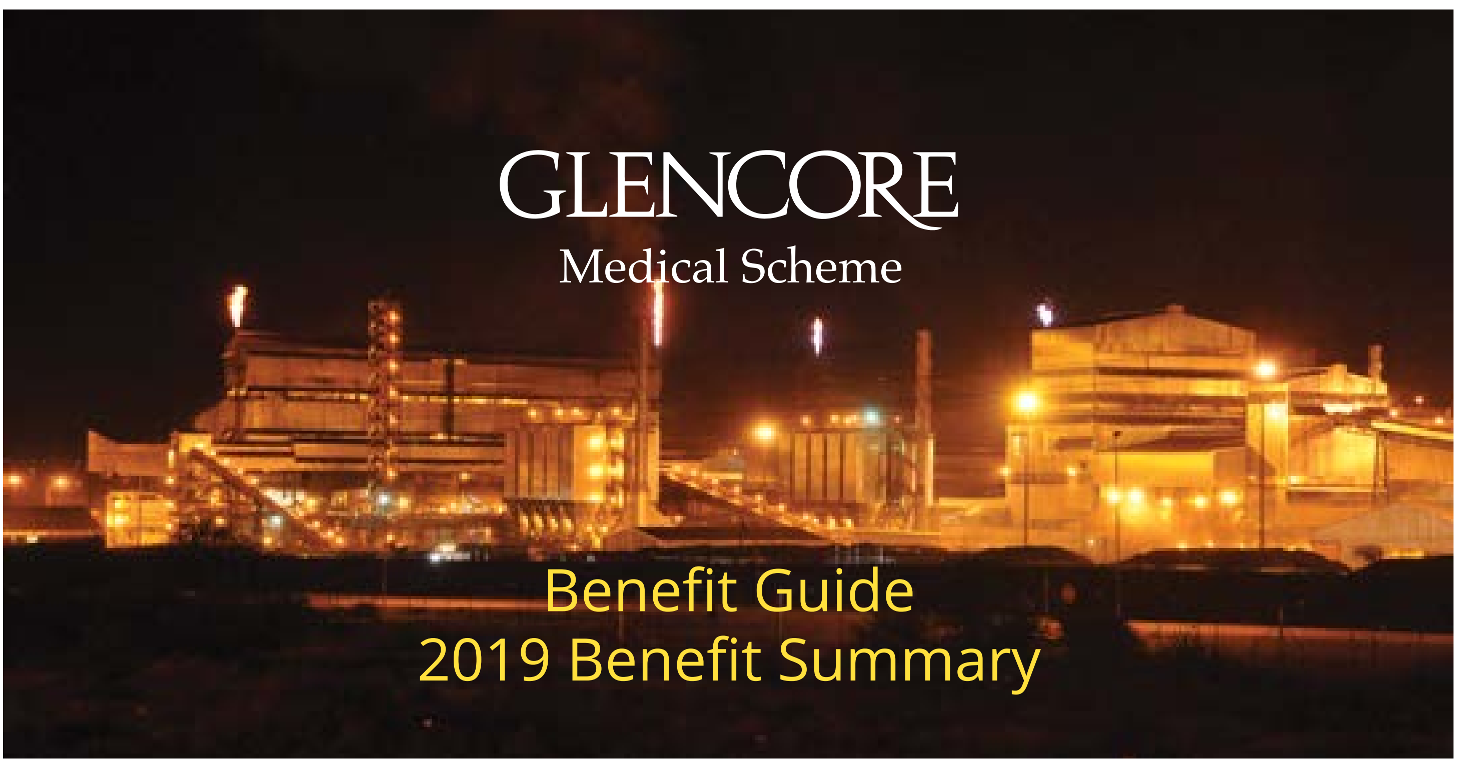

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Overall Annual Limit (OAL)		R1 000 000 for a family. All limits are subject to the Overall Annual Limit (OAL)	
Alternative healthcare			
Homeopathic consultations and medicine only	80% of the lower of cost or Scheme Rate	R7 440 for a family	
Ambulance service			
	100% if authorised by the preferred provider		Subject to approval by preferred provider
Appliances, external accessories and orthotics			
General medical and surgical appliances and appliance repairs	100% of the lower of cost or negotiated Scheme Rate	R18 150 for a family (Appliances limit)	
CPAP (Continuous Positive Airway Pressure)		Subject to the Appliances limit	
Glucometers		R1 080 for a beneficiary, included in the Appliances limit	
Peak flow meters		R460 for a beneficiary, included in the Appliances limit	
Nebulisers		R1 240 for a beneficiary, included in the Appliances limit	
Foot orthotics		R4 600 for a beneficiary, included in the Appliances limit	
Keratoconus contact lenses		Subject to the Appliances limit	Authorisation required
Oxygen therapy and home ventilators		Subject to OAL	Authorisation required
Incontinence products	100% of the lower of cost or negotiated fee	Subject to OAL	Authorisation required
You need to preauthorise accessories and appliances (except glucometers) for diabetes and these need to be claimed from the Chronic Illness Benefit unless you are registered on the Centre for Diabetes and Endocrinology (CDE) Programme.			

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Blood, blood equivalents and blood products			
	100% of negotiated fee	Subject to the OAL	Authorisation required
CONSULTATIONS AND VISITS **General Practitioners and Medical Specialists**			
In-hospital	100% of the lower of cost or Scheme Rate	Subject to the OAL. Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy	
