

GLENCORE

Medical Scheme

BENEFIT GUIDE 2027

BENEFIT SUMMARY 2027

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Alternative healthcare			
Homoeopathic consultations and medicine only	80% of the lower of cost or Scheme Rate	R10 700 for a family	
Ambulance service			
	Subject to approval by preferred provider		Authorisation required contact 0861 333 032 for authorisation
Appliances, external accessories and orthotics			
General medical and surgical appliances and appliance repairs	100% of the lower of cost or Scheme Rate	R24 960 for a family (Appliances limit)	
CPAP (Continuous Positive Airway Pressure)		Subject to the Appliances limit	
Glucometers		R1 570 for a beneficiary, included in the Appliances limit	
Peak flow meters		R680 for a beneficiary, included in the Appliances limit	
Nebulisers		R1 810 for a beneficiary, included in the Appliances limit	
Foot orthotics		R6 700 for a beneficiary, included in the Appliances limit	
Keratoconus contact lenses		Subject to the Appliances limit	Authorisation required
Oxygen therapy and home ventilators			Authorisation required
Incontinence products	100% of the lower of cost or Scheme Rate		Authorisation required
You need to pre-authorise accessories and appliances (except glucometers) for diabetes and these need to be claimed from the Chronic Illness Benefit unless you are registered on the appropriate Chronic Care Programme.			
Blood, blood equivalents and blood products			
	100% of negotiated fee		Authorisation required
Consultations and visits by medical practitioners			
In-hospital	100% of the lower of cost or Scheme Rate	Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy	Authorisation required
Out-of-hospital	Chronic Condition Consultations • Nominated Primary Care Provider (PCP): 100% of the lower of cost or Scheme Rate. • First two non-PCP consultations: 100% of the lower of cost or Scheme Rate. • Subsequent non-PCP consultations: 80% of the lower of cost or Scheme Rate. Other Consultations • 100% of the lower of cost or Scheme Rate.	M0: R7 910 M1: R11 820 M2: R15 820 M3+: R19 870 Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, physiotherapy	Nominate a Primary Care Provider (PCP) GP for consultations relating to your chronic condition/s
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 cost or Scheme Rate	R19 170 for a family	Authorisation required prior to all dental treatment
Advanced: Oral surgery, metal base dentures, inlays, crowns, bridges, study models, orthodontics, periodontics, posthodontics, osseointegrated implants, orthognathic surgery and dental technician fees	100% of the lower of cost or Scheme Rate	R19 970 for a family	Authorisation required prior to all dental treatment

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Hospitalisation			
Accommodation in a general ward, high-care ward and intensive care unit, theatre fees, ward drug and surgical items	100% of the lower of cost or Scheme Rate		Authorisation required
Alternatives to hospitalisation			
Physical rehabilitation facilities, nursing services and sub-acute facilities	100% of the lower of cost or Scheme Rate	R106 000 for a family	Authorisation required
Immunodeficiency syndrome (HIV/AIDS)			
	100% of cost		Authorisation required
Maternity			
Hospital: General ward accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. **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		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	R12 470 per family per year. 3D scan paid up to cost of 2D scan	
Amniocentesis and NIPT	80% of the lower of cost or Scheme Rate	R12 470 per family per year. Further limited to one amniocentesis and one NIPT per family per year	Authorisation required
Medicine and injection material			
Acute medicine: including malarial prophylactics	100% of the approved price	M0: R7 840 M1: R13 550 M2: R18 060 M3+: R21 010 (Acute Medicine limit)	
Medicine on discharge from hospital	100% of the approved price	R690 for a beneficiary per admission, included in the Acute Medicine limit	
Over-the-counter medicine	100% of the approved price	R2 330 per family; maximum R570 per script. Included in the Acute Medicine limit	
Chronic medicine	**Chronic Disease List conditions** Approved chronic medicine on formulary: Up to 100% of MMAP or Scheme Rate. Approved chronic medicine not on formulary: 80% of MMAP or Scheme Rate. **Additional Disease List conditions** Approved chronic medicine: Up to 100% of MMAP or Scheme Rate.		Authorisation required
Contraceptive benefit: Oral, injectable, patches, rings, devices and implants	Up to 100% of MMAP or Scheme Rate. Included in the Acute Medicine Limit.		Only if prescribed for contraception (not approved for skin conditions)

