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The benefit guide is a summary of the Rules of the Scheme. In the event of a discrepancy between this guide and the registered Rules, the Rules will prevail. A copy of the Scheme Rules is available on request from your HR department.
Co-payments

The most significant change for 2014 is the removal of the 20% co-payment in respect of the following benefits:

- Acute medicines.
- Medicine on discharge from hospital.
- Over the counter medicine.
- General Practitioner and Specialist consultations out of hospital.
- Related Maternity services.
- Additional Medical Services in and out of hospital.
- Rehabilitation for substance abuse.

There will still be co-payments for costs above scheme tariff and the medicine price list (MPL). To limit these co-payments it is recommended that you make use of Network GPs and pharmacies.

There are monetary limits on a number of scheme benefits and monetary limits have also now been introduced for acute medicines, out of hospital pathology and additional medical services in hospital. The limit for out of hospital GP consultations has changed from a limit in respect of the number of visits to a monetary limit. The monetary limits compare very favourably with those of other schemes and have been set taking into account use by members as well as the industry norm.

It is important to note that once limits are reached no further claims will be paid by the scheme except claims that qualify for prescribed minimum benefits (PMB).

Find out

If you need more information about benefits, changes to benefits, whether a procedure or specific treatment is covered by your scheme, the amount that is covered by the scheme tariff or any other aspect of your healthcare cover that you are unsure about, contact customer services on 0860 002 141 or email glencore@medscheme.co.za

You also have the option of visiting your HR department to ask for help.

Your scheme provides additional information about various aspects of healthcare on a regular basis in its newsletters.

See page 24 of this benefit guide for all scheme contact details.
<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Tariff</th>
<th>Monetary limit per annum</th>
<th>Authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL ANNUAL LIMIT (OAL)</td>
<td></td>
<td>R500 000 per family. All limits are subject to the Overall Annual Limit (OAL)</td>
<td></td>
</tr>
<tr>
<td>ALTERNATIVE HEALTHCARE</td>
<td></td>
<td>R5 660 per family</td>
<td></td>
</tr>
<tr>
<td>Homeopathic consultations &amp; medicine only</td>
<td>80% of the lower of cost or scheme tariff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMBULANCE SERVICES</td>
<td>100% if authorised by the preferred provider</td>
<td></td>
<td>Subject to approval by the EMS service provider</td>
</tr>
<tr>
<td>APPLIANCES, EXTERNAL ACCESSORIES &amp; ORTHOTICS</td>
<td></td>
<td>R13 800 per family</td>
<td></td>
</tr>
<tr>
<td>General medical and surgical appliances and appliance repairs</td>
<td>100% of the lower of cost or negotiated scheme tariff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPAP</td>
<td></td>
<td></td>
<td>Subject to the Appliances limit</td>
</tr>
<tr>
<td>Glucometers</td>
<td>R825 per beneficiary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peakflow meters</td>
<td>R355 per beneficiary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebulisers</td>
<td>R944 per beneficiary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot orthotics</td>
<td>R3 500 per beneficiary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen therapy equipment and home ventilators</td>
<td></td>
<td></td>
<td>HRM Hospital Benefit Management</td>
</tr>
</tbody>
</table>

