Barloworld
Medical Scheme

Member Guide
2021

This benefit guide is for information purposes only and does not supersede the Rules of the Barloworld Medical Scheme ("the Scheme"). In the event of any dispute, the Rules of the Scheme shall prevail.

INDEX

DEFINITIONS OF ACRONYMS USED IN THE MEDICAL SCHEME INDUSTRY

You may come across these acronyms in this benefit guide and in medical scheme industry related communications. For your ease of reference the most frequently used acronyms are listed for you in the table below:

Abbr.	Description	Explanation
AfA	Aid for AIDS	The division responsible for managing HIV/Aids.
BOT	Board of Trustees	The Board of Trustees appointed and elected to manage your Scheme affairs.
CDE	Centre for Diabetes and Endocrinology	A service provider contracted with the Scheme to manage Diabetes and Endocrinology as detailed in this benefit guide.
CDL	Chronic Disease List	A list of conditions for which medication and treatment is specified.
CLO	Client Liaison Officer	An employee of Medscheme visiting agreed offices of your employer for on-site assistance in resolving queries.
CMS	Council for Medical Schemes	A statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.
DPM	Direct Paying Member	Where the member pays the Scheme directly and not through the employer.
DSP	Designated Service Provider	A preferred provider contracted with the Scheme to treat members and/or beneficiaries when they need diagnosis, treatment or care for a prescribed minimum benefit condition.
DUR	Drug Utilisation Review	A programme checking that drugs prescribed do not interact adversely with each other.
HBM	Hospital Benefit Management	A programme to manage, verify and validate the status of a member and/or dependant who requires to be admitted at hospital, as well as to ensure that the correct procedure codes are approved and used by the hospital in accordance with the pre-authorisation protocols being granted. The programme **does not** confirm payment or guarantee payment of an account.
LOS	Length of Stay	The length of stay of the patient in hospital.
MEL	Medicine Exclusion List	A list of drugs not approved, due to them being not significantly cost effective and/or not clinically proven to be effective.
HRS	Health Risk Solutions	Managed healthcare division of Medscheme that manages all aspects of a contracted medical scheme's managed healthcare programmes.
MPL	Medicine Price List	List of approved drugs associated with a reference price list.
NAPPI	National Pharmaceutical Price Index	As per www.medikredit.co.za, the NAPPI code is a claiming standard for medicines and surgical products. This list of codes is maintained and published by Medikredit in the public domain. Product information that is not available in the public domain is available from MediKredit at a fee, subject to certain conditions.
PMB	Prescribed Minimum Benefits	Benefits that medical schemes are required by law to cover. See further details in this benefit guide.
PO	Principal Officer	An executive officer of the Scheme who is required to attend to a range of fiduciary and administrative duties, as required by statute and the Scheme Rules.
RAF	Road Accident Fund	As per www.raf.co.za, a public entity which provides appropriate cover to all road users within the borders of South Africa for incidents arising from the use of motor vehicles and, in a timely and caring manner, compensate persons injured or their families in the event of fatal accidents, rehabilitate the injured, indemnify the wrongdoers, and actively promote the safe use of the roads.
SADA	South African Dental Association	An association that is committed to oral health by promoting the provision of oral healthcare services of the highest professional and ethical standards.
SEP	Single Exit Price	Legislated drug price from manufacturer to end user.
STR	Scheme Tariff Rate	The Scheme's approved tariff rate for all services.
LGRC	Legal Governance Risk Compliance Department	Medscheme department responsible for managing and reporting fraud investigations conducted on behalf of the Scheme, as well as monitoring the legal governance and risk compliance of Medscheme.

PRESCRIBED MINIMUM BENEFITS ("PMB")

According to the Council for Medical Schemes ("CMS"), Prescribed Minimum Benefits are a statutory set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, irrespective of the benefits disclosed in the rules of the medical scheme. The aim is to provide all members with continuous care to improve their health and well-being and to make healthcare more affordable. PMB are a feature of the Medical Schemes Act, in terms of which medical schemes are required to cover the costs related to the diagnosis, treatment and care of:

- Any emergency medical condition that results in an unexpected onset of a health condition, which requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.
- In an emergency it is not always possible to diagnose the condition before admitting the patient for treatment, however, if the treating doctor suspects that the patient suffers from a condition that is covered by PMB, the medical scheme is required to approve treatment. The Scheme may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.
- 26 Chronic conditions defined in the Chronic Disease List as detailed in this benefit guide.
- A limited set of 270 medical conditions (defined in the Diagnosis Treatment Pairs) are detailed below:

The Regulations to the Medical Schemes Act provide a long list of conditions identified as Prescribed Minimum Benefits. The list is in the form of **Diagnosis and Treatment Pairs ("DTPs")**.

A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated. It aims to treat existing PMB conditions appropriately and cost-effectively, whilst ensuring high-quality care. Should there be a disagreement about the treatment of a specific case; the standards (also called practice and protocols) in the public sector are applied.

The treatment and care of some of the conditions included in the DTPs may include chronic medicine, e.g. HIV-infection and management of menopause. In these cases, the public sector protocols will also apply to the chronic medication.

An example of a DTP as it appears in the Medical Schemes Act is as follows:

Code	Diagnosis	Treatment
109A	Vertebral dislocations/ fractures, open or closed with injury to spinal cord	Repair/reconstruction; medical management; inpatient rehabilitation up to two months

The 270 conditions that qualify for PMB cover are diagnosis-specific and include a range of ailments that can be divided into 15 broad categories:

PMB Category	Example
Brain and nervous system	Stroke
Eye	Glaucoma
Ear, nose, mouth and throat	Cancer of oral cavity, pharynx, nose, ear, and larynx
Respiratory system	Pneumonia
Heart and vasculature (blood vessels)	Heart attacks
Gastro-intestinal system	Appendicitis
Liver, pancreas and spleen	Gallstones with cholecystitis
Musculoskeletal system (muscles and bones); Trauma NOS	Fracture of the hip
Skin and breast	Treatable breast cancer
Endocrine, metabolic and nutritional	Disorders of the parathyroid gland
Urinary and male genital system	End-stage kidney disease
Female reproductive system	Cancer of the cervix, ovaries and uterus

Pregnancy and childbirth	Antenatal and obstetric care requiring hospitalisation, including delivery
Haematological, infectious and miscellaneous systemic conditions	HIV/Aids and TB
Mental illness	Schizophrenia
Chronic conditions	Asthma, diabetes, epilepsy, hypothyroidism, schizophrenia, glaucoma, hypertension

No exclusions

Your medical scheme has a list of conditions – such as cosmetic surgery – for which it will not pay. These exclusions may not be applied to PMB. If a member contracts septicaemia after cosmetic surgery for example, the medical scheme will provide funding for the treatment of the septicaemia, however, the costs of the cosmetic surgery remain an exclusion.

26 Chronic Conditions (Chronic Disease List)

Only medicines used to treat PMB conditions, that are authorised by Chronic Medicine Management and fall within the protocols specified by CMS will be reimbursed. The 26 conditions, considered as PMB, are the following:

- Addison's disease
- Asthma
- Bi-polar Mood Disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disorder
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- HIV/Aids
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

To manage risk and ensure appropriate standards of healthcare, treatment algorithms were developed for the Chronic Disease List ("CDL") conditions.

The algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment the Scheme must provide for may not be inferior to the algorithms.

When deciding whether a condition is a PMB, the doctor should only look at the symptoms, not how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis of a PMB condition has been made, the appropriate treatment and care is decided upon, as well as where the patient should receive the treatment, for instance whether they should be treated at a hospital, as an outpatient or at a doctor's rooms.

If you have one of the 26 listed chronic diseases, the Scheme may cover the costs of your medication, and will also cover certain amounts of the doctors' consultations and tests specific to your condition. The Scheme may make use of protocols, formularies (lists of specified medicines) and Designated Service Providers ("DSPs") to manage this benefit.

MEMBERSHIP

Membership of the Scheme is compulsory for employees of Barloworld as set out in the terms of their employment contracts. Employees can belong to a spouse's scheme, but must provide proof of this. No-one is permitted by law to belong to more than one medical scheme at a time.

Dependants: Your spouse or Life Partner (as defined in the Rules of the Scheme), dependent children or other members of your family who you can prove are financially dependent and you therefore support and take care of can apply to become dependants on your medical scheme. An adult dependant is your spouse or Life Partner and any other dependant older than 25 (including student dependants older than 25). A child dependant is younger than 21 or is a student younger than 25 who is registered at a recognised tertiary institution.

Pensioners: As continuation members, pensioners are entitled to the same benefits as other members if they have reached minimum retirement age in terms of their employment contracts or have stopped working due to ill- health or another disability.

