



Barloworld
Medical Scheme

Member Guide 2012

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.

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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	26 Conditions for which medication and treatment is specified.
CLO	Client Liaison Officer	An employee of Medscheme visiting agreed site 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
DOH	Department of Health	
DPM	Direct Paying Member	Where the member pays the fund 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 do not interact adversely with each other
HBMP	Hospital Benefit Management Programme	A programme to manage, verify and validate the membership of a member and/or dependant who requires to be admitted at hospital for a hospital event, as well as to ensure that the correct and appropriate procedure codes are approved and used in surgical cases through issuing a pre-authorisation number to the hospital event.
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 being not the most cost effective and/or not clinically proven.
MHRS	Medscheme Health Risk Solutions	Managed health care company of Medscheme that manages the Scheme's managed healthcare programme as detailed in this guide.
MPL	Medscheme 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 are maintained and published by an organisation called 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.
PMBs	Prescribed Minimum Benefit	Benefits that medical schemes must cover. See further details in this benefit guide.
PO	Principal Officer	An executive officer of the Scheme who is required to attend to a list of duties as contained in the Scheme Rules.
RAF	Road Accident Fund	As per www.raf.co.za , a public entity which provide 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.
SEP	Single Exit Price	Legislated drug price from manufacturer to end user.
SID	Special Investigations Department	Medscheme department responsible for managing and reporting fraud investigations conducted on behalf of the Scheme.

PRESCRIBED MINIMUM BENEFITS (“PMBs”)

According to the Council for Medical Schemes (“CMS”), Prescribed Minimum Benefits (“PMBs”) are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable. PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- Any emergency medical condition, which is an emergency medical condition that is sudden and, at the time, results in an unexpected onset of a health condition that 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 suspect that the patient suffers from a condition that is covered by PMBs, the medical scheme has 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) as 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 PMB conditions appropriately and cost-effectively whilst ensuring high quality care. 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:

PMBs 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	Cancer of the cervix, ovaries system and uterus

Pregnancy	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

- Chronic obstructive pulmonary disorder
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

No exclusions

Medical schemes often have a list of conditions – such as cosmetic surgery – for which they will not pay, or circumstances – such as travel costs and examinations for insurance purposes. These are called exclusions. Exclusions, however, do not apply to PMBs. If you contract septicaemia after cosmetic surgery, for example, the Scheme will provide healthcare cover for the septicaemia part because septicaemia is a PMB. (Cosmetic surgery remains an exclusion) PMBs are concerned about the diagnosis; it doesn't matter how you got the condition.

26 Chronic Conditions (Chronic Disease List)

Only medicines used to treat PMB diseases authorised by Chronic Medicine Management that fall within the protocols specified by CMS will be reimbursed. The 26 conditions, excluding HIV/Aids, which is also considered to be a PMB, are the following:

- Addison's disease
- Asthma
- Bi-polar Mood Disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy

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, such as 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 (at a hospital, as an outpatient or at a doctor's rooms).

If you have one of the 26 listed chronic diseases, the Scheme will cover the medication, but also the doctors' consultations and tests related to your condition. The Scheme may make use of

protocols, formularies (lists of specified medicines) and Designated Service Providers (“DSPs”) to manage this benefit.

What is a designated service provider? (“DSP”)

Your medical scheme may choose a healthcare provider or group of providers (doctors, pharmacists, hospitals, network, or so on) to be the preferred provider or providers to its members when they need diagnosis, treatment or care for a prescribed minimum benefit condition.

If you do not use the designated service provider your scheme has chosen, you may have to pay the costs yourself, or your scheme may only pay as much as it would have cost you to make use of the designated service provider, and you will have to pay the difference.

If your scheme expects you to use a designated service provider, it must inform you and the rules of the scheme must also state which service providers are the designated ones and what the scheme will or won't pay if you use a provider other than the designated one.

The Council for Medical Schemes believes that if your scheme does not appoint a designated service provider, you are entitled to obtain a service listed in the PMBs from any provider and the scheme must pay.

When can I use a doctor, pharmacist or hospital other than a designated service provider?
The regulations provide for instances in which it is not possible for you to make use of the designated service provider for the diagnosis, treatment or care of a prescribed minimum benefit condition. For example, if you need treatment very urgently. In this case you will be regarded as having obtained the service involuntarily and the scheme will have to pay. The three cases in which you will be regarded as having obtained the

service involuntarily are:

- i) If the service was not available from the designated service provider or could not be provided without an unreasonable delay;
- ii) If you needed immediate treatment under circumstances that prevented you from using the designated service provider; and
- iii) If there was no designated service provider within reasonable proximity of your place of work or residence.