Diabetic accessories and appliances (except glucometers) to be pre-authorised and claimed from the chronic medicine benefit unless the patient is registered on the CDE programme.
<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Tariff</th>
<th>Monetary limit per annum</th>
<th>Authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLOOD, BLOOD EQUIVALENTS &amp; BLOOD PRODUCTS</strong></td>
<td>100% of negotiated fee</td>
<td>Subject to the OAL</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>CONSULTATIONS &amp; VISITS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioners and Medical Specialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td>Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy</td>
</tr>
<tr>
<td>Out of hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>M0: R4 000 M1: R6 000 M2: R8 000 M3+: R10 000 per family. Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy</td>
<td>Refer to page 22 (General Practitioner Network)</td>
</tr>
<tr>
<td><strong>DENTISTRY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic: Includes plastic dentures and dental technician’s fees</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R10 030 per family</td>
<td></td>
</tr>
<tr>
<td>Advanced: Oral surgery, metal base dentures, inlays, crowns, bridges, study models, orthodontics, periodontics, prosthodontics, osseointegrated implants, orthognathic surgery, hospitalisation and dental technician’s fees</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R10 380 per family</td>
<td>HRM Dental Management</td>
</tr>
<tr>
<td><strong>HOSPITALISATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation in a general ward, high care ward and intensive care unit, theatre fees, ward drugs and surgical items</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>Benefit Category</td>
<td>Tariff</td>
<td>Monetary limit per annum</td>
<td>Authorisation</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td><strong>ALTERNATIVES TO HOSPITALISATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical rehabilitation facilities, hospice, nursing</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R54 980 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>services and sub-acute facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMMUNE DEFICIENCY SYNDROME (HIV/AIDS)</strong></td>
<td>100% of cost</td>
<td></td>
<td>As determined by the Aid for AIDS programme</td>
</tr>
<tr>
<td><strong>INFERTILITY</strong></td>
<td>100% of the lower of cost or negotiated fee for public hospitals</td>
<td>Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes Act</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>MATERNITY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital: Accommodation, theatre fees, labour</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the Hospitalisation limit</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>ward fees, dressings, medicines and materials Note: For confinement in a registered birthing unit or out of hospital, 4 x post-natal midwifery consultations per family per annum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related maternity services: 12 antenatal consultations, 2 x 2D scans, pregnancy related tests and procedures</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R6 466 per family</td>
<td></td>
</tr>
<tr>
<td>Amniocentesis</td>
<td>80% of the lower of cost or scheme tariff</td>
<td>R6 490 per family and further limited to one test per family per annum</td>
<td></td>
</tr>
<tr>
<td><strong>MEDICINE &amp; INJECTION MATERIAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute medicine: including malarial prophylactics</td>
<td>100% of the approved price</td>
<td>M0: R4 000 M1: R7 000</td>
<td>Refer to page 13 (Medicine Management) and page 23 (General Scheme Exclusions)</td>
</tr>
<tr>
<td>Medicine on discharge from hospital</td>
<td>100% of the approved price</td>
<td>R392 per beneficiary per admission subject to the Acute Medicine limit</td>
<td>Refer to page 13 (Medicine Management) and page 23 (General Scheme Exclusions)</td>
</tr>
<tr>
<td>Benefit Category</td>
<td>Tariff</td>
<td>Monetary limit per annum</td>
<td>Authorisation</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medicine &amp; Injection Material continued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Advised Therapy (over the counter medicine)</td>
<td>100% of the approved price</td>
<td>R1 300 per family, maximum R323 per script subject to the</td>
<td>Refer to page 13 (Medicine Management) and page 23 (General Scheme Exclusions)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute Medicine limit</td>
<td></td>
</tr>
<tr>
<td>Chronic medicine</td>
<td>100% of the approved price if within the HRM</td>
<td>Subject to the OAL Refer to page 13 (Medicine Management)</td>
<td>Chronic Medicine Management</td>
</tr>
<tr>
<td></td>
<td>formulary 80% if outside the HRM formulary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric treatment and psychology in hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R28 780 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>(including hospitalisation costs and procedures)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation for substance abuse</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Included in the Mental Health limit and further limited to</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>one rehabilitation programme per beneficiary per annum</td>
<td></td>
</tr>
<tr>