Dependants of deceased members: In most instances, these dependants are allowed to continue their membership with the Scheme if they were registered with the Scheme at the time of the member's death. The contribution payable may, however, change depending on the rules of the Scheme.

CONTRIBUTIONS:

The contribution rates of the Scheme for 2019 are:

Monthly Income R	Dependant Category		
	Member	Adult Dependant Note 1*	Child Dependant Note 2**/3***
R0 - R16 630	R3 007	R3 007	R969
R16 631 - R27 810	R3 431	R3 431	R1 121
R27 811 - R38 990	R3 699	R3 699	R1 219
R38 991 - R50 020	R4 006	R4 006	R1 281
R50 021+	R4 135	R4 135	R1 345

Note 1*: A registered dependant who is 21 years of age or older.

Note 2**: Child rates will apply to registered dependants under the age of 21 and to students 21 - 25 years of age, i.e. child rates will apply until the day the student turns 25 years old.

Note 3 ***: Child rates will apply to registered dependants under the age of 21, where dependants are incapacitated by physical or mental medical condition from maintaining themselves, i.e. child rates will apply until such dependants turns 21 years old.

Late Joiner Penalties, waiting periods and exclusions: In terms of the Medical Schemes Act, No 131 of 1998 ("the Act") Late Joiner Penalties ("LJP") may be applied to an applicant or to the adult dependant of an applicant older than age 35. Depending on the number of years they have not belonged to a registered South African medical scheme, an additional penalty (a percentage of the contribution) may be added to the member's monthly contribution, as shown in the table below:

Penalty bands	Maximum penalty
1 to 4 years	0,05 X contributions
5 to 14 years	0,25 X contributions
15 to 24 years	0,50 X contributions
25+ years	0,75 X contributions

The LJP is calculated as follows:

A = B minus (35 + C)

Where:

A = the number of years in the first column

B = the age of the applicant at the time of application

C = the number of years of creditable cover.

Waiting periods: A waiting period is the period and time that a member and/or dependants are required to wait before medical expenses incurred will be refunded and/or payable.

A three-month waiting period may be applied where a member and/or his dependants waited more than 90 days after leaving a previous medical scheme to join the Scheme and the member and/or his dependants were members for less than 24 months with the previous medical scheme.

A12-month condition-specific waiting period may also be applied where the member and/or dependant have a pre-existing condition that he/she was diagnosed with before joining the Scheme.

Proof of membership: Your membership card will show your membership number, your name and the names of your registered dependants, as well as the date from which you can claim benefits. You will need to present this membership card when visiting a healthcare service provider and/or should be admitted at hospital. You therefore need to ensure that your membership card is kept securely with you at all times in order to prove membership of a private medical scheme when requiring services in the private healthcare sector.

Remember: Look after your medical scheme card. Do not give it to anyone except your dependants to use. If your card is abused, you can face disciplinary and/or legal action.

Important: Fill in the member Record Amendment forms at the HR Department to let the Scheme know about any change in your personal details or those of your dependants.

End of membership: Membership ends when you leave the service of your employer and it will be effective on the last day of your employment with your employer. Please remember to hand in your membership card at your HR Department.

What are my contribution rates when I retire?

Upon retirement, 100% of your last salary is used to determine the income category and the contribution amount that you will need to pay as a continuation member of the Scheme. Your income is deemed to increase annually thereafter on 1 January of each benefit year, in accordance with the official consumer price index ("CPI") published by Statistical Services in respect of the twelve month period ended 30 September each year preceding such adjustment date.

ADMINISTRATION

How to look after the administration of your benefits?

This benefit guide will give you most of the answers about how the administration of your medical scheme benefits takes place at Medscheme. Let's start by looking at how the claims chain at Medscheme works.

Handing in medical bills and accounts

- Healthcare suppliers will give you an invoice and a receipt if you pay your account upfront.
- Send your original invoice together with the receipt to us as soon as possible, via e-mail to claims@medscheme.co.za, or via post to Barloworld Medical Scheme, P.O. Box 74, Vereeniging, 1930.
- Only claims received within four months after the date of treatment will be paid.
- Only send the invoice and not the statements.
- Do not send in bills marked "for your information only" or bills that only show a balance. These bills are only for your records and must be used to check the payments.
- If you send a receipt, clearly mark the account as "paid".
- The Medical Schemes Act states that healthcare service providers must give all the information about the treatment you received on the account. Therefore the accounts from these service suppliers must show:
  - Your name and initials;
  - Your medical aid number;
  - The date of the treatment;
  - The name of the patient (this must be the full names and not the short name or nickname);
  - The amount charged; and
  - The ICD-10 and tariff code where it is relevant.

THE IMPORTANCE OF ICD-10 CODES

ICD-10 stands for International Classification of Diseases and related health problems and the 10 shows that it is the tenth revision. It is a set of codes developed by the World Health Organisation (WHO) that translates the written description of medical and health information into codes in a standard format. For example, J03.9 is acute tonsillitis and G41.0 stands for epilepsy, unspecified.

This set of codes form part of an international standard which South Africa must comply with according to the Medical Schemes Act.

All healthcare providers were required to include diagnostic information in the form of ICD-10 codes on all claims or accounts. These codes must be given in addition to treatment codes, such as for

consultations and surgery.

ICD-10 codes must be given for all claims, whether the healthcare practitioner claims directly from the medical scheme or whether you pay upfront and claim the benefits from your medical scheme.

Claims or accounts without the accurate and complete ICD-10 codes will be rejected and will not be paid. Healthcare providers know about this requirement.

Remember!

Check that prescriptions for medicine show all your details. Also check that the correct quantity 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 submit both accounts and ensure that your name and membership number are reflected on both accounts.

Payment of medical accounts

Medscheme processes payments of accounts regularly at least three times per month to members and healthcare service providers. If a month has five weeks, four payments will be done. All valid claims we receive are paid in this way.

After it has been received and dealt with, the healthcare service provider is paid directly into

a bank account depending on the method of payment chosen and the rate the healthcare service provider charged.

When your claim has been processed and the payment is ready for the next payment run, you will be informed by email or SMS to advise you how much has been paid.

The proof of payment, called a "Remittance Advice" will be available on our website the Monday after the payment run.

This is why it is very important to make sure that we have all your updated correct personal details.

You will receive a monthly statement that will show the claims paid during that month. You should receive the statement around the 12th day of the following month. The statement will give you information about:

- The tax amount for the current and previous year on claims paid
- Your beneficiary status
- A benefit summary
- The amounts that were paid to you and the healthcare service providers.
- The amount paid out to you, called an "ACB Remittance".

If you have access to the internet, you can see your statements immediately by registering on the Member Zone at www.medscheme.com.

You will also be able to view your claims history, premium payments, personal information and much more. Furthermore, you are able to update your personal details and view your available benefits.

Car accidents

If you are involved in a car accident, you could have a claim against the Road Accident Fund ("RAF"), you must contact us on 0860 002 106 to receive the necessary assistance.

Injury at work

Any injury sustained whilst at work should be reported to your Human Resources department in order for the GPA process to be followed.

OVERALL ANNUAL LIMIT

The Scheme does not limit your **OVERALL ANNUAL LIMIT**. Your contribution is used to pay for all treatments received up to the benefit limits and amounts as set out in this benefit guide and the Scheme applies a recognised Scheme Tariff Rate per service or event to fund each service or treatment received on your behalf. Members are advised to discuss fees charged for services and treatment with their treating provider, prior to the treatment, to

prevent unnecessary co-payments and potential out-of-pocket expenses.

Unless specified otherwise all benefits are funded up to 100% of the Scheme Tariff Rate. It is important to note that where service providers' tariffs differ from the set price as determined by the Scheme as a 'Scheme Tariff', you may be liable for co-payments.

GAP COVER (additional cover) is only applicable to procedures in hospital for services provided by general practitioners, medical and dental specialists, dental practitioners, physiotherapists and bio-kineticists.

Where the service provider has charged a higher rate, the difference between the service provider's charge and the Scheme Tariff Rate, up to a maximum of 200%, would be covered.

There is no need for you to apply for GAP Cover. GAP cover is is processed automatically from Day 1 of the hospitalisation when an in-hospital claim is received from one of the above associated provider disciplines.

All benefits in the guide show the maximum amount per year, except maternity, which is covered each time an event occurs.

POOLED DAY-TO-DAY BENEFITS (PER FAMILY)

The Scheme has a Pooled Day-to-Day benefit and the following benefits are paid from the pooled funds. You must familiarise yourself with the benefits included in the pooled fund to manage your individual needs and benefits you'll need during the year as best as possible.

