gems
Government Employees
Medical Scheme

YOUR 2021 **MEMBER GUIDE**

DISCOVER the BRILLIANCE of GEMS

Working towards a healthier you

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Welcome

Thank you for choosing and trusting GEMS to take care of your healthcare needs. As a Scheme, we are passionate about finding new ways of delivering increased member value and access to quality healthcare services for you and your family.

This guide provides more information on how to use your benefits and the many services that are available to you.

It is a summary of the Scheme's benefits and rules and does not replace the registered rules. If there is a difference between what is in the guide and the rules, the Scheme Rules registered with the Council for Medical Schemes (CMS) will apply. These can be viewed at **www.gems.gov.za** or you can request a copy via **enquiries@gems.gov.za** or call us on **0860 00 4367**.

DISCOVER the BRILLIANCE of GEMS

ACCESS

- With the goal of universal health coverage in mind, our 2021 benefit enhancements place greater focus on vulnerable groups – children, women and the elderly.
- GEMS provides greater access to quality healthcare through a wide array of networks.
- Because of our wide beneficiary definition, you can care for more of your family members.

AFFORDABILITY

- Our growing reserve ratio provides security for you and your family.
- Low contribution increases keep us affordable.

RICHER BENEFITS

- GEMS has better and richer benefits – our flagship options, Tanzanite One and EVO, are richer in benefits than other similar priced products in the market.
- GEMS truly understand the needs of the South African family, and we provide greater access to quality healthcare through a wide array of networks. The South African definition of family extends far beyond the immediate family. GEMS understands this, and we cover up to 5 generations, so that no family member is left uncared for.
- GEMS reassures members that it remains committed to delivering excellent health plans that will see our members and dependants through any challenges that they will face in the current year.

We also give you the flexibility to choose between six plans, so that you enjoy the benefits that suit you best:

Tanzanite One

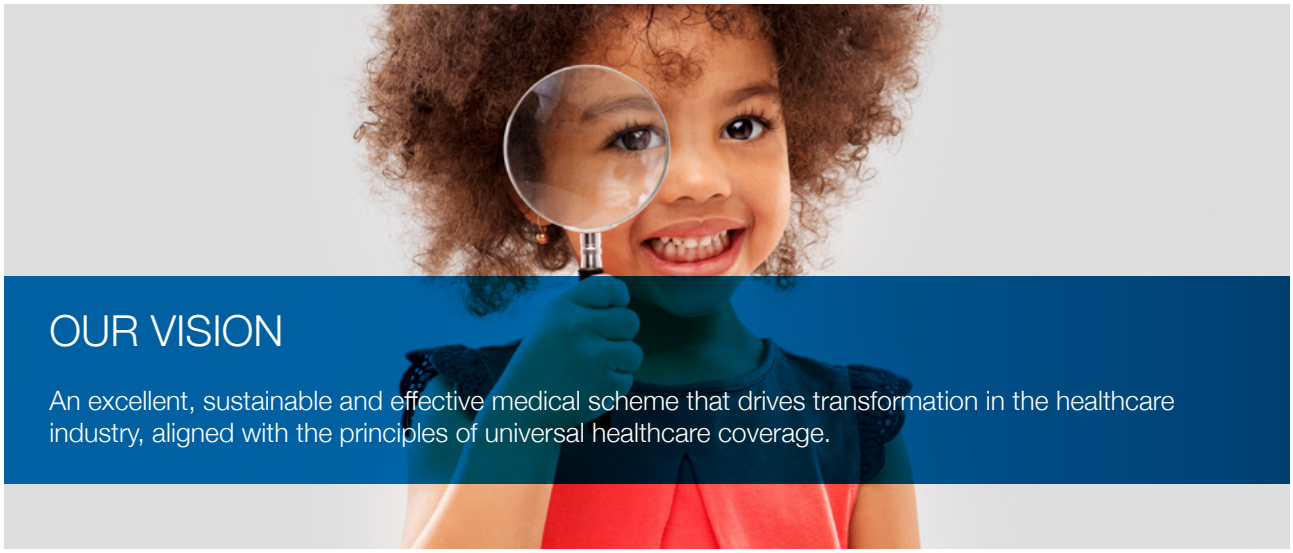
Emerald Value

Beryl

Emerald

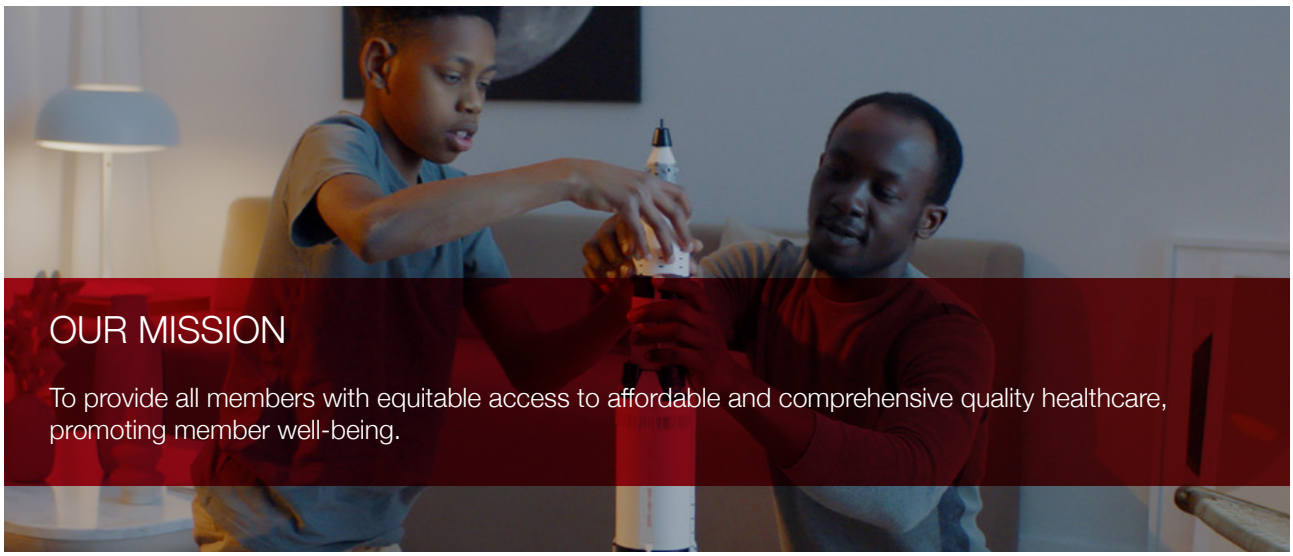
Ruby

Onyx



OUR VISION

An excellent, sustainable and effective medical scheme that drives transformation in the healthcare industry, aligned with the principles of universal healthcare coverage.



OUR MISSION

To provide all members with equitable access to affordable and comprehensive quality healthcare, promoting member well-being.

OUR VALUES

These values guide all representatives of GEMS at all times:

- Excellence
- Member Value
- Integrity
- Collaboration
- Innovation

Who can be a member of GEMS?

