SAAB

GEMAS 2019

Grintek Electronics Medical Aid Scheme

Summary of Benefits & Contributions

Registered Office:

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Prescribed minimum benefit

	100% of cost unlimited
Prescribed minimum benefits (PMBs)	Subject to PMB protocols
Hospitalisation and medical management (in and out of hospital)	Subject to treatment at DSP or state facility **(for further information call Universal Care on 011 208 1100)**
Medicines for PMB conditions	Chronic Medicine Management Programme (registration and pre-authorisation) **Tel: 0860 102 312 / Email: chronicmedicine@universal.co.za**

Major medical expenses benefit (In hospital)

Annual major medical expenses limit (MME)	**Unlimited**
Pre-authorisation is required 48 hours in advance for all elective procedures, failing which a co-payment of R1 800 per admission will apply (for pre-authorisation call Universal Care on 0860 102 312)	
Private and public hospitals, nursing homes, step-down facilities, day clinics and hospice	
Accommodation in a general ward, high care ward or intensive care unit and theatre fees	100% of AT or contracted fee subject to MME Co-payments are applicable for certain in-hospital procedures*
Medicines while hospitalised	100% of cost subject to MME (excludes dental materials)
GPs and specialists in hospital: visits, consultations, surgical/non-surgical procedures and operations, including anaesthesia, as well as maxillo-facial and oral surgeons	100% of cost up to a maximum of 250% of the AT, subject to MME (maxillo-facial and oral surgery excluded, except for trauma and PMB cases)
Radiology and pathology	100% of cost up to a maximum of 250% of the AT, subject to MME
Blood transfusions	100% of cost, subject to MME
Psychology and psychiatry	100% of AT or contracted fee subject, to MME/ 21 days PMF
Confinements - hospitalisation Deliveries performed by GP/ Specialist: • Normal deliveries • Caesarean deliveries	100% of AT or contracted fee, subject to MME 100% of cost up to a maximum of 250% of the AT and three days, 100% of cost up to a maximum of 250% of the AT and four days
Surgical/medical prostheses and electronic/ nuclear aids used in operations	100% of cost subject to MME, sub-limits applicable**
Clinical technologists	100% of AT, subject to MME
Oncology	100% of cost subject to MME, limited to R579 700 per member family
Organ Transplants	Solid Organ Transplant 100% of cost subject to MME, limited to PMB Corneal Transplant 100% of cost subject to MME, Organ transplant limited to South Africa Other Transplants 100% of cost subject to MME, limited to R447 950 per member family
Hospitalisation alternatives:	
Step-down, nursing facilities and hospice	100% of AT or contracted fee, subject to MME
Surgical procedures performed out of hospital, in lieu of hospitalisation	100% of cost up to a maximum of 250% of the AT, subject to MME
Haemodialyses	100% of AT, subject to MME
Chemotherapy and radium treatments	100% of AT, subject to MME
Biological agents	100% of AT, subject to MME and an overall limit of R 262 810
Scans	**Pre-authorisation required - Call 011 208 1100**
MRI and computerised axial tomographies	100% of AT, subject to MME. If pre-authorisation is not obtained a R1 000 levy will be imposed on each account except in case of an emergency.
High-resolution CT scans	80% of AT, subject to MME. If pre-authorisation is not obtained a R1 000 levy will be imposed on each account except in case of an emergency.
Ambulance Services	**100% AT**
ER-24 emergency services	Call 0800 127 614 or 084 124

* See section on co-payments ** See section on sub-limits

Annual Flexi Benefit (Out of hospital)