Pooled Benefits 2021 - Limits by family size

	Category	M	M+1	M+2	M+3	M+4+
Pooled Benefit	**Acute Medicines, OTC medicines / PAT** ***Out-of-hospital Procedures and Non- surgical procedures and tests** **Out-of-hospital Pathology, General Radiology and Physical Therapy** **General Practitioner, Medical Specialist, Optical, Additional Medical services and Alternative Healthcare**	R20 600	R30 900	R40 180	R48 210	R53 030
	Sub-Limits:					
	Acute Medicines	R12 100	R18 160	R23 590	R28 300	R31 120
	****OTC medicines /PAT**	R2 380	R3 570	R4 640	R5 550	R6 120
		(max R350 per OTC/PAT script)				
2-year cycle	**Optical**	R5 620	R11 190	R16 710	R22 170	R27 600
	Frames **Readers** **Spectacle Lenses**	Includes prescribed contact lenses, appropriate lens enhancements and diagnostic tests. Subject to a maximum of R5 620 per beneficiary every 2-year cycle. Frames sub-limit of R2 390 per beneficiary every 2-year cycle, included in the above limit Readers sub-limit R240 per beneficiary every 2-year cycle. Spectacle lenses are funded from Risk - refer to the Optometry section on page 23 for more detail.				

*Out of hospital procedures are procedures that are done in the doctor's rooms
**OTC = Over the counter. PAT = Pharmacy Advised Therapy

ALTERNATIVE HEALTHCARE

The Alternative Healthcare benefit is included in the Pooled Day-to-Day benefit and includes Acupuncturists, Homeopaths and Naturopaths' consultations and medication. All other Alternative Healthcare Practitioners are excluded.

APPLIANCES

(IN and OUT of Hospital benefit)

General Medical and Surgical Appliances Benefit

These appliances are funded up to a maximum of R22 980 per beneficiary and R28 710 per family for all services combined.

The benefit includes large orthopaedic orthotics/ appliances, stoma products (excluding incontinence products) and the following appliances where sub-limits are applicable:

- Glucometers with a sub-limit of R1 030 per beneficiary, Nebulizers with a sub-limit of R1 030 per beneficiary and Peak flow meters with a sub-limit of R960 per beneficiary.
- Hearing aids, including repairs within the first twelve months, with a sub-limit of R22 980 per beneficiary every 3 years (effective from the date of last claim). Bilateral requests make allowance for the benefit limit to be applied to each ear.
- CPAP apparatus for sleep apnoea requires pre-authorisation and the Authorisation Centre must be contacted at 0860 002 106 (8:30 to 16:00) from Monday to Friday, or e-mail: barloworld.authorisations@medscheme.co.za.
- Unlisted appliances are limited to R13 830 per beneficiary, further limited to R17 020 per family per annum.

Specific Appliances and accessories

Oxygen therapy equipment, which does not include hyperbaric oxygen treatment and home ventilators, are unlimited, while long leg calipers and low-vision appliances are limited to a maximum of R22 980 per beneficiary and R28 710 per family.

BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS

These products are funded at 100% of the Scheme Tariff Rate and is an unlimited benefit, however, funding does require pre-authorisation. The **Authorisation Centre** must be contacted at 0860 002 106 (8:30 – 16:00) Monday to Friday. Or email: barloworld.authorisations@medscheme.co.za.

The transportation of the blood is included if pre-authorised.

CONSULTATIONS

Out of hospital:

The out of hospital consultations for GP's, Specialist's and Mental Health are funded up to 150% of the Scheme Tariff Rate from the Pooled Day-to-Day benefit.

In hospital:

Up to 200% of the Scheme Tariff Rate funded from the Overall Annual Limit, however, the consultations in hospital exclude consultations by the following disciplines:

- Alternative healthcare practitioners
- Dental practitioners, technologists and therapists
- Ante-natal visits and consultations
- Psychiatrists, psychologists, psychometrists and registered counsellors' consultations
- Oncologists, haematologists and credentialed medical practitioners during active and post-active treatment period
- Healthcare service providers for Additional Medical Services and
- Physiotherapists.

For these disciplines, please refer to the detailed benefits mentioned under the relevant sections in this guide.

DENTISTRY

Benefits

The combined Basic and Advanced dentistry benefits are funded from Risk. The Scheme funds dentistry up to 100% of the negotiated fee, or in the

absence of such fee, up to 100% of the Scheme Tariff Rate or the lower cost, or 100% of the Uniform Patient Fee Schedule for public hospitals.

The combined dentistry benefit is limited as follows and it includes dentistry performed by a dental practitioner and/or dental therapist including minor oral surgery.

M: R18 480

M+1: R27 730

M+2: R36 050

M+3: R43 260

M+4+: R47 570

The benefit provides for the removal of teeth, removal of wisdom teeth, exposure of teeth for orthodontic reasons and suturing of traumatic wounds. The Oral Medical Procedures include the diagnosis and treatment of oral and associated conditions and dental technician's fees for all such dentistry.

The combined benefit incorporates more advanced dental procedures, including treatment for inlays, crowns, root canal therapy, bridges, mounted study models, dentures and the treatment by periodontists, prosthodontists and dental technician's fees for all such dentistry.

The benefit includes Oral medical procedures and metal base to complete denture code 8663.

Osseo-integrated implants and orthognathic surgery (functional correction of malocclusions) are included in the combined benefit and includes the cost of special investigations, hospitalisation, all general and specialist dental practitioners, their assistants and anesthetists as well as the cost of materials, all implant components, plates, screws and bone and bone equivalents for all related services rendered.

Furthermore, it includes all stages of treatment required to achieve the end result of placing an implant supported tooth or teeth into spaces left by previous removals of natural teeth, the surgical augmentation of jaw bone and surgical placement and exposure of implant/s.

Oral surgery is included in the combined benefit and includes consultations, visits, removal of teeth, para-orthodontic surgical procedures and preparations of jaws for prosthetics as performed by maxillo-facial specialists.

Orthodontic Treatment is included in the combined benefit.

Maxillo-facial surgery is included in the Specific Surgical Procedures benefit reflected later in this guide. A formal quotation should be submitted to the Scheme for review and approval.

It is important to note that the Barloworld Medical Scheme has designed a dental benefit to ensure cost-effective, quality dentistry for those who care for their teeth. The Scheme therefore contracted with a Dental Benefit Management Programme and pre-authorisation is required for any dental or special dental procedure where general anaesthetic or conscious sedation is performed. You are therefore required to contact the **Call Centre at 0860 002 106** between 8:30 and 16:00 Monday to Friday to receive more information and to obtain the required pre-authorisation number.

In many instances you may be asked to provide a quotation and motivation for the planned procedure and will need to contact the **Authorisation Centre** at least 72 hours before treatment.

For special dentistry a written treatment plan and cost estimate from your dentist will help us to determine your available benefit. Please obtain the necessary information/details from your dentist before contacting the Call Centre.

There may be some dental procedures which cannot be covered because of academic, cosmetic, financial or other reasons.

Dental Accounts Management

Your dental claims are audited before the dentist is paid.

The claims are examined in line with the South African Dental Association ("SADA") guidelines and dentists must use the correct treatment codes according to these rules.

Claims will not be paid for treatment which was done outside the rules of SADA or if your scheme rules do not allow certain procedures. If this happens, your dentist will be asked for a motivation, to amend the claim or we will send a reason for not paying a claim to you and/or the dentist.

AMBULANCE AND EMERGENCY MEDICAL SERVICES

Netcare 911 (082 911) has been contracted by the Scheme to provide members with Ambulance and Emergency Medical Services such as:

- Emergency medical response by road or air from the scene of a medical emergency.
- Inter-hospital transfers, only if a medical professional can motivate why it is medically necessary.
- Health-on-Line emergency telephonic medical advice and information.

Points to remember when calling Netcare 911

- Members and beneficiaries must dial 082 911 if there is a medical emergency.
- Give your name and the telephone number you are calling from.
- Give a brief description of what has happened and try to explain how serious the situation is.
- Give the address or location of the incident as well as the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please, if possible, tell the person who answered your call which medical scheme you belong to.
- Do not put the phone down until the Call Taker has disconnected.

Ambulance authorisation procedure

Netcare 911 must be contacted in all instances. In the case of an inter-hospital transfer, when

you are admitted to hospital, please inform the admitting hospital that you are a Netcare 911

member and that any transfers must be authorised through 082 911.

What to do with the vehicle stickers you receive?

Netcare 911 encourages you to place a vehicle sticker on one of the rear side windows of your motor vehicle. This will alert any emergency service on the scene that you are a member of Netcare 911.

IMPORTANT INFORMATION

The Medical Schemes Act 131 of 1998 defines an "emergency medical condition" as "the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a body organ or part, or would place the person's life in serious jeopardy".

