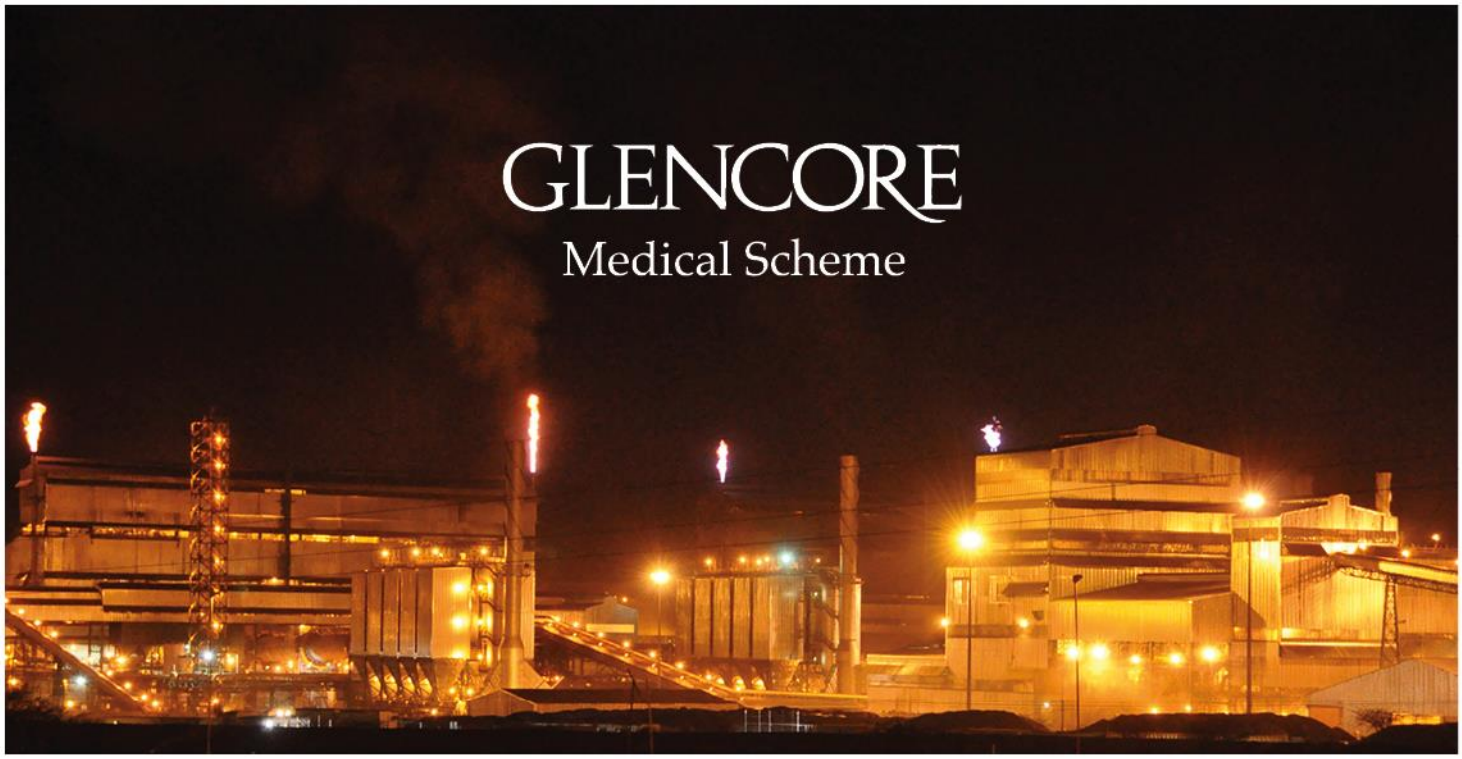

Guide to Prescribed Minimum Benefits for In-Hospital Treatment 2021

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.

Overview

In terms of the Medical Schemes Act No. 131 of 1998, Prescribed Minimum Benefits (PMB) are a set of defined benefits that all registered medical schemes in South Africa are obliged to provide for all their members. All members have access to these benefits, irrespective of their chosen plan type. PMB's ensure that all medical scheme members have access to continuous care to improve their health.

The Glencore Medical Scheme plan is structured in such a way that the member's plan provides comprehensive cover. Irrespective of this, our plan covers more than just the minimum benefits required by law. Always consult your Health Plan Guide to see how you are covered.