Annual Flexi Benefit (AFB) - please note: all sub-limits below are subject to the AFB limit					
Day-to-day claims are paid at 90% of the agreed tariff (AT) from the (AFB)	M R9 844	M+1 R15 495	M+2 R18 782	M+3 R21 322	M+4+ R22 804
Specialists	**90% of AT, subject to AFB**				
Consultations and visits Member must get a referral from a GP to visit a specialist. If no referral is obtained, a 10% co-payment will apply	M R2 862	M+1 R5 836	M+2 R 8 956	M+3 R 9 748	M+4+ R 9 992
Dental services	**90% of AT subject to AFB**				
Specialised (crowns, bridgework and orthodontics)	M R7 298	M+1 R11 496	M+2 R13 980	M+3 R16 120	M+4+ R17 045
Prescribed medication & injection material	**90% of cost, subject to AFB and MMAP**				
Acute and homeopathic medication, including vaccinations	Subject to AFB				
Chronic Medication • Non-PMB medication	Subject to AFB				
Pharmacy advised therapy • Limited to R 210 per script	M R1 170	M+1 R1 870	M+2 R2 750	M+3 R3 430	M+4+ R4 010
Optical services	**90% of SAOA, subject to AFB**				
Lenses, contact lenses, disposable lenses • Single vision and contact lenses • All other lenses	Limited to a maximum of R 8 938 PMF 90% of SAOA tariff: R2 562 PB 90% of SAOA tariff: R 3 476 PB				
Frames	90% of cost: R1 460 per case - excluded from lens limit				
Optometrists – eye examinations	90% of SAOA tariff: one test PB per year				
Radial keratotomy/excimer laser	90% of AT, limited to R5 994 per eye and pre-authorisation				

Insured benefits

GP consultations out of hospital	**Unlimited**	
Consultation, visits, at rooms or patients residence (excluding procedures and materials)	90% of AT - Unlimited	
Dentistry	**Unlimited**	
Conservative and restorative dentistry treatment out of hospital	Unlimited	
Chronic Medication	**100% of AT**	
PMB medication	100% Unlimited, 20% co-payment for non-formulary medication Suject to formulary	
Auxiliary services	**90% of AT, limited to PMF**	
Chiropractors; naturopaths/homeopaths; chiropodists/ podiatrists; physiotherapists; audiologists/speech and occupational therapists; dieticians; acupuncturists; radiologists/pathologists; orthoptists; biokineticists and private nursing at home (excluding post-partum cases)	M R11 185	M+1+ R14 996
Psychology and psychiatry	90% of AT limited to R8 690 PMF, subject to auxiliary services limit	
Medical appliances	90% of cost subject to auxiliary services limit	
Wheelchairs, hearing aids, nebulisers, electronic/nuclear appliances, prostheses and ancillary apparatus		
Back and Neck	**100% of AT**	
Back and Neck Rehabilitation	100% of negotiated fee or in the absence of such fee, 100% of AT subject to MME. R3 000 hospital co-payment should an eligible member or beneficiary decline to follow the Back and Neck Rehabilitation Programme before going for non-PMB or non-emergency spinal surgery.	

Wellness benefits (claims are paid from insured benefits)

Benefit	Limits
Universal 360° check, including: blood pressure, cholesterol, glucose, BMI, waist circumference, exercise and meal plan	Limited to R140 PB. One per year PB over the age of 18 years at a DSP
Childhood immunisations	Applicable to children up to the age of six years, as per recommendation of the Department of Health
Baby wellness visits	Two visits per year for children between four weeks and 18 months at a DSP
Flu vaccinations	Limited to R 95 PB
Adult pneumococcal vaccines	Subject to pre-authorisation, for beneficiaries over the age of 60
Malaria prophylaxis	As required
Mammograms	One test per female beneficiary over the age of 35, every 24 months
Pap smears	One test per female beneficiary over the age of 18 per year
Prostate specific antigens (PSAs)	One test per male beneficiary over the age of 40 per year
Annual fitness assessments	At a biokineticist, applicable to beneficiaries over the age of 21
Nutritional assessments	At a dietician, applicable to beneficiaries over the age of 21

Surgical and medical prosthesis sub-limits

Subject to MME and limits below for 2019	
Stents (maximum of three stents)	R16 242
Medicated stents (maximum of three stents)	R25 100
Abdominal aortic aneurysm stents	R73 716
Hip prostheses	R57 595
Knee prostheses	R48 742
Shoulder prostheses	R48 742
Spinal instrumentation (per level, limited to two levels and one procedure PB per year)	R32 495
Spinal cages	R16 242
Imported lenses	R11 810
Heart valves (mitral, etc.)	R32 495
Intra-ocular lenses (per eye)	R7 386
Normal bladder slings	R11 808
Artificial limbs	
Through-knee prostheses	R73 840
Below-knee prostheses	R56 104
Above-knee prostheses	R64 974
Partial-foot prostheses	R28 064
Electronic and nuclear devices	
Defibrillators	R177 215
Single pacemakers	R66 465
Dual pacemakers	R81 228
Internal nerve stimulators	R147 682
Cochlear implants	R187 544