You can join GEMS if you are employed in:

- A National Department and Provincial Administration listed in Schedule 1 of the Public Service Act.
- A Provincial Department listed in Schedule 2 of the Public Service Act.
- Government components listed in Schedule 3 of the Public Service Act.
- Any employer group approved by the Board (a list of these employers is available in Annexure A of the Scheme Rules).

You cannot join GEMS if you are employed by:

- The South African National Defence Force (SANDF) under the Defence Act.
- The National Intelligence Agency (NIA).
- The South African Secret Service (SASS).
- Uniformed members of the South African Police Service (SAPS).
- Any department where the conditions of service do not allow you to join GEMS.

Membership cards and certificates

- Every main member receives a membership card and certificate when they join the Scheme, change their benefit option, or remove or add a dependant. A card is also issued to each registered adult dependant (i.e. a dependant older than 21 years of age).
- Only you and the registered dependants reflected on the back of your membership card may use the card to claim for benefits. It is fraud if you give your membership card to someone who is not your registered dependant and they use it to claim benefits.
- If you resign you cannot use the membership card, it is fraud if you use the card after your resignation.
- Please use your membership number as a reference on all correspondence with the Scheme so that we can help you as quickly as possible.
- Remember to show your membership card to your doctor, dentist, pharmacist, specialist and all other allied healthcare service providers (as listed in your benefit guide) when you visit them.

To know more about your membership cards and certificates, visit **www.gems.gov.za** and read Rule 10 of the Scheme Rules. You can also request a copy using **enquiries@gems.co.za** or by calling **0860 00 4367.**

Why is it important to manage your GEMS membership?

Getting the most out of your GEMS membership, you need to make sure that you understand and follow the Scheme Rules and procedures.

Change of banking details: FICA

To protect your benefits and ensure efficient refunding of claims, please send us the following should you require an update of your banking details:

- A copy of your Identity Document (ID);
- A bank account statement, crossed cheque or a signed or stamped bank letter (not older than three months);
- Proof of residence (not older than 3 months).

Any documents older than three months will be rejected and this may delay your refunds. It is important to submit these documents, as GEMS prescribes to the FICA (Financial Intelligence Centre Act 38 of 2001), which fights money theft and fraud by helping to identify individuals who engage in such illegal activities.

Stay informed:
Remember to update your contact details so that we can keep you informed with important healthcare and membership information.

Let us know if:

- You want to add or remove dependants;
- The main member or any of the registered dependants pass away;
- The main member resigns from the Public Service or a GEMS participating employer;
- You or your dependants will be residing outside the borders of South Africa, temporarily or permanently.

Let us know as soon as any of the following details change:

- Address, telephone number or other contact details;
- Banking details;
- Marital status;
- Change in employment;
- Monthly income.

You can update your details by:

- Calling the GEMS Call Centre on **0860 00 4367**
- Sending an email to **enquiries@gems.gov.za**
- Visiting a GEMS Walk-in Centre

You and your dependants are not allowed to belong to more than one medical scheme at the same time.

HOW TO REGISTER

A completed GEMS application form may be submitted via email to **enquiries@gems.gov.za**, fax to **0861 00 4367**, post to GEMS at **Private Bag X782, Cape Town 8000**, or dropped off at one of the GEMS Walk-in Centres, with the following supporting documents:

For member:

- Clear copy of Green ID book/Smart ID with both sides/SA Passport
- Latest salary advice or letter of appointment (not older than 3 months)
- Bank statement with stamp (not older than 3 months)
- Previous medical aid certificate with resignation date (if applicable)

For each dependant:

- Clear copy of Green ID book/Smart ID with both sides/Birth Certificate/SA Passport
- Previous medical aid certificate with resignation date (if applicable)

For Pensioner:

- Clear copy of Green ID book/Smart ID with both sides/SA Passport
- Z583 (stamped by Commissioner of Oaths)
- Previous medical aid certificate with resignation date (if applicable)

ABOUT YOUR DEPENDANTS

How to register your dependants

You and your dependants are always at the heart of all our efforts. The following family members may qualify as your dependants:

- Husband, wife or partner involved with the main member.
- Ex-husband or ex-wife, if required by a divorce settlement.
- Biological, adopted, step or foster children. Child dependants are persons:
  - Under the age of 21;
  - Under the age of 28 and registered as a bona fide student at an educational institution recognised as such by the Board, within South Africa or any other educational institution abroad; or
  - Totally dependent on the main member and who is deemed by the Board to be permanently disabled, irrespective of age.
- Parents, parents-in-law, step-parents, step-parents-in-law, grandparents and grandparents-in-law, if they are factually dependent on the main member.
- Grandchildren and great-grandchildren, if they are factually dependent on the main member.
- Siblings (brothers and sisters), half-siblings, step-siblings and in-law siblings, if they are factually dependent on the main member.
- Nephews and nieces, if they are factually dependent on the main member or a member's spouse.
- A person (including in-laws), other than family, who is dependent on the main member for family care and support.
- Neither you nor any of your dependants may be a beneficiary of more than one medical scheme; belonging to more than one medical scheme is a criminal offence.

Additional requirements and documents to register a dependant

Husband or wife

- A declaration letter, email or telephone call from the main member confirming the obligation towards the husband or wife for customary marriages.
- A copy of the marriage certificate if married and the surname of the husband or wife is different from the main member's surname.

Ex-husband or ex-wife

- A copy of the court order to provide medical support as required by the divorce settlement.

Partner

- A declaration letter, email or telephone call from the main member, confirming that the dependant is the main member's life partner.

Biological, adopted, step or foster children under the age of 21

- If the child's surname is different from the main member's, the main member must provide a declaration letter, email or telephone call stating the reason for the difference and confirming the obligation towards the child.

Biological, adopted, step or foster children over the age of 21

If the child is a student and not yet 28 years old, we need the following on an annual basis:

- Proof of registration at a recognised tertiary institution;
- Declaration letter, email or telephone call from the main member confirming factual dependency.

If the child is totally dependent due to mental or physical disability, we need:

- Proof of disability from a medical practitioner (medical assessment report to be completed, signed and stamped by a medical practitioner);
- A declaration letter, email or telephone call from the main member confirming factual dependency, and that the child is not in a state institution.

If the child dependant is neither a student nor disabled, we need:

- A declaration letter, email or telephone call from the main member confirming factual dependency.
- Very important to note: in this instance you will pay adult rates for this dependant.

Parents, parents-in-law, grand-parents and grandparents-in-law

- A declaration letter, email or telephone call from the main member confirming factual dependency of the dependants.

Grandchildren and great-grandchildren

- A declaration letter, email or telephone call from the main member confirming factual dependency of the dependants.

Siblings (brothers or sisters), half- siblings, step-siblings and siblings in-law

- A declaration letter, email or telephone call from the main member confirming factual dependency of the sibling on the main member.

Nephews and nieces (including in-laws)

- A declaration letter, email or telephone call from the main member confirming factual dependency of nephews and nieces on the main member.

Special dependants (where the member is liable for family care and support)

- The Addition of Dependants Form must be completed by the main member and a copy of the dependant's ID must be submitted to the Scheme.
- A declaration letter, email or telephone call from the main member confirming factual dependency of the special dependant.