Diagnosis alone is not enough to conclude that a condition is a medical emergency. The condition must require immediate treatment before it can qualify as an emergency and, subsequently, a Prescribed Minimum Benefit.

Put simply, the following factors must be present before an emergency can be concluded:

1. There must be an onset of a health condition.

2. This onset must be sudden and unexpected.

3. The health condition must require immediate treatment (medical or surgical).

4. If not immediately treated, one of three things would result: serious impairment to a bodily function, serious dysfunction of a body part or organ, or death.

Ambulance claims can only be initially assessed based on the clinical notes that are documented on the patient report form (PRF) provided by the ambulance personnel.

If the case is assessed and found to not meet the criteria of a medical emergency, the invoice will become the member's responsibility. Should additional information (i.e hospital documents) become available following the assessment, the claim can be re-assessed.

Should Netcare 911 not have resources available in the immediate vicinity, they will contact a closer service provider.

IMPORTANT CONTACT DETAILS

Netcare 911 Head Office: 010 209 8911
Emergencies: 082 911
Health-on-Line: 082 911
Website: www.netcare911.co.za
E-mail: customer.service@netcare.co.za

We encourage you to share this information with your family, so that they too will know what to do in an emergency situation.

HOSPITALISATION

Accommodation in general ward, high care and intensive care units are covered, as well as theatre fees, materials and medication used in hospital and is unlimited. Deep Brain Stimulation Implantation for Parkinsons' Disease and Intractable Epilepsy limited to R58 840 per beneficiary. Balloon Sinuplasty is limited to R12 780 for the disposable kit.

Medicine on discharge ("TTO") is funded from the unlimited hospital benefit, provided it is obtained on the date of discharge. This benefit includes anticoagulants post-surgery.

Facility fee and Consultations are funded from the Pooled Day-to-Day consultations benefit, while all casualty and emergency room medication is funded from the Pooled Day-to-Day acute medication benefit.

The Hospital Benefit Management Programme ensures that you receive appropriate care in hospital in line with the benefits made available by the Scheme. Admission or an out-patient visit to a hospital, CT scan, MRI scan and radio-isotope study must be authorised first by calling **0860 002 106** or sending an email to barloworld.authorisations@medscheme.co.za.

Apply for a Pre-Authorisation Reference ("PAR") Number as soon as you or one of your dependants need to be admitted to hospital or need to have a CT scan, MRI scan or radio-isotope study.

If you or one of your dependants need emergency treatment, you have to call the Authorisation Centre on the first working day after the incident.

If you do not obtain a PAR number for hospitalisation, a CT scan, a MRI scan or a radio-isotope study, or for an emergency on the first working day after the incident, you could be required to pay a penalty.

When you apply for a PAR number, you must give:

- Your membership number.
- The name and date of birth of the patient who needs treatment.
- Your contact details.
- Reason for admission and tariff codes for the treatment.
- Date of admission and operation.
- Name, telephone numbers and practice number of the doctor.
- Name, telephone numbers and practice number of the hospital.
- The name of the radiology practice for a CT scan, MRI scan or radio-isotope study.

You will then get:

- A unique PAR number.
- The initial length of stay approved.
- The approved tariff codes for treatment.

If you need to stay in hospital longer than the period approved, your doctor, the hospital case manager or a family member must inform the **Authorisation Centre** that the patient has to stay longer. This will be approved if there is a clinical reason, otherwise the member will have to pay for the days and treatment that was not approved.

We do our best to establish whether members are eligible for the approved treatment and that they have the funds required, but any authorisation could be excluded by the scheme rules. **It is important to note that authorisation is not a guarantee of payment.**

Alternatives to hospital stay include sub-acute facilities, nursing services for patients at home (this excludes midwifery services), physical rehabilitation facilities and hospice, which is limited to R40 280 per member family.

Maternity accommodation and other services in hospital is unlimited, however, **a co-payment of R2 410 is applicable if the patient chooses, through personal preference, to have a caesarean section.**

Related out-of-hospital maternity services are limited to R11 210 per pregnancy event and include 3x 2D scans, 12x ante-natal consultations, 4x post-natal midwife consults and 1x amniocentesis per pregnancy event.

Please contact the **Contact Centre** for more information relating to the funding of Maternity benefits, if required.

Infertility treatment benefits are provided in accordance with the treatment as prescribed by the Regulations of the Medical Schemes Act No. 131 of 1998 as set out in Annexure A, paragraph 9, Code 902M.

Organ and bone marrow transplants, including the harvesting and transplantation, immune-suppressive medicine and post-transplantation biopsies and scans, the related radiology and pathology is limited to R355 070 per beneficiary.
Corneal grafts (local and imported) are limited to R36 010 per beneficiary per annum and further limited and included in the R355 070 per beneficiary overall limit.

Surgical procedures in hospital and unattached operating theatres are unlimited. Refractive (eye) surgery is limited to R9 850 per family and requires pre-authorisation by the **Authorisation Centre**.

Non-surgical procedures in hospital are unlimited. Sleep studies in hospital are unlimited, but must be part of neurological investigations and be requested and motivated by a Neurologist.

Maxillo facial surgery if treatment is received in hospital is limited to and included in the unlimited hospital benefit. **Out of hospital consultations** are funded from the consultations benefit included in the Pooled Day-to-Day benefit.

Internal prostheses: Per beneficiary

Aorta stent grafts: R58 840

Bone lengthening devices: R48 560

Cardiac valves: R47 090

Cardiac pacemakers: R58 840

Cardiac stents: R53 000

Carotid stent: R22 060

Detachable platinum coils: R54 460

Embolic protection device: R54 460

Intra-ocular lens: R3800 per lens, unless PMB

Joint replacements: R48 560 (bilateral prostheses reimbursed up to the lower of the claimed amount or maximum double the benefit value of a single prosthesis)

Neuro-stimulation devices: R58 840

Peripheral arterial stent grafts: R41 170

Spinal plates and screws and other approved spinal implantable devices: R48 560

Vagal stimulator: R58 840
Artificial Iris: R14 290
Any unlisted internal prostheses: Combined limit of R35 330 per beneficiary.
External prostheses: Limited to R55 880 per beneficiary.
Renal dialysis includes all services and related radiology and pathology and is unlimited per beneficiary.

HIV & AIDS MANAGEMENT

HIV/Aids can now be managed like other chronic and life-threatening conditions and is no longer a death sentence if managed and treated correctly.

The Barloworld Medical Scheme strategy is aligned with the employer strategy and encourages members and their spouses/partners to know their HIV status. Pre- and post-test counselling are provided and HIV negative individuals are encouraged to strive to maintain their status and HIV positive individuals to access appropriate care and treatment.

The **Aid for Aids programme** is a comprehensive and confidential HIV disease

management programme that offers members and beneficiaries:

- Medicine to treat HIV at the best time, which includes medicine to prevent mother-to-child transmission and infection after sexual assault or occupational exposure.
- Treatment to prevent opportunistic infections such as specific serious pneumonias and TB.
- Regular monitoring of disease progression and response to therapy.
- Regular monitoring tests to pick up possible side-effects of treatment.
- Ongoing patient support through the nurse line.
- Best practice clinical guidelines and telephone support for doctors by a team of clinical experts.
- Help to find a registered counsellor for emotional support.

Contact Aid for Aids on **0860 100 646** or send a fax to **0800 600 773**, or email afa@afadm.co.za or send an sms to **083 410 9078 and ask that an AFA clinical expert contacts you**. Visit the website at www.aidforaids.co.za for more information regarding HIV/Aids and the programme.

Anti-retrovirals, related medicine, pathology and radiology, consultations and HIV Counselling and Testing ("HCT") relating to the condition are unlimited, provided that you register on the programme. Without registration on the programme, the benefits will be funded from the normal Pooled Day-to-Day benefits; this is incorrect and you need to ensure that your condition is registered to be funded from the PMB chronic benefit.

Action and information: the first step is to find out if you have been infected with the virus, how to protect others and stay healthy. Medication can suppress the virus and vitamins, good eating habits and exercise can help keep your body strong and healthy. If you start treatment early enough the medication can really improve your quality of life and decrease the risk of serious infections and other complications. Register on the Aid for Aids programme as soon as possible by calling **0860 100 646** to get an application form. Complete the form with your doctor and fax it to the confidential fax line. A highly qualified medical team will review the information and if necessary, discuss cost-effective and appropriate treatment with your doctor. The team will give you and your doctor a detailed treatment plan with a list of the approved medicine with instructions on how to take it and a list of the regular tests that will ensure that the medication works correctly and safely after they have agreed on the correct treatment. Your doctor can also contact Aid for Aids on your behalf and speak to the medical team for advice.