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Mental health			
Psychiatric and psychiatric treatment in hospital	100% of the lower of cost or Scheme Rate.	R62 190 limit per family per year for in-hospital and out-of-hospital treatment for mental health and substance abuse. Limited to a maximum of 21 days in-hospital or 15 out-of-hospital psychotherapy sessions per beneficiary per year. Subject to managed care protocols.	Authorisation required
Substance abuse rehabilitation	100% of the Scheme Rate, where there is an agreement in place, or at cost.	R62 190 limit per family per year for in-hospital and out-of-hospital treatment for mental health and substance abuse. Limited to a maximum of 3 days per detoxification admission and 21 days for rehabilitation per beneficiary per year.	Authorisation required
Out-of-hospital: Consultations, visits, assessments, therapy, treatment and counselling	100% of the lower of cost or Scheme Rate	R10 820 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		Authorisation required
Out-of-hospital	100% of the lower of cost or Scheme Rate	R13 050 for a family	Authorisation required
Optometry			
Eye examinations	100% of the IsoLeso agreed rate	One (1) examination for a beneficiary each year. 12 months calculated from date of last claim	
Spectacle Lenses	100% of the IsoLeso agreed rate	Spectacle lenses limited to one pair of lenses per beneficiary in every 24-month period. 24 months calculated from date of last claim	
Frames	100% of the IsoLeso agreed rate	Limited to one frame and up to an amount of R1 976 per beneficiary (for frames and/or lens enhancements) in every 24-month period. 24 months calculated from date of last claim	
Contact lenses	100% of the IsoLeso agreed rate	Contact lenses in lieu of spectacles limited to R4 160 per beneficiary in every 24-month period. 24-month calculated from date of last claim	
Readers	100% of the IsoLeso agreed 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	R26 420 for a family	Authorisation required
Organ and tissue transplants			
Harvesting of organ/s, tissue and the transplantation of them (limited to the Republic of South Africa)	100% of the lower of cost or Scheme Rate	R304 400 Organ Transplant Limit per family	Authorisation required
Medicines & additional services including: - Immuno-suppressive medicine - Post transplantation biopsies and scans - Radiology and pathology associated with the transplantation treatment	100% of the approved price	Included in the Organ Transplant limit	Authorisation required
Corneal grafts. Organ harvesting not limited to the Republic of South Africa	100% of the lower of cost or Scheme Rate	R40 770 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% if within formulary recommended by the managed healthcare programme; 80% if outside of formulary	Subject to the Scheme's clinical protocols	Authorisation required

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Brachytherapy	100% of the lower of cost or Scheme Rate	R72 800 for a family	Authorisation required
Preventive 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 Scheme's clinical protocols	Authorisation required
Out-of-hospital	100% of the lower of cost or Scheme Rate	R13 800 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	R19 170 for a family	Authorisation required
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	R6 840 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 Scheme's clinical protocols	Authorisation required
Out-of-hospital: Physiotherapy and biokinetics and chiropractics	100% of the lower of cost or Scheme Rate	R12 200 for a family	
Prostheses and devices (internal and external)			
Internal and external devices and prostheses: Including artificial eyes and artificial limbs	100% of the authorised cost	R83 720 for a family (Prostheses Limit)	Authorisation required
Intraocular lenses	100% of Scheme Rate	R5 220 for a beneficiary, included in the Prostheses Limit	
Radiology and radiography			
In-hospital	100% of Scheme Rate	Subject to the Scheme's clinical protocols	Authorisation required
Out-of-hospital	100% of Scheme Rate	R15 130 for a family	
Specialised (in and out of hospital)	100% of Scheme Rate	R27 200 for a family	Authorisation required
PET and PET-CT scans	100% of Scheme Rate		Authorisation required
Renal dialysis (chronic)			
	100% of Scheme Rate	R304 700 for a family	Authorisation required
Surgical procedures (including maxillo-facial surgery)			
	100% of Scheme Rate		Authorisation required