<td>Out of hospital: Consultations, visits, assessments,</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R5 660 per family included in the Mental Health Limit</td>
<td></td>
</tr>
<tr>
<td>therapy, treatment and counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-surgical Procedures &amp; Tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital</td>
<td>80% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>Out of hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R6 820 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>Optometry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye examinations</td>
<td>100% of the lower of cost or SAOA tariff</td>
<td>One (1) examination per beneficiary per annum</td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>100% of the lower of cost or SAOA tariff</td>
<td>Clinically essential every 24 months - effective 1 Jan. 2013</td>
<td>No benefit for lens add-ons</td>
</tr>
<tr>
<td>Benefit Category</td>
<td>Tariff</td>
<td>Monetary limit per annum</td>
<td>Authorisation</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>OPTOMETRY continued</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>100% of the lower of cost or SAOA tariff</td>
<td>One frame per beneficiary, further limited to R1 240 per beneficiary every 24 months - effective 1 Jan. 2013</td>
<td></td>
</tr>
<tr>
<td>Contact lenses</td>
<td>100% of the lower of cost or SAOA tariff</td>
<td>R2 226 per beneficiary every 24 months - effective 1 Jan. 2013 instead of spectacle lenses above</td>
<td></td>
</tr>
<tr>
<td>Readers</td>
<td>100% of the lower of cost or SAOA tariff</td>
<td>Limited to and included in the frames limit if obtained from a registered practice</td>
<td></td>
</tr>
<tr>
<td>Refractive surgery</td>
<td>80% of the lower of cost or scheme tariff</td>
<td>R13 800 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>ORGAN &amp; TISSUE TRANSPLANTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harvesting of organ/s, tissue and the transplantation thereof (limited to RSA)</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R159 000 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>Immunosuppressive medication</td>
<td>100% of the approved price</td>
<td>Included in the Organ Transplant limit</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>Corneal grafts</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R21 200 per beneficiary included in the Organ Transplant limit</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>ONCOLOGY (Cancer)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active treatment period. Includes approved pathology and post active treatment for 12 months</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td></td>
</tr>
<tr>
<td>Brachytherapy</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R37 750 per family included in the Oncology limit</td>
<td>HRM Oncology Management</td>
</tr>
<tr>
<td><strong>PATHOLOGY &amp; MEDICAL TECHNOLOGY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td></td>
</tr>
<tr>
<td>Out of hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R7 200 per family</td>
<td></td>
</tr>
<tr>
<td>Benefit Category</td>
<td>Tariff</td>
<td>Monetary limit per annum</td>
<td>Authorisation</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
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<td>--------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>ADDITIONAL MEDICAL SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital: Dietetics, occupational therapy, speech therapy and social workers</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R10 000 per family</td>
<td></td>
</tr>
<tr>
<td>Out of hospital: Audiology, dietetics, genetic counselling, hearing aid acoustics, occupational therapy, orthoptics, podiatry, private nurse practitioners, speech therapy and social workers</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R3 578 per family</td>
<td></td>
</tr>
<tr>
<td><strong>PHYSIOTHERAPY, BIOKINETICS &amp; CHIROPRACTICS</strong> (excluding X-rays)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital (physiotherapy and biokinetics)</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td></td>
</tr>
<tr>
<td>Out of hospital (physiotherapy, biokinetics and chiropractics)</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R6 250 per family</td>
<td></td>
</tr>
<tr>
<td><strong>PROSTHESES &amp; DEVICES</strong> (internal &amp; external)</td>
<td>100% of the authorised cost</td>
<td>R43 770 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>RADIOLOGY &amp; RADIOGRAPHY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td></td>
</tr>
<tr>
<td>Out of hospital</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R7 900 per family</td>
<td></td>
</tr>
<tr>
<td>Specialised (in and out of hospital)</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R14 980 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td>PET &amp; PET-CT scans</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>One (1) per family and subject to the OAL</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>RENAL DIALYSIS</strong> (chronic)</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>R159 000 per family</td>
<td>HRM Hospital Benefit Management</td>
</tr>
<tr>
<td><strong>SURGICAL PROCEDURES</strong> (including maxillo facial surgery)</td>
<td>100% of the lower of cost or scheme tariff</td>
<td>Subject to the OAL</td>
<td>HRM Hospital Benefit Management</td>
</tr>
</tbody>
</table>
Contributions are based on a member’s income and the number of dependants registered.