Confidentiality:

We understand that HIV infection is a sensitive matter and we try very hard to keep the condition of Aids sufferers confidential. Therefore the staff at our Aid for Aids programme each sign a confidentiality agreement and work in a separate area away from the medical scheme. They also use separate telephone, fax and mailbag facilities so that patients can make use of them with confidence.

Sexual assault and needle injuries can expose you to HIV infection. Ask your doctor to call Aid for Aids to authorise special antiretroviral medicine to help prevent HIV infection. You have to take this medicine as soon as possible after the incident. If it happens on a weekend, you or your doctor can contact Aid for Aids on the Monday morning to get authorisation.

MEDICINES

Acute (short course) and homeopathic medicine:

Acute and homeopathic medicines are funded up to the single exit price ("SEP") and a dispensing fee, which is limited to 30% capped at a maximum of R30 (VAT exclusive). It is subject to a re-imbursement limit, i.e. Maximum Generic Price or Medicine Price List ("MPL") and the pharmacist's administration fee is excluded and not funded by the Scheme. The benefit limits are as follows:

M: R12 100
M+1: R18 160
M+2: R23 590
M+3: R28 300
M+4+: R31 120, which is further limited and included in the Pooled Day-to-Day benefit limit.

Over-the-counter medicine (OTC), Pharmacy Advised Therapy (PAT) and Registered Vitamins prescribed by a GP or Specialist are funded up to SEP and a dispensing fee will be payable as set out above. This medicine is dispensed by a registered pharmacist and has the following sub-limits:
M: R2 380
M+1: R3 570
M+2: R4 640
M+3: R5 550
M+4+: R6 120, which is limited and included in the above Acute Medicine benefit and a maximum of R350 per script is applicable.

Oral Contraceptives, including the Mirena® device are limited to R2 130 per family and must be prescribed for contraception and not cosmetic purposes. Consultations and related costs are excluded from this benefit and more information may be obtained via the Contact Centre.

Chronic medicine is funded up to the single exit price ("SEP") and a dispensing fee, which is limited to 30% capped at a maximum of R30 (VAT exclusive). It is subject to a reimbursement limit, i.e. Maximum Generic Price or Medicine Price List ("MPL"). Levies and co-payments are applicable, where relevant. The benefit limits are as follows:
M: R15 140
M+1: R30 150
M+2: R38 530
M+3: R46 830
M+4+: R55 270
It is restricted to a maximum of one month's supply, unless specifically pre- authorised and approved. It includes diabetic disposables such as syringes, needles, strips and lancets for patients not registered on the Centre for Diabetes and Endocrinology ("CDE") programme.

Specialised drugs for Non-Oncology are limited to R227 260 per member family and are subject to the relevant managed healthcare programme and to prior authorisation for the treatment of:

- Multiple Sclerosis (as per the Prescribed Minimum Benefit Algorithm);
- Inflammatory Bowel disease;
- Chronic Hepatitis;
- Psoriasis;
- Iron Chelating agents for chronic iron overload and prevention of RSV infection, as well as

Sevelamer (Renagel®), Lantanum (Fosrenol®) and Cinacalcet (Sensipar®), which are recognised non calcium phosphate binders and calcimimetrics for renal osteodystrophy, as a result of chronic kidney disease.

Any other diseases, where the use of the drug is deemed appropriate by the contracted managed healthcare service provider will also be considered and approved. You may contact the **Authorisation Centre** to obtain more details and information in this regard.

Drugs for the treatment of macular degeneration have a sub-limit of R56 770 per family, which is included in the Specialised drugs for Non-Oncology overall limit of R227 260 per family.

The **HPV Vaccine** is funded as 1 Course (usually 3 injections) per lifetime per female beneficiary from the Wellness Benefit of the Scheme. Only female beneficiaries between the ages of 9 and 26 qualify for this benefit in terms of the applicable clinical protocols.

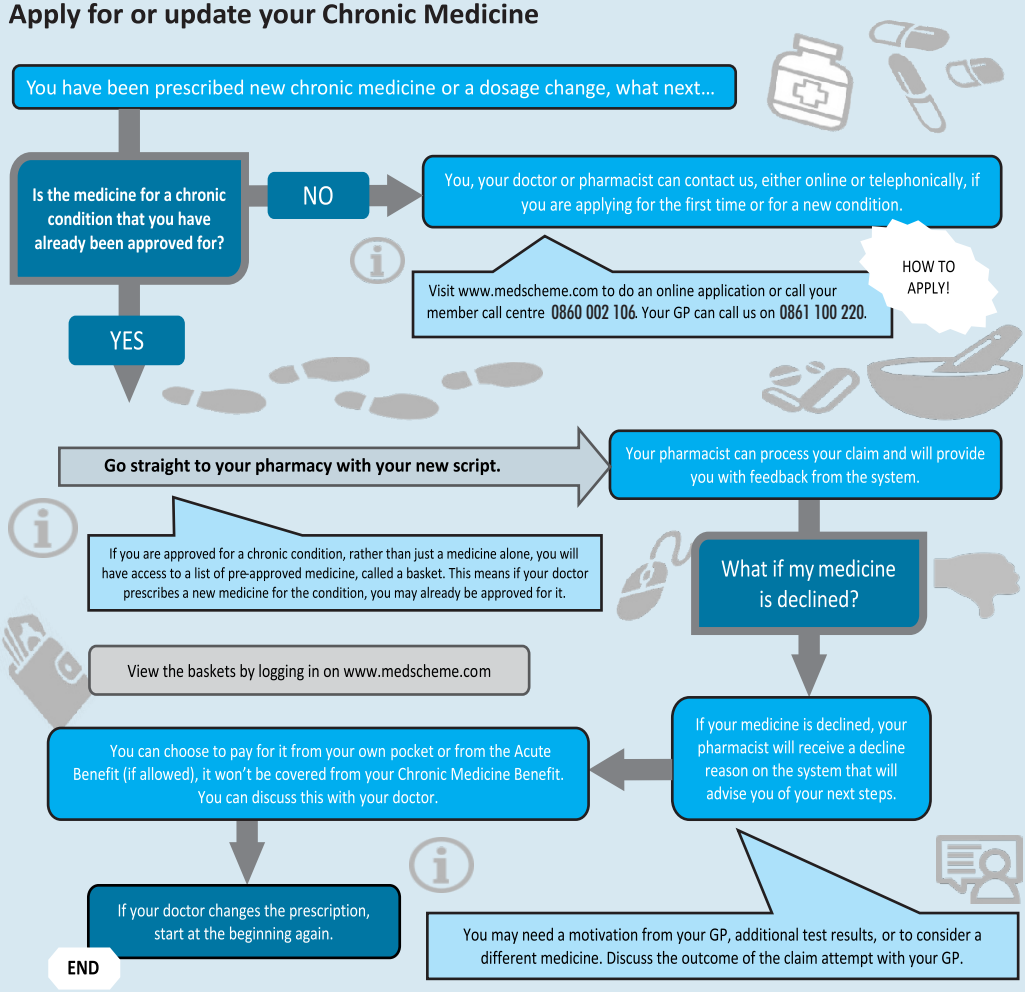
MEDICINE MANAGEMENT

The Barloworld Medical Scheme has contracted with a Managed Healthcare and Medicine Management Programme to ensure effective management and control of your acute and chronic medicine benefits**.**

Chronic medicine

Chronic medicines are indicated for prolonged illnesses that are often lifelong. Payment for these conditions must be approved by the Scheme to ensure that the most appropriate and cost- effective treatment is used. Each application for authorisation for medicine from the chronic medicine benefit is considered according to the current clinical guidelines and protocols of chronic medicine management. These payments are also done according to scheme rules, waiting periods,

Apply for or update your Chronic Medicine



exclusions and available benefits as it changes from time to time.

How your medicine is approved

Disease authorisations: 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 medicine, 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 need to still 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 a quantity or dosage of a medicine that is listed in the basket.

Pre-approved medicine in the basket will still be subject to MPL and formulary co-payments.

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

How to apply on the telephone and online

If you need to register for, or update your chronic medicine, you can do this on the telephone or online through the Chronic Medicine Management Department ("CMM"). The advantages of using these systems are that we can give you a quicker response and the online applications are available after hours as well. You, your doctor, or pharmacist or even your broker can complete the application. Below we provide you with a little more information on how.

When you contact us, it is important to have a copy of your current prescription with you during the phone call, although there is no need to send it in to us. Have the following information on hand:

- your membership number;
- the date of birth of the person applying;
- the ICD 10 code; and
- the doctor's practice number.

