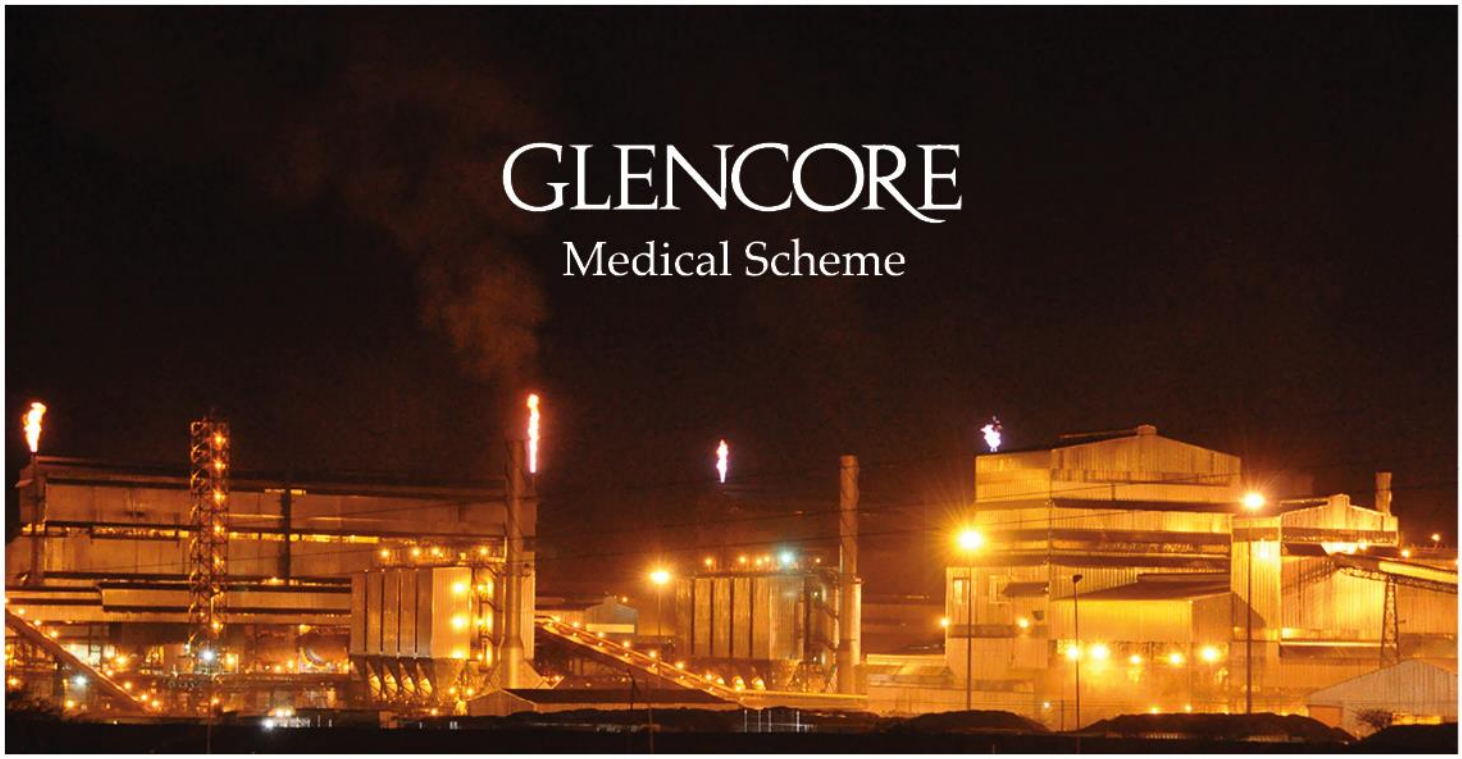

Guide to Prescribed Minimum Benefits 2020

Who we are

Glencore Medical Scheme (referred to as 'the Scheme"), registration number 1253, is a non -profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as "the administrator"), is a separate company and an authorised financial services provider (registration number 1997/013480/07), that administers the Glencore Medical Scheme.

General contact details

You can call us on **0860 00 21 41** or visit www.glencoremedicalscheme.co.za for more information.

There are some common benefits of medical schemes that apply to all members

This document tells you how the Scheme covers members for a list of conditions that form part of the Prescribed Minimum Benefits (PMBs).

Understanding the Prescribed Minimum Benefits (PMBs)

What are (PMBs)?

They are a set of minimum benefits that medical schemes must give to all their members according to the Medical Schemes Act of 1998 (Act number 131 of 1998. 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 diagnoses

- A defined list of 27 chronic conditions (Chronic Disease List conditions).

All medical schemes in South Africa have to include the PMBs in health plans they offer.

How does the Scheme pay claims for PMBs and non-PMB benefits?

We cover PMBs in full from the Hospital Benefit on approval of benefits. We fund non-PMB benefits from your day-to-day benefits in accordance with your chosen health plan.

Requirements you must meet

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

This does not apply in emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised should you want to avoid copayments. If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

PMB regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
PMB-related claims for services obtained outside the borders of South Africa shall be treated as normal (non-PMB) claims, subject to the relevant Scheme Rate and any other limitations applicable to normal (non-PMB) claims within the borders of South Africa.

You and your dependants must register to get cover for PMBs and Chronic Disease List conditions (CDL)

There are different types of PMB claims such as claims for In Hospital admissions, Out of Hospital PMB's (OHPMBs), PMB CDL conditions, Oncology and HIV.