Registering your newborn or newly adopted child

- Send a completed newborn registration form and a certified copy of the child's birth certificate to the Scheme within 60 days of birth so that they can be registered as a dependant on the Scheme from the date of birth. Provide the final letter of adoption if your child is adopted. We will then also cover medical expenses related to the newborn's birth. If your newborn's surname is different from yours you must provide the Scheme with a declaration letter, email or telephone call confirming that the child is yours.
- You can get the newborn registration form by clicking on '**Forms**' under '**Members**' > '**Tools**' on our website: **www.gems.gov.za**

When the baby is registered within 60 days of birth or adoption the full monthly contribution will be due from the month of birth or the adoption date, regardless of the newborn's registration date with the Scheme. This will ensure that the newborn and/or adopted child has medical aid cover from the birth and/or adoption date. Should the newborn/adopted baby be registered to the Scheme after 60 days of birth/adoption, the medical cover will commence on the first day of the next month from the date of registration. Registration of the baby to the Scheme after 90 days of birth or adoption will be subjected to underwriting according to the Medical Scheme's Act.

Yearly review of dependants

Every year, the Scheme reviews whether dependants still qualify to receive benefits according to the Scheme Rules. This means that each year main members must give us proof of factual dependency for all dependants aged 21 and older.

For disabled dependants and parents, parents-in-law, and partners who are over 65 years or pensioners, the main member only needs to give the Scheme supporting documents once.

Eligibility review – implementation of Rule 4.9.5

- The implementation of Rule 4.9.5 allows for students studying short courses at any time during the year, to be registered at the child rate. Previously, you could only register your dependant for child rates if they studied as a full-time student.
- The implementation of Rule 4.9.5 means we will review their eligibility throughout the year, triggered by students' study completion dates.
- The new short course rule allows a main member to pay a child rate for a dependant for the duration of their registration on a short course. The child rate will return to an adult rate after the completion date of the short course.
- For example, if a student is studying a three-month diploma course at an educational institution, the main member will be required to pay a child rate during the three-month course period.

AGE	RATES TO BE PAID	REVIEW PERIOD
Under 21 years old	You pay child rates	
21 years and older, but under 28 years	You pay child rates as long as you have provided proof that the student is studying at a recognised educational institution. You also need to provide a declaration letter, email or telephone call stating factual dependency. **Note:** If the dependant is not a student, but is factually dependent on the main member, they may continue as a dependant at adult contribution rates, if all relevant documents are submitted.	Documents must be provided before the end of March every year for full-time students. Students studying short courses must provide proof of study at the time they register.

Students studying abroad may be dependants while studying, but cannot claim for benefits while abroad as they are not considered to be "ordinarily residing in SA". According to rule 6.2: "The membership of the Scheme is limited to those Members and their Dependants who are ordinarily resident within the Republic of South Africa, or who are stationed abroad on or by virtue of instructions, requirements or obligations of the Member's Employer, or who are studying abroad".

Why it is important to send your documents to us on time

We need to receive all required documentation and supporting documents requested in the eligibility review letters, so that your dependant can continue to receive benefits. If documents for a newborn are provided more than 60 days after birth, the dependant will not be covered by the Scheme from the date of birth. This means you will have to pay the hospital costs of the newborn out of your own pocket.

International Eligibility

Membership to the Scheme is only for members residing within the borders of the Republic of South Africa. Certain groups of members who are stationed abroad due to the nature of employment and certain retired members who left government service prior to 1992, are exempt from this requirement.

Members rejoining the Scheme

Members who have, during a previous period of membership, left the Scheme with debt owing, will be required to make payment or enter into a payment arrangement with the Scheme before a new membership period is effected.

Continuation of membership

The dependants of a GEMS member are able to continue with Membership to the Scheme after the main member is deceased. The surviving dependants are required to nominate a dependant who will be elevated to be the main member and continue with membership.

UNDERWRITING

Underwriting is the assessment of a new member or beneficiary's risk profile to determine whether waiting periods should be imposed with a view to reduce GEMS' exposure to anti-selective behaviour.

A waiting period is a period during which a beneficiary is liable for contributions without having access to all or certain benefits. There are two types of waiting periods that GEMS may apply. These are:

- A General Waiting Period (GWP) of up to 3 months; and/or
- A Condition-Specific Waiting Period (CSWP) of up to 12 months.

A General Waiting Period is a period in which a beneficiary is not entitled to claim any benefits, or in certain circumstances, only in respect of Prescribed Minimum Benefit (PMB) conditions.

A Condition-Specific Waiting Period is a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period prior to when the application for membership was made.

If it is found that the beneficiary failed to disclose a pre-existing condition, GEMS will not cover any costs associated with such condition and the beneficiary may be terminated from the Scheme for non-disclosure.

GEMS has a process for members to make an informed decision regarding their underwriting status by signing an acceptance letter. The acceptance letter will be sent to members who qualify for underwriting, to review their waiting periods, then sign and return the acceptance letter to the Scheme to finalise the application process.

Underwriting protects GEMS and its members from abuse by persons who join GEMS only to claim in respect of certain, usually pre-existing, medical conditions but have no intention of contributing fairly after their claims have been paid, and then resign from the Scheme.

COST OF MEMBERSHIP

To make healthcare more affordable for you, GEMS brings you the best possible benefits to suit your healthcare needs and your pocket.

These are the monthly contributions (how much you pay each month to be a member of GEMS) for 2021. They do not show how much you will pay when the employer subsidy is included. Where an employee qualifies for a subsidy, the employer will pay a part of the contribution and the employee will pay the balance. Read about how the subsidy works on **page 12**.

TANZANITE ONE OPTION

Salary	Member contribution	Adult contribution	Child contribution
R0 - R9 728.00	R1 163	R919	R500
R9 728.01 - R13 651.00	R1 219	R976	R539
R13 651.01 - R23 386.00	R1 296	R1 026	R572
R23 386.01 +	R1 517	R1 283	R726

BERYL OPTION

Salary	Member contribution	Adult contribution	Child contribution
R0 - R9 728.00	R1 312	R1 308	R735
R9 728.01 - R13 651.00	R1 423	R1 412	R812
R13 651.01 - R23 386.00	R1 553	R1 553	R872
R23 386.01 +	R1 865	R1 865	R1 058

Please note: 20% of contributions on the Ruby Option will go towards the Personal Medical Savings Account.

RUBY OPTION

Salary	Member contribution	Adult contribution	Child contribution
R0 - R14 650.00	R2 710	R2 035	R1 050
R14 650.01 - R25 301.00	R3 020	R2 270	R1 175
R25 301.01 +	R3 345	R2 520	R1 295

EMERALD VALUE OPTION

Salary	Member contribution	Adult contribution	Child contribution
R0 - R14 650.00	R2 537	R1 938	R943
R14 650.01 - R25 301.00	R2 808	R2 176	R1 058
R25 301.01 +	R3 146	R2 419	R1 178

EMERALD OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R14 650.00	R3 030	R2 308	R1 125
R14 650.01 - R25 301.00	R3 354	R2 593	R1 261
R25 301.01 +	R3 760	R2 883	R1 406

ONYX OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R14 650.00	R5 228	R4 004	R1 572
R14 650.01 - R31 216.00	R5 442	R4 143	R1 707
R31 216.01 +	R5 875	R4 516	R1 905

How the subsidy works

New approved medical scheme subsidy

One of our objectives as GEMS is to ensure that member contributions remain affordable and the medical scheme subsidy provided by your employer plays an important role in ensuring the continued affordability of your medical benefits. Please consult your employer regarding the subsidy as well as information on how this applies to you as an individual.