Contributions with effect from 1 January 2019

Income p/m	Group	Principal Member	Adult Dependant	Child Dependant
Up to R4 724	A	R1 770	R1 321	R435
R4 725 - R6 299	B	R2 379	R1 763	R581
R6 300 - R8 399	C	R2 756	R2 060	R667
R8 400 - R10 499	D	R3 134	R2 350	R740
R10 500 - R15 749	E	R3 235	R2 422	R784
R15 750 - R19 999	F	R3 398	R2 556	R813
R20 000 - R29 999	G	R3 583	R2 696	R857
R30 000 +	H	R3 599	R2 707	R861

Co-payment for in-hospital procedures

A co-payment of R1 800 is payable for procedures done in hospital (as opposed to a day surgery facility).
Should the procedures below be done in a day surgery facility, no co-payment will be charged.

Colonoscopies	Flexible sigmoidoscopies
Cystoscopies	Tonsillectomies and adenoidectomies
Functional nasal surgery	Varicose vein surgery
Gastroscopies	Arthroscopies
Hysteroscopies (but not endometrial ablations)	Diagnostic laparoscopies
Myringotomies	

Member guide

Abbreviations

AFB	Annual Flexi Benefit	MME	Annual major medical expenses limit conditions
AT	Agreed tariff	PB	Per beneficiary
CDL	Chronic Disease List	PMB	Prescribed minimum benefits
DSP	Designated service provider	PMF	Per member family
GRP	GEMAS Reference Price	SAOA	South African Optometric Association

Membership

Membership is restricted to eligible employees of Saab SA (Pty) Ltd, all subsidiaries and such associated companies, as approved by the Board of Trustees.

Registration of dependants

A member may apply for the registration of his/her dependants at the time of applying for membership. The following persons can qualify as a dependant:

- A spouse or partner;
- Dependant children under the age of 21;
- Dependant children over the age of 21, but under the age of 25 and who are students at a recognised tertiary educational institute;
- Immediate family for which the member is liable for family care and support (proof of legal duty required);
- Disabled/mentally challenged children.

Members may add a dependant by completing the necessary form. The following information is required:

- Previous medical scheme membership certificates;
- Copy of IDs for adults and birth certificates for children;
- Marriage certificate;
- An affidavit where surnames in a partnered relationship differ;
- Adopted children – legal documentation to be provided;
- Student certificate and/or proof of registration from a registered tertiary educational institute;
- Proof of dependency when child is over 21.

The dependants of a deceased member, who are registered with the scheme as his/her dependants at the time of such member's death, shall be entitled to continued membership of the scheme.

Students and children older than 21 years

Children above the age of 21 years are regarded as adult dependants, unless they are studying at a recognised secondary or educational institution. A member should submit annual proof of registration for their dependants who are still studying at an educational institution. The dependant will be regarded as a child dependant. The dependant will be removed from the scheme should the required documentation not be received timeously.

Membership card
Every member shall receive a membership card which must be exhibited to the supplier of a service on request. It remains the property of the scheme and must be returned to the scheme on termination of membership. Members will receive cards for each adult dependant registered. Members may apply for additional cards or replacement cards.

Change of address
A member must notify the scheme within 30 days of any change of address, including his/her domicilium citandi et executandi (address at which legal proceedings may be instituted). The scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member neglecting to comply with the requirements of this rule.

Resignation
A member who, in terms of the conditions of employment, is required to be a member of the scheme, may not terminate membership while still an employee without prior written consent from the employer.

Contributions
Contributions shall be due monthly in arrears. Where contributions or any other debt owing to the scheme has not been paid within three days of the due date, the scheme shall have the right to suspend all benefit payments in respect of claims which arose during the period of default.

In the event that payments are brought up to date, and provided membership has not been cancelled, benefits shall be reinstated without any break in continuity. If such payments are not brought up to date, no benefits shall be due to the member from the date of default and any such benefit paid will be recovered by the scheme.

Members' portions
Members' portions arise when healthcare service providers are refunded in full by the scheme, but the member still has to cover the cost of a co-payment applicable to the particular benefit or where levies are imposed. Thereafter, claims will be refunded at the AT and any co-payments will be collected at the point of sale at pharmacies.