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. Nobody is allowed to belong to more than one scheme.

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 be dependants. 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 full time 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: These dependants can stay on the Scheme if they were registered with the Scheme at the time of the member's death until joining another scheme as a member or dependant.

Late Joiner Penalties, waiting periods and exclusions:

The contribution rates are:

The above rates do not take into account any Late Joiner Penalties (“LJP”) that may be applied to an

Monthly Income R	Dependant Category		
	Member	Adult Dependant Note 1*	Child Dependant Note 2*
0 - 9 850	1 920	1 745	570
9 851 - 16 440	2 200	2 000	665
16 441 - 23 020	2 375	2 160	725
23 021 - 29 540	2 565	2 320	765
29 541 - PLUS	2 665	2 410	805

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

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

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) will 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:

$A = B \text{ minus } (35 + C)$

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.

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. A **twelve month condition-specific waiting period** may also be applied where the member and/or dependant has 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 on the last day of the month in which you stop working there. Please remember to hand in your membership card at your HR Department.

ADMINISTRATION

How to look after the administration of your benefits?

This benefit guide will give you most of the answers about how to look after the administration of your Scheme benefits. Let's start by looking at how the claims chain at Medscheme, who is the Administrator processing the claims on your behalf, 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 or receipt (not a copy) to us as soon as possible. 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 says 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 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 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 we receive and deal with your claim we pay you or the healthcare service provider directly into a bank account depending on the way 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, we will let you know by email or SMS and tell you if we will pay you or the healthcare service provider. Later in the payment run we will send you another

email or SMS to advise you how much we are paying. 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.

We will send you 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 our website at www.medscheme.co.za that will show your claims history, premium payments, personal information and much more. You will also be able to change your personal details here and view your benefits.

Car accidents, assault and injury at work

If you are involved in a car accident and you could have a claim against the Road Accident Fund (“RAF”), you have to contact us to get the information and help to claim against the RAF. If you are unsure of the benefits we offer or if you got hurt in the accident, assault or if you were injured at work, call us on **0860 002 106** to find out what to do.

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 per service or event to fund each service or treatment received on your behalf. Members are advised to negotiate and discuss Scheme Tariffs and fees to be charged for services and treatment to be received upfront to prevent unnecessary co-payments and out-of-pocket expenses.

Unless specified otherwise all benefits are funded up to 100% of Scheme Tariff.

GAP COVER (additional cover) is only for procedures in hospital for services provided by **general practitioners, medical and dental specialists, dental practitioners, physiotherapists and biokenitcists**. It covers the difference between the Scheme Tariff up to a maximum of 250% of the Scheme Tariff.

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 2012 - Limits by family size

Category		M	M+1	M+2	M+3	M+4+
Pooled Benefit	Acute Medicines, OTC medicines / PAT					
	Advanced dentistry					
	Basic Dentistry					
	*Out-of-hospital Procedures and Non- surgical procedures and tests					
	Out-of-hospital Pathology, General Radiology and Physical Therapy	R13 700	R17 900	R21 350	R24 600	R29 300
	General Practitioner, Medical Specialist, Optical, Additional Medical services and Alternative Healthcare					
	HPV vaccine					
Sub-Limits:						
Acute Medicines	R3 020	R4 700	R5 630	R7 100	R7 260	
**OTC medicines /PAT	R460	R690	R850	R1 050	R1 070	
Advanced Dentistry (out of hospital procedures)	(max R230 per script)					
	R8 500	R11 500	R13 000	R14 500	R16 000	
Optical sub-limit	R3 000	R6 000	R9 000	R12 000	R15 000	
	Subject to R3 000 per beneficiary per annum. (Readers sub-limit R150)					
HPV vaccine	R1 500 per female beneficiary age 10 - 45 years only.					

*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 R12 500 per beneficiary and R15 000 per member family for all services combined.

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

- Glucometers with a sub-limit of R640 per beneficiary, Nebulizers with a sub-limit of R640 per beneficiary and Peak flow meters with a sub-limit of R600 per beneficiary.
- Hearing aids, including repairs within the first twelve months with a sub-limit of R12 500 per beneficiary.
- CPAP apparatus for sleep apnoea requires pre-authorization and the **Authorisation Centre** must be contacted at 0860 002 144 (8:30 – 16:00) Monday to Friday. Or email: authorisations.cpt@medscheme.co.za.

