



Benefit Guide 2008





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Bepmeds – The Medical Scheme Specifically For Built Environment Professionals

The Built Environment Professional Associations' Medical Scheme (BEPMEDS) is a restricted medical scheme which was created for members of the supporting Professional Associations, SAACE, SAIA and ASAQS and their employees. BEPMEDS has a vision to achieve and maintain a sustainable medical scheme that has a benefit structure designed to meet the specific needs of its professional member base.

“BEPMEDS IS A PROFESSIONAL MEDICAL SCHEME, BY PROFESSIONALS, FOR PROFESSIONALS!”

BEPMEDS uses an administrator, which provides a diversity of managed healthcare programmes that include Maternity Care, Renal Care, Oncology Management, HIV/AIDS Management in conjunction with Aid for Aids and the ChroniCare Network. BEPMEDS utilises Netcare 911 to provide emergency road and air evacuation and transportation. BEPMEDS members also have automatic access to an International Medical Travel Benefit through Netcare 911 for an amount of R10 million per family per annum. BEPMEDS members also have access to a Lifestyle Programme called MULTIPLY, that provides discounted rates on gym membership via Virgin Active / Planet Fitness, movie tickets via Nu-Metro, flights via several airlines and accommodation at selected hotels, along with a host of other exciting benefits.

The Scheme relies on the services of Profhealth Benefit Consulting (PBC), Alexander Forbes, NMG, AON Consulting and Glenrand MIB to market the product offering, as well as to provide support services in terms of administration.

The Trustees and the supporting Professional Associations look forward to your ongoing loyal support and wish you a healthy and wonderful year in 2008!



About Bepmeds

BEPMEDS benefit design and structure offers a choice of simple and easy to understand plans, with the flexibility to meet specific requirements. On a yearly basis the claiming patterns of the members are analysed and reviewed and the details of this analysis are used to design the next year's benefits.

WHAT COVER DOES BEPMEDS OFFER?

- Cover for hospitalisation and certain insured out-patient procedures e.g. Colonoscopies, are accessible across ALL BEPMEDS plans. BEPMEDS covers all Prescribed Minimum Benefits (PMB) for the 270 diagnoses and 25 Chronic PMB conditions at the Scheme's Designated Service Providers (DSPs).
- Benefits in and out of hospital are payable at the BEPMEDS Scheme Tariff (BST) and the rate varies across the options
- Day to day/Out of Hospital benefits are payable from a personal Medical Savings Account (MSA) which is advanced to members at the beginning of the benefit year, on the Pro Core and Pro Elite options. Day to day benefits include but are not limited to Acute Medicines, Dentistry, Optical, Physiotherapy, Radiology and Pathology.
- Day to day benefits on the Pro Basic option are obtainable at the contracted network, CareCross. The network service provider provides quality healthcare at affordable cost.
- The Pro Elite option is a unique option which provides the most comprehensive benefits, both in and out of hospital. This option has an Above Threshold Benefit (ATB) that acts as a safety net to fund high costs incurred out of hospital. Cover from the ATB becomes accessible when the Threshold is reached; details of the Threshold and ATB are available on the Comparison Table and in the Glossary on page 19.



Membership

WHO CAN JOIN BEPMEDS?

You or your employer firm will have to be a registered member of one of the following Professional Associations in order to qualify to be a member of BEPMEDS:

- ASAQS (The Association of South African Quantity Surveyors)
- SAACE (The South African Association of Consulting Engineers)
- SAIA (The South African Institute of Architects)

HOW DO I JOIN BEPMEDS ?

To join BEPMEDS, you simply need to complete a membership application form, that can be obtained either from one of the accredited brokers or by contacting the Scheme's administrator on 0860 10 29 03. Alternatively you can access the application form directly via the website on www.bepmeds.co.za. When completing the application form, you must ensure that all required details on the form are included, and the application is signed by you (and your employer where applicable).

MEMBERSHIP CARD

Your membership card is essential once you become a member of BEPMEDS, as all doctors and other medical service providers that treat you will require this card to be produced as your proof of your membership to BEPMEDS. All medical claims that are submitted to BEPMEDS will be processed in accordance with the details reflected on your medical aid card, so when you receive your card, please verify that all details are correct. Should you need to change any details on your membership card, you can do so by calling the BEPMEDS Contact Centre on 0860 10 29 03.

Should you have any further questions on BEPMEDS membership, you can call 0860 10 29 03 or access details directly via the Scheme's website: www.bepmeds.co.za.



Chronic Registration

In order to access benefits for the benefits mentioned on page 7, relevant to your specific policy option, you are required to register on the Chronic Management Programme.

Medicine benefits for the PMB conditions are unlimited across ALL options; however there are certain clinical and funding policies that are applied such as Reference Pricing and Maximum Medical Aid Pricing (MMAP).

Medicine Benefits for the extended list of the Chronic non PMB conditions are limited, and are only available on the Pro Elite option. These extended benefits are also subject to authorisation and clinical and cost effectiveness policies.

THE SIMPLE PROCESS FOR THE AUTHORISATION OF CHRONIC BENEFITS IS AS FOLLOWS:

1. Your treating doctor or Pharmacist calls the Contact Centre on 0860 10 29 03 and will be routed to a Chronic Care Consultant
2. The Chronic Care Consultant approves the application telephonically and immediately releases an authorisation number.
3. Once approved you may collect your medication from your pharmacy or dispensing doctor
4. Pro Basic members must contact their CareCross provider to access chronic benefits.
Call 0860 10 11 59.