Payment of claims
GEMAS has a weekly payment run to suppliers and members. Members will receive a monthly statement containing details of all payments made to suppliers.

Members can track the payment of their claims on the scheme's website: www.gemas.co.za

Submission of claims
Claims may be submitted to the scheme electronically, either by the supplier, or by the member. Paper claims may be faxed, emailed or posted to the details below:
Fax: 011 208 1028 / Email: gemas@universal.co.za
Post: Private Bag X1897, Rivonia, 2128

Medication
A 20% co-payment is payable for the voluntary use of non-formulary PMB medicines.

Chronic Benefit
Members diagnosed with chronic conditions need to register their chronic conditions in order to access the Chronic medicine benefit. Members are required to email or fax their chronic prescription to the GEMAS chronic department to register their chronic conditions or to notify the chronic department of any changes or additions to their chronic conditions. Alternatively your doctor or pharmacy can call the GEMAS chronic department directly on your behalf.

Your chronic medicine claims are to be submitted by your pharmacy to the pharmaceutical benefit manager for real-time electronic claims processing.
Tel: 086 0102 312 / Fax: 086 210 8743
Email: chronicmedicine@universal.co.za

GEMAS Reference Price (GRP)
GEMAS has chosen to settle medicine claims at cost, subject to the GEMAS Reference Price.

The GRP is a list of generic equivalent medicines that are available at a substantially lower cost than that of the original medicine and can extend the value of a member's benefit.

Generic medicines
A generic medicine is the equivalent of a well-known pharmaceutical product with proven efficacy and safety, that has been utilised over an extended period of time and of which the patent has expired. Such a generic medicine has the same active ingredient as the original pharmaceutical product and is supplied in the same strengths and dosage forms. GEMAS suggests that you request your doctor to prescribe generic medicines for you.

Prescribed minimum benefits
- Hospitalisation – all services are paid at 100% of cost in terms of PMB criteria and are subject to pre-authorisation and protocols.
- Medication must be dispensed by a DSP and is subject to the scheme's formulary, as well as the reference price.
- Benefits are subject to treatment protocols.
- All medical services must be supplied by DSPs, as specified in the rules of the Scheme.

Hospitalisation
- All treatment received in hospital is subject to pre-authorisation, case management and scheme protocols.
- In the case of elective admissions, authorisation must be obtained from the scheme's designated agent at least 48 hours prior to a beneficiary being admitted to a hospital or day clinic (except in the case of an emergency), failing which a co-payment of R1 800 per admission shall apply.

Hospital utilisation management
Universal Care is contracted by GEMAS to manage the hospital utilisation management pre-authorisation process and care received by members and beneficiaries.

Members are required to call 0860 102 312 for pre-authorisation for all urgent and elective procedures 48 hours in advance and for emergency admissions, on the first working day following the admission.

On requesting pre-authorisation for a hospital admission membership, benefits and medical appropriateness are all verified and an authorisation number is issued. Guidance and advice will also be provided to patients regarding the proposed procedure or treatment. Motivations for treatment may be requested from the treating doctor. The call centre is staffed by trained nursing staff.

Back and Neck Rehabilitation programme
Back and neck pain is the most common form of pain which can cause ill health and incapacity. In order to assist in reducing pain and a possible need for invasive surgery, the Scheme is offering access to a conservative Back and Neck Rehabilitation programme. Members enrolled on the programme will be identified for either an intensive multi-disciplinary or physiotherapy programme. This programme is provided either at a contracted Document Based Care (DBC) Clinic or at

a physiotherapy practice accredited by the South African Association of Physiotherapists, which are the preferred providers for this programme
How does it benefit you?

By participating in the Back and Neck rehabilitation programme, your quality of life will improve and your pain may be reduced. The programme is based on internationally recognised care pathways that reduces pain and improves flexibility. It has been proven to reduce the need for or even avoid surgery. Should you require surgery, following assessment by the programme, this will be funded in accordance with the scheme's rules and protocols. The Scheme will impose a R 3000 hospital co-payment should an eligible member or beneficiary decline to participate in the Back and Neck rehabilitation programme prior to going for non PMB or non-emergency surgery.