CONTRIBUTION 1 JULY 2026 - 30 JUNE 2027

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	Monthly Income Band Low	Monthly Income Band High	Principal Member	Per Adult dependant *	Per child dependant **
280	R0	R20 100	R3 038	R2 385	R814
430	R20 101	R28 800	R3 883	R3 062	R1 044
550	R28 801	R37 000	R4 206	R3 232	R1 128
800	R37 001	R73 000	R5 249	R4 067	R1 247
999	R73 001	plus	R6 219	R4 941	R1 463

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.

The brochure is a summary of the benefits and features of Glencore Medical Scheme. The Scheme's rules take precedence over the brochure.

IMPORTANT

Payment information

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 (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.

The registration and contribution of certain dependants (such as adult children) on your membership is subject to the dependant meeting the requirements as determined by the scheme from time to time. If you would like more information in this regard, please contact your HR team.

A newborn or adopted child should be registered within 30 days of birth or adoption. If registered within 30 days, the benefits and contributions start at the date of birth or adoption. 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

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 MMAP or Scheme Rate in absence of MMAP. Approved medicine not on the medicine list will be funded up to 80% of the Maximum Medical Aid Price (MMAP), or 80% of Scheme rate in the absence of 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), or up to the Scheme Rate in the absence of the 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 (PMBs).

The latest Chronic Illness Benefit application form is available on **www.glencoremedicalscheme.co.za >ADMIN> Find a document**

You need to let us know when your treatment plan changes

You do not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your approved chronic condition, however, you do need to let us know when your doctor makes these changes to your treatment so that we can update your chronic authorisation. You can email the prescription for changes to your treatment plan for an approved chronic condition to **CIB_APP_FORMS@glencoremedicalscheme.co.za.** Alternatively, your doctor can submit changes to your treatment plan through HealthID, provided that you have given consent to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

Should you be diagnosed with a new chronic condition, a new Chronic Illness Benefit application form would need to be completed.

Primary Care Provider

To ensure you receive optimal healthcare, it is important to have one doctor managing and coordinating care, particularly in respect of chronic conditions. This doctor is your Primary Care Provider (PCP). If you have a chronic condition, you must nominate a doctor (Primary Care Provider) to coordinate your care for chronic conditions. We encourage all members, even those without chronic conditions, to nominate a doctor.

Your doctor is able to assist to do the nomination via the HealthID app or you may contact the Scheme's call centre to do the nomination or online on **www.glencoremedicalscheme.co.za/portal/individual/glencore-single-primary-care-gp.**

Coverage for Visits:

If you nominate a PCP and visit your nominated PCP, your consultation will be covered at the Scheme Rate. if you have not nominated a PCP or see a different doctor (not your nominated PCP) regarding your chronic condition, the Scheme will cover 80% of the Scheme's Rate.

Emergency and Non-Chronic Visits:

This requirement does not apply for emergencies or consultations unrelated to your chronic condition.

Flexibility:

You can change your nominated doctor up to 3 times a year. You're also allowed 2 visits relating to your chronic condition to non-nominated doctors per year which are covered at the full Scheme Rate.

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 on-going care for:

- Any life-threatening emergency medical condition.
- A defined set of 271 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 BENEFITS 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 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 or out-patient visit to a hospital must be authorised.

Obtaining authorisation

You can obtain authorisation by calling 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, if available.
- In the event of a CT scan, MRI scan or other radiology treatment, 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.