Employees on salary level 1 to 5 on the Tanzanite One option will continue to be subsidised at 100%, up to the maximum amounts indicated below. In-service employees on GEMS will receive a subsidy of 75% of their total contribution, up to the maximum as indicated below. Please note that your eligibility for subsidy is dependent on your employment conditions, therefore your employer will be able to confirm the subsidy you qualify for. Should you add more dependants and have reached the maximum subsidy offered by your employer, you will be expected to pay the amount not covered by the subsidy as a member contribution.

The subsidy policy for pensioners is as follows: Pensioner members who were on salary level 1 to 5 and on the Tanzanite One option while they were active employees, and retire on the same option, will now continue to receive a 100% subsidy for the main member and up to one dependant, up to a maximum of R3 052, as indicated in the table below.

Pensioner members on GEMS will receive 75% of their monthly contribution as a subsidy up to the following maximum of R1 526 for a member without dependants and R3 052 for a member with dependants. If you have any questions about your subsidy, you should discuss them with the Government Pensions Administration Agency (GPAA). Please note that eligibility for pensioner members is determined by the Government Pensioner Administration Agency.

One of our objectives as GEMS is to ensure that member contributions remain affordable.

Please visit our contribution calculator on our website at **www.gems.gov.za**. The calculator will help you work out your monthly contributions.

Employer subsidy for in-service employees effective from 1 January 2021.

MEMBER PROFILE	1 JANUARY 2020 MONTHLY EMPLOYER SUBSIDY	1 JANUARY 2021 MONTHLY EMPLOYER SUBSIDY
Single Principle Member	R1 406	R1 526
Principal Member with one dependant	R2 812	R3 052
Principal Member with two dependants	R3 671	R3 985
Principal Member with three dependants	R4 530	R4 918
Principal Member with four dependants	R5 389	R5 851

Note: Your subsidy is determined by your employer and not by GEMS.

Contribution statements

We send a contribution statement to all members once a quarter. Members who owe money to GEMS will receive a monthly contribution statement that sets out monthly contribution payments and any money owed to GEMS. This statement helps you check that your contributions are always up to date.

Managing arrear contributions

You might be behind in your payments to GEMS if:

- Your employer has not deducted your monthly contribution costs from your salary. This may happen to new members when the membership start date is captured after the date of the monthly deductions for that particular month. This might also happen if you move between departments.
- You added a dependant, but the additional contribution for the new dependant was not taken into account on time for the next contribution payment.
- Your employment contract ended and your new contract was not active in time for the next payment.

We will send you a letter confirming the amount you owe the Scheme. If you need help with paying the contributions you owe, please contact the Scheme or ask your HR Department to help you with the repayment terms.

Different types of debts, what causes it and how to prevent it

TYPE OF DEBT	CAUSES	PREVENTION
Change of employment or Bureau	Transfers	Provide the relevant letter of appointment to **premiums@gems.gov.za** to adjust your contributions accordingly.
Employer/Persal clawback (Code 39)	The member's termination date is backdated	Inform GEMS via **premiums@gems.gov.za** when your employment has been or will be terminated
Retirement	Pensioners are responsible for the full contribution while awaiting GEPF subsidy approval	Submit your GEPF approval letter to **premiums@gems.gov.za**. You will be refunded for the months you contributed without subsidy approval
Short-payment of contributions for dependants	Dependants who are registered after payroll cut-off date and over-age dependants who are still studying and proof has not been submitted to GEMS	Notify your employer or relevant department as soon as you register a dependant so that your contributions are adjusted on time via Persal. Provide the relevant documents regarding your dependant's study to GEMS

Note: Members must make payments towards their arrears using their membership number as a reference.

Personal Medical Savings Account

A Personal Medical Savings Account (PMSA) only applies to members who select the Ruby option. The PMSA is 20% of the contribution allocated to a savings account in the main member's name. The amount that is allocated to the PMSA depends on the main member's salary and how many beneficiaries they have. The PMSA pays for out-of-hospital and day-to-day medical expenses. Once the PMSA is depleted, out-of-hospital claims will be paid from the limited Block Benefit which covers Family Practitioner services, Pathology and Medical Technology, Optical Services, Allied Health Services, Other Professional Health Services, Physiotherapy, Audiology, Occupational Therapy and Speech Therapy.

Funds in the PMSA that are not used during the year will be carried over to the next year, or paid out to you (or to your new medical scheme) five months after you have terminated your membership or changed to an option that does not have a medical savings account. Please note that this payment amount is taxable. Ensure that the Scheme has your most recent banking details in the case that a refund is owed to you.

PMSA statements

Ruby members will receive an annual PMSA statement. This statement will show you all transactions and entries made on your savings account and balances at each month-end. This is a separate statement from the normal claims and contribution statements sent quarterly. This statement is distributed to members once a year and will be distributed at the time IT3 (b) statements and tax certificates are issued. Note that you will not earn interest on your PMSA.

A Personal Medical Savings Account (PMSA) only applies to members who select the Ruby option.

PRESCRIBED MINIMUM BENEFITS

Prescribed Minimum Benefits (PMBs) are minimum benefits that GEMS provides for in accordance with the Medical Schemes Act.

GEMS is required to offer benefits for the diagnosis, treatment and care of the specified medical conditions, including:

- A list of 270 medical conditions;
- Any emergency medical condition;
- 26 chronic conditions that can be found on the Chronic Disease List (CDL) on page 35; provided in the Regulations to the Medical Schemes Act.

What you need to know about PMBs

- Qualifying for PMBs is not only based on the condition or diagnosis (ICD10 code) but also on the treatment type provided by the healthcare provider. The treatment must be in line with what is prescribed in the Medical Schemes Act Regulations. If the treatment provided is not what is written in the Regulations, it cannot be claimed as a PMB.
- PMBs will be covered from your available benefits and when your benefits are depleted, the Scheme will continue to pay for PMBs above the benefits.
- PMBs may not be covered from your Personal Medical Savings Account (PMSA) if you are on the Ruby option.
- Codes used by healthcare providers to identify the condition (ICD10 code) and the treatment given (Tariff code or NAPPI code) are required to ensure GEMS identifies and pays PMBs correctly.
- Please remind your doctor to provide the relevant codes to you or include them on the claim to ensure that your claim is processed correctly. Read all about submitting claims to the Scheme on pages 26 to 31.
- Healthcare providers who treat you for a PMB condition while you are in hospital should include the hospital pre-authorisation number when they claim. It is not always possible for the Scheme or your healthcare provider to know the diagnosis or treatment at the time when authorisation is obtained. In such situations, a letter of motivation (or more information) may be required from your healthcare provider after the claim has been submitted, for GEMS to process the claim correctly as a PMB.
- GEMS uses measures such as pre-authorisation, formularies and Designated Service Providers (DSPs) to manage the costs of PMB care. If a member or healthcare provider does not follow the processes in respect of these measures, claims may not be paid as PMBs.