How to access this programme

- Your family practitioner or specialist may refer you
- If you are diagnosed with a back or neck problem, you can contact Universal on 0860 102 312 or e-mail preauthorisation@universal.co.za who will refer you to a practice near you.
- Once you have had an initial assessment at the healthcare provider, they will advise you as to the duration of the treatment. Either the practice or you can contact Universal for an authorisation number in order to ensure that the treatment will be covered from your risk benefits

Trauma expense recovery

Universal Care has designed a unique system to recover money from the Road Accident Fund (RAF). By splitting the claim for medical expenses and personal injury, recovery of the medical expenses can be accelerated. Should any member be involved in an accident, they can contact Universal Care on 011 208 1100 and speak to an agent who will advise them on the correct procedures to follow.
Email: trauma@universal.co.za

Fraud detection

Fraud is a major problem in South Africa and the healthcare industry is no exception. If you are aware of any fraudulent activity or have any information, please fax Universal on 011 807 6165.

Special limitations

1. All benefits are pro-rated during the first year of membership.
   The following limitations include all services rendered, i.e. hospitalisation and related services, and are subject to the limits below in a private institution. Where a benefit is part of the statutory PMBs, treatment in state facilities will be paid in terms of the PMB criteria.
2. In cases where a specialist, except an eye specialist or gynaecologist, is consulted without the recommendation of a general practitioner, a co- payment of 10% will apply.
3. In order to qualify for benefits, claims must be received at the scheme's offices within four (4) months after the end of the month in which the treatment occurred.

Exclusions

The following exclusions will apply to a member and/or his dependant/s, unless that particular exclusion is covered under the statutory PMBs and the treatment is supplied via a state facility, unless otherwise decided by the Board.

1. All costs of whatsoever nature for the treatment of sickness, conditions, or injuries sustained by a member or a dependant and for which any other party may be liable, unless the Board is satisfied that there is no reasonable prospect of the member or dependant recovering adequate damages from the other party. In the case of such a claim, after deliberation is repudiated by the parties concerned, the member is entitled to such benefits as would have applied under normal conditions, irrespective of the lapse of time.

2. Expenses incurred by a member or dependant in the case of or arising out of wilful self-injury, professional sport, speed contests and speed trials.
3. Operations, treatments and examinations for obesity, cosmetic purposes, or of the member's own choosing where this has no connection with any illness, presumed illness, accident or other medical disability. In this regard (but without derogation of the a foregoing), no benefits will be paid in respect of any examinations, operations or surgical procedures relating to jaw, ear, eye-lids or abdomen without approval of the Board.
4. Holidays for recuperative purposes.
5. The purchase of: patent medicines and proprietary preparations; applications, toiletries and beauty preparations; bandages, cotton wool and similar aids; patented foods, including baby foods; contraceptives and apparatus to prevent pregnancy; tonics, slimming preparations and drugs advertised to the public; household and biochemical remedies; vitamins and mineral supplements.
6. All costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules of the scheme.
7. In cases of a protracted nature, the Board shall have the right to insist upon a member or dependant consulting any particular specialist the Board may nominate in consultation with the attending practitioner. In such case, if the specialist's proposed treatment is not acted upon, no further benefits will be allowed for that particular illness.
8. Costs for services rendered by:
   8.1 Persons not registered with the South African Medical and Dental Council; the Chiropractors, Homeopaths and Allied Health Service Professions Council of South Africa; and the South African Nursing Council;
   8.2 Any institution, except a state or provincial hospital, not registered in terms of any law.
9. Appointments cancelled or not kept by members.
10. Travelling expenses other than ambulance services.
11. Hospital or nursing home expenses, where free hospitalisation was obtained.
12. Private nursing fees in respect of both mother and child in post-partum cases.
13. Artificial insemination of a person, as defined in the Human Tissue Act 1983 (Act No. 65 of 1983).

Waiting periods

If a member does not have continuous membership, the scheme will impose a 12-month waiting period on a pre-existing medical condition/s, for that specific condition/s.

Important notice

This is a summary of benefits, which are applicable in terms of the rules of the scheme. A copy of the rules may be obtained from the administrators if required. GEMAS does not provide international medical cover.

PLEASE NOTE: The rules of the Scheme, which are subject to the approval of the Registrar of Medical Schemes, will always take precedence over this summary.