Specific Appliances and accessories

Oxygen therapy equipment, which does not include hyperbaric oxygen treatment and home ventilators are unlimited, while long leg callipers and low-vision appliances are limited to a maximum of R12 500 per beneficiary and R15 000 per member family.

BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS

These products are funded at 100% of the Scheme Tariff and is an unlimited benefit,

however, funding does require pre-authorization. The **Authorisation Centre** must be contacted at 0860 002 144 (8:30 – 16:00) Monday to Friday. Or email: authorisations.cpt@medscheme.co.za. The transportation of the blood is included if pre-authorized.

CONSULTATIONS

Out of hospital:

The out of hospital consultations are funded at 100% of the Scheme Tariff from the Pooled Day-to-Day benefit.

In hospital:

100% of the Scheme Tariff funded unlimited, however the consultations in hospital excludes consultations by:

- 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
- Physical therapists.

For these visits, please see the detail in this benefit guide as mentioned under these benefits in the guide.

DENTISTRY

Benefits

The Scheme fund dentistry up to 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme Tariff or Uniform Patient Fee Schedule for public hospitals.

Funding for **Basic Dentistry** is limited to and included in the Pooled Day-to-Day benefit limit and includes basic dentistry performed by a dental practitioner and/or dental therapist including

minor oral surgery as defined in Section J of General Practitioners; Dental Schedule and Oral Medical Procedures (as defined in the Dental Schedule). Basic Dentistry includes the removal of teeth, removal of wisdom teeth, exposure of teeth for orthodontic reasons and suturing of traumatic wounds. The Oral Medical Procedures includes the diagnosis and treatment of oral and associated conditions and dental technician's fees for all such dentistry.

Advanced Dentistry includes services 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.

It is limited as follows:

M0 = R8 500;

M1 = R11 500;

M2 = R13 000;

M3 = R14 500;

M4+ = R16 000, which is further limited and included in the Pooled Day-to-Day benefit limit.

The benefit excludes 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 above Advanced Dentistry benefit and includes the cost of special investigations, hospitalisation, all general and specialist dental practitioners, their assistants and anaesthetists as well as the cost of materials, all implant components, plates, screws and bone and bone equivalents for all related services rendered. It furthermore, 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 above Advanced Dentistry benefit and includes consultations, visits, removal of teeth, para-orthodontic surgical procedures and preparations of jaws for prosthetics as defined in the dental tariff schedule

and performed by maxillo facial specialists.

Orthodontic Treatment is included in the above Advanced Dentistry benefit.

Maxillo-facial surgery is included in the Surgical Procedures benefit of the Scheme and the benefit guide needs to be consulted under this benefit for more details.

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 for dental procedures that requires general anaesthetic and conscious sedation is required, as well if special dentistry is required. 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 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.
- Transfer by road or air to the closest, most suitable medical facility.
- Ambulance transfers to special care centres.
- Inter-hospital transfers only if a medical professional can motivate why it is medically necessary.

In a medical emergency only dial 082 911 and:

- Give your name and number of the phone you are calling from.
- Give a brief description of what has happened.
- Where, and how serious the situation is.
- Provide the address or location of the incident to help paramedics to get there.
- **DO NOT HANG UP UNTIL THE PERSON WHO ANSWERED YOUR CALL DOES.**
 - Please make sure that all your registered dependants know about this service.
 - Ensure that you have the emergency service stickers on your vehicles and inform your child or children of your membership and give them the number.

Patient Transport Services (“PTS”)

The Patient Transport Service of Netcare911 provides a suitable means of seated transport to patients who do not require the assistance of an Emergency Ambulance and who are unable to make use of private or fare paying transport due to physical or medical limitations.

Apart from providing an easy, more affordable form of access to the patient, this service will also allow the traditional ambulance to remain free to attend to emergency cases as and when required. The PTS vehicle is crewed and equipped to Basic Life Support Level, affording safe, non urgent/ pre-planned transportation of patients from point A to point B.

Only the following patient groups will be considered for PTS transportation:

- Patients attending outpatient clinics for follow-up appointments – patients with no transportation;
- Patients who are elderly/weak/mentally incapacitated – patients with no companion/transportation;
- Step down from hospital ward to step down facility/hospice/residence;
- Wheelchair-bound patients;
- Patients with difficult access at the patient's place of residence (stair access/etc);
- Oncology patients for chemotherapy;
- Ambulance transfer request to hospital – for patients not warranting an ambulance;
- Patient return trips for diagnostic purposes.