To authorise certain medicine you may also need to supply:

- 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; and/or
- motivation provided by your prescribing doctor.

Telephonically:

- Contact Chronic Medicine Management between 8:30 and 16:00 by calling 0860 002 106
- 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.com.
- 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 you will need to register.
- Go to "Clinical Information" and click on "Online Chronic Application".
- 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 for follow-up on the progress of the application.

The registration process is then completed and for both processes you may receive an immediate response. Where more clinical information is required, members of the clinical team will review

the information supplied and correspond with you and your doctor either telephonically or in writing, on the status of the medicine requested. You can follow-up on 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 need to take your original prescription to the pharmacy for the dispensing of your chronic medication.

What if my medicine 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 a quantity or dosage of a medicine that is more than the quantity listed in the basket.

MPL and out of formulary co-payments will still apply to medicine that is pre-approved in baskets. Check the basket for your condition, as well as the formularies and MPL information on www.medscheme.com.

Once your application has been approved

- We will send you a Medicine Access Card that lists the medicines and conditions that will be paid from your chronic medicine benefit.
- If the medicines on the card are different from the medicine prescribed, you will receive a letter with the card that explains why. Your doctor will also get a copy of the letter.
- Your doctor decides how many times the prescription will be repeated and will tell you how often he needs to see you to check on your condition.
- The period for which the medicine is authorised differs from medicine to medicine. Some will be authorised as ongoing, whilst others may only be authorised for a limited time. Please note that your prescriptions have to be renewed every six months as required by law.

What if your medicine request is declined?

You and your doctor will receive a letter from us to explain why a request was declined, with a reason such as that a cheaper alternative is available. Your doctor can appeal a decision by submitting a clinical motivation to barloworldcmm@medscheme.co.za or calling 0861 100 220.

Chronic medicine for prescribed minimum benefits

The Medical Schemes Act provides a list of Prescribed Minimum Benefits ("PMB") that all medical schemes must offer. This list contains chronic conditions which have to be covered without any benefit limit by all schemes, called the Chronic Disease List ("CDL"). Specific treatment protocols can be used to treat CDL conditions, which means that the Chronic Medicine Management clinical protocols, guidelines and the Medicine Price List ("MPL") will apply to the Chronic Medicine Benefit.

How does this affect your chronic medicines benefit?

Only medicines used to treat PMB conditions, that are authorised by Chronic Disease Management and that fall within the protocols specified by the Council for Medical Schemes, will be paid. Please see more information about these conditions in this benefit guide.

How can healthcare practitioners ensure payment of claims for PMB?

The hospital, doctor, pharmacist or other healthcare service provider must indicate on the account that the treatment is for a PMB condition. They must use specific ICD-10 codes to ensure that claims are processed correctly. (See section on ICD-10 codes in this booklet.)

Medicine Price List ("MPL")

The MPL is used for acute and chronic medication, because medicines are an important part of healthcare spending and need to be carefully managed. The Barloworld Medical Scheme has adopted the MPL for acute and chronic medication

so that members can continue enjoying affordable contribution increases without compromising quality of care.

MPL is a reference pricing system that uses a benchmark price for medicines that have the same ingredients. This list does not limit your choice of medicine, but only limits the amount that will be paid. If you prefer the more expensive medicine, you have to pay in the difference to the pharmacy. All the medicines in a specific MPL group have the same active ingredients. You can avoid paying extra if it is not necessary and you can ask your doctor and pharmacist to prescribe and dispense medicines that are completely covered by the MPL.

Medicine Exclusion List ("MEL")

The MEL is a list of medicines that are excluded for payment from the acute medicine benefit for reasons such as:

- Medicines with no proven clinical value.
- Medicines that are more expensive than similar medicines that do the same for less.
- Medicines that could be abused.
- Some expensive chronic medicines that require specific pre-authorisation.
- Some combination medicines where it would be better to use medicines with single ingredients.
- New medicines that are still under review.

More information about the MPL and MEL is available on the Medscheme website at www.medscheme.com.

MENTAL HEALTH (IN and OUT of Hospital)

An overall limit of R59 040 per family is made available for all non-PMB mental health treatment.

All PMB mental health treatment is funded from Risk per the legislated guidelines.

Procedures in and out of hospital have a sub-limit of R33 500 per family which are further limited and included in the overall limit of R59 040 per family. This benefit includes accommodation, use of operating theatres and hospital equipment, medicine, pharmaceutical and surgical items and procedures performed by general practitioners, psychiatrists or psychologists, psychometrists or registered counsellors at the supplier's rooms or in any facility or at any place, including a public hospital.

A pre-authorisation number must be obtained via the Authorisation Centre and the benefit is limited to 3 days hospitalisation for beneficiaries admitted by a general practitioner or specialist physician.

Procedures out of hospital will be funded up to 150% of the Scheme Tariff Rate.

Consultations and visits in and out of hospital are limited to R25 200 per family and limited and included in the overall limit of R59 040 per family.

Consultations and visits out of hospital will be funded up to 150% of the Scheme Tariff Rate.

The Rehabilitation for Substance Abuse benefit is limited to the overall limit of R59 040 per family and more details may be obtained from the Call Centre at 0860 002 106.

The Childhood Support Therapies benefit is available to registered child beneficiaries under 21 years of age that are diagnosed with a childhood mental health condition; these beneficiaries often require additional dedicated Physiotherapy, Occupational Therapy and Speech Therapy needs.

The benefit is limited to R34 040 per child beneficiary per annum and includes specific treatment limited to:

- **Anxiety disorders**

Children who have anxiety disorders such as obsessive compulsive disorder, post-traumatic stress disorder, social phobia and generalized anxiety disorder experience anxiety as a persistent problem that interferes with their daily activities.

- **Attention-deficit/hyperactivity disorder (ADHD)**

This condition typically includes a combination of issues, such as difficulty sustaining attention, hyperactivity and impulsive behaviour.

- **Autism Spectrum Disorders**

Autism spectrum disorders appear in early childhood - usually before age 3. Though symptoms and severity vary, all autism disorders affect a child's ability to communicate and interact with others.

All cases are managed as follows:

- An annual review of existing approved cases needs to be performed by the Medical Advisor.
- The individual patient treatment plans are requested by the Medical Advisor in September

each year for the following year. All new case candidates that fall within the scope of support therapies for childhood mental conditions will be identified by the Medical Advisor.
- The scope of each annual review will be defined by and limited to the conditions set out above.
- A de-identified detailed per-case report will be made available to the Trustees after review of the individual treatment plans.

Should any case request exceed the level of R34 040 per annum, it will be referred to the Trustees for additional funding consideration.

NON-SURGICAL PROCEDURES AND TESTS (OUT of hospital)

This benefit is limited and included in the Pooled Day-to-Day benefit limit.

Specific non-surgical procedures in practitioner's rooms include:

- Routine diagnostic upper and lower gastro-intestinal fibre optic endoscopy (excluding rigid sigmoidoscopy and anoscopy)
- Cystoscopy
- 24hr oesophageal PH studies
- Oesophageal motility studies
- Breast fine needle biopsy
- Prostate needle biopsy

The above limit includes related consultation, materials, pathology and radiology if done on the same day.

ONCOLOGY (Cancer Management)

Benefits:

The Oncology benefit is limited to R536 930 per beneficiary per annum for all services combined.

PET and PET-CT scans are included in the above limit and limited to one per beneficiary per annum and restricted for the staging of malignant tumours.

All Specialised Drugs for Oncology are limited to R284 040 per beneficiary and are limited to and included in the R536 930 per beneficiary overall Oncology limit.

Brachytherapy is funded up to R99 400 per beneficiary per annum and included in the R536 930 per beneficiary overall Oncology limit. The seeds and disposables are limited to R36 920 per beneficiary per annum and are funded from the overall Brachytherapy limit of R99 400 per beneficiary per annum.

Please contact the **Call Centre** at **0860 002 106** for more information relating to the funding of Cancer Treatment during the Active and Post-Active Treatment periods.

Oncology Disease Management Programme

Your Scheme provides you with the Oncology Disease Management Programme for support and management of your oncology benefits, should you be diagnosed with cancer and need to receive treatment. It is important that you register on the Oncology Disease Management Programme on diagnosis or before treatment begins.

You will need to ask your doctor to send your treatment plan to the clinical team, because all oncology treatment is subject to pre-authorisation and case management.

The Case Management Team will then review your treatment plan and contact your doctor to discuss more appropriate or cost-effective treatment alternatives.

An authorisation letter will be sent to you and your treating doctor after your treatment plan has been assessed and approved. The letter will show which treatment is authorised, the approved quantities and the period of treatment authorised.