What is a Designated Service Provider (DSP)?

A DSP is a healthcare provider or group of providers who have been selected by and have a contract with GEMS to provide members with the diagnosis, treatment and care in respect of medical conditions, including PMB conditions according to an agreed fee schedule. GEMS has selected the following DSPs for PMB care:

- State hospitals: The state is GEMS' DSP for the treatment of in-hospital PMBs.
- Chronic medicine DSPs: Members should use a GEMS Medicine Provider Network Pharmacy or the Chronic Medicine Courier Pharmacy (Medipost) to obtain their authorised chronic medicine, including medicine for HIV.
- If you use a pharmacy which is not on the network or a network pharmacy which you are not allocated to obtain your chronic medicine, you may have to make a 30% co-payment out of your own pocket. Members may choose either the Courier Pharmacy or any Network Pharmacy within 10 kilometres of their workplace or home as their chronic medicine DSP. Also refer to **'How to avoid co-payments' on** **page 17** or visit **www.gems.gov.za**

Members are required to remain with the pharmacy they have chosen for a period of six months, which is in line with the six-month prescription validity cycle. Please contact us on **0860 00 4367** for assistance in selecting or changing your choice of DSP pharmacy.

Note: For Oncology patients, the Oncology DSP is not always the General Chronic DSP. To verify your Oncology DSP, call **0860 00 4367** and select the Oncology option.

There is allowance for one non-nominated pharmacy claim per year. This enables chronic registered beneficiaries to obtain their chronic medication from any pharmacy in South Africa.

Using non-DSPs

If you choose to use a healthcare provider other than the DSP for the in-hospital treatment of a PMB, the Scheme may apply a co-payment or limit the rate at which the claim is reimbursed. To determine the reimbursement that should be made for PMB treatment provided, the Scheme will find out whether the beneficiary voluntarily or involuntarily made use of the non-DSP.

Involuntary use means that:

- The service was not available from the DSP or could not be provided without unreasonable delay.
- Immediate (emergency) medical or surgical treatment for a PMB condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider.
- The DSP was not within reasonable distance to the beneficiary's ordinary place of business or personal residence.

Except in the case of an emergency medical condition, pre-authorisation must be obtained prior to the involuntary use of a non-DSP. In the case of an emergency hospital admission, a pre-authorisation must be obtained within one working day after the admission, a co-payment of R1 000 per admission shall apply.

WHAT GEMS DOES NOT PAY FOR

All medical schemes have a list of medicines, treatments and procedures that they do not pay for. These are called scheme exclusions. This is because funds for healthcare are not unlimited.

All Scheme exclusions are listed in detail in Rule 16 and Annexure E of the Scheme Rules. You must make sure that the procedures, treatments or medicine you receive will be paid for before obtaining them, as excluded services or items will not be paid for by GEMS and you will be responsible for paying those costs.

GEMS also applies the Medicine Exclusions List (MEL) to all medicine benefits specified in Annexure C of the Scheme Rules. This list contains:

- Medicine exclusions on acute and chronic medication;
- New products that are still under review.

The list can be found on **www.gems.gov.za** under Members > Tools > ICD10 Codes.

Examples of exclusions – items that GEMS does not pay for:

- All costs for operations, medicines, treatments and procedures for cosmetic purposes (cosmetic refers to procedures such as liposuction).
- Holidays taken for recovery.
- Medicines not registered with the South African Health Products Regulatory Authority.
- Toiletries, beauty products, slimming products, homemade remedies and alternative medicines.
- Household products such as disinfectants, soaps, food and fitness-related nutritional supplements.

- Treatments by a healthcare provider who is not registered with a recognised professional body or any healthcare facility that is not registered in terms of the law.
- Any medicine, procedure or treatment that is not in line with evidence-based medicine principles and not supported by the Scheme Rules and managed care guidelines.
- Penalties that members incur and must pay to a healthcare provider because they did not keep an appointment.

Remember, even if a treatment is not excluded by the Scheme and is approved or authorised, it will still not be paid or not be paid in full if it exceeds the Scheme Rate/Tariff and benefit limits. Claims may also be declined if they do not comply with managed care rules. The Scheme Rules can be found at **www.gems.gov.za** or you can ask for a copy by calling us on **0860 00 4367.**

No exclusions on PMBs

Exclusions may not apply to PMBs. For example, if a member contracts septicaemia (blood poisoning) after cosmetic surgery – a Scheme exclusion – GEMS will still provide healthcare cover for the septicaemia because it is a PMB. PMBs are about the diagnosis and how you got the condition does not matter.

HOW TO AVOID CO-PAYMENTS

What is a co-payment?

Co-payments are portions of the cost of procedures or medical services provided by doctors and/or pharmacies that members must pay for out of their pockets. The co-payment can be a certain amount or a percentage of the total bill. These are amounts over and above a set rate that GEMS covers and usually apply to members who do not follow the Scheme Rules or managed care processes.

How can co-payments be avoided?

Use Designated Service Providers (DSPs)

A DSP is a healthcare provider or group of providers who have been selected and contracted by GEMS to provide members with the diagnosis, treatment and care in respect of medical conditions, including PMB conditions. For example, if you receive chronic medicine from any pharmacy other than your allocated DSP pharmacy, you will have a 30% co-payment, even if the medicine you are claiming for is on the formulary. In addition to obtaining chronic medicines from a network pharmacy, Tanzanite One and Beryl members must also obtain their acute medicines either from a network dispensing doctor or from a network pharmacy.

Tanzanite One members can prevent a co-payment by visiting their nominated FP. These members have unlimited nominated FP visits with three non-nominated visits per beneficiary. A 30% co-payment will apply once the three visits have been exhausted.

Beryl members can prevent a co-payment by visiting a GEMS network FP. These members have unlimited network FP visits. Visits to a non-network FP are limited to three visits per family, subject to limits, including a 30% co-payment.

Emerald Value members can prevent a co-payment by visiting their nominated FP. These members have unlimited nominated FP visits subject to the block benefit. Members may obtain authorisation for 3 (three) out-of-hospital (OH) non-nominated network FP visits per family, with no co-payment. Once the three visits have been exhausted, a 30% co-payment will apply to claims for any additional non-nominated network FP visits, subject to benefits and limits.

Consult healthcare providers on the GEMS Network

GEMS has a network of healthcare providers consisting of Family Practitioners (FPs), Specialists, Pharmacies, Dental Providers, Optometrists, Renal Dialysis Providers, Hospitals, Emergency Care Practitioners who have promised to deliver quality healthcare to GEMS members. Network healthcare providers have committed to providing excellent quality healthcare to you at Scheme rates and will not charge you any co-payments or additional costs. If a healthcare provider on the GEMS Network wants you to pay upfront or requests you to

pay from your pocket, contact GEMS immediately on **0860 00 4367**. Report any irregularities relating to GEMS Network healthcare providers to the Scheme.