### Monthly contributions from 1 July 2013 to 30 June 2014

<table>
<thead>
<tr>
<th>Monthly Income Band Low</th>
<th>Monthly Income Band High</th>
<th>Principal Member</th>
<th>Per Adult Dependant*</th>
<th>Per Child Dependant**</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>280</td>
<td>0</td>
<td>7074</td>
<td>1188</td>
<td>933</td>
</tr>
<tr>
<td>430</td>
<td>7075</td>
<td>10792</td>
<td>1519</td>
<td>1197</td>
</tr>
<tr>
<td>550</td>
<td>10793</td>
<td>15391</td>
<td>1645</td>
<td>1264</td>
</tr>
<tr>
<td>800</td>
<td>15392</td>
<td>30316</td>
<td>2053</td>
<td>1592</td>
</tr>
<tr>
<td>999</td>
<td>30317</td>
<td>999999999</td>
<td>2434</td>
<td>1933</td>
</tr>
</tbody>
</table>

* Adult dependant = a dependant who is 21 years of age or older

** Child dependant = a dependant who is under the age of 21

Tariff for child dependant: A charge will be levied for a maximum of three children.
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 the employ of Glencore.

Proof of membership
Your membership card is proof of your membership of 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.

You cannot join the scheme if...
You are registered as a dependant on another medical scheme because the Medical Schemes Act does not allow membership of more than one 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 liable 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 the Glencore Medical Scheme immediately if your personal details change (for example, your address, telephone number, marital status and number of dependants).

You will need to complete a Member Record Amendment form which is available from your Human Resources Department.

Your Scheme membership ends when you leave the service of your employer. Please remember to return your membership card to your employer before you leave.

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.
Prescribed Minimum Benefits

Specific Hospital Procedures and Chronic Conditions

The Medical Schemes Act specifies a list of Prescribed Minimum Benefits (PMB) that must be offered by all medical schemes. Within the list of PMB, there are specified chronic conditions that must be covered, without any benefit limit, by all schemes. The list is referred to as the Chronic Disease List (CDL).

In accordance with legislation, medicine formularies, Designated Service Providers and specific treatment protocols may be used in respect of these conditions.

How this affects your Chronic Medicine Benefit

Once you reach your chronic medicine limit, your scheme will continue to pay for medicines used to treat PMB conditions that are authorised by Chronic Medicine Management and fall within the protocols specified by the Council for Medical Schemes. You will continue to receive cover, up to the available chronic benefit limit, for chronic conditions not listed.

How healthcare professionals ensure payment of claims for PMB

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.

Chronic conditions that qualify for PMB

- Addison’s disease
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Coronary Artery disease
- Chronic Obstructive
- Pulmonary disorder
- Chronic Renal disease
- Crohn’s disease
- Diabetes Insipidus
- Diabetes Mellitus Types 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson’s disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic Lupus
- Erythematous
- Ulcerative Colitis
The Hospital Benefit Management Programme ensures that you receive appropriate, quality care whilst in hospital and value for your benefits.

When do you need a pre-authorisation number (PAR)?

You need to obtain a PAR at least 2 days before going to a hospital for any treatment (in- or out-patient), including a CT scan, MRI scan or radioisotope study.

• In the event of emergency treatment or admission to hospital over a weekend, public holiday or outside normal working hours, you must contact the Authorisation department on the first working day after the incident.

• If you do not obtain pre-authorisation 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/out-patient visit to a hospital, CT scan, MRI scan and radioisotope study must be authorised.

Obtaining a PAR

You can obtain a PAR by calling, emailing or applying online. To apply telephonically, phone the Hospital and Specialised Radiology Authorisation department on 0860 002 141. To apply by email, send the relevant information to: glencore.authorisations@medscheme.co.za.

To apply online, visit the Medscheme website (www.medscheme.co.za), click on the drop down arrow in the log in box at the top right-hand corner and select "member" to log into the secure area. Then click on the pre-authorisation button.

Information you need to apply for a PAR

• Membership number.
• Member or beneficiary name and date of birth.
• Date of admission and the proposed date for the operation.
• Name of the doctor and his/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, etc, 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.

Once the PAR has been approved you will receive the following information:

• The unique PAR 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 Authorisation Centre 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 liable 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 getting authorisation for non-emergency procedures.
Medicine Price List (MPL)

MPL is a reference pricing system that uses a benchmark (reference) price for generically similar products.

The fundamental principle of any reference pricing system is that it does not restrict your choice of medicines, but instead limits the amount that will be paid.