Medication claims will fund at the lower of Scheme Rate or MMAP (Maximum Medical Aid Price). You may limit your co-payments by going to a network pharmacy and asking for the generic medication.

DENTISTRY

Pre-authorisation is required for certain dental treatment, including general and specialised dentistry. Your dental provider must contact the Dental Risk Company (DRC) directly to obtain pre-authorisation before treatment. A treatment plan and cost estimate may be required to determine available benefits and cover. This is especially important for dental implants and associated treatment, as well as orthodontic treatment that includes orthognathic (jaw) surgery, where benefits may be limited. Some dental procedures may not be covered by the Scheme. To confirm authorisation for treatment, kindly contact the Dental Risk Company on 087 943 9611.

ONCOLOGY MANAGEMENT

If you are diagnosed with cancer, you will be supported through a structured oncology care programme designed to ensure timely, coordinated and clinically appropriate treatment.

Members have access to PMB (Prescribed Minimum Benefits) and standard, evidence-based "tier 1" oncology care, ensuring that essential cancer treatment is covered in line with Scheme rules and clinical protocols.

Treatment within approved formularies is funded according to Scheme benefits.

All oncology treatment is managed through pre-authorisation and case management, and any changes to your treatment plan must be communicated to the Scheme to ensure uninterrupted, appropriate cover.

IsoLeso has been contracted by the Scheme in respect of optometry benefits. For more information about IsoLeso visit their website www.isoleso.co.za.

OPTOMETRY BENEFITS

IsoLeso manages the optometry benefit on behalf of the Scheme in respect of certain optometry benefits such as eye examinations, spectacle lenses, frames and contact lenses. It is not compulsory for you to visit an IsoLeso contracted optometrist but recommended that you do so. If you visit a provider that is not an IsoLeso contracted provider and the claim is for an amount that exceeds the benefit limit, you may be required to make an upfront payment to the provider and thereafter claim a refund and/or there will be co-payments. You can identify providers that are in the IsoLeso network near you by:

- Contacting the IsoLeso call centre on 011 340 9200
- Using the search option on the Iso Leso website https://www.isoleso.co.za - selecting the Medical Aid Member field and then the Glencore logo. Or
- Contacting your HR team.

HIV

HIV treatment is available and allows the majority of people living with this condition 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.

DIABETES CARE PROGRAMME

Members with diabetes have access to the Diabetes Care Programme.

The Diabetes Care Programme supports you in managing your diabetes through coordinated, ongoing care. You have access to a dedicated healthcare team, including doctors, specialists and allied healthcare professionals, who work together to help improve your health outcomes.

Your care is guided by a personalised care plan, with goals and regular monitoring to help keep your condition under control. Healthcare professionals use tools such as HealthID to track your progress and adjust treatment where needed. Once you are registered on the Chronic Illness Benefit (CIB) for diabetes, you will be enrolled on this programme by your chosen Primary Care Provider (PCP).

The programme also gives you access to dedicated diabetes care navigators who can help you understand your benefits, access appropriate healthcare professionals such as dietitians, biokineticists and podiatrists, and make the most of the support tools and services available to you.

MENTAL HEALTH CARE PROGRAMME

The Mental Health Care Programme is designed to offer our Members diagnosed with acute or episodic major depression the optimal care from the best Service Providers in a coordinated network, to ensure the best outcomes and quality of life.

To access the programme, you need to be diagnosed with acute or episodic Major depression. A GP in the Premier Plus GP network or a psychologist in the Mental Health Care Programme network can do the assessment to confirm the diagnosis and enroll you onto the programme.

The Programme, which will be active for 6 months from the date of enrollment, will give your healthcare provider access to tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care.

By Joining the Mental Health Care Programme, you will have access to a basket of care including limited GP consultations, psychotherapy and certain first line anti-depressant therapy.

Please call 0861 333 032 if you need emergency medical assistance or transportation by ambulance.