Consult renal facilities on the GEMS Network

GEMS has contracted a network of Renal Dialysis Providers. If you do not use a provider on the network for chronic renal dialysis subject to authorisation, a 30% co-payment will apply.

Use Network facilities for EVO and Tanzanite One members

Emerald Value (EVO) and Tanzanite One options have a hospital network consisting of selected private hospitals (057 and 058), day clinics (076/077) and Mental Health Institutions (055). If a member is admitted at a non-network hospital, a co-payment of R12 000 will be applicable for the member's account unless the admission was an emergency or the services were not available at the network hospital.

This list is available on the GEMS website at **www.gems.gov.za** or the member may contact GEMS on **0860 00 4367** or **enquiries@gems.gov.za**. The GEMS walk-in centres can also assist members with locating a Network Hospital.

Use in-formulary medicine

1. **Comprehensive Chronic Formulary**
   The Comprehensive Chronic Formulary is a list of cost-effective medicine which GEMS pays in full according to Scheme Rules. If your doctor prescribes medicine that is not on the GEMS Comprehensive Chronic Formulary (medicine list), you will have to pay a 30% out-of-formulary co-payment.
2. **The Acute Formulary for Tanzanite One and Beryl options**
   The Acute Formulary list for Tanzanite One and Beryl is a list of medicines and associated rules that will be applied to acute medicine claims on the Tanzanite One and Beryl options. These medicine rules can include:
   - in-formulary medicine rules (medicines funded in full provided the quantity and frequency limits are followed);
   - out-of-formulary medicine rules (which will attract a 30% co-payment).

   Therefore, it is important to ensure that your prescribing doctor refers to the acute formulary applicable to your option when prescribing acute medicine.
3. **The Acute Out-of-Formulary list for REO**
   The Acute Out-of-Formulary list is applied to acute medicine claims on the Ruby, Emerald, Emerald Value and Onyx options. Medicines listed on this formulary will always attract a 30% co-payment. If the medicine is not listed on this formulary, it will not attract a formulary co-payment, however this is subject to the available benefits, Medicine Exclusion List (MEL) and the use of generic medicines.

Formularies, exclusions and medicine price lists can be found on **www.gems.gov.za** under Members > Tools > ICD-10 Codes.

Use generic medicine

Generic medicines are safe, registered medicines that contain the same active ingredients as the original or branded medicine and achieves the same therapeutic results at a lower cost.

GEMS uses a medicine reference pricing tool called the Medicine Price List (MPL) to set the maximum price that the Scheme will pay for certain groups of generically similar medicines.

The medicines are grouped according to their similarity in ingredients, strength and dosage form (i.e. tablet, syrup, etc.) and the maximum price that GEMS will pay for medicine is also indicated on the list.

Where a beneficiary or service provider chooses medicine that costs more than the reference price indicated on the MPL, the beneficiary will pay the difference. The MPL can be found on the GEMS website **www.gems.gov.za.** The MPL does not restrict the beneficiary's choice of medicine - it just limits the price that GEMS will pay for the medicine.

Ask your pharmacist to supply generic medicine within the MPL where possible, so that you avoid making MPL co-payments.

Get pre-authorisation

If you plan to visit or be admitted to a hospital (out-patient or in-patient) or to go for a scan, please let us know at least 48 hours before you go to hospital. For example, if you do not obtain pre-authorisation for your maternity admission, you will have to pay a co-payment of R1 000.

Pre-authorisation is also required for:

- Certain out-of-hospital procedures, for example: where a member obtains dialysis on an out-patient basis;
- In-hospital physiotherapy;
- Specialised radiology investigations (e.g. CT, MRI, Angiogram, Radio-isotope scans).

Pre-authorisation is also required for access to the chronic medicine benefits. Chronic medicine management programme registration and updates can be done telephonically by the member, pharmacist or doctor by contacting **0860 00 4367.**

Use registered doctors

GEMS will not pay claims for services provided by a healthcare provider who is not registered in terms of a relevant law. For example, doctors not registered to practice medicine in South Africa, doctors with restrictions placed against them by GEMS or doctors without written permission to perform remunerative work outside the Public Service. Speak to your doctor to ensure that your claims meet the necessary requirements before you send the claims to the Scheme or before you make use of the provider's services.

WHAT TO DO BEFORE GOING TO HOSPITAL

Get pre-authorisation (PAR) first!

48 hours before you are admitted to a private hospital, make an out-patient visit to a hospital (excluding emergencies and public hospitals), or have a CT scan, MRI scan or Radio-Isotope study, you need to get a pre-authorisation number (PAR) from GEMS by contacting **0860 00 4367**.

What happens in an emergency if I cannot apply for a PAR (pre-authorisation number)?

If you need to go for an emergency treatment or be admitted to hospital over a weekend, public holiday or at night, you or a family member must call on the first working day after the incident. Failure to request the authorisation will attract a co-payment of R1 000 as per the Scheme Rules, and the member will have to pay the penalty out of their pocket.

Discuss costs with the doctor

Obtaining pre-authorisation does not guarantee payment, nor does it mean that the Scheme will cover the event in full. All benefits will be paid according to the Scheme Rules. For example, if the benefit is covered at 100% of the Scheme Rate and the doctor charges 200% of the Scheme Rate, you will be liable for the difference in cost. Speak to your doctor and find out if they will be charging Scheme Rates and if they will be using any non-covered items during your stay, procedure or treatment. In this way you can plan better and be aware of all payments that you may need to pay out of your own pocket.

It is your responsibility as a member/beneficiary to ensure that there will not be charges above Scheme Rates and procedures that are excluded or not covered. Refer to Section 7 – 'What GEMS does not pay for' – for a list of Scheme exclusions.

What happens if I do not apply for a PAR?

If you fail to get pre-authorisation for a planned event or authorisation on the first working day after an emergency event, public holiday or weekend you will be liable for a co-payment of R1 000. Refer to Hospital Management on page 44 for more information on pre-authorisation.

How to avoid being over-serviced when admitted in hospital

Being over-serviced means that a provider conducts tests that are not necessary or medically required for your condition. Fraudulent claims means that a provider bills you for services not rendered. Always check your claims and codes billed. If you suspect that there is either over-servicing or fraudulent billing, please contact the call centre on **0860 00 5467**.

The most common scenarios include:

- When you have a consultation with a healthcare provider for the first time, your doctor must charge for the first consultation. Should you have a follow-up consultation, you must be charged for a follow-up. Some providers will charge the initial consultation cost for both visits, which is incorrect as the cost of an initial consultation and a follow-up is not the same.
- Use of code 0011 for 'emergency for after-hours consultations', which is used even when it is not an emergency but the doctor was in theatre for the day.