MPL reference prices are structured to ensure availability of medicines without additional co-payments being necessary. To avoid unnecessary co-payments ask your pharmacist to prescribe and dispense medicines that are fully reimbursed within the MPL.

In other words you will be able to afford the medicine you need without paying for it personally but you may have to choose a generic over a brand name product. If you prefer the more expensive product the scheme will only pay up to the MPL reference price and you will be liable for the difference in price.

Considering that medicines within a specific MPL group are either identical to one another (except for appearance and packaging) or otherwise very similar (e.g. only the inactive ingredients of products differ slightly), a given condition can be treated with any one medicine within such a group.

Medicine Exclusion List (MEL)

The Medicine Exclusion List (MEL) is a list of medicines that will not be paid from the Acute Medicine Benefit for various reasons. These include:

- medicine not proven to have relevant clinical value;
- medicine too expensive in comparison to cheaper but equally effective and safe alternatives;
- medication prone to abuse;
- expensive chronic medicines that require pre-authorisation;
- combination products, where it is more appropriate to use single ingredient products;
- newly registered medicine under review.

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.

Chronic Medicine Management (CMM)

Chronic medicines are prescribed for prolonged conditions that are often life-long.

To ensure you get the most appropriate, cost-effective treatment for your chronic condition, you need to register on the Chronic Medicine Management (CMM) program.

All applications and claims will be subject to the scheme rules and CMM clinical guidelines and protocols.

How your medicine is approved

Your scheme has introduced a new way of approving chronic medicine to make management of changes easier for you, your pharmacist and your doctor. When you
apply for chronic medicine, you are approved for treatment of your chronic condition and will have access to a list of pre-approved medicines, referred to as a basket. This means that when you need to change or add a new medicine for your condition, you can do this quickly and easily at your pharmacy with your new prescription.

It is important to note that not all conditions are managed this way and you may still need to call in to update us if you have a medicine that is not in your condition’s basket or if you are diagnosed with a new condition.

The quantity of each medicine in the basket is limited to the most commonly prescribed monthly dose. If you require higher quantities than those in the basket, you will have to contact us for authorisation.

You do not need to update us with your new medicine if:
- your medicine is in the basket; or
- you change to another medicine in the basket; or
- you need the quantity or dosage of a medicine listed in the basket.

Pre-approved medicine in the basket will still be subject to MPL (Medicine Price List) and formulary co-payments.

You can check for co-payments with your pharmacist or view the baskets, formularies and MPL lists on www.medscheme.co.za.

How to apply over the telephone and online:
If you need to register for, or update, your chronic medicine, you can do this over the telephone or online.

You, your doctor or pharmacist can complete the application. Below is a little more information about how to do this.

When you contact us, it is important to have a copy of your current prescription with you. Have the following information on hand:
- your membership number;
- the date of birth of the person applying;
- the ICD 10 code, and
- your doctor’s practice number.

To authorise certain medicine you may also need to provide us with:
- medicine details;
- the clinical examination data, e.g. weight, height, BP readings, smoking status, allergy information;
- test results, e.g. lipogram results, Hba1c, lung function tests;
- motivation provided by your prescribing doctor.

Telephonically:
- Call Chronic Medicine Management (CMM) between 8:30am and 5pm by using the contact details supplied in this guide.
- Follow the prompts, once you select the appropriate option your call will be routed through to a clinical consultant who will guide you through the process.
- You will be informed of any co-payments.

Online:
- Go to the Medscheme website at www.medscheme.co.za
- On the top right hand side of the web page login as a “Member” with your username and password. If you are a first time user please register.
- Go to “Clinical Information” and click on “Online Chronic Application”.

You do not need to update us with your new medicine if:
- your medicine is in the basket; or
- you change to another medicine in the basket; or
- you need the quantity or dosage of a medicine listed in the basket.
• Follow the prompts on the system and once all information has been captured click on “View Summary”. You can print this screen for your records.
• Click on “Submit” and a reference number will be provided to follow up on the progress of the application.

The registration process is then complete. Should additional clinical information be required, members of the clinical team will review the information and correspond with you and your doctor about the status of the medicine requested. You can follow the progress of your application at any time by contacting CMM.