How to register your chronic or PMB conditions to get cover

To apply for out-of-hospital PMBs or cover for a Chronic Disease List condition, you must get a *Prescribed Minimum Benefit* or a *Chronic Illness Benefit* Application form:
Both forms are available to download and print from www.glencoremedicalscheme.co.za.

- Log in to the website using your username and password. Then go to 'Find a document' and click on 'application forms'
- You can also call **0860 00 21 41** to request any of the above forms.

Once we receive the application form and it meets the PMB requirements we will automatically pay the associated approved investigations, treatment and consultations for that condition from risk benefits (not from your day-to-day benefits). We will also let you know about the outcome of the application.

More information on Out of Hospital PMB's (OHPMBs) and PMB CDL conditions is available on www.glencoremedicalscheme.co.za. under Medical Aid > Find a document.

If you want to apply for in-hospital PMB cover, you must call us on 0860 00 21 41 to request authorisation.

In an emergency a member must go directly to a hospital and notify the scheme as soon as possible of their admission. In cases of emergency, members are covered at cost for the first 24hrs or until stable.

Why is it important for you and your dependents to register your PMB or chronic conditions?

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include consultations, blood tests and other investigative tests. We pay for the services without lessening your day-to-day benefits because we pay it from your Hospital Benefit.

We pay for treatment that is not approved or falls outside the defined benefits from your available benefits according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay the claims.

There are times when you need to apply for cover under the PMBs. Once your healthcare professional confirms the diagnosis as a PMB condition, you can apply for us to pay the claims from your Hospital Benefit without using your day-to-day cover. Once approved, we will automatically recognise that the medical services you are claiming for falls under the PMBs.

Who must register to receive chronic medicine for PMB or chronic conditions?

The main member and all dependants with PMB or chronic conditions must register. Each member must register their specific conditions. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can just let us know about the changes.

If you get another condition, you have to register for the new condition before we will cover the treatment and consultations from the Hospital Benefit and not from your day-to-day benefits.

Additional documents needed to support the application

You may need to send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition. This will help us to identify that your condition qualifies for the treatment.

We need additional clinical information from your doctor if you request funding of any treatment that falls outside the standard treatment for the condition. If treatment that falls outside the defined benefits is not approved, it will be paid from your available day-to-day benefits according to your chosen health plan. If your health plan does not cover these expenses you will be responsible to pay the claims.

Where you must send the completed registration form

You can send the completed ***PMB application form***:

- By fax to: **011 539 2780**
- By email to: medicalscheme.enquiries@glencore.co.za
- By post to: Glencore Medical Scheme, PMB Department, PO Box 652509, Benmore, 2010.

You can send the completed ***Chronic application*** **form**:

- By fax to: **011 539 7000**

- By email to: medicalscheme.enquiries@glencore.co.za
- By post to: Glencore Medical Scheme, CIB Department, PO Box 652509, Benmore, 2010.

We will let you know if we approve your application

We will inform you of your entitlement to PMBs when your condition and treatment has been approved.

We will do this by fax, email or mail (as you indicated on the application form).

What happens if there is a change in your treatment?

Your treating doctor can call **0860 00 21 41** to register changes to your medicine for an approved condition. You only need to complete an application form when applying for a new PMB or chronic condition.

What happens if a doctor changes the medicine in the middle of the month?

For chronic conditions, the treating doctor or dispensing pharmacist can make changes to medicines telephonically. You or your treating doctor can also send the updated prescription by fax to 011 5397000 or email it to medicalscheme.enquiries@glencore.co.za.

For PMB conditions, the treating doctor or dispensing pharmacist can make changes to medicines by sending the updated prescription by fax to **011 539 2780** or email it to medicalscheme.enquiries@glencore.co.za

Why use your plan's medicine list?

We pay for medicine on the medicine list (formulary) up to the Scheme Rate for medicines. There will be no co-payment for medicine selected from the medicine list.

What happens when you need treatment that is not on the list?

The Scheme is only required to cover treatments, procedures, investigations and consultations that is given for each specific condition on the list.

If you need treatment that is not on the list and you send additional clinical information that thoroughly explains why you need the treatment, the Scheme will review it and may choose to approve the treatment. If we decline the appeal, you may contact us to lodge a formal dispute.

Oncology

Depending on your health plan, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Discovery Health Rate, in accordance with your plan benefits. For non-malignant PMB conditions, please follow the OHPMB process outlined previously. For more information please visit the website www.glencoremedicalscheme.co.za.

HIV

When you register for our HIV Care Programme to manage your condition, you are covered for the care you need. For more information please visit the website (www.glencoremedicalscheme.co.za) for information.

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The Scheme offers benefits far richer than that of the PMBs

The Scheme covers more than just the minimum benefits required by law. Sometimes the Scheme will only pay a claim as a PMB.

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded by your plan. But you can still have cover in full if you meet the requirements stipulated by the PMBs regulations.

What is a waiting period?

A waiting period can be general or condition-specific and means that you have to wait for a set time before you can claim from your chosen plan's cover.

Instances where you do not have cover under PMBs

There are some circumstances where you do not have cover for the PMBs. This can happen when you join a medical scheme for the first time with no medical scheme membership before that.

It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period during which you and your dependants will not have access to the PMBs no matter what conditions you might have.

Complaints process

You may lodge a complaint or query with Glencore Medical Scheme directly on **0860 00 21 41** or address a complaint in writing directly to the Principal Officer at the scheme's registered address. If your complaint remains unresolved, you may lodge a formal dispute by following Glencore Medical Scheme's internal disputes process.

You may, as a last resort, approach the Council for Medical Schemes for assistance. Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / **0861 123 267** /complaints@medicalschemes.com/ www.medicalschemes.com.