It is important to be mindful of the following as it contributes to fraud, waste and abuse:

1. Always check with the treating doctor or specialist if they charge the Scheme Rate. The difference between the billed rate and the Scheme Rate could be very high and will become your responsibility. Negotiate with your service provider for the best rates.
2. Do not share your medical aid card or details with anyone. It is fraudulent to have a third party receiving treatment using your medical aid card.
3. Make sure you have an authorisation number at least 48 hours prior to admission. In an emergency an authorisation can be obtained the next working day.
4. Always use hospitals and service providers on the GEMS Network to avoid co-payments.
5. Ensure that you have enough benefits to cover the cost of the treatment.
6. Confirm any possible exclusion codes that the Scheme would not cover with the service providers.
7. Ensure that you get a copy of the authorisation, codes and approved length of stay in hospital.
8. To avoid an extended length of stay in hospital, ask your doctor if you can take antibiotics at home.
9. Before you are discharged, check with the hospital if all codes, length of stay and level of care has been updated.
10. Check that the claim reflects the treatment that you have received and report when you are charged for treatment not received.

Tip: Avoid being charged for an extra day's stay, ask your doctor about the discharge times. If your doctor discharges you in the morning ensure that you are also discharged by 12H00 midday. Staying longer, for example to wait for transport without being discharged by the hospital, will result in an additional half day's stay charged on the hospital account, which will not be covered by the Scheme.

CLAIMS SIMPLIFIED

Who can claim?

The registered member or dependants can claim from the Scheme. The healthcare provider can submit a claim on behalf of the registered member or dependant. It must be borne in mind that membership at the time of service being rendered must be valid before the said claim can be considered for payment.

What information must be on members claims?

- Patient's full membership number;
- The Scheme's name (i.e. GEMS);
- Patient's benefit option (e.g. Tanzanite One, Beryl, Ruby, Emerald Value, Emerald or Onyx);
- Patient's surname and initials;
- The patient's date of birth and dependant code as it appears on their membership card;
- The name of the healthcare provider;
- The valid practice code of the healthcare provider;
- The date of service;
- The type and cost of treatment;
- The pre-authorisation number, if applicable;
- The Tariff code (treatment);
- The relevant ICD10 code (condition);
- Main member signature to confirm that the account is valid;
- If the patient or main member paid for the service, attach the actual healthcare provider invoice with the proof of payment and highlight it clearly. Proof of payment can be a valid receipt from the healthcare provider, an Electronic Fund Transfer (EFT) slip or a bank deposit slip.

How is the claim processed?

The Claims department receives the claim and assesses it according to the industry and Scheme Rules as well as the benefits. This includes the assessment of the validity of the claims received. If the Scheme Rules allow, the claim will be paid.

Sometimes additional information is required from you or your healthcare provider, e.g. ICD10 code, request for clinical motivation, a clear copy of account, detailed account, proof of payment, etc. when assessing claims. If this information is not available, some claims may not be paid.

When does GEMS pay claims

There are two claims payment runs per month; mid-month and at the end of the month. Depending on when your claim is received, it can be settled at either of these runs.

Are medicine claims processed immediately?

Your pharmacy can send medicine claims to us electronically at the point of sale. The Scheme Rules will be applied immediately, so you will know right away if GEMS will pay for the medicine. You will get your medicine without you having to pay for it in cash if there are sufficient funds available.

If the medicine is not on the Scheme's formulary, you may have to make a co-payment or your claim may be rejected. If rejected, please speak to your provider to prescribe a medicine that is listed on the formulary. Members can opt to choose available generics to aid the prolonging of medicine benefits as generics are less costly.

Claims refunds

When you have paid a healthcare provider for a service, you may claim a refund from the Scheme, provided the service is covered by the Scheme. Your available benefits, the applicable Scheme Rules and the Scheme Rate will determine whether a refund will be paid and how much will be paid. When submitting a claim, you need to ensure that all supporting documents are attached to the claim, including a valid proof of payment and the actual healthcare provider invoice.

The proof of payment can be a valid receipt from the healthcare provider, an Electronic Fund Transfer (EFT) slip or bank deposit slip.

Refunds are paid to members electronically, so you need to make sure that we have your updated, correct banking details. We need the following banking information:

- Account holder;
- Account number;
- Bank name;
- Branch code;
- Account type (cheque, current or savings).

Fax this information to **0861 00 4367** or email it to **enquiries@gems.gov.za**, using your membership number as a reference. You can also deliver the information to one of the **GEMS Walk-in Centres** (addresses are on page 56 and 57) or post it to **GEMS, Private Bag X782, Cape Town 8000.**

To update your banking details, submit the following documents:

- A certified copy of your ID;
- A bank account statement, cancelled cheque or letter from the bank either signed or stamped (not older than three months);
- Proof of your residential address, which can be in the form of a utility bill such as your municipal account (not older than three months).

Claims alert SMS

You may receive a claims alert SMS or email each time GEMS processes your claims. The SMS and email informs you when a claim has been processed, but it is not a guarantee of payment. Guarantee of payment is reflected on your claims statement. To receive a claim alert SMS, please call **0860 00 4367** and make sure that we have your current cellphone number.

Your claims statement

You will receive a claims statement when a claim has been settled. Please read your claims statement to see if your claims were paid or not. If a claim was not paid, your claims statement will show a rejection reason code in line with what was not paid. If the rejection reason indicates an action, please resubmit the claim with the applicable information. The rejection reason applied on the statement is also shared with the healthcare provider. Members can therefore verify if the remedial action to correct the claim submission has been undertaken by the healthcare provider.

Paying a healthcare provider directly

To protect your benefits from irregular claims being submitted to the Scheme, GEMS has processes in place that allow us to validate the submission and payment of claims.

One of these processes is the termination of direct payments to certain healthcare providers who have had sanctions placed against them by the Scheme. These healthcare providers' claims will be rejected. You will have to pay the provider directly, and the Scheme will reimburse you at the relevant scheme rate and in South African currency.

Your claim submission must include corresponding details with the actual healthcare provider invoice and valid proof of payment, signed by the main member, in the form of:

- A valid stamped receipt from the provider;
- An Electronic Funds Transfer (EFT) slip; or
- A bank deposit slip.

Remember: If you receive a claim alert SMS for a claim you are not aware of, please report it to GEMS as soon as possible by calling us on **0860 00 4367**.