Things to be aware of:
• Approved medicine will be paid from the chronic medicine benefit.
• You will still need to take your original prescription to the pharmacy to have your chronic medication dispensed.

Once you have registered and your application has been approved, you will receive a Medicine Access Card listing the medicines and/or conditions to be paid from your Chronic Medicine Benefit. The access card may indicate which medicines are on the Medicine Price List (MPL); medicines that will attract formulary co-payments as well as the duration for which the medication is authorised.

To have your medicine dispensed, you will need a handwritten repeat script from your treating doctor for the medicine listed on the card. The access card is not a prescription and cannot be used to have medicines dispensed.

Your treating doctor determines the number of repeats and will also advise you on how often he needs to see you to monitor your condition.

What if your medicine request has been declined?
If your medicine request has been declined, e.g. requesting a less costly alternative, a letter of explanation will be sent to you and a copy to your treating doctor. Please ensure that the treating doctor provides the requested information (where relevant). Your request will be reconsidered once all the relevant information has been received. Your doctor can appeal any decision by submitting a motivation for consideration to CMM.

What if your chronic medication changes?
In most cases where your medicine is changed by your treating doctor, you will be able to go straight to your pharmacist with a new script. If you have a Disease Authorisation you will have access to a basket of pre-approved medicines for your condition.

You only need to update us with your new medicine, either telephonically or online as described above, if:
• your medicine is not in the basket; or
• you are diagnosed with a new chronic condition; or
• you need to change the quantity or dosage of the medicine listed in the basket.

Chronic Medicine Management (CMM)
Call centre: 0860 002 141
Email: glencorecmm@medscheme.co.za
Website: www.medscheme.co.za
**Disease Management**

A formal disease management programme is provided for members with chronic conditions such as asthma, diabetes and ischaemic heart disease.

The programme offers support and education to assist you in managing your chronic condition.

The programme helps you:
- keep healthy;
- change your lifestyle to reduce risks for developing other conditions and limiting the impact of existing conditions;
- manage the effects and side-effects of treatment;
- recognise the importance of adhering to prescribed treatment;
- rehabilitate after disease events (such as a stroke or an operation);
- set personal healthcare targets.

All information regarding your medical condition is kept strictly confidential.

Your scheme will automatically identify and contact you if it believes you would benefit from receiving additional care. You therefore need not apply to participate in the programme.

If you would like to know more about the programme you are welcome to call one of our consultants on 0860 106 155 or email membercare@medscheme.co.za.

**Dentistry**

The scheme only covers dental treatment under general anaesthetic or conscious sedation for children under the age of eight. The only exception is when impacted wisdom teeth need to be removed.

Before undergoing treatment requiring general anaesthetic or conscious sedation you need to obtain a pre-authorisation as well as a motivation explaining why it is medically necessary.

When you need 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. **All orthodontic treatment must be pre-authorised.** 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.

**Dental accounts**

The Dental Management programme audits all dental claims before a dentist is paid. Claims will not be paid for treatment that does not fall within the dental management protocols, or if the scheme rules do not allow certain procedures.

In a case such as this, your dentist will be asked for a motivation, an amended account, or be sent a reason for the non-payment of the claim.
If you are diagnosed with cancer and need treatment, it is important that you register on the Oncology Disease Management programme and that your treatment plan is forwarded to the clinical team, as all oncology treatment is subject to pre-authorisation and case management.

Once the Oncology Management team receives your treatment plan, your details, information about your condition and proposed treatment will be recorded. The treatment plan is then reviewed and, if necessary, a member of the clinical team will contact your doctor to discuss more appropriate treatment alternatives.

After the treatment plan has been assessed and approved, an authorisation letter will be sent to you and your treating doctor. The letter will indicate the treatment authorised, the approved quantities and for how long the authorisation is valid.

Please make sure your doctor advises the Oncology Management team of any change to your treatment, as your authorisation will need to be evaluated and updated. If this is not done, there will be a mismatch between the claim and the authorisation which may result in the claim being rejected or paid from the incorrect benefit category.