You need to make sure that your doctor lets the Oncology Disease Management team know of any change in your treatment, because your authorisation will have to be reassessed and updated. Otherwise your claims may be rejected or paid from the incorrect benefit, such as day-to-day benefits, because there will not be a matching oncology authorisation.

Note: You will also need to obtain a Pre-Authorisation Number (PAR) from Hospital Benefit Management when going to hospital for specialised radiology such as MRI and CT scans, angiography and private nursing care or hospice services.

Who should register on this programme?

Members who have been diagnosed with cancer and members who will receive treatment.

How do I register for this programme?

Your doctor can submit a detailed copy of your treatment plan by email or fax, email to cancerinfo@medscheme.co.za, or fax to (021) 466 2303. An oncology case manager will take the process from there.

Call the programme on **0860 100 572**

OPTOMETRY

In line with the industry standards, the optometry benefit became a 2-year benefit from 1 January 2020, as follows:

M: R5 620

M+1: R11 190

M+2: R16 710

M+3: R22 170

M+4+: R27 600, which is included in the Pooled Day-to-Day benefit limit and further limited to R5 620 per beneficiary every 2-year cycle.

The above optometry benefit limits allow for:

Diagnostic procedures, Contact Lenses and clinically appropriate Lens Enhancements/Add-ons, funded at the Optical Assistant guideline rates.

Readers are limited to R240 per beneficiary every 2-year cycle, included in the above optometry benefit limit.

Frames have their own sub-limit of R2 390 per beneficiary every 2-year cycle, included in the above optometry benefit limit.

Optometric Consultations (Eye Tests) will be funded from the Risk benefit, limited to two (2) consultations per beneficiary per annum, including tests for glaucoma.

Spectacle Lenses, including prescribed single vision, bifocal, multifocal and special lenses are limited to one (1) pair of clinically appropriate lenses per beneficiary every 2-year cycle, funded from the Risk benefit.

ADDITIONAL MEDICAL SERVICES (IN and OUT of hospital)

The benefit is limited to and included in the Pooled Day-to-Day benefit limit and covers:

- Audiology (hearing)
- Dietetics
- Genetic counselling
- Hearing aid acoustics
- Occupational therapy
- Orthoptics (eye movement)
- Podiatry
- Speech therapy
- Social workers
- Private nurse practitioners

There is no benefit for pharmacy services.

PATHOLOGY

The Scheme utilises a Pathology Management Programme to ensure pathology tests that the Scheme pays for are not only clinically appropriate for your medical condition, but also cost effective.

Unnecessary testing can lead to money being wasted, which uses up your benefits and leaves you short when you need it most. Steps were therefore put in place to encourage healthcare providers to carefully consider the necessity, appropriateness and value of tests before ordering them.

How will this programme impact you?

Pathology claims are assessed and paid after the tests have already been done. It is therefore important for you and your doctor to discuss the tests and that you familiarise yourself with the funding rules and your available benefits before testing is done.

A detailed breakdown of the affected tests, listed below, is available to both you and your doctor online at www.medscheme.com. A copy of this breakdown is forwarded to your treating provider.

Funding for pathology tests is subject to your Scheme's benefit rules and the available benefit limits at the time of the claim being received by the Scheme for processing.

Which tests are affected?

The following tests may be affected by the Programme. Please note that limits may apply to some of the tests listed below, while a motivation from your doctor may be required for others and it is therefore important that, as mentioned, that you and your doctor discuss the following tests and the necessity for them to be done, before visiting the chosen pathology laboratory.

- Blood tests for allergy - limits apply
- Tests for tuberculosis (TB), e.g. GeneXpert® and T-Spot®
- Certain malaria tests (quantitative buffy coat/QBC)

- Insulin level testing (note: insulin level testing does not form part of routine care or diagnosis of diabetes)
- Blood tests for Vitamin D levels
- HIV testing: Western blot tests
- Blood tests for chest pain: AST (aspartate aminotransferase) and myoglobin
- Blood tests for liver function- LDH (Lactate dehydrogenase)
- Blood gas tests (usually performed in the hospital ward)
- Blood count tests automatically added by the laboratory (reticulocyte count)

If you have any further queries in this regard, you are welcome to contact your Scheme Contact Centre at 0860 002 106 from Monday to Friday between 08:30 and 16:00.

PHYSICAL THERAPY

In hospital physical therapy and biokinetics are unlimited, whilst any out of hospital treatment is included in the Pooled Day-to-Day benefit limit.

RADIOLOGY

GENERAL RADIOLOGY

In-hospital general radiology is unlimited, whilst any out of hospital treatment is funded from the Pooled Day-to-Day benefit limit.

SPECIALISED RADIOLOGY

In-hospital specialised radiology is unlimited, whilst any out of hospital specialised radiology is limited to R30 000 per family per annum.

Please note that certain specialised scans, such as MRI, CT and PET, require pre-authorisation and the **Authorisation Centre** must be contacted to obtain more information.

SPECIFIC SURGICAL PROCEDURES

There is an unlimited benefit for Circumcision, Laser Tonsillectomy and Vasectomy, which includes the related consultations, materials, pathology and radiology if done on the same day.

CENTRE FOR DIABETES AND ENDOCRINOLOGY ("CDE")

Members with diabetes have access to the CDE Diabetes Management Programme offered by the Centre for Diabetes and Endocrinology. This programme offers you support services to manage your illness and focus on ways to prevent complications such as diet, exercise and regular check-ups with specialists. You will also get medication and a device to monitor your diabetes. You can get details of these services from the CDE.

Call the CDE to register for this programme on (011) 712 6000 from Monday to Friday 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.

MANAGEMENT OF FRAUD AND ABUSE

As the losses to medical schemes due to fraud increase, your contribution to your medical scheme may also increase to help cover this loss.

You can help to combat fraud by calling our Fraud Hotline if you are aware of any practitioner or patient who is abusing the system. You do not have to give your name and all calls are treated in the strictest confidence.

Medscheme Fraud Hotline 0800 112 811

BARLOWORLD BABY

Having children is one of life's exciting adventures and Barloworld Medical Scheme understands that along with this excitement, there may also be a certain amount of apprehension. So, to both celebrate and help expectant parents cope with aspects of pregnancy and childbirth, Barmed offers Barloworld Baby, in conjunction with the DLA Group.

As a valued member, once you have registered on the programme (usually after your 12th week of pregnancy) you will receive:

- A welcome pack with a Baby and Child Care handbook, discount vouchers and a gift
- Weekly e-mails for mom-to-be
- E-mails twice a month for dad-to-be
- In mom's third trimester, we will deliver your Barloworld Medical Scheme Baby Gift Bag, filled to the brim with wonderful goodies for both mom and baby
- Our Barloworld Baby team will give you a call after baby's birth to see how both mom and your baby

are doing and to send off our Congratulations!
- After baby's birth, you can choose to enroll on the immunisation information programme

This is an opt-in service and you may register on Barloworld Baby by calling the information line on 0861 99 88 90 (Monday to Friday from 08h30 to 16h30, excluding public holidays), or send us an email at info@babyhealth.co.za with your name, contact telephone number and Barloworld Medical Scheme membership number.

DBC BACK AND NECK REHABILITATION PROGRAMME

What is DBC?

The DBC (Documention Based Care) back and neck rehabilitation programme is an evidence based physiotherapy and active rehabilitation programme that concentrates primarily on back and neck problems, helping you manage severe neck and back pain. The programme consists of up to 12 sessions over a 6 week period and the treatment takes place at specific DBC centres.

The treatment system was developed in Finland more than 20 years ago and today the DBC network spans treatment providers in more than 22 countries. The system is completely evidence and outcomes based with a current global success rate in excess of 85% after an average of 3 to 9 weeks' treatment.

The Benefits:

- Barmed covers the full cost of the programme, so it won't impact your Pooled Day-to-Day benefits.
- An initial assessment to determine the level of treatment required.
- A personalised treatment plan for up to 6 weeks.
- This includes treatment from doctors, physiotherapists and biokineticists.
- Gives you access to a home care plan to maintain your results long-term.
- Highly effective and low-risk, with an excellent success rate.

How can DBC help me?

- Restore the range of motion;
- Restore muscle co-ordination and movement control;
- Improve muscle endurance;
- Improve your general condition ;
- Re-educate you in the difference between normal physical loading and pain;
- Reduce fears and avoidance behaviour;
- Tackle the psychological/ social/ occupational obstacles to return to normal daily living.

Treatment

The treatment consists of active exercise with appropriate weights and motion. Guidance on how to use the spine and lead a normal life is an important component of the treatment. The exercises are targeted at the trunk muscles of the spine, helping to restore mobility and control.

Relaxation is an essential part of the program. After the initial treatment, you receive a home program on how to maintain the results long term. The attending doctor can follow your progress based on regular check-ups.