EMERGENCY SERVICES

Emergencies in South Africa

In an emergency, call Azoza on 0861 333 032. This number is displayed on your membership card for ease of reference.

Reporting a medical emergency:

- 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 professional 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 invoice 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. 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
- Rate and ICD-10 code where applicable.
- Details of the healthcare professional and their practice number.

GP Network

The Scheme has entered into a network arrangement with certain GPs. This means that the GP will charge at the contracted Scheme rate. There will be no administration fees and, where the Scheme covers 100% of Scheme rate, there will be no co-payment. There may be circumstances relating to chronic conditions where the Scheme only covers 80% of the Scheme rate - please see the details regarding the nomination of a Primary Care Provider under Chronic Illness.

It is not compulsory for you to visit a network GP nor to nominate a Primary Care Provider for the management of your chronic conditions (please see details under Chronic Illness). If, however you do nominate a Primary Care Provider and they are a network GP or you visit a network GP for non-chronic condition related consultations, 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.

You may also visit the Scheme's website at www.glencoremedicalscheme.co.za, log on and use the "Find a healthcare professional" search facility under the "DOCTOR VISITS" tab.

Pharmacy Network

Pharmacies that form part of 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.

Gynaecologist, anaesthetist and orthopaedic Networks

The Scheme has entered into a network arrangement with certain gynaecologists, anaesthetists and orthopaedic surgeons. This means that members can go to the relevant specialists in these networks in order to minimise co-payments in and out-of-pocket.

It is not compulsory for you to visit a network gynaecologist, anaesthetist and orthopeadic surgeon but if you decide to use one of these network specialists you will reduce your co-payments and your out of pocket expenses.

If you wish to find out whether or not the gynaecologist, anaesthetist and orthopeadic surgeon you may be using is on the network, please contact Customer Services or your HR department for assistance or visit the Scheme's website at www.glencoremedicalscheme.co.za, logon and use the "Find a healthcare professional" search facility under the "DOCTOR VISITS" tab.

Members are encouraged to use network providers to reduce co-payments.

GLENCORE MEDICAL SCHEME PRIVACY STATEMENT

HOW WE WILL PROCESS AND DISCLOSE YOUR PERSONAL INFORMATION AND COMMUNICATE WITH YOU

The security of your personal information is extremely important to us. The Privacy Statement explains how we obtain, use, disclose and process your information in a manner that is compliant, ethical, adheres to industry best practice and the Protection of Personal Information legislation. Access the full Statement. www.glencoremedicalscheme.co.za

GLENCORE 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 bi-annual maximum allowed for by particular benefit set out in the Scheme Rules.

Expenses incurred for operations, medicines, or treatments that are primarily for cosmetic or personal reasons, and not medically necessary or directly related to an illness, accident, or medical condition, are not covered by the Scheme.

Healthcare services must be medically necessary and appropriate for the diagnosis or treatment of a medical condition. The Scheme may not cover services that are considered unnecessary, inappropriate, or not cost-effective based on clinical assessment by the medical or dental adviser.

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.

The Scheme may not pay for treatment resulting from a member's deliberate failure to follow medical advice or treatment instructions, where this directly leads to or worsens a medical condition.

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

HOW TO FILE A COMPLAINT AGAINST THE GLENCORE MEDICAL SCHEME

01 STEP

Contact our service team with your complaint by

- Calling 0860 00 21 41 (Remember to ask for a reference number);
- Sending an email to enquiries@glencoremedicalscheme.co.za;
- Speaking to your On site Consultant (the consultant's details may be obtained from your HR department).

02 STEP

If you have followed the step detailed in 1 above and the complaint is not resolved to your satisfaction, please contact us again with the details of your query and reference number and request that your query is escalated to the consultant's team leader and/or a Client Relationship Manager.

