INSURANCE (EUROP ASSISTANCE)
Tel: 0861 838 333
Claims and emergencies:
assist@europassistance.co.za
Travel registrations:
bestmed-assist@linkham.com

TEMPO WELLNESS PROGRAMME
Tel: 086 000 2378
Email: tempo@bestmed.co.za
https://www.bestmed.co.za/tempo-wellness/tempo-wellness-programme

MATERNITY CARE
Tel: 012 472 6797
Email: maternity@bestmed.co.za

ER24 (AMBULANCE SERVICES)
Tel: 084 124

BESTMED HOTLINE, OPERATED BY KPMG
Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed, members, service providers or employees, please report this anonymously to KPMG.

Hotline:	080 111 0210 toll-free from any Telkom line
Hotfax:	080 020 0796
Hotmail:	fraud@kpmg.co.za
Postal:	KPMG Hotpost, at BNT 371, PO Box 14671, Sinoville, 0129, South Africa

INDIVIDUAL CLIENTS APPLYING FOR NEW MEMBERSHIP AFTER THE FINAL DEBIT ORDER CLOSING DATE, WILL BE SUBJECT TO REGISTRATION DATE CHANGE. PLEASE CONSULT YOUR ADVISOR OR BESTMED FOR MORE INFORMATION.

For a more detailed overview of your benefit option and to receive a membership guide please contact service@bestmed.co.za.

Bestmed Medical Scheme is a registered medical scheme (Reg. no. 1252) and an Authorised Financial Services Provider (FSP no. 44058). ©Bestmed Medical Scheme.
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