How to access the Programme

You can access the programme in various ways.

Barmed may refer you to the programme if:

- you request a pre-authorisation for an admission related to back/neck surgery (for example a spinal fusion), pain management (for example a rhizotomy) or specialised radiology (for example an MRI scan), or;
- the Medscheme predictive model identifies you as being at risk of a back/neck admission within the next year (if you haven't yet visited one of the accredited centres).

Barmed will only identify and contact members within 30km of a DBC centre, as it's often found that members who have to travel more than 30km would decline the Programme.

- Your specialist or GP may refer you to the Programme.
- You may self-refer by contacting the Member Contact Centre on 0860 002 106 should you experience chronic, ongoing back or neck pain.

Where are the DBC centres?

Please call the Member Contact Centre on 0860 002 106

WELLNESS AND PREVENTATIVE BENEFITS

Improve your Health!

Barmed's vision for wellness is to improve the health and well-being of members through awareness and education, prevention and screening, targeted interventions and a focused rewards program that supports positive lifestyle changes, in order to improve health outcomes and reduce overall scheme costs.

The Wellness and Preventative Benefits offer cover the following tests and procedures, per beneficiary per annum:

- HPV Vaccine (Human Papillomavirus vaccine to prevent cervical cancer): 1 Course per lifetime, usually consisting of 3 injections, for female beneficiaries aged between 9 and 26 years only
- 1 Gynaecologist visit (Female beneficiaries above the age of 13)
- 1 Pap smear (Female beneficiaries above the age of 13)
- 1 Mammogram (Female beneficiaries above the age of 30)
- 1 Bone Density Scan (Female or male beneficiaries above the age of 50)
- 1 Prostate test (Male beneficiaries above the age of 40)
- 1 Glucose test
- 1 Cholesterol test
- 1 Midstream urine dipstick test
- 1 HIV test, in addition to the minimum requirements of Prescribed Minimum Benefits (PMB)
- 1 Flu vaccine
- Pneumonia Vaccine - 1 per beneficiary aged 19 or older, every 5 years
- Incontinence Benefit
- 3-part Health Risk Assessment
- Extended consultations for High Risk Beneficiaries registered on the Beneficiary Risk Management Programme
- The Personal Health Record (PHR) for High Risk Beneficiaries registered on the BRM Programme; the PHR is also available to all registered members.

Child Immunisations (per the Department of Health guideline)

Age	Vaccine
At birth	Tuberculosis (BCG), Polio (OPV)
6 weeks	Polio (OPV), Diphtheria, Tetanus , Whooping Cough (DTP), Hepatitis B, Hemophilus Influenzae B (HIB)
10 weeks	Polio, Diphtheria, Tetanus Whooping Cough (DTP), Hepatitis B, Hemophilus Influenzae B (HIB)
14 weeks	Polio, Diphtheria, Tetanus Whooping Cough (DTP), Hepatitis B, Hemophilus Influenzae B (HIB)
9 months	Measles
18 months	Polio, Diphtheria, Whooping Cough (DTP), Tetanus, Measles, Hemophilus Influenzae B (HIB)
6 years	Diphtheria and Tetanus (DT)
12 years	Diphtheria and Tetanus (DT) Offer Measles, Mumps and Rubella (MMR) as a choice to parents in place of Measles

The three-part Health Risk Assessment (HRA)

The three-part HRA consists of a lifestyle questionnaire, wellness screening and physical screening assessments. Participating individuals will be provided with a report upon completion of each component of the HRA. The assessments must be completed in sequence in order to gain a comprehensive understanding of an individual's health status and enable the delivery of holistic integrated wellness interventions to influence health behaviour.

1. The lifestyle questionnaire – self reported information captured on-line

The subjective assessment can be completed on-line through the member's personal health record (PHR) or at a pharmacy using Allegra software or during consultation with a Biokineticist. High Risk Beneficiaries who have enrolled on the BRM programme will be afforded the opportunity to complete the assessment verbally should they not have internet access.

The questionnaire provides insight into an individual's lifestyle habits, family history, general health status (includes mental), and their "willingness to change". Feedback is provided in the form of a report, highlighting areas where the individual is doing well and areas for improvement.

The individual is empowered through behaviour change principles and knowledge of their health status to adopt a healthier lifestyle.

2. The wellness screening - performed by a nurse or Biokinetics Association of South Africa (BASA) registered Biokineticist

The measurements taken as part of the wellness screening include: blood pressure; body mass index (BMI); waist circumference; random blood cholesterol and random blood glucose. Upon conclusion of these tests, the individual will receive a report containing feedback on whether he/she has a healthy weight - a key risk factor for developing chronic diseases such as hypertension and type 2 diabetes - and whether they should consult with their Family Practitioner to have their blood pressure, cholesterol and glucose levels monitored.

Barmed intends driving participation in wellness screening by increasing beneficiary access to service providers. Part two of the HRA can be performed at wellness days by the Scheme's existing service providers or at any time that is convenient for a beneficiary through consultation with one of BASA's network of 1100 peer-managed Biokineticists or with a nurse at any pharmacy or occupational health clinic that uses Allegra software.

3. The physical screening - performed by a BASA Biokineticist

Part three of the HRA includes an evaluation of the individual's fitness, body fat composition, peak flow and waist to hip ratio. The assessment will be performed by a BASA Biokineticist, who will provide the individual with a report on their specific risk for metabolic syndrome, Type II diabetes and cardiovascular disease and their Family Practitioner will also be notified if and when needed.

A calculated "heart age" score which compares the individual's real age to a predicted heart age is also provided so that individuals have an indication of whether they are living a healthy lifestyle or not. The individual will then receive personalised advice on how to increase their physical activity and improve their nutrition.

The Health Professional Council of South Africa accredits and recognises Biokineticists for their role in prescribing exercise to both the healthy and "at risk" populations, and to consult around lifestyle interventions. Previously, beneficiaries received generic, often inappropriate, advice with regards to increasing their physical activity. The inclusion of a physical assessment enables the provision of tailored appropriate advice. Furthermore, face-to face interventions have been shown to improve participation and adherence to wellness interventions.

QUERIES AND AUTHORISATION CENTRE

If you require further information or have any questions, please call the Member Contact Centre on **0860 002 106** between **08:30** and **16:00** from Monday to Friday. Using this number you only pay the rate of a local call no matter where you are calling from within South Africa. Queries may also be e-mailed to us at **Barloworld@medscheme.co.za**

Members and Healthcare Professionals may post their claims to: **P.O. Box 74, Vereeniging, 1930**

First time e-mailed claim submissions may be sent to: **Claims@medscheme.co.za**
You can also register/login to the Barloworld Medical Scheme Member Zone at www.medscheme.com to access all relevant information relating to your benefits, claims and statements.

HOSPITAL AND SPECIALISED RADIOLOGY AUTHORISATION requests take place from Monday to Friday between 08:30 and 16:15, with an automated voice system available 24 hours a day, seven days a week for out of hours requests.
Requests can be e-mailed to **Barloworld.Authorisations@medscheme.co.za** or faxed to **021 466 1913** or phone **0860 002 106.**

VISIT US

Please visit **www.medscheme.com** and navigate to *Contact Us* for the latest walk-in Branch addresses and contact details.

COMPLAINTS AND APPEALS PROCESS

Should you not be satisfied with the manner in which your claims were processed and/or wish to lodge a complaint with the Scheme, the processes to be followed are as follows:

1. Contact the Scheme's Member Contact Centre during office hours and try to resolve your query with the contact center. If the result is not considered to be satisfactory by you, then

2. Request that the Principal Officer of the Scheme be advised to contact you to discuss the complaint. If you are still dissatisfied, you may

3. Lodge your complaint in writing to Barloworld@medscheme.co.za, for the attention of the Disputes Committee, c/o The Principal Officer. The Disputes Committee will convene a meeting to adjudicate your complaint and/or dispute, and determine the procedure to be followed. You have the right to be heard at these proceedings, either in person or through a representative, if you choose.

4. Lastly, should your complaint remain unresolved, you may take your appeal further by approaching the Council for Medical Schemes ("CMS") for resolution. They will make a conclusive decision, which will be communicated to you in writing. The CMS contact details are as follows:

Council for Medical Schemes

Block A Eco Glades 2 Office Park, 420 Witch-Hazel Street, Ecopark

CENTURION 0157

Website address: www.medicalschemes.com (on the landing page, select "Consumer Assistance", then select "The Complaints Procedure" link for further information)

Telephone no. (012) 431 0500. Fax no. (012) 431 7544

Customer Care Share call no. 0861 123 267

E-mail address: complaints@medicalschemes.com