Out-of-hospital	100% of the lower of cost or Scheme Rate	M0: R5 390 M1: R8 080 M2: R10 770 M3+: R13 470. Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy	
Dentistry			
Basic: Includes plastic dentures and basic dentistry performed in-hospital for children under eight (8) and for removal of impacted wisdom teeth	100% of the lower of the cost or Scheme Rate	R13 190 for a family	Authorisation required for all dental treatment in-hospital
Advanced: Oral surgery, metal base dentures, inlays, crowns, bridges, study models, orthodontics, periodontics, prosthodontics, osseointegrated implants, orthognathic surgery and dental technician fees	100% of the lower of the cost or Scheme Rate	R13 650 for a family	Authorisation required for advanced dentistry in hospital
Hospitalisation			
Accommodation in a general ward, high-care ward and intensive care unit, theatre fees, ward drugs and surgical items	100% of the lower of the cost or Scheme Rate	Subject to the OAL	Authorisation required
Alternatives to hospitalisation			
Physical rehabilitation facilities, hospice, nursing services and sub-acute facilities	100% of the lower of the cost or Scheme Rate	R72 920 for a family	Authorisation required
Immunodeficiency syndrome (hiv/aids)			
	100% of cost		Authorisation required
Infertility			
	100% of the lower of cost or negotiated fee for public hospitals	Limited to interventions and investigations as prescribed by the regulations to the Medical Scheme Act	Authorisation required
Maternity			
Hospital: Accommodation, theatre fees, labour ward fees, dressings, medicines and materials. **Note:** For confinement in a registered birthing unit or out-of-hospital, four (4) post-natal midwife consultations for a family each year	100% of the lower of cost or Scheme Rate	Subject to the OAL	Authorisation required
Related maternity services: 12 antenatal consultations, two (2) 2D scans, pregnancy related tests and procedures	100% of the lower of cost or Scheme Rate	R8 500 per family. 3D scan paid up to cost of 2D scan	