Specialist referral and authorisation process

Members and their beneficiaries are required to obtain a referral from a GP before going to a specialist for a consultation and treatment. This is only for out-of-hospital consultations.

The benefits of this initiative are as follows:

- It ensures that your GP is in control of your healthcare, co-ordinates your health care and has a holistic view of your health.
- It ensures that only appropriate, complex cases are referred to specialists for treatment.
- It ensures that referral to the correct type of specialist takes place.

The authorisation process will support the process that is used by your GP. When you obtain the referral letter from your GP, the referral letter should be submitted to Universal Health. Based on the referral letter, an authorisation will be created in the administration system. If a referral has been obtained the claim will be paid, subject to limits and the scheme rate.

The referral letter can be submitted via:
E-mail to specauth@universal.co.za;
Fax to 0866 151 509;
The call centre on 0800 002 636.

The authorisation will be:

- Granted for a period of three months in order to give the member a chance to obtain an appointment with a specialist.
- Limited to one consultation.
- For the speciality and not a particular specialist.

The following will be excluded from the specialist authorisation requirement process:

- One gynaecologist visit per female, over the age of 16, per annum;
- One urologist visit per male beneficiary, over the age of 40, per annum;
- Paediatrician consultations for children under the age of 3;
- Pregnancies;
- Oncology (will be approved as part of the oncology management programme).

In cases where a specialist, except an eye specialist or gynaecologist, is consulted without the recommendation of a general practitioner, a co- payment of 10% will apply.

Ambulance Services

ER24 offers a 24-hour/7 days a week integrated service to all its clients. The clinical staff are all highly specialised in emergency care and include friendly and helpful professional nurses and paramedics.

Medical Information and Assistance Line – **084 124 ER24** medical personnel, including doctors, paramedics and nurses, will be available 24 hours a day to provide general medical information and advice. This is an advisory and information service, as a telephonic conversation does not permit an accurate diagnosis.

24 hour "Ask the Nurse" Health Line

- Members are encouraged to utilise this 24-hour cost-saving service.
- Our trained medical staff use documented medical algorithms and protocols to advise members on healthcare solutions.
- Members can first seek advice as to:
- Urgency of attention needed: dispatch ambulance, go to the hospital, go to the doctor.
- Generic medication advice: go to the pharmacy for over-the-counter medication;
- Self-medicate from home.

Trauma lines

In addition, the members have access to a 24-hour Crisis Counselling line where trained healthcare professionals will telephonically assist with advice/counselling for:

- Domestic violence
- Family, domestic and child abuse
- Bereavement
- Hijacking
- Armed robbery
- Assault
- Kidnapping
- HIV/AIDS information
- Trauma counselling
- Rape/referral to rape centres
- Substance abuse
- Poison advice
- Suicide hotline

What to do in the case of an emergency

- Call **084 124**.
- If someone else is calling on your behalf, tell them to call **084 124**.
- Tell the ER24 operator that you are a GEMAS Medical Scheme member - they will prompt you or the caller for all the information they require to get help to you.

Useful tips

- Teach your family members to call **084 124** in case of an emergency.
- In an accident, take note of road names and numbers as this will expedite the emergency services.

Contact Us

Universal Healthcare Administration (Administrative)	
Contact number: 011 591 8207	**Email:** gemas@universal.co.za
Fax number: 011 208 1028	**Postal address:** Private Bag X 1897, Rivonia, 2128
Website: www.gemas.co.za	

Universal Care (Hospital pre-authorisation)	
Contact number: 011 591 8207	**Email:** preauthorisation@universal.co.za
Fax number: 0862 957 355	**Postal address:** PO Box 2570, Rivonia, 2128
Website: www.gemas.co.za	

Universal Care (Chronic authorisation)	
Contact number: 0860 102 312	**Email:** chronicmedicine@universal.co.za
Fax number: 0862 108 743	**Postal address:** PO Box 2570, Rivonia, 2128
Website: www.gemas.co.za	

Emergency services (Emergency rescue)
Contact number: 0800 127 614 or 084 124

Council for Medical Schemes Complaints	
Contact number: 0861 113 267	**Email:** complaints@medicalschemes.com
Website: www.medicalschemes.com	

Administered by:

UNIVERSAL HEALTHCARE ADMINISTRATORS (PTY) LTD