WHAT HAPPENS WHEN THERE ARE CHANGES TO MY CHRONIC CONDITION OR MEDICATION?

Simply ask your treating doctor or pharmacist to follow the simple 3 step process above.

Note: Should additional motivation or test results be required, these will be requested by the Chronic Care consultant during the call.

Chronic Conditions

Chronic Disease List (25 PMB Conditions) (available on ALL options)	Extended Chronic Conditions (Non PMB) (available on the Pro Elite Option only)
Addison's Disease	Alzheimer's Disease
Asthma	Ankylosing Spondylitis
Bipolar Mood Disorder	Cerebral Palsy
Bronchiectasis	Cerebrovascular Accident (stroke)
Cardiac Failure	Cushing's Disease
Cardiomyopathy	Cystic Fibrosis
Chronic Renal Disease	Depression
Coronary Artery Diseases	Endometriosis
Crohn's Disease	Gastro - Oesophageal Disease
Chronic Obstructive Pulmonary Disease	Gout
Diabetes Insipidus	Hyperthyroidism
Diabetes Mellitus Type I and Type II	Menopause
Dysrhythmias	Motor Neurone Disease
Epilepsy	Muscular Dystrophy
Glaucoma	Narcolepsy
Haemophilia	Obstructive Airways Disease
Hypertension	Osteoarthritis
Hypothyroidism	Osteoporosis
Hyperlipidaemia and Hypercholesterolemia	Paget's Disease
Multiple Sclerosis	Peripheral Vascular Disease
Parkinson's Disease	Pituitary Disease
Rheumatoid Arthritis	Prostatic Hypertrophy (Benign)
Schizophrenia	Pseudohypoparathyroidism
Systemic Lupus Erythematosus	Psoriasis
Ulcerative Colitis	Tourette's Syndrome
	Wilson's Disease



Pro Basic

PRO BASIC RISK BENEFITS

- Hospital Cover is available at 100% of the Bepmeds Scheme Tariff (BST)
- An overall annual limit applies depending on family size. These limits have been increased from R500 000 in 2007 to R600 000 for a single member and from R1million for a family to R1.2 million.
- Chronic Medicine benefits are accessible via the CareCross Network providers and are in accordance with the Carecross Medicine Formulary
- Local Air and Road Emergency Medical Transport and Evacuation available through Netcare 911

PRO BASIC DAY TO DAY BENEFITS

- Defined benefits for day to day medical expenses are obtained from the CareCross Network Providers

Pro Core

PRO CORE RISK BENEFITS

- Unlimited Hospital Cover payable at 300% of the Bepmeds Scheme Tariff (BST)
- Chronic Medicine benefits are available for the 25 PMB Chronic Conditions, subject to Reference Pricing and MMAP
- Local and international air and road emergency evacuation and transport is available through Netcare 911
- Access to all the Disease Management Programmes managed through the administrator
- Oncology, Chemotherapy and Radiotherapy treatment upon registration on the Oncology Management Programme
- Cover for insured procedures, e.g, tonsillectomy, colonoscopy

PRO CORE DAY TO DAY/OUT OF HOSPITAL BENEFITS

- A generous Medical Savings Account, the amount of which depends upon the size of your family, is available to fund the day to day benefits
- The full MSA is advanced up front at the beginning of the year

Pro Elite

PRO ELITE RISK BENEFITS

- Unlimited hospital cover payable at 300% of the Bepmeds Scheme Tariff (BST)
- Chronic Medicine benefits are available for the 25 PMB Chronic Conditions, subject to Reference Pricing and MMAP
- An Extended List of Chronic conditions, which are not PMB conditions, are payable on the Pro Elite option, e.g. Menopause, Osteoporosis, Depression
- Local and international air and road emergency evacuation and transport is available through Netcare 911
- Access to all the Disease Management Programmes managed through the Administrator
- Oncology, Chemotherapy and Radiotherapy treatment upon registration on the Oncology Management Programme
- Cover for insured procedures eg, tonsillectomy, colonoscopy

PRO ELITE DAY TO DAY BENEFITS

- A generous Medical Savings Account, the amount of which depends upon the size of your family, is available to fund the day to day benefits
- The full MSA is advanced up front at the beginning of the year
- Additional benefits are payable through the safety net feature on this option, otherwise referred to as the Above Threshold Benefit (ATB)
- All claims paid from the MSA are accumulated towards the Threshold limit at BST rates. As soon as the Accumulated claims value equals the Threshold amounts, the benefits then become payable from the ATB
- The Threshold and ATB values are determined by your family size

Note: The Threshold levels for 2008 have been adjusted accordingly to ensure members are not prejudiced.



Hospital Management

ALL YOU NEED TO KNOW ABOUT HOSPITAL BENEFITS

Hospital Benefits are payable by the Scheme and are the most costly benefits available. All Hospitalisation events and related procedures require pre-notification at least 24 hours prior to admission. In the case of an emergency, members must obtain authorisation after the event but within 72 hours of admission. Failure to obtain authorisation will result in you being liable for the full cost of the admission and all its related expenses.

HELP KEEP SCHEME CONTRIBUTIONS LOW

In an effort to create member awareness and educate members on the impact of hospital costs on your contributions, we urge you to play a more active role in respect of your hospital admissions. Ensure that you ask your doctor all the relevant questions surrounding your admission and know what you are being treated for. In particular, you must obtain from your doctor a list of all the ICD10 Codes applicable to your treatment and advise these when seeking authorisation. The Hospital Management Programme that we apply is not to prevent you accessing benefits but to try and ensure that you receive appropriate and necessary hospital care for your condition. Possible questions to ask your doctor:

- What is the main reason or diagnosis for my admission?
- Is there alternative treatment available that I can obtain that will be as effective as the admission to hospital?
- Will there be any potential costs that I may be liable for following the admission?

WHAT INFORMATION DO I NEED TO PRE-AUTHORISE?

- BEPMEDS membership number (as appears on your member card)
- Complete details of the patient - Date of birth, full name and surname
- Name and Practice number of the Admitting and Treating doctor
- Date of the admission
- Reason for the admission
- Medical Diagnosis with the Relevant ICD 10 Diagnosis code (obtain details from your doctor)
- Type of Procedure /surgery and is the procedure/surgery being done laparoscopically
- Name of Hospital/Clinic
- Tariff Codes applicable to admission (ICD10 Codes)

NOW THAT YOU HAVE ALL OF THE ABOVE DETAILS, CALL 0860 10 29 03

Health Risk Management

BEPMEDS utilises the managed care services of the administrator to actively manage the various diseases. This involves the use of a wide range of Disease Management Programmes which apply Clinical Protocols based on Industry Research.

ONCOLOGY MANAGEMENT PROGRAMME

Registration on the Oncology Management Programme is compulsory for all Cancer Patients wanting to access oncology benefits. Your treating oncologist must provide a detailed treatment plan, outlining all chemotherapy, radiotherapy, drugs required for side effects, radiology and pathology that is required. All applications are assessed in accordance with the treatment protocols and benefits are provided in accordance with your relevant plan option. In order to avoid co-payments which will be payable by yourself, please negotiate with your doctor to charge you the preferred tariff.

CALL 0860 10 29 03

RENAL MANAGEMENT PROGRAMME

A detailed written request outlining details of the renal treatment must be submitted to the administrator for registration on the Renal Management Programme. Benefits for renal dialysis and renal transplants are based on the details provided by the treating doctor and in accordance with the relevant treatment protocols. The Scheme has also negotiated preferential rates with certain service providers, so to ensure that you are not liable for co-payments, please negotiate that your doctor charges preferred tariffs.

CALL 0860 10 29 03





Maternity Management Programme

Pregnant mums have access to an enhanced maternity benefit by registering on the Maternity Management Programme. On the Pro Elite and Pro Core options, the following benefits are paid by the Scheme and not from your Medical Savings Account upon registration:

- 12 Antenatal Consults
- 2 Maternity Ultrasounds
- 2 Paediatrician Consults
- Antenatal Classes (Preferred tariff at a preferred provider)
- Informative Handbook on Pregnancy

Important Note: Failure to register on the Maternity Management Programme between 12 – 20 weeks of your pregnancy will result in the above maternity benefits being paid from you MSA and not by the Scheme. You can also during the duration of your pregnancy, and following registration on the Programme, pay for Vitamins from your MSA.

REGISTER BETWEEN 12 – 20 WEEKS OF PREGNANCY BY CALLING 0860 10 29 03



HIV / Aids Management - Aid For Aids

The specific objective of the programme is to manage the individual living with HIV in the most efficient and cost-effective way, helping the individual to remain as healthy and productive as possible.

To ensure confidentiality, the programme will be managed by Aid for Aids (AfA). To obtain benefits relating to HIV/AIDS, members must register on the programme.

HOW TO JOIN AID FOR AIDS (AFA)

- Members or their dependants should contact AfA, on 0860 10 06 46, and ask for an application form and/or for counselling.
- The applicant/legal guardian must complete the first section of the application.
- The applicant's doctor should examine them and complete the application form.
- The completed form should be faxed to AfA on 0800 60 07 73 or mailed to AfA (address below)
- The AfA medical team will review the application and contact the patient's doctor, if necessary, to discuss a treatment programme. In the unfortunate event where the member or dependant has been raped or has been accidentally exposed to blood, the member must see their doctor immediately. The doctor will phone AfA to request a PEP (post exposure prophylaxis) form to be faxed to them. The form must be completed and faxed back to AfA as soon as possible.

PLEASE NOTE THAT PEP MUST BE STARTED IMMEDIATELY AFTER THE EXPOSURE OR WITHIN 72 HOURS. THE DOCTOR CAN GIVE A STARTER PACK IF THE INCIDENT HAPPENED AFTER HOURS OR ON WEEKENDS.

- Both the applicant and doctor will receive letters confirming the treatment that will be paid or the tests that need to be done. Soon after these letters are sent, an AfA nurse adherence co-ordinator will contact the patient to explain their treatment. In addition AfA has introduced an SMS facility, to communicate to patients, about adherence issues and general information.
- If there are any medicines in the treatment plan, the patient's doctor is asked to supply a matching prescription. This should be given to the pharmacist, together with the treatment letter, in order for the medicines to be dispensed. Patients continue to see their doctor regularly, or when there is a problem.
- Their doctor should contact AfA to inform them of any changes in their condition, and to update their authorised treatment.

All claims/accounts/bills for the patient's HIV/AIDS treatment must be sent directly to Aid for AIDS, at this address:

Accounts

P.O Box 38597, Howard Place, 7450

Members may also contact AfA by SMS on 083 410 90 78



Third Party / Motor Vehicle Accident (MVA) Claims

Should you be involved in a MVA, please complete the necessary Undertaking Document that will be forwarded to you by the MVA Department. The form must be completed and returned to BEPMEDS even if you do not qualify for a valid third party claim – all you need to state on the form is that you will not be proceeding with an Undertaking. BEPMEDS will provide bridging financial assistance to cover the Third Party claim, however, any recoveries in respect of medical expenses received from any Third Party must be re-imbursed to the Scheme to offset the amounts advanced by BEPMEDS. CALL 0860 10 29 03 for additional details.

Medicine Claims Management

Mediscor PBM is an independent and accredited managed healthcare organisation that focuses on the management of medicine benefits for their various medical scheme clients. Their sophisticated real-time claims processing and pharmaceutical benefit management system provides a leading, flexible and reliable medicine management solution to BEPMEDS. It allows BEPMEDS to process and verify medicine claims from pharmacies and dispensing doctors who submit claims electronically. What this means for you is that the pharmacy or doctor can verify your benefits at the point of service and whilst you are at the pharmacy. Any shortfalls resulting from MMAP or Reference Pricing or scheme exclusions are communicated to the pharmacy or doctor real-time, and members can be immediately informed.

Substance Abuse Focus

BEPMEDS members must make use of the SANCA programme for the treatment of alcohol and drug abuse and addiction. Proper management of these conditions leads to improved health and decreases the utilisation of medicine. The programme provides enormous benefits for the patient and the family and the respective employer. Patients are strictly monitored and must remain and adhere to the programme for the full duration. Failure to complete the entire programme will result in the entire account being rejected by the Scheme. Pre-Authorisation can be obtained by calling 0860 10 29 03.

Hassle Free Claiming

Always produce your ID document and membership card at the service provider so that correct details are captured by your provider.

PLEASE CHECK THAT YOUR CLAIMS HAVE THE FOLLOWING DETAILS BEFORE SUBMITTING TO BEPMEDS:

- Name and surname of the Main member
- Member number as it appears on your membership card
- Name, surname, date of birth of patient receiving treatment
- Date/s of treatment
- Tariff code and description eg. Tariff Code 801/consultation
- ICD 10 Code – eg. E10/Hypertension
- Practice Number
- Costs of Services provided
- Copy of the receipt if you have paid the claim
- For Medicine claims you will need the following additional information: name and nappi code of medicine, dosage and quantity of medicine, and referring doctor's practice number for prescribed medicine

OTHER IMPORTANT FACTORS TO CONSIDER:

- Always keep a copy of the claims submitted in the event that the claim is lost
- Do not staple papers together when submitting claims
- Ensure that all claims are legible and that your member number appears on every page submitted
- Claims that are charged above the Bepmeds Scheme Tariff will be paid to the member
- Check your statements to monitor claims payments. Ensure that you pay attention to the pay codes reflected on the statements sent to you by Bepmeds, as these provide you with details of rejected claims or claims that have been short paid.
- Failure to submit claims within 4 months of the treatment date, will render you being liable for the full account yourself.

CLAIMS CAN BE SUBMITTED TO:

P O BOX 2338
DURBAN
4000

Or By Fax: (031) 580 04 80



MULTIPLY Lifestyle Programme

All BEPMEDS members have access to a Lifestyle Programme called MULTIPLY, which offers exclusive discounts on gym membership, movie tickets, CD/DVDs, travel and leisure facilities, flights and other exciting offers. Details are available on the BEPMEDS website (www.bepmeds.co.za). Should you wish to register on the MULTIPLY programme, please call the MULTIPLY call centre directly on 0860 11 28 39.

Bepmeds Interactive

<http://www.bepmeds.co.za>

Bepmeds website truly reflects the state-of-the-art technological systems members benefit from on a daily basis. On the site, members have instant access to benefit information. Members, employers and service providers can register to view their monthly statements and claims information on-line. Just complete an on-line application form and fax it to the administrator on (031) 580 04 85. On registration, a user name and computer generated password will be e-mailed to the member or employer and by logging onto the website using the username and assigned password, members and employers alike can access information pertaining to themselves, ie: statements, contact details, plan option details, etc.



Netcare 911 Emergency Services (Local and International)

LOCAL EMERGENCY SERVICES THROUGH NETCARE 911 INCLUDE:

- Call 082 911
- Emergency medical response by road or air to the scene of the medical emergency;
- Transfer by road or air to the closest, most appropriate medical facility;
- Repatriation of patient where medical intervention is required;
- Inter Hospital Transfers only when pre-authorized by Netcare 911
- Emergency telephonic medical advice and information – Call 0800 22 34 34;

WHAT TO DO IN THE CASE OF A LOCAL MEDICAL EMERGENCY?

- Dial 082 911
- Provide your name and the telephone number that you are calling from;
- Provide a brief description of what has happened and how serious the situation is;
- Give the address or location of the incident to assist paramedics to get there as quickly as possible;

IMPORTANT:

Netcare 911 is BEPMEDS designated service provider for all emergency services. In instances where a member is involuntarily transported by any other service provider, the member must ensure that they obtain approval from Netcare 911 by calling 082 911. Once approved, the non-designated service provider that was used must submit an invoice to Netcare 911 within 10 days of the service date to facilitate payment of the account.

INTERNATIONAL EMERGENCY SERVICES THROUGH NETCARE 911 INCLUDE:

- R10 million medical expenses coverage per family per annum
- 90 days cover per trip, worldwide
- No limit on the amount of times a person travels per annum
- R1000 excess payable on out-of-hospital claims
- No excess payable if claims are for hospitalization
- Repatriation and evacuation should a member need medical assistance en-route home, worldwide
- Medical assistance and advice 24 hours a day, 7 days a week

IMPORTANT:

Please ensure that you notify Netcare 911 prior to your departure so that a travel certificate confirming benefits is issued to you. Failure to pre-notify Netcare 911 will result in no benefit. Call +27 11 254 1387 for international assistance, as well as to pre-notify.



Glossary

Above Threshold Benefit (ATB)	Applies only to the Pro-Elite option. ATB is a “safety net” intended to cover excess out of hospital claims. Benefits are payable from the ATB upon the Threshold limit being reached.
Annual Threshold	Applies to the Pro-Elite option only. This is the cumulative claims level, that is calculated at the Bepmeds Scheme Tariff, which you have to reach before the Scheme takes over paying for out of hospital expenses.
DSP	Designated Service Provider. A DSP is the Scheme’s preferred provider for the treatment of PMB conditions. The scheme’s DSP is the state public facility.
Generic Medicine	Medicine that contains the same active ingredients and formulation as a branded medicine but is manufactured only once the patent on the branded product has expired. Generic medicine is usually significantly less costly than its branded equivalents.
MMAF	Maximum Medical Aid Price is the maximum price the Scheme will pay for the cost of generic medicine. If no generic is available, the Scheme will cover the cost of the prescribed branded medicine. Should members elect to purchase the branded product in lieu of the generic, only MMAF for the generic will be paid by the Scheme and the member is liable for the difference.
BEPMEDS Scheme Tariff (BST)	This is the rate, which is linked to the National Health Reference Price List, at which the Scheme will calculate benefits for the various service providers.
Medical Savings Account (MSA)	This is an account towards which Pro Elite and Pro Core members contribute in order to cover out of hospital expenses.
NAPPI Code	Is the specific code that is used to describe and identify type of medication.
National Health Reference Price List (NHRPL)	The benchmark tariff published by the Council for Medical Schemes.
Negotiated Tariff	The rate at which claims will be paid which is negotiated by the Scheme and which applies to various service providers including hospitals.
Prescribed Minimum Benefit (PMB)	A PMB is defined as the minimum level of benefit that must be available to members. The current list as published by the Council for Medical Schemes includes 270 diagnoses and 25 Chronic PMB conditions.

2008 Benefits Table

DEFINITIONS & ABBREVIATIONS: -

ATB	Above Threshold Benefit
CCM	Chronic Care Management
MMAP	Maximum Medical Aid Price (Generic Equivalents as approved by the Medicine Control Council of South Africa)
BST	Bepmeds Scheme Tariff
PMB	Prescribed Minimum Benefits
REFERENCE PRICE	The maximum price the Scheme will pay for your chronic medicine
NHRPL	National Health Reference Price List.
SEP	Single Exit Price.

IMPORTANT NOTE:

Bepmeds Medical Scheme administrator applies research-based clinical intervention policies as part of its managed care initiatives, clinical guidelines and protocols. Core Risk Benefits require Pre-Authorisation from Scheme's Administrator

CORE RISK BENEFITS		Pro Basic	Pro Core	Pro Elite
Overall Annual Limit	M : R600 000 p.a M+1 or more : R1.2 million p.a (Once limits are reached all PMB benefits will be obtained from a State Facility)	No overall annual limit	No overall annual limit	No overall annual limit
Hospital ward and theatre fees		100% of negotiated Hospital Tariff	100% of negotiated Hospital Tariff	100% of negotiated Hospital Tariff
Limit per annum		Subject to overall annual limit	No Limit	No Limit
To Take Out Medication		No Benefit	Limited to 7 days supply	Limited to 7 days supply
Psychiatric Hospitalisation (Including all related expenses)		100% of BST rate	100% of BST rate	100% of BST rate
Limit		R5000 Subject to overall annual limit	R10 000 per beneficiary p.a.	R20 000 per beneficiary p.a.
Kidney Dialysis & Major Organ Transplants (subject to criteria and pre-authorisation)		100% of BST rate	100% of BST rate	100% of BST rate
Limit		R15 000 per family p.a. Subject to overall annual limit	R 60 000 per family p.a.	No limit
Internal Prosthesis		100% of Preferred Provider Approved Tariff	100% of Preferred Provider Approved Tariff	100% of Preferred Provider Approved Tariff
Limit per annum		R5 000 per family p.a. Subject to overall annual limit	R18 000 per beneficiary p.a.	R30 000 per beneficiary p.a.
External Prosthesis and Hearing Aids		100% of Preferred Provider Approved Tariff	100% of Preferred Provider Approved Tariff	100% of Preferred Provider Approved Tariff
Limit	Combined overall limit of R21 000 per family per annum applicable on the Pro Core and Pro Elite options only	R1000 per beneficiary	R1300 per beneficiary	R5 000 per beneficiary
Medical Appliances		100% of Preferred Provider Approved Tariff. Subject to overall annual limit	100% of Preferred Provider Approved Tariff.	100% of Preferred Provider Approved Tariff.
Limit		R1000 per beneficiary	R1300 per beneficiary	R5 000 per beneficiary
Private Nursing / Step Down Facilities / Rehabilitation (Subject to clinical protocols and pre-authorisation)		Subject to overall annual limit 100% of Negotiated Tariff	100% of Negotiated Tariff	100% of Negotiated Tariff
Limit		R7500 per family p.a	R7500 per family p.a	No limit
Hospice (Subject to protocols and pre-authorisation)		Subject to overall annual limit. 100% of Negotiated Tariff	100% of Negotiated Tariff	100% of Negotiated Tariff
Emergency Medical Transport Services (Designated Provider contracted by the scheme is Netcare 911)		Available through Netcare 911 (Otherwise no benefit)	Available through Netcare 911 (Otherwise no benefit)	Available through Netcare 911 (Otherwise no benefit)
Blood transfusions		100% of BST rate Subject to overall annual limit	100% of BST rate	100% of BST rate
Radiology/ Pathology (In Hospital Only)		100% of BST rate subject to overall annual limit	100% of BST rate	100% of BST rate
MRI / CAT Scans (In Hospital) (Out of Hospital)	Subject to clinical criteria and pre-authorisation	100% of BST rate	100% of BST rate	100% of BST rate
		Subject to overall annual limit	No Limit	No Limit
Treatment of Oncology (subject to registration on the Oncology Management Programme)		100% of DSP Tariff	100% of BST rate	100% of BST rate
Limit		PMB Criteria - DSP only.	R400 000 per family p.a	R400 000 per family p.a
Outpatient Procedures (as listed in Scheme Rules - including Gastroscopy, Colonoscopy, Tonsillectomy) (Subject to criteria and pre-authorisation)		CareCross Facility Only	100% of BST rate	100% of BST rate
HIV/AIDS Treatment (Subject to criteria & registration on the HIV Management Programme)		Subject to overall annual limit	No Limit	No Limit
Limit per annum		100% of DSP Tariff	100% of DSP Tariff	100% of DSP Tariff
Drug / Alcohol related conditions at SANCA approved facilities only. (Subject to criteria and pre-authorisation). Patients must adhere to SANCA Programmes. If programme not completed, no benefit.		DSP Tariffs	DSP Tariffs	DSP Tariffs
		No Benefit	100% Negotiated Tariff	100% Negotiated Tariff

CORE RISK BENEFITS (cont.)

	Pro Basic	Pro Core	Pro Elite
GP's and Specialists (In hospital)	100% of BST rate Subject to overall annual limit	300% of BST rate	300% of BST rate
Maternity benefits (Out of hospital) (Registration on the Maternity Programme is compulsory on Pro Core and Pro Elite)	100% of BST rate. Only at CareCross Facility	100% of BST rate 12 Antenatal consultations 2 maternity scans 2 paediatrician visits	100% of BST rate 12 Antenatal consultations 2 maternity scans 2 paediatrician visits
Confinement / Delivery	100% of BST rate	300% of BST rate.	300% of BST rate.
Limit	R5000 Subject to overall annual limit	No limit	No limit
Chronic Medication.	100% of SEP + regulated dispensing fee (CareCross formulary applies)	100% of SEP + regulated dispensing fee (Reference Pricing/MMAP applies)	100% of SEP + regulated dispensing fee (Reference Pricing/MMAP applies)
Limits per annum	25 PMB Chronic conditions at CareCross providers only	25 PMB Chronic conditions only	R20 000 per family (Includes PMBs + Extended Chronic Conditions List once limit exhausted. 25 PMB unlimited)
(Subject to registration)	Registration via Carecross Facilities	Chronic registration via CCM	Chronic registration via the administrator (CCM)
PMB Medical Management	CareCross facilities only	Scheme's Designated Service Providers (state facilities)	Scheme's Designated Service Providers (state facilities)
Limits per annum	Subject to CareCross criteria	Subject to Scheme Protocols	Subject to Scheme Protocols
Co-payment	No benefit if not through CareCross	20% of BST rate if voluntary use of non DSP	No co-payment

OUT OF HOSPITAL (DAY TO DAY BENEFITS)