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Amniocentesis	80% of the lower of cost or Scheme Rate	R8 560 for a family and further limited to one test for a family each year	
Medicine and injection material			
Acute medicine: including malarial prophylactics	100% of the approved price	M0: R5 400 M1: R9 400 M2: R12 500 M3+: R14 500 (Acute Medicine limit)	Refer to general Scheme exclusions
Medicine on discharge from hospital	100% of the approved price	R480 for a beneficiary per admission, included in the Acute Medicine limit	Refer to general Scheme exclusions
Over-the-counter medicine	100% of the approved price	R1 610 for a family; maximum R400 per script. Included in the Acute Medicine limit	Refer to general Scheme exclusions
Chronic medicine	**Chronic Disease List conditions** Up to 100% of Scheme Rate for approved chronic medicine on the medicine list (formulary). Up to 80% of MMAP for approved chronic medicine not on the medicine list (formulary). **Additional Disease List conditions** Up to 100% of MMAP for approved chronic medicine.	Subject to the OAL	Authorisation required. Refer to general Scheme exclusions
Contraceptive benefits: Oral, injectable, patches, rings, devices and implants	100% of the approved price	Subject to the OAL	Only if prescribed for contraception (not approved for skin conditions)
Mental health			
Psychiatric and psychological treatment in-hospital (including hospitalisation costs and procedures)	100% of the lower of cost or Scheme Rate	R37 860 for a family (Mental Health limit)	Authorisation required
Rehabilitation for substance abuse	100% of the lower of cost or Scheme Rate	21 days for a person each year, included in the Mental Health Limit	Authorisation required
Out-of-hospital: Consultations, visits, assessments, therapy, treatment and counselling	100% of the lower of cost or Scheme Rate	R7 440 for a family, included in the Mental Health limit	
Non-surgical procedures and tests			
In-hospital	80% of the lower of cost or Scheme Rate	Subject to OAL	Authorisation required
Out-of-hospital	100% of the lower of cost or Scheme Rate	R8 970 for a family	Authorisation required
Optometry			
Eye examinations	100% of the lower of cost or SAOA Rate	One (1) examination for a beneficiary each year	
Lenses	100% of the lower of cost or SAOA Rate	Clinically essential every 24 months – effective 1 Jan, 2018	No benefit for lens add-ons
Frames	100% of the lower of cost or SAOA Rate	One frame for a beneficiary, further limited to R1 460 for a beneficiary every 24 months – effective 1 Jan, 2018	

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Contact lenses	100% of the lower of cost or SAOA Rate	R3 000 for a beneficiary every 24 months effective 1 Jan 2018, instead of spectacle lenses above	
Readers	100% of the lower of cost or SAOA Rate	Limited to and included in the frames limit above, if obtained from a registered practice	
Refractive eye surgery	80% of the lower of cost or Scheme Rate	R18 150 for a family	Authorisation required
Organ and tissue transplants			
Harvesting of organ/s, tissue and the transplantation of them (limited to RSA)	100% of the lower of cost or Scheme Rate	R209 190 for a family	Authorisation required
Immunosuppressive medication	100% of the approved price	Included in the Organ Transplant limit	Authorisation required
Corneal grafts. Organ harvesting not limited to RSA	100% of the lower of cost or Scheme Rate	R27 890 for a beneficiary, included in the Organ Transplant limit	Authorisation required
Oncology (cancer)			
Active treatment period. Includes approved pathology and post active treatment for 12 months	100% of the lower of cost or Scheme Rate	Subject to the OAL	
Brachytherapy	100% of the lower of cost or Scheme Rate	R49 660 for a family	Authorisation required
Preventative care			
Childhood Immunisation Benefit	100% of the lower of cost or Scheme Rate	According to the Department of Health protocols (excludes consultation cost)	
Pathology and medical technology			
In-hospital	100% of the lower of cost or Scheme Rate	Subject to the OAL	
Out-of-hospital	100% of the lower of cost or Scheme Rate	R9 470 for a family	
Additional medical services			
In-hospital: Dietetics, occupational therapy, speech therapy and social workers	100% of the lower of cost or Scheme Rate	R13 150 for a family	
Out-of-hospital: Audiology, dietetics, genetic counselling, hearing aid acoustics, occupational therapy, orthoptics, podiatry, private nurse practitioners, speech therapy and social workers	100% of the lower of cost or Scheme Rate	R4 700 for a family	
Physiotherapy, biokinetics and chiropractics (excluding x-rays)			
In-hospital: Physiotherapy and biokinetics	100% of the lower of cost or Scheme Rate	Subject to the OAL	
Out-of-hospital: Physiotherapy, biokinetics and chiropractics	100% of the lower of cost or Scheme Rate	R8 230 for a family	
Prostheses and devices (internal and external)			
	100% of the authorised cost	R57 580 for a family	Authorisation required
Radiology And Radiography			
In-hospital	100% of the lower of cost or Scheme Rate	Subject to the OAL	
Out-of-hospital	100% of the lower of cost or Scheme Rate	R10 380 for a family	
Specialised (in- and out-of-hospital)	100% of the lower of cost or Scheme Rate	R19 710 for a family	Authorisation required
PET and PET-CT scans	100% of the lower of cost or Scheme Rate	One (1) for a family	Authorisation required