**Registering on the programme**

Your treating doctor should either fax a copy of your treatment plan to (021) 466 2303 or email it to cancerinfo@medscheme.co.za. An oncology case manager will then take the process forward.

In addition to the authorisation from the Oncology Management team, you will need to get pre-authorisation from Hospital Benefit Management for any hospitalisation, specialised radiology (e.g. MRI scans, CT scans, angiography) private nursing/hospice services.

**Oncology Management**

Telephone: 0860 100 572
Fax: 021 466 2303
Email: cancerinfo@medscheme.co.za
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 infections or other complications. Our Aid for AIDS programme can help you access benefits and advise you on the best way to manage HIV/AIDS.

**We can help you to manage your condition**

Your medical scheme has a benefit specifically for HIV/AIDS related medicine. This benefit is used to pay for medicine to restrict the spread of the virus, vaccinations to protect against illnesses such as TB and flu, vitamins to boost your immune system and regular monitoring and testing.

**Your condition will stay confidential**

HIV is a sensitive matter and your condition will remain confidential. Staff members at our Aid for AIDS unit sign confidentiality agreements and work in a separate area away from the medical scheme. They use separate telephone, fax and private mailbag facilities.

To safeguard that your medical details remain strictly private, please only use these facilities.

**You must register on our Aid for AIDS programme**

If your test shows you are HIV-positive you must register with Aid for AIDS as soon as possible to make use of this benefit. Request an application form by telephoning the Aid for AIDS unit in confidence on 0860 100 646. Your doctor can also contact Aid for AIDS on your behalf.

**After you have registered**

After you receive the application form, you and your doctor must complete it and return it to the Aid for AIDS programme by using the confidential, toll-free fax line number on the form.
A highly qualified medical team will examine your details and, if necessary, discuss the most cost-effective and appropriate treatment with your doctor. Once treatment has been agreed upon, you and your doctor will be sent a detailed treatment plan that explains the approved medicine as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

If you are exposed to HIV infection through sexual assault or a needle-stick injury, please ask your doctor to contact Aid for AIDS 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. If the incident happens over a weekend you or your doctor can contact the Aid for AIDS programme on the Monday morning to arrange authorisation of the drugs for payment by your medical scheme.

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 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.

Call CDE on 011 712 6000 from Monday to Friday to register on the programme or send a fax to 011 728 6661. Visit the CDE website at www.cdecentre.co.za for more information about diabetes and the CDE Diabetes Management Programme.

Aid for AIDS

Telephone: 0860 100 646
Fax: 0800 600 773
Email: afa@afadm.co.za
SMS (call me): 083 410 9078
Please call Europ Assistance on 0861 333 032 if you need emergency medical assistance.

Europ Assistance

Emergency transportation will be facilitated through the Europ Assistance Medical Contact Centre. The contact centre staff includes registered nurses, paramedics and doctors who are well versed in all aspects of patient transportation.

Europ Assistance uses all the ambulance service providers in South Africa including ER24, Netcare911 and approximately 80 independent providers.

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 en route.
- Do not put the phone down until the controller has disconnected.

Additional benefits

A personal health advisor will provide you with access to important medical advice and assistance 24/7.
Submitting your claims
Your healthcare provider will give you an invoice. If you have paid at the time of your visit or after receiving treatment, you will also get a receipt.

Post, deliver or email the original invoice and receipt to us as quickly as possible. We will only pay your claim if we receive it within four 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 Schemes 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; and
- tariff and ICD-10 code where applicable.

You may email first time claims to: claims@medscheme.co.za

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

Dental treatment often requires additional work by a dental technician. He bills the dentist who adds this to your account and attaches a copy of the technician’s account. Please send us both accounts and ensure that your name and membership number are shown on each account.

When to expect payment?
Medscheme has a regular payment cycle: three payment runs per month to members and healthcare providers. If the month extends to five weeks, then four payment runs will take place. After we receive your claim we will process it and either refund you or pay the healthcare provider, depending on the payment method that has been chosen. If you have provided the scheme with a valid email address, you will receive an email notification every time we receive a claim from you as well as once the claim has been processed and is ready for payment. This mail will also tell you if you will be refunded, or if we will pay the healthcare provider directly.