Top 10 reasons why claims are rejected (not paid)

1. **Incorrect member or dependant information**
   - It is important that GEMS receives up-to-date member information to process your claims. We need this information to make sure we pay claims correctly and that our member records are always complete and current.
   - When making claims for dependants, ensure that they are registered and their details appear on the claim.
2. **No pre-authorisation number for treatment such as oncology and hospitalisation**
   - Even after your treatment is authorised, your doctor needs to inform GEMS of any change in your treatment so that we can evaluate the treatment plan and update the authorisation. If your doctor does not inform us of the changes, GEMS may reject your claims or pay them from the incorrect benefit.
   - Physiotherapy treatment in hospital must also be authorised.
3. **No benefits are available**

   When your benefits have reached the benefit limits or sub-limits, GEMS will not pay any more claims.
4. **When a member or dependant does not keep a doctor's appointment**

   GEMS will not pay penalties for that missed doctor's visit.
5. **GEMS will not pay for claims or services given by a healthcare provider who is not registered in terms of a relevant law**

   For example, if a doctor is not registered to practice medicine in South Africa. Speak to your doctor to ensure that your claims meet the necessary requirements before you send them to the Scheme.
6. **Claims sent to us too late**

   Claims must reach the Scheme by the last day of the fourth month following the month in which the service was rendered. For example, if the service is rendered on 15 February 2021, the claim must reach us by 30 June 2021 (i.e. 120 days). GEMS will not pay claims received after this time frame. This is according to the Regulations of the Medical Schemes Act. You will have to pay for claims that you have not sent to us within four months of the treatment date. To avoid claims from becoming stale, double check with your healthcare provider if a claim will be submitted directly to the Scheme or whether you should submit the claim yourself.
7. **Claims we receive for treatment after a member has resigned from the Public Service or from GEMS**

   GEMS is a restricted medical scheme designed for Public Service employees or participating employers approved by the Board of Trustees. Anyone who is not an employee or retired employee of the Public Service or a GEMS participating employer cannot belong to GEMS. If you resign, you cannot use your GEMS membership card for healthcare services. If you or a healthcare provider claims for services after the date that you resigned from the Public Service or from GEMS, you will have to pay this money back to GEMS.

8. **Scheme exclusions**

   For all GEMS options there are specific conditions and treatment facilities that are not paid for, in line with the Medical Schemes Act. The items or procedures that are not covered by the Scheme are called Scheme exclusions. You must make sure that the procedures, treatments or medicine you receive will be covered for, before getting them because GEMS will not pay for excluded services or items. You will be responsible for paying those costs. Medicine exclusions are listed in the Medicines Exclusion List (MEL), it can also be found on the GEMS website at **www.gems.gov.za**

9. **The ICD10 codes on the claim are not correct**

   Ensure that the ICD10 code provided on the claim correctly identifies the condition the patient is being treated for.

10. **Duplicate claim**

    A claim will be rejected if the same claim was already submitted to and paid by the Scheme.

Remember: claims submitted incorrectly will not be paid. You will receive a claims statement explaining the reason why your claim has not been paid. Your claim will be returned and you or your healthcare provider would need to provide the correct information and resubmit the claim within 60 days from the date the claim was returned for correction.

Contact GEMS on **0860 00 4367** if you are not sure why your claim was rejected.
Visit **www.gems.gov.za** for a useful Claims Guide.

THE GEMS NETWORK OF HEALTHCARE PROVIDERS

GEMS has a network of healthcare providers consisting of Family Practitioners (FPs), Specialists, Pharmacies, Dental Providers, Optometrists, Emergency Medical Services, Hospitals, Renal Dialysis Providers and Chronic Back and Neck Rehabilitation who have promised to deliver quality healthcare at Scheme Rates to our members.

This means you will not have to pay any amounts above the set amount GEMS has agreed with the healthcare providers. All GEMS Network healthcare providers will display a GEMS Network logo or sticker on their window or door, making it easy for you to identify them. You can also find a GEMS Network provider by calling us on **0860 00 4367** or visiting **www.gems.gov.za**.

Family Practitioner (FP) nomination

Your FP plays a vital role in providing you with quality healthcare. Consulting the same FP helps the doctor to develop a good understanding of your health and treatment history so that they can make informed decisions about your healthcare, such as determining if you need to be referred to a specialist. You will therefore receive the best possible healthcare from the right person with the necessary skills and knowledge about your condition. This means that you will have better control over how your benefits are managed.

It is because of these benefits that GEMS encourages you and your dependants to nominate a GEMS Network FP in 2021 if you have not already done so. Although failure to nominate a FP will not result in any penalties for members on the Ruby, Emerald and Onyx options.

Tanzanite One members have unlimited nominated FP visits with (3) three non-nominated visits at a network provider. A 30% co-payment will apply once the (3) three visits have been exhausted.

Emerald Value members need to visit a nominated FP and the benefit is subject to the block benefit. Members may obtain authorisation for three out-of-hospital (OH) non-nominated network FP visits per family, with no co-payment. Once the (3) three visits have been exhausted, a 30% co-payment will apply to claims for any additional non-nominated network FP visits, subject to benefits and limits.

Family Practitioner Network FP

Beryl members have unlimited network FP visits. Visits to a non-network FP are limited to (3) three visits per family, subject to limits including a 30% co-payment.

FP nomination for EVO/Tanzanite One members

- It is compulsory for members on the Emerald Value/Tanzanite One option to nominate a FP to coordinate their care.
- You can nominate two different FPs for each of your dependants if you need to. Failure to nominate a FP will result in your application to join EVO/Tanzanite One being pended according to the Scheme Rules.
- Once your nominated network FP is selected, you will receive communication confirming this. GEMS encourages you to present this confirmation to your FP at the time of the consultation.

It is compulsory for members on the Tanzanite One and Emerald Value option to nominate a FP to coordinate their care.

What happens if my nominated FP is not available?

- Members on the REO options can consult with any other REO network FP. Non-network FP consultations will be reimbursed at Scheme Rates and might result in a co-payment to the member.
- Members on the Emerald Value/Tanzanite One option need to consult with their nominated FP.
- Members on the Emerald Value option may obtain authorisation for 3 (three) voluntary out-of-hospital (OH) non-nominated network FP visits per family, with no co-payment subject to available benefits and limits. Once the three visits have been exhausted, a 30% co-payment will apply to claims for any additional non-nominated network FP visits, subject to available benefits and limits.
- Members on Tanzanite One will have a limit of (3) three non-nominated FP consultations per beneficiary, once the three visits are depleted a co-payment of 30% will apply.
- You can update your nominated FP every six months.
- You are allowed to nominate two FPs to your profile per beneficiary.

Note: Members on the Beryl option can consult with any other GEMS Network FP. Should the member need to visit a non-network FP, the visit will be reimbursed from the out-of-network benefit subject to available benefits.

If you want to report any irregularities relating to healthcare providers on the GEMS Network, have any queries about FP nomination or nominating an additional FP, please contact GEMS on **0860 00 4367** or email **enquiries@gems.gov.za.**

Coordination of Specialist Care

Specialist referral is in place for Tanzanite One, Beryl and Emerald Value options. Members on Tanzanite One and Emerald Value options need a referral letter. Referrals from a non-nominated FP will require a specialist referral authorisation number. In the event of the visit not being approved a 30% co-payment will be applied.

The Beryl network FP must obtain a referral number for their Beryl patient before making an appointment to see a Specialist. This can be done by calling the GEMS Provider Call Centre on 0860 436 777.

We encourage members to consult their network FP before making an appointment to consult a Specialist. This will ensure that the patient is referred to the appropriate Specialist.

Types of Specialist practices requiring a referral from a nominated FP:

- Cardiologist
- Cardiology Paediatricians
- Dermatologist
- Gastroenterologist
- Gynaecologist
- Neurologist
- Neurosurgeons
- Orthopaedic surgeons
- Otorhinolaryngology (ENT)
- Paediatricians
- Physician
- Plastic and reconstructive surgeons
- Psychiatrists
- Pulmonologist
- Rheumatologist
- Surgeons
- Urologist

The GEMS Specialist Network comprