

2. BENEFITS EXCLUDED

- 2.1 All costs incurred for the treatment or surgery not medically necessary for obesity.
- 2.2 All costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease.
- 2.3 All costs related to wilfully self-inflicted injuries.
- 2.4 The treatment for infertility including artificial insemination.
- 2.5 All costs in respect of injuries arising from professional sport, speed contests and speed trials.
- 2.6 All costs that are more than the annual maximum benefit to which a member is entitled in terms of the Rules of the Fund.
- 2.7 All costs in respect of pre-existing conditions which were specifically excluded from benefits when the member joined the Fund.
- 2.8 All costs of whatsoever nature incurred for treatment of sickness, conditions or injuries sustained by a member or a dependant and for which any other party may be liable, unless the Committee is satisfied that there is no reasonable prospect of the member or dependant recovering adequate damages from the other party.
- 2.9 All costs incurred for treatment of an illness or injury sustained by a member or a dependant of a member where such illness or injury is directly attributable to failure to carry out the instructions of a medical practitioner or due to negligence on the part of the member or dependant.
- 2.10 The purchase of medicines not included in a prescription from a person legally entitled to prescribe.
- 2.11 All costs for services rendered by:
 - 2.11.1 any person not registered with the Botswana Health Professions Council or a similar body of the country in which she/he practices;
 - 2.11.2 any person not registered as a nurse with the Botswana Nursing Council or a similar body, of the country in which she/he practices;
 - 2.11.3 any place, nursing or similar institution, except a government hospital, not registered in terms of the applicable legislation as a private hospital, unattached theatre or day clinic and any institution not licensed in terms of the appropriate legislation of the country concerned to provide healthcare services.
- 2.12 Purchase of:
 - patent medicines and proprietary preparations;
 - applicators, toiletries and beauty preparations;
 - bandages, cotton wool and similar aids;
 - patented foods, including baby foods;
 - contraceptives and apparatus to prevent pregnancy (please note that male and female sterilisation is covered only once);
 - tonics, slimming preparations and drugs as advertised to the public;
 - household and biochemical remedies.
- 2.13 Holidays for recuperative purposes.
- 2.14 All costs for vaccination.

PLEASE READ THIS GUIDE CAREFULLY AND RETAIN IT FOR FUTURE REFERENCE AS IT CONTAINS VERY IMPORTANT INFORMATION RELATING TO MEMBERSHIP, BENEFITS AND EXCLUSIONS.

This guide summarises the Rules of the Fund which are most important to members. In case of a dispute over the contents, the Rules of the Fund shall be final and binding on members.

The Fund is managed and controlled by a Management Committee ("the Committee") elected by the members from among their number.

The Fund is administered by:

ASSOCIATED FUND ADMINISTRATORS BOTSWANA (PTY) LTD

AFA House Plot 61918 Showgrounds Office Park P O Box 1212, Gaborone Tel: 365 0585/6 Fax: 395 1165 E-mail: marketing@pulamed.co.bw	Autolot House Plot 2074, Suite 104 Blue Jacket Street P O Box 323, Francistown Tel: 241 2290/241 2390 Fax: 241 2340
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Please quote your membership number on all claims and in any correspondence.

MEMBERSHIP

Membership of the Fund is available to employees of a participating employer group.

How do I join?

You must complete the prescribed application form and hand it to your employer before submitting it to the Fund.

You have a choice of two benefit options:

- Standard Benefit Option
- De-luxe Benefit Option

These options differ in terms of contributions paid and benefits received.

Are there any restrictions on joining?

Pre-existing health conditions may be excluded unless you were a member or the dependant of a member of any approved medical scheme for a continuous period of at least one year and your application to join the Fund is made within three months after the date on which you ceased to be a member or a dependant of a member, of such scheme.

Should I register my spouse and children?

You are advised to register the following persons as your dependants on the Fund:

- Your spouse;
- Your child or children under the age of 21 years provided they are unmarried and not in receipt of a regular remuneration in excess of the amount shown in Part 2 of Inserts A and B.

Does the Fund cover other members of my family?

You may apply for the registration of the following persons provided they are dependent on you. The acceptance of such dependants is subject to the approval of the Committee and on such conditions as it may prescribe. They are subject to annual review. Applications must be made on the appropriate form.

- A child over the age of 21 years but under 25 years, unmarried and whose regular remuneration does not exceed the prescribed amount shown in Part 2 of Inserts A and B.
- A child over the age of 21 years, totally dependent on the member because of mental or physical defects, unmarried and whose regular monthly remuneration is not in excess of the prescribed amount shown in Part 2 of Inserts A and B.
- A relative dependant who resides with the member or at an institution where free medical services are not available, and who is not in receipt of a regular income in excess of the prescribed amount shown in Part 2 of Inserts A and B.

What is my proof of membership?

After receipt and processing of your application form by the Administrators, a membership card will be issued promptly. Your membership card is very important and will reflect:

- your membership number;
- your name;
- the names of your registered dependants and their dates of birth;
- the date from which you and your dependants are entitled to benefits;
- the name of your employer;
- any exclusion imposed in respect of a pre-existing condition at the time of admission.

How do I advise the Fund of changes in my membership details e.g:

- a change in your marital status;
- the birth or legal adoption of a child;
- any dependant who is no longer entitled to dependant membership.
- contact details

You must complete the appropriate form to advise the Administrators of the change in membership.

Any changes to these particulars must be advised and submitted via your employer to the Fund within 30 days. Members are urged to advise of any change promptly since delay may affect the efficient settlement of claims.