Access your medical aid information on the internet
If you have internet access you can obtain a real-time view of your statements, claims’ history, contributions, personal information and much more. You will be able to view your benefits and update certain personal details.

Visit www.medscheme.co.za and follow the easy steps to register as a user.
With healthcare fees continually rising, members of the Board of Trustees always look for new ways to enhance the level of healthcare while keeping a close eye on the financial security of the scheme.

Our records and your communication indicate that many of you are finding it difficult to fund costs required by healthcare providers at the time of service. To assist in reducing unexpected cash outlays and improve the quality of healthcare received, the Board of Trustees implemented General Practitioner and Pharmacy networks.

**GP Network**

The GP Network focuses on providing you and your beneficiaries with reasonably priced quality healthcare.

The contracted GP Network doctors undertake:
- not to charge Glencore members above the contracted scheme rate; and
- to work closely with the scheme to improve quality and cost of care to members.

It is suggested that you make use of the contracted general practitioner network in order to minimise personal payments and ensure you receive the most appropriate quality healthcare.

**Pharmacy Network**

All pharmacies charge a dispensing fee to dispense medicines.

Pharmacies that form part of the Glencore Medical Scheme network have agreed to offer reduced dispensing fees to members.

It is not mandatory 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.

The following pharmacies form part of the network: Clicks, Dischem, Medirite (Shoprite/Checkers), CPN (Carepoint Independents), Pharmacross, Pick 'n Pay, Script Savers and Chronic Medicine Dispensary (CMD).

If you wish to find out whether your doctor or pharmacist is on the network, please contact our Customer Services department on 0860 002 141 or your HR department for assistance.
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 medicines for the treatment of chronic conditions not on the list of conditions covered, with the exception of medicines for the treatment of an excluded chronic condition which the Chronic Medicine Programme has specifically determined should be treated to achieve overall cost effective treatment of the beneficiary;

- all costs incurred for treatment of any sickness and/or condition(s) by a member or dependant of a member where such sickness and/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.

FRAUD

Fraud is regrettably experienced by all sectors of society and the medical scheme industry has not remained unscathed by this form of criminality. Disciplinary action, that may result in dismissal, will be taken against any member who commits fraud.

Glencore uses a number of methods to detect suspicious activity but we ask that you assist us by calling the Fraud Hotline if you know of any provider or member who is guilty of fraud. You may remain anonymous and your call will be confidential.

Medscheme Fraud Hotline
0800 112 811
Contact your scheme

Customer Services
0860 002 141

Email Queries
glencore@medscheme.co.za

Postal Address
Glencore Medical Scheme
PO Box 1101
Florida Glen
1708

Claims
First time claim submissions only
Email: claims@medscheme.co.za

Authorisations
Hospital and Specialised Radiology
Telephone: 0860 002 141
Email: glencore.authorisations@medscheme.co.za
Fax: 0860 212 223

Chronic Medicine Management
Telephone: 0860 002 141
Email: glencorecmm@medscheme.co.za
Fax: 0800 223 670/80
Website: www.medscheme.co.za

Member Care
Telephone: 0860 106 155
Email: membercare@medscheme.co.za
Website: www.medscheme.co.za

Oncology Management
Telephone: 0860 100 572
Fax: 021 466 2303
Email: cancerinfo@medscheme.co.za

Healthcare Provider Call Centre
Membership and benefit confirmations
Telephone: 0861 112 666
Chronic medicine and hospital authorisations
Telephone: 0861 100 220

Aid for AIDS
Telephone: 0860 100 646
Fax: 0800 600 773
Email: afa@afadm.co.za
SMS (call me): 083 410 9078

Centre for Diabetes and Endocrinology
(CDE)
Telephone: 011 712 6000
Email: medscheme@cdecentr.co.za

Europ Assistance (ambulance)
0861 333 032

Fraud Hotline
0800 112 811

Complaints and Disputes
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 Share call number:
0861 123 267
Email: complaints@medicalschemes.com
Website: www.medicalschemes.com
There is a quick links toolbar on the landing page;
click on the “How to lodge a complaint” link for further information