This document tells you how the Scheme covers the Prescribed Minimum Benefits specifically for In-hospital treatment. Please refer to the Prescribe Minimum Benefit guide on it www.glencoremedicalscheme.co.za for more details about PMBs and how they are covered.

TERMINOLOGY	DESCRIPTION
Co-payment	This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service, the age of the patient or if the amount the service provider charges is higher than the rate we cover.
Designated service provider (DSP)	A healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate. Visit it www.glencoremedicalscheme.co.za to view the full list of DSPs.
Scheme Rate (SR)	This is a rate set by us. We pay for healthcare services from hospitals, pharmacies and healthcare professionals at this rate.
Member	The reference to member in this document also includes dependants, where applicable.
Prescribed Minimum Benefits (PMBs)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of: ▪ An emergency medical condition ▪ A defined list of 270 diagnoses ▪ A defined list of 27 chronic conditions. To access Prescribed Minimum Benefits, there are rules defined by the Council for Medical Schemes (CMS) that apply: ▪ Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions ▪ The treatment needed must match the treatments in the defined benefits ▪ The scheme shall pay the cost of PMB's in full, without a co-payment. This applies in both voluntary and involuntary use of a DSP or non-DSP. If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.
Emergency medical condition	An emergency medical condition, also referred to as an emergency, is the sudden and, at the time unexpected onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.
Related accounts	Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

How we cover In-Hospital claims

We pay for confirmed PMBs in full from the hospital benefit.

We pay for benefits not included in the PMBs from your appropriate and available hospital benefit and day-to-day benefits, according to the rules of the Scheme.

There are some circumstances where you do not have cover for 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. We will communicate with you at the time of applying for membership if waiting periods apply.

There are a few instances when the Scheme will only pay a claim as a PMB

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by the Scheme. This can be a three-month general waiting period or a 12-month condition-specific waiting period. But you might have cover in full, if you meet the requirements stipulated by the PMB regulations.

Get preauthorisation for hospitalisation and other procedures

What preauthorisation is and what it means

Preauthorisation is the approval of certain procedures and any planned admission to a hospital before the procedure or planned admission takes place. It includes associated treatment or procedures performed during hospitalisation. Whenever your doctor plans a hospital or day-clinic admission for you, you must let us know at least 72 hours before you go to the hospital or day-clinic.

You also need specific preauthorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether done in hospital or not.

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

Contact us for preauthorisation

Call us on 0860 00 21 41 to get preauthorisation. We will give you an authorisation number. Please give the authorisation number to the relevant healthcare provider and ask them to include this when they submit their claims.

Please make sure you understand what is included in the authorisation and how we will pay your claims.

We will ask for the following information when you request preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number, etc.)
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating doctor).

Please note: *If you don't preauthorise your admission, we will not pay your claim, unless it is an emergency.*
Visit www.glencoremedicalscheme.co.za *or call us on 0860 00 21 41 find a healthcare provider.*

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Preauthorisation does not guarantee payment of all claims

Your hospital cover is made up of:

Cover for the account from the hospital (the ward and theatre fees), and cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology), which are separate from the hospital account and are called related accounts.

There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover.
Certain procedures, medicine and new technologies need separate approval. It is important that you discuss this with your healthcare professional.

How we pay your in-hospital PMB claims

We pay for confirmed PMBs in full from the hospital benefit. Treatment received from a non-DSP will also be paid in full from the hospital benefit, with no co-payments.
You will continue for have cover for your claims for approved PMB admissions in instances when your Overall annual Limit is depleted.

In order for some claims to qualify for cover as a PMB, supporting documents may be requested confirming your PMB diagnosis. Examples of such claims include MRI scans and endoscopic procedures.

We pay for benefits not included in PMBs according to the rules and benefits of the Scheme. There are some in-hospital expenses you may have as part of a planned admission that your Hospital Benefit does not cover. Certain procedures, medicine and new technologies need separate approval. It is important that you discuss this with your healthcare provider. Remember: Benefit limits, Scheme rules, treatment guidelines and managed care criteria may apply to some healthcare services and procedures in hospital. Find out more about these by contacting us on 0860 00 21 41 or visit www.glencoremedicalscheme.co.za.

Contact us

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

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.co.za/ www.medicalschemes.co.za.