The following exclusion criteria will apply to the PTS service:

- No patients under 8 years of age;
- No patients with deranged vital signs;
- No patients with an IV line in situ;
- No patients who require IV medication;
- No instances where Intermediate Life Support or Advanced Life support is required.

To make a booking for this service you need to dial 082 911 and request a PTS booking.

NETCARE 911 Health-on-Line medical advice line: 082 911

This medical advice line is a unique toll-free service giving medical guidance and emotional support 24 hours per day seven days per week. The service includes:

- Assessment of symptoms.
- Counselling.
- Home care.
- Mother/baby programmes.
- Free HIV counselling and advice.
- Access to Rape Crisis Centres at any Netcare hospital or dial **011 647 3400**.
- Specialised travel advice through SAA/Netcare Travel Clinics on **011 026 4157**.
- Confidential medical information and advice about:
 - General medical advice and generic medicine.
 - Chemical and substance abuse.
 - Poison information.
 - Alternative treatment options.

Put the NETCARE911 sticker on the back window of your car to ensure that any emergency service can see you are a member.

There is only one number to dial in an emergency: 082 911.

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 is limited to R200 000 per beneficiary. Balloon Sinuplasty is limited to R9 000 for the disposable kit.

Medicine on discharge ("TTO") is funded from the unlimited hospital benefit provided it is obtained on the date of discharge.

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 Management Programme ensures that you receive appropriate, quality care in

hospital and value for your money. Admission or an out-patient visit to a hospital, CT scan, MRI scan and radio-isotope study must be authorised first by calling **0860 00 2144** or sending an email to authorisations.cpt@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 needs emergency treatment, you have to call the Authorisation Centre on the first working day after the incident.

If you do not get 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 in terms of the scheme rules.

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 as well 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 have 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.

Authorisation is therefore not a guarantee of payment.

Alternatives to hospital stay includes sub-acute facilities, nursing services for patients at home (this excludes midwifery services), physical rehabilitation facilities and hospice, which is limited to R23 110 per member family.

Maternity accommodation and other services in hospital is unlimited, however **a co-payment of R2 000 is applicable if the patient chooses to have a caesarean section as personal preference.**

Related out-of-hospital maternity services are limited to R7 890 per pregnancy event and include 2 x 2D scans and 12 ante-natal consultations and 1 x 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 R250 000 per beneficiary. Corneal grafts (local and imported) is limited to R20 000 per beneficiary per annum and further limited and included in the R250 000 per beneficiary overall limit.

Surgical procedures in hospital and unattached operating theatres are unlimited. Refractive (eye) surgery is limited to R6 940 per

member 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

Cardiac valves: R32 000

Cardiac pacemakers: R40 000

Cardiac stents: R36 000

Neuro-stimulation devices: R40 000

Vagal stimulator: R40 000

Aorta stent grafts: R40 000

Carotid stent: R15 000

Peripheral arterial stents grafts: R28 000

Embolic protection device: R37 000

Detachable platinum coils: R37 000

Joint replacements: R33 000 (bilateral prostheses reimbursed up to the lower of the claimed amount or maximum double the benefit value of a single prosthesis)

Bone lengthening devices: R33 000

Spinal plates and screws and other approved spinal implantable devices: R33 000

Intra-ocular lens: R2 000, unless PMB

Any unlisted internal prostheses: Combined limit of R24 000 per beneficiary

External prostheses: Limited to R33 000 per beneficiary

Renal dialysis includes all services and related radiology and pathology and is limited to R133 000 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 counseling 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 to afa@afadm.co.za or send a sms to **083 410 9078** to 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, which 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 and how to protect others and stay healthy. Medication can suppress the virus and vitamins, good eating habits and exercise can help to 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 instruction of 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) medicine:

The acute medicine benefit is funded up to the single exit price ("SEP") and a dispensing fee, which is limited to 26% capped at a maximum of R26 (VAT exclusive). It is subject to a re-imbursalment 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:

M0 = R3 020

M1 = R4 700

M2 = R5 630

M3 = R7 100

M4+ = R7 260, which is further limited and included in the Pooled Day-to-Day benefit limit.

Over-the-counter medicine is also 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:

M0 = R460

M1 = R690

M2 = R850

M3 = R1 050

M4+ = R1 070, which is limited and included in the above Acute Medicine benefit and a maximum of R230 per script are applicable.