Threshold Pre-determined values that claims paid from Savings accumulate towards. (Once Threshold is reached, the Above Threshold Benefit kicks in)	Not applicable to Pro Basic	Not applicable to Pro Core	Member = R4728 Adult Dep = R4068 Child Dep = R1716
Above Threshold Benefit (ATB) (Day to day safety net that kicks in when threshold is reached)	Not applicable to Pro Basic	Not applicable to Pro Core	M = R 8 500 p.a M+1 = R14 500 p.a M+2 = R16 500 p.a M+3+ = R20 500 p.a
General Practitioners	Designated CareCross provider. No limit	100% of BST rate Subject to Savings	100% of BST rate Subject to Savings and then ATB
Specialists	No benefit	100% of BST rate Subject to Savings	100% of BST rate Subject to Savings and then ATB
Radiology (MRI, CT & Bone Densitometry scans require prior approval from Scheme's Administrator)	100% of BST rate CareCross provider - no limit (Basic X-rays)	100% of BST rate Subject to Savings	100% of BST rate Subject to Savings and then ATB
Pathology	100% of BST rate CareCross provider - no limit (Basic tests)	100% of BST rate Subject to Savings	100% of BST rate Subject to Savings and then ATB
1. Acute Medicines	100% of SEP + regulated dispensing fee	100% of SEP + regulated dispensing fee	100% of SEP + regulated dispensing fee
Tariff	CareCross formulary applies	MMAP applies	MMAP applies
Limits per annum	Subject to CareCross Providers only	Subject to Savings	Subject to savings and then ATB M = R 8 000 p.a M+1 = R10 000 p.a M+2 = R12 500 p.a M+3 = R15 000 p.a
2. PAT (Pharmacy Advised Therapy) Limit per annum	No benefit	Subject to Savings	Limits apply before and after threshold. Subject to Savings. This will not accrue to threshold R1000 limit per annum per family.

OUT OF HOSPITAL (DAY TO DAY BENEFITS)

Pro Basic

Pro Core

Pro Elite

Auxiliary and Alternative Medical Services
 Physiotherapy, Bio-Kinetics, Chiropractors, Clinical Psychology, Speech & Occupational Therapy, Audiology, Dieticians, Osteopaths, Naturopaths, Homeopaths

No benefit

100% of NHRPL
 Subject to Savings

100% of NHRPL
 Subject to Savings and then ATB
 R9000 limit p.a per family
Limits apply before and after threshold.

Dental
 1. Conservative

2. Specialised
 Limits per annum

CareCross Provider only

100% of NHRPL
 Subject to Savings

100% of NHRPL
 Subject to Savings and then ATB

Optometric Tests

100% of NHRPL
 Subject to Savings

100% of NHRPL
 Subject to Savings and then ATB
 Single member : R10 000 p.a
 Family : R18 000 p.a
Limits apply before and after threshold.

Optometric Tests

Subject to CareCross criteria

100% of NHRPL
 Subject to Savings

100% of NHRPL
 Subject to Savings and then ATB

Optometric benefits every 2 years per beneficiary

Subject to CareCross criteria

100% of NHRPL
 Subject to Savings

100% of NHRPL
 Subject to Savings and then ATB
 R3000 per beneficiary
 Family limit of R9000
 Subject to Savings and then ATB
Limits apply before and after threshold.

Laser treatment limited to Savings

No benefit

Subject to Positive Savings

Subject to Positive Savings

Immunisation Benefit

No benefit

Subject to Positive Savings

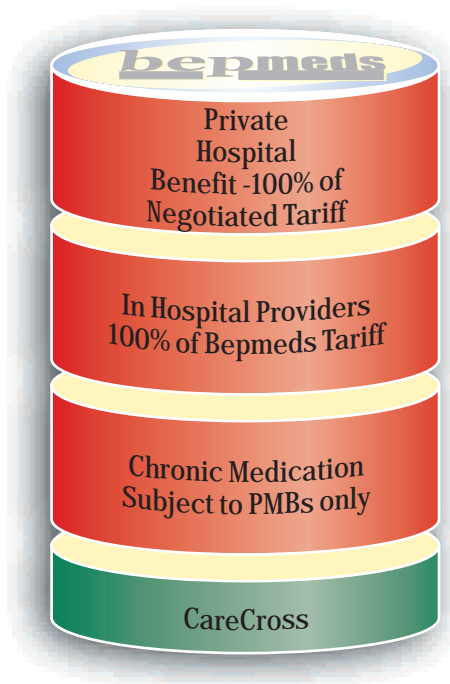
Subject to Positive Savings. This does not accrue to threshold and is not paid from above threshold benefit

Prescribed Minimum Benefits

Prescribed Minimum Benefits will be provided across all options as per the current legislation. Members will be required to register and to obtain their benefits from the Scheme's Designated Service Providers which are the State Public Facilities



Pro Basic



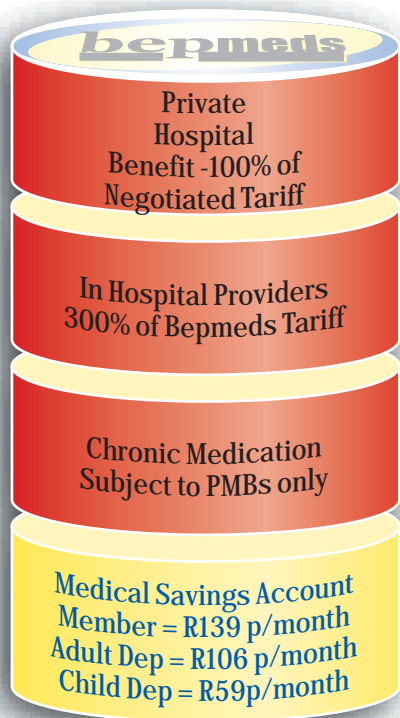
CORE RISK BENEFITS

Cover for your major medical benefits such as hospitalisation is provided by the Scheme subject to an overall annual limit that is based on your family size (single member R600 000 limit applies, family R1.2 million). In addition, a Chronic Medicines Benefit is provided through CareCross facilities subject to the CareCross formulary. CareCross is the DSP for this option in terms of both the diagnosis and treatment of chronic PMB conditions.

DAY TO DAY BENEFITS

The Pro Basic Option provides day-to-day cover through the use of CareCross Doctors which are located nationwide. A list of these doctors may be found on either the Bepmeds website or the CareCross website at www.carecross.co.za

Pro Core



CORE RISK BENEFITS

Unlimited cover for private hospitalisation at 100% of negotiated tariffs with in-hospital professional services paid to a maximum of 300% of Bepmeds Scheme Tariff. In addition, unlimited cover for your 25 Prescribed Minimum Benefit Chronic Conditions. The Chronic Medication benefit is subject to MMAP/Reference Pricing (see Benefits Table 2008 for more detail).

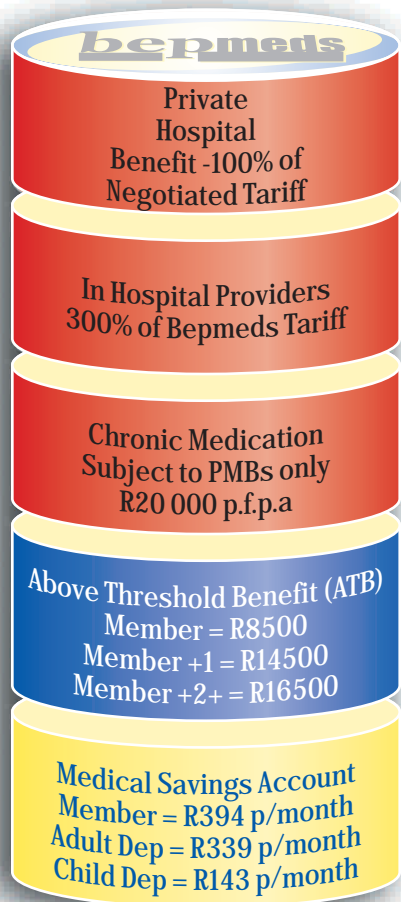
DAY TO DAY BENEFITS

A Medical Savings Account (MSA) is available on this option to cover out of hospital benefits, and is calculated by the family size. The MSA is advanced for the full 12 months.

Example:

A family of 1 principal member 1 adult and and 1 child will contribute an amount of R304 per family per month, towards the MSA. The total MSA of R3648 will be advanced in January for utilisation on day to day benefits, or the pro rata amount is available to members that join during the course of the year.

Pro Elite



CORE RISK BENEFITS

Unlimited cover for private hospitalisation at 100% of negotiated tariffs with in hospital service providers paid to a maximum of 300% of Bepmeds Scheme Tariff. In addition a chronic medication benefit of R20,000 per family per annum to include the Prescribed Minimum Benefit Chronic Conditions plus the extended chronic conditions listed on page 7. Once the above limit is reached, the Scheme will continue to provide unlimited benefit for your Prescribed Minimum Benefit Chronic Conditions only. The chronic benefit will be subject to MMAP/Reference Pricing.

DAY TO DAY BENEFITS

Out-of-hospital expenses are paid from the Medical Savings Account up to the threshold level, calculated according to family size. Thereafter the Scheme will pay for benefits from the ATB, subject to limits as specified in the Benefit Comparison Table (see Benefits Table for more details on the threshold levels).

A Medical Savings Account is available to enhance the level of cover for out of hospital expenses and is calculated by family size. The MSA is advanced for the full 12 months of the calendar year.

Example:

A family of 1 principal member, 1 adult and 1 child will contribute an amount of R876 per family per month, towards the MSA. The total MSA of R10 512 will be advanced in January for utilisation on day to day benefits.



2008 Bepmeds Contribution Table

PRO BASIC	Risk Portion	Savings (0%)	Total Contribution
Principal Member	539	N/A	539
Adult Dependant	441	N/A	441
Child Dependant	213	N/A	213

PRO CORE	Risk Portion	Savings (18%)	Total Contribution
Principal Member	634	139	773
Adult Dependant	485	106	591
Child Dependant	267	59	326

PRO ELITE	Risk Portion	Savings (25%)	Total Contribution
Principal Member	1183	394	1577
Adult Dependant	1018	339	1357
Child Dependant	430	143	573

Note: The Medical Savings Account is "COMPULSORY" on the PRO CORE and PRO ELITE options, and is not available on the PRO BASIC option.



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Aids for Aids (HIV Management)
0860 10 06 46

CareCross
0860 10 11 59

Oncology Management
0860 10 29 03

ChroniCare Management (CCM)
0860 10 29 03

Pre-Authorisation (Hospital Authorisation)
0860 10 29 03

Maternity Programme
0860 10 29 03

Renal Management
0860 10 29 03

Netcare Nurseline
0800 22 34 34

Netcare 911
082 911

Please note that this brochure is a condensed version of benefits for information purposes only. All benefits are governed by the Rules of the Scheme. In the event of a conflict the rules take precedence. Brochure published in October 2007 for benefits to be implemented 1 January 2008.

Benefit Guide

2008

A decorative graphic consisting of several overlapping, curved, light blue shapes that sweep across the bottom half of the page, creating a sense of movement and depth.