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Renal dialysis (chronic)			
	100% of the lower of cost or Scheme Rate	R209 190 for a family	Authorisation required
Surgical procedures (including maxillo-facial surgery)			
	100% of the lower of cost or Scheme Rate	Subject to the OAL	Authorisation required

Contributions (1 July 2018 – 30 June 2019)

Contributions are based on a member's income and the number of dependants registered.

* Adult dependant = a dependant who is 21 years of age or older. ** Child dependant = a dependant who is under the age of 21.

Income group	Monthly Income Band Low	Monthly Income Band High	Principal Member	Per Adult dependant*	Per child dependant**
280	0	R10 705	R1 621	R1 272	R434
430	R10 706	R15 970	R2 072	R1 633	R558
550	R15 971	R21 998	R2 243	R1 724	R602
800	R21 999	R44 728	R2 801	R2 171	R666
999	R44 729	Plus	R3 319	R2 636	R780

Rate for child dependant/s: Contributions will be charged for a maximum of three (3) children, if there are more than three (3) children on the membership, no additional contributions will be charged.

Important out-of-hospital payment information

It is important to note that once limits are reached on out-of-hospital claims, no further claims will be paid by the Scheme, except claims that qualify for Prescribed Minimum Benefits (PMBs).

Membership

Who can be a member?

Only permanent employees of the Alloys operations of Glencore are eligible to join the Scheme and only retired employees may remain members after leaving Glencore.

Proof of membership

Your membership card is proof of your membership on the Glencore Medical Scheme and shows the following:

- Your membership number
- Your name and surname
- The names, surnames and dates of birth of your registered dependants
- The dates from which you are entitled to benefits
- Any exclusions or waiting periods.

Please look after your membership card. Do not lend it to anyone other than your registered dependants.

Allowing anyone else to use your card is fraud and may lead to suspension or termination of your membership.

You cannot join the Scheme if:

You are registered as a dependant on another medical scheme. This is because the Medical Schemes Act does not allow membership of more than one (1) scheme at a time.

Who can be registered as a dependant?

Your spouse or partner, dependent children or other members of your immediate family for whom you are responsible for family care and support in terms of the Scheme Rules.

A newborn or adopted child must be registered within 30 days of birth or adoption. Benefits and contributions start at the date of birth or adoption, but no benefits will be paid until the dependant is registered.

Please inform Glencore Medical Scheme immediately, if your personal details change (for example, your address, telephone number, marital status or number of dependants).

Chronic Illness Benefit

The Chronic Illness Benefit (CIB) covers approved medicine for a list of 26 Chronic Disease List (CDL) conditions. Approved medicine on the medicine list (formulary) will be funded in full up to the Scheme Rate for medicine. Approved medicine not on the medicine list, will be funded up to 80% of the Maximum Medical Aid Price (MMAP). You will be responsible for the difference.

Chronic Disease List (CDL) conditions:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic renal disease
- Crohn's disease
- Diabetes insipidus
- Diabetes Mellitus type 1
- Diabetes Mellitus type 2
- Dysrhythmia
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Ischaemic heart disease
- Multiple Sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative Colitis.

There are further Additional Disease List (ADL) conditions. There is no medicine list (formulary) for these conditions. Approved medicine for these conditions will be funded up to the Maximum Medical Aid Price (MMAP).

If you want to access the Chronic Illness Benefit, you must apply for it. You must complete a Chronic Illness Benefit application form with your doctor and submit it for review.

If your Chronic Disease List (CDL) condition is approved, the Chronic Illness Benefit will cover certain tests, procedures and consultations for the diagnosis and ongoing management of the condition in line with Prescribed Minimum Benefits.

Prescribed Minimum Benefits (PMBs)

A set of minimum benefits that, by law, must be provided to all medical scheme members. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions.

What benefits are included under the Prescribed Minimum Benefits (PMBs)

The cover it gives includes the diagnosis, treatment and cost of ongoing care for:

- Any life-threatening emergency medical condition
- A defined set of 270 conditions.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the Prescribed Minimum Benefits.

The requirements are:

1 | The condition must be on the list of defined PMB conditions.

2 | The treatment needed must match the treatments in the defined benefits on the PMB list.

3 | You must use the Scheme's designated service providers unless there is no designated service provider.

Cover for medical emergencies

A medical emergency is the sudden and unexpected onset of a health condition that needs immediate medical or surgical treatment, where failure to provide this treatment would result in:

- Serious impairment to bodily functions, or
- Serious dysfunction of a bodily organ or part, or
- Placing the person's life in serious jeopardy.

Cover for going to hospital

In an emergency, go straight to hospital. If you need medically equipped transport, call 0861 333 032.

Application for Prescribed Minimum Benefits (PMBs) cover

PMBs are subject to authorisation, registration or application before PMB benefits can be confirmed.

How healthcare professionals ensure payment of claims for PMBs

To ensure that claims are correctly processed, the hospital, healthcare professional and pharmacist must use specific codes (ICD-10 codes) on the account to indicate that the treatment was for a condition qualifying for Prescribed Minimum Benefits.

Hospital benefit management

When do you need an authorisation number?

You need to obtain authorisation at least two (2) days before going to a hospital for any treatment (in- or out-patient).

- In the event of emergency treatment or admission to hospital over a weekend, public holiday or outside normal working hours, you must contact the Scheme for authorisation on the first working day after the incident.
- If you do not obtain preauthorisation for a planned event, or fail to authorise hospital treatment on the first working day after an emergency event, your claim may be rejected for payment.
- Any admission or out-patient visit to a hospital, must be authorised.

Obtaining authorisation

You can obtain authorisation by calling or emailing the Scheme using the contact details provided at the end of this document.

Information you need to apply for authorisation

- Membership number.
- Member or dependant name and date of birth.
- Date of admission and the proposed date for the operation
- Name of the doctor and his or her telephone and practice numbers, if available.
- Name of the hospital with the telephone and practice numbers if available.
- In the event of a CT scan, MRI procedure, and so on, the name and practice number of the radiology practice is also required.

Ask your doctor for full details of:

- The reason for admission to hospital, or scan.
- Applicable procedure/tariff code(s).
- Your diagnosis and ICD-10 code if available.

Once the authorisation request has been approved, you will receive the following information:

- The unique authorisation number.
- The initial length of stay approved.
- The approved codes.

If your hospital stay is longer than expected

Please arrange that your doctor, the hospital case manager or a family member, informs the Scheme of the extended length of stay.

If there is a clinical reason for the extended stay we will approve the extra days. If not, you will be responsible for the costs of the non-approved days and treatment.

> Although we check if a member is eligible for treatment and that sufficient benefits are available to cover costs, an authorisation is not an automatic guarantee that claims will be paid. You are encouraged to ask for details about how much will be paid by the Scheme when requesting authorisation for non-emergency procedures.

Medicine management

Pharmacy Advised Therapy (over-the-counter medicine)

Your pharmacist can prescribe and dispense certain medicine without a doctor's prescription. If you have a sore throat, cold, a mild cough or anything similar, ask your pharmacist for advice on which medicine to use.

Special dentistry

Please contact Customer Services before undergoing any special dentistry to confirm that you have benefits available and that the procedure will be covered. A written treatment plan and cost estimate from your dentist will help to determine the available benefits.

This is especially important before you have dental implants or undergo any associated treatment. It is essential to find out if orthognathic (jaw) surgery is part of the orthodontic treatment plan as the benefit for this type of treatment is limited. There may be some dental procedures that are not covered by the Scheme.

Oncology management

If you are diagnosed with cancer and need treatment, it is important that you register your treatment plan with the Scheme. All oncology treatment is subject to preauthorisation and case management.

Please make sure your doctor advises you of any change to your treatment, as your authorisation will need to be evaluated and updated. If this is not done, claims could be rejected for payment or paid from the incorrect benefit.

In addition to registering your treatment plan with the Scheme, you will need to obtain preauthorisation for any hospitalisation, private nursing or hospice services.

HIV

For most people HIV/AIDS is a frightening condition, but today treatment is available that allows the majority of people living with HIV to lead healthy and productive lives for many years.

Action and information

The first step is to find out whether you have been infected with HIV and what you can do to protect your loved ones and stay healthy.

Starting treatment at the right time ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infection or other complications.

We can help you to manage your condition

HIV is a sensitive matter and your condition will remain confidential.

For more information you can contact the Scheme using the contact details provided at the end of this document.

If you are exposed to HIV infection through sexual assault or a needle-stick injury, please ask your doctor to contact the Scheme to authorise special antiretroviral medicine to help prevent possible HIV infection. It is best to take this medicine as soon as possible (within hours) after exposure.

Centre for Diabetes and Endocrinology (CDE)

Members with diabetes have access to a Programme run by the Centre for Diabetes and Endocrinology (CDE).

This Programme offers you support services to manage your condition and focus on ways to prevent diabetes complications. A full set of diabetes-related consultations is provided as well as medication and a device to monitor your diabetes. You can obtain details of these services from the CDE. All services are covered by a monthly maximum amount paid from your overall annual limit and will not affect your day-to-day benefits.

Visit the CDE website at www.cdecentre.co.za for more information about diabetes and the CDE Diabetes Management Programme.

> Please call 0861 333 032 if you need emergency medical assistance.

Emergency services

Reporting a medical emergency:

- Dial 0861 333 032.
- Give your name, and the telephone number you are calling from.
- Identify yourself as a Glencore Medical Scheme member.
- Give a brief description of what has happened.
- Give the address at which the incident happened, as well as the nearest landmark.
- The call centre controller will be able to provide you with emergency medical advice while the ambulance is on its way.
- Do not put the phone down until the controller has disconnected.

Claims

Submitting your claims

Your healthcare provider will give you an invoice after a healthcare service has been rendered. If you have paid at the time of your visit or after receiving treatment, you will also get a receipt. Send the detailed account and receipt to us as quickly as possible. We will only pay your claim if we receive it within four (4) months of the treatment date. Send the first account you receive. Please do not send statements. If you have already paid the account and have attached the receipt, clearly mark the account "paid".

Please do not send us accounts marked "for your information only", or accounts showing only a balance brought forward. Keep these accounts for your records and use them to check against payments shown on your statements. The Medical Scheme Act requires that healthcare providers give full details on all accounts.

Please check that your account shows:

- Your name and initials.
- Your medical aid number.
- The treatment date.
- Name of patient (as indicated on the membership card, not a nickname).
- Amount charged.
- Tariff and ICD-10 code where applicable.

Tips on claiming

Check that prescriptions for medicine show all your details. Also check that the correct amount of the medicine dispensed is shown on the claim. If the pharmacy omits any of these details, the Scheme will not be able to process your claim and this may lead to delays.

GP Network

The Scheme has entered into a network arrangement with certain GP's. This means that members can go to a GP in the network and be certain that they will get full cover as the GP will change at the contracted Scheme rate with no co-payments and no administration fees. It is not compulsory for you to visit a network GP, but if you decide to visit a network GP you will reduce your co-payments and your out-of pocket expenses. If you wish to find out whether or not your GP is on the Scheme network, please contact Customer Services or your HR department for assistance.

Pharmacy Network

Pharmacies that form the Glencore Medical Scheme network have agreed to offer reduced dispensing fees to members. It is not compulsory that you have your medicine dispensed by one of the preferred providers, but by doing so you will be able to reduce your co-payments (pay less from your own pocket). If you wish to find out whether your pharmacist is on the network, please contact Customer Services or your HR department for assistance.

General Scheme exclusions

Unless otherwise approved by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme), expenses incurred in connection with any of the following will not be paid by the Scheme:

- All costs that exceed the annual or biennial maximum allowed for the particular benefit set out in the Scheme Rules.
- 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 condition.
- All costs for healthcare services if, in the opinion of the medical or dental adviser, such healthcare services are not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost.

- All costs in respect of injuries or conditions wilfully self-inflicted or injuries sustained while voluntarily participating in a riot, civil commotion, war, invasion, act of foreign enemy, hostilities whether war is declared or not, and civil war; or injuries arising from professional sport, speed contests and speed trials; or any other recreational activity which is not commonly recognised as a sport; involves uncontrolled competition, unusual skill or violent activity and is generally considered to be inherently dangerous, unless a Prescribed Minimum Benefit condition.
- All costs for medicine for the treatment of chronic conditions not on the list of conditions covered, with the exception of medicine for the treatment of an excluded chronic condition which the Scheme has specifically determined needs to be treated to achieve overall cost effective treatment of the beneficiary.
- All costs incurred for treatment of any sickness or condition(s) by a member or dependant of a member where such sickness or condition(s) is directly attributable to deliberate and wilful failure to carry out the instruction of a medical practitioner.

The Scheme will not pay costs related to any medical services rendered outside the borders of South Africa.

Scheme contact information

Customer Services

Telephone: 0860 00 21 41

Email: medicalscheme.enquiries@glencore.co.za

Claims

First time claim submissions:
email: medicalscheme.claims@glencore.co.za

Hospital authorisations

Telephone: 0860 00 21 41

Email: medicalscheme.authorisations@glencore.co.za

Chronic medicine authorisations

Telephone: 0860 00 21 41

Email: medicalscheme.cmm@glencore.co.za

Oncology (cancer) management

Email: medicalscheme.cancerinfo@glencore.co.za

Centre for Diabetes and Endocrinology (CDE)

Telephone: 011 712 6000

Email: members@cdediabetes.co.za

Emergency services (ambulance)

Telephone: 0861 333 032

Fraud hotline

Telephone toll free: 0800 004 500

SMS: 43477 and include the description of the alleged fraud

Fax toll free: 0800 007 788

Complaints and disputes

Members must first try and resolve their complaint with the Scheme and only contact The Council for Medical Schemes if they are still in disagreement with their medical scheme.

The Council for Medical Schemes
Block A Eco Glades 2 Office Park
420 Witch-Hazel Street, Ecopark,
Centurion 0157

Telephone: 012 431 0500

Fax: 012 431 7544

Customer Care call-share number:

0861 123 267

Email: **complaints@medicalschemes.com**

Website: **www.medicalschemes.com**