03 STEP

If you have followed step 1 and 2 above and feel that your complaint is still not resolved, you can send the complaint to the Scheme's Fund Manager. You can get the Fund Manager's contact details from your HR department.

When sending a complaint to the Scheme's Fund Manager, please ensure that you include full details of the complaint including the reference number. If you do not have a reference number, please send the names of the people you dealt with and the dates when you lodged your complaint, made enquiries or had discussions with the service team.

04 STEP

If the matter is still not resolved after referring the matter to the Scheme's Fund Manager, you can contact the Principal Officer's office. You can get the Principal Officer's contact details from your HR department.

Once you have exhausted all the internal processes of the Scheme as detailed in steps 1 to 4 above, you may declare a dispute by giving written notice to the Principal Officer. The Scheme will appoint a Disputes Committee to decide on the matter.

The Disputes Committee is an independent body that makes fair and honest decisions. The members of the Disputes Committee are independent of the Scheme and look at all the facts of the dispute before making a decision.

The process works like a legal arbitration:

01| You will be given the first opportunity to set out the details of your case

02| A representative of the Scheme will then have an opportunity to respond

03| The Disputes Committee will make their decision and let us know

04| You will receive written confirmation of the decision

05 STEP

06 STEP

If you have taken the steps above and this has failed to resolve the matter, you can file a formal complaint directly with the Council for Medical Schemes (CMS). The CMS will then make a ruling based on submissions from all parties involved.



INFORMATION REGARDING

The Council of Medical Schemes

The Council for Medical Schemes (CMS) is a statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical scheme industry. The CMS's vision is to promote vibrant and affordable healthcare cover for all.

Complaints can be submitted to the CMS by letter, email or in person at their offices from Mondays to Fridays (08:00 to 16:30). More information about the CMS and the complaint form, refer to www.medicalschemes.co.za

Your complaints should be in writing, detailing the following: Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiate the complaint.

The CMS contact details are:

Customer Care Centre

0861 123 267

0861 123 CMS

Reception

Tel: 012 431 0500

General enquiries

Email enquiries: information@medicalschemes.co.za

www.medicalschemes.co.za

Complaints

Email: complaints@medicalschemes.co.za

Physical address

Block A, Eco Glades 2 Office Park

420 Witch-Hazel Avenue

Eco Park, Centurion,

0157

SCHEME

Contact information

Customer Services

Telephone: 0860 00 21 41
Email: **enquiries@glencoremedicalscheme.co.za**

Claims

First time claim submissions:
Email: **claims@glencoremedicalscheme.co.za**

Hospital authorisations

Telephone: 0860 00 21 41

Chronic Medicine Authorisations

Telephone: 0860 00 21 41
Email: **chronicqueries@glencoremedicalscheme.co.za**

Oncology (cancer) Management

Email: **DCO_oncology@glencoremedicalscheme.co.za**

Diabetes Care Programme

Telephone: **0860 444 439**
Email: **Members_DCP@glencoremedicalscheme.co.za**

Dentistry

DRC provider contact number 087 943 9611
Customer Care on 086 112 3267

Optometry

IsoLeso 011 340 9200
www.isoleso.co.za

HIV Management Programme

Email: **hivprogramme@glencoremedicalscheme.co.za**
Tel: 0860 002 141

Emergency Services (ambulance)

Telephone: 0861 333 032

Fraud Hotline

Telephone toll free: 0800 004 500
SMS: 33490 and include the description of the alleged fraud

Council for Medical Schemes

The Council for Medical Schemes (CMS) is a statutory body established in terms of the Medical Schemes Act 13, of 1998 to provide regulatory oversight to the medical scheme industry. More information about CMS is available on www.medicalschemes.co.za

The Council for Medical Schemes

Block A Eco Glades 2 Office Park,
420 Witch-Hazel Street, Ecopark,
Centurion 0157
Telephone: 012 431 0500

Customer Care call-share number:

0861 123 267
Email: complaints@medicalschemes.com