Are pensioners and widows/widowers covered by the Fund?

Pensioners and widows/widowers of deceased members are covered in terms of the Rules. They are entitled to the same benefits as other members of the Fund.

Pensioner Members

- Must have attained the age of 60 years unless retired due to ill health, in which case a doctor's report must be submitted to substantiate ill health.
- Must have at least two continuous years' membership of the Fund at the date of retirement, or must have paid contributions in respect of any shortfall of such membership, based on the rate of contributions at the time of retirement; provided that previous membership of a recognised medical scheme shall be recognised for the purpose of determining such period of membership.

Widow/Widower Members

- A widow/widower must have been registered as a dependant at the time of the member's death;
- If a widow/widower is entitled to membership of another scheme by virtue of employment, she/he does not qualify for widow/widower membership;
- Widow/widower membership automatically terminates if he/she remarries and becomes eligible for membership of the spouse's medical scheme or if she/he terminates membership in writing.

BENEFITS

Is there a waiting period?

Except for the three (3) specified below, there are no waiting periods.

1. Maternity - 9 month waiting period
2. Specialised Dentistry -12 month waiting period
3. Infants not registered within 30 days of birth - 3 month waiting period from registration date

These waiting periods only apply if at the time of joining the member had not been a member of any recognised medical aid scheme for at least 12 months.

What is my benefit entitlement?

Your benefit entitlement will depend on the option you choose to join; Standard benefit or De-luxe benefit option.

What are the annual benefit limits?

The annual benefit limits are shown in Part 1 of Inserts A and B. Please note "member" means the family.

What limits apply if I join during the year?

All new members admitted during the course of a financial year shall be entitled to the benefits set out in Part 1 of Inserts A and B with the maximum benefits being adjusted in proportion to the period of membership during the particular financial year; calculated from the admission date to the end of that financial year.

What limitations apply to my benefits?

The following limitations are placed on your benefits:

- Treatment for a pre-existing condition which the Fund specifically excludes at the time of admission (**pre-existing conditions are excluded for a period of two years of membership**);
- treatment which is specifically excluded by the Rules;
- the annual or case limits which are imposed on specific categories of treatment. Full details are contained in Part 1 of Inserts A and B.
- **NB: THERE ARE NO EXCLUSIONS OR WAITING PERIODS FOR HIV/AIDS**

CLAIMING OF BENEFITS

Is a claim form necessary?

You are not required to complete a claim form.

How do I submit a claim?

Mail or deliver your claim without delay to The Administrators, Associated Fund Administrators Botswana (Pty) Ltd. Please ensure that you sign each account.

It is essential that you quote your full membership number on the top right corner of each account. You are required to always present your membership card when seeking medical attention.

In addition to your membership number you must ensure that all the following details are stated on each account:

- name of principal member;
- name of patient, as reflected on your membership card;
- full details of treatment;
- date(s) of treatment.

Please sign your account before you leave the health facility. Your signature is proof of receipt of service.

When must I submit my claims?

You are urged to submit your claim (account) without delay. Any account which is not submitted within four months from the date on which services were rendered will not qualify for benefits.

PLEASE DO NOT DELAY SUBMISSION OF YOUR CLAIMS AS THIS MAY EMBARRASS YOU, YOUR PRACTITIONER AND THE FUND,

When are my claims paid?

Claims payments are made twice a month.

How do I know that my account has been paid?

Your Claims Advice, together with advice of a direct bank transfer or refund cheque if due, reflecting full details of how your accounts have been processed and paid will be dispatched to you by the end of each payment run.

What if I am hospitalised?

In a private hospital

On admission, the hospital may contact the Administrators to confirm your membership of the Fund. The Administrators will on such request issue a guarantee of payment of your account at agreed rates, subject to your benefit entitlement in accordance with the Fund's rules. This will avoid the need for you to settle the account on discharge. If, however, you have been hospitalised in a private ward, you may be charged personally and may be required to pay, on discharge, the difference between private and general ward rates. You must ensure that your hospital account is submitted to the Administrators promptly.

In a state hospital

If you are hospitalised in a state hospital the Administrators will, if so requested, issue a guarantee of payment to the hospital. You must ensure that your account is submitted promptly.

In a maternity home

Certain hospitals require the payment of a deposit for maternity hospitalisation. This deposit must be paid by you and the Fund will only refund the benefit on submission of the final account. A private maternity home may require you to settle the account before discharge. If required, the Administrators can arrange an immediate refund on presentation of the account.

LIMITATION OF BENEFITS AND BENEFITS EXCLUDED

1. LIMITATION OF BENEFITS

- 1.1 The maximum benefits to which a member and his dependants shall be entitled in any financial year are set out in Part 1 of Inserts A and B.
- 1.2 All new members admitted during the course of a financial year shall be entitled to the benefits set out in Part 1 of Inserts A and B with the maximum benefits being adjusted in proportion to the period of membership from the date of admission to the end of that particular financial year.
- 1.3 In case of illness of a protracted nature, the Committee shall have the right to insist that a member or dependant of a member consult a particular specialist or specialists the Committee may nominate in consultation with the attending practitioner. In such cases, if the specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.
- 1.4 In cases where a specialist, except an eye specialist or gynaecologist, is consulted without the recommendation of a general practitioner, the benefit allowed by the Fund may, at the discretion of the Committee, be limited to the amount that would have been paid to the general practitioner for the same service.
- 1.5 Unless otherwise decided by the Committee, benefits in respect of medicine obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.