Oral Contraceptives and intra-uterine devices are limited to R1 500 per family member and must be prescribed for contraception and not cosmetic purposes.

Chronic medicine is funded up to the single exit

price ("SEP") and a dispensing fee, which is limited to 26% capped at a maximum of R26 (VAT exclusive). It is subject to a re-imbursalment 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:

M0 = R9 500

M1 = R19 000

M2 = R24 400

M3 = R29 800

M4+ = R35 300. 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 R160 000 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.

Drugs for the treatment of macular degeneration have a sub-limit of R40 000 per member family, which is included in the Specialised drugs for Non-Oncology overall limit of R160 000 per member family.

The **HPV Vaccine** is funded up to a limit of R1 500 per female beneficiary per annum and is included in the pooled day-to-day limit. Only female beneficiaries between the age of 10 and 45 qualifies for this benefit in terms of clinical protocols as applicable.

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

How to apply

You, the doctor prescribing the treatment or the pharmacist can call the Chronic Medicine management **Call Centre** with the relevant details on 0860 100 608 or send an email to cmm@medscheme.co.za. The chronic application form is also available on the website, www.medscheme.co.za and can be filled in online. Paper applications are not accepted.

What if your authorised chronic medication changes?

If your medication is changed, Chronic Medicine management must be informed in advance. Ask the doctor or pharmacist to call the **Call Centre** to have this done quickly or ask them to do this online at www.medscheme.co.za.

Once your application has been approved

- We will send you a Medicine Access Card that lists the medicines that will be paid from your chronic medicine benefit.
- The Access Card will also show which medicines are on the MPL and medicines that you will pay extra for.
- 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 tell you how often he needs to see you to check on your condition.
- The period which the medicine is authorised for differs from medicine to medicine. Some will be authorised as ongoing, while others may be authorised only for a limited time. The card will indicate the time the medicine is authorised for. Please note that your prescription 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. You have to make sure that your doctor provides the information needed.

Chronic medicine for prescribed minimum benefits

The Medical Schemes Act gives a list of Prescribed Minimum Benefits ("PMBs") 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 mean 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 diseases that are authorised by Chronic Disease Management and that falls 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 PMBs?

The hospital, doctor, pharmacist or other

healthcare professional 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 ICD-10 codes in this booklet.)

Medicine Price List (“MPL”)

The MPL was adopted by the Scheme 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, 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 another medicine that do the same for less.
- Medicines that could be abused.
- Some expensive chronic medicines that require 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 are available on the Medscheme website at www.medscheme.co.za.

MENTAL HEALTH (IN and OUT of Hospital)

An overall limit of R37 000 per member family is made available.

Procedures are sub-limited to R21 000 per member family and limited and included in the overall limit of R37 000 per member family. This benefit includes accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals 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.

Consultations and visits in and out of hospital is limited to R15 800 per member family and limited and included in the overall limit of R37 000 per member family.

The Rehabilitation for substance abuse benefit is limited to the overall limit of R37 000 per member family and more details may be obtained from the **Call Centre** at 0860 100 608.

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 R265 000 per beneficiary 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.

Specialised Drugs for Oncology is limited to R200 000 per beneficiary and limited and included in the R265 000 per beneficiary overall limit.

Brachytherapy is funded up to R70 000 per beneficiary per annum and included in the R265 000 per beneficiary overall oncology benefit limit. The seeds and disposables are limited to R26 000 per beneficiary per annum and funded from the overall Brachytherapy limit of R70 000 per beneficiary per annum.

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

Oncology Disease Management Programme

The Scheme is contracted with the Oncology Disease Management Programme and therefore should you be diagnosed with cancer and will receive treatment, it is important that you register on the Oncology Disease Management Programme.

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.

We will send an authorisation letter to you and your doctor after we have assessed and approved the treatment plan. The letter will show which treatment is authorised, the approved quantities and the period of treatment authorised.

You have 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 will 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 have to get pre-authorisation from Hospital Benefit Management for going to hospital, specialised radiology such as MRI and CT scans or angiography or private nursing care or hospice services.

Who should register on this programme?

Only patients who have been diagnosed with cancer and will receive treatment.

How do I register for this programme?

Your doctor must fax or email a copy of your treatment plan to (021) 514 2303 or cancerinfo@medscheme.co.za. An oncology case manager will then take the process from there.

Call the programme on 0860 002 106

OPTOMETRY

The Optometry benefit is unmanaged and is an annual benefit limit.

The limits are as follows:

M0 = R3 000

M1 = R6 000

M2 = R9 000

M3 = R12 000

M4+ = R15 000, which is included in the Pooled Day-to-Day benefit limit and further limited to a R3 000 per beneficiary.

The benefit includes:

- One eye test per year, including tests for glaucoma.
- Frames, lenses including single vision, bifocal, multifocal, special, as well as contact lenses and fittings thereof (including lens add-ons)

Readers are limited to R150 per beneficiary and included in the above Optometry 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 aids
- Occupational therapy
- Orthoptics (eye movement)
- Podiatry
- Speech therapy
- Social worker
- Private nurse practitioners

There is no benefit for pharmacy services.

PATHOLOGY

Tests performed by a general practitioner, medical specialist, medical technologist or/and private nurse practitioner are unlimited in hospital and out of hospital are limited to and included in the Pooled Day-to-Day benefit limit.

PATHOLOGY MANAGEMENT

Managing pathology costs

No pre-authorisation is necessary, although all pathology accounts are audited to ensure that billing is correct. Pathology Management takes decisions or clinical interventions in line with the standard practice, scheme rules and scientific evidence. If we need a motivation for certain tests based on these standards, we will contact the pathology laboratory directly.

How to manage your pathology benefits

Although tests are important tools, they have their limits. More tests do not necessarily mean better care. You can help to manage and preserve your benefits by remembering to:

- Give a complete description of your symptoms and do not simply only answer questions when you visit a healthcare professional.
- Make sure that you give a complete history if

you have an allergy. A general allergy test can cost as much as R3 000 or more, while a specific allergy test, such as one for an allergy to cat hair can cost as little as R200.

- Ask the doctor if all the tests are necessary when a lot of tests must be done. Ask if individual tests will not be enough.
- Ask if the pathologist can call your doctor and discuss your case so that further tests can be done on the sample already with the laboratory in cases where a single test shows an abnormal result and further testing is required.
- Keep where possible a copy of the request note in case there is a disagreement between the tests ordered and the account or if you have to pay a portion of the account.
- Ask beforehand if there is any preparation required for the tests, such as fasting, no exercising and no smoking, which could affect the results of certain tests.
- Ask to review the results and if possible, take notes for your own records the next time you see the healthcare professional.
- Ask your general practitioner to send your results to the specialist you are referred to or ask the laboratory to copy the specialist on your results. Up to 15% of the costs of all pathology tests are from duplicate tests.
- When you receive an account from the laboratory showing an amount that you must pay, you can call the **Call Centre** to find out why you have to pay.

PHYSICAL THERAPY

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

RADIOLOGY

GENERAL RADIOLOGY

In hospital general radiology is unlimited and out of hospital is funded from the Pooled Day-to-Day benefit limit.

SPECIALISED RADIOLOGY

This benefit is unlimited in and out of hospital. Interventional radiology replacing surgical procedures are unlimited.

Please note that certain scans 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 increases, your contribution to your medical scheme will 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.

Medscheme Fraud Hotline 0800 112 811

QUERIES

If you have any questions call: **0860 002 106** between **08:30 and 16:00** from Monday to Friday. On this number you only pay the rates for a local call no matter where you are calling from in South Africa.

Mail your claims to: **P.O. Box 74, Vereeniging, 1931.**

Providers to post their claims to: Private Bag X089, Vereeniging, 1930

First time claim submission can be sent to: claims@medscheme.co.za

Or email us at Barloworld@medscheme.co.za.

You can also log into the Barloworld Intranet or the Barloworld Medical Scheme (www.medscheme.co.za) member website with your membership number.

VISIT US

Durban

3rd Floor, 67 Old Fort Road, Durban

Woodstock

15th Floor, Atterbury House, 9 Riebeeck Street, Cape Town, 7430

Port Elizabeth

Block 6, Greenacres Office Park, 2nd Avenue, Newton Park, Port Elizabeth

Pretoria

Ground Floor, Benstra Building, 473B Church Street, Arcadia, Pretoria

Roodepoort

37 Conrad Road, Florida North, Johannesburg

Secunda

Shop 1, Sanlam Plaza, Howard Street, Secunda

Vereeniging

Ground Floor, 36 Merriman Avenue, Vereeniging

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, please do not hesitate to contact the Contact Centre and request that the Principal Officer of the Scheme contact you to discuss the complaint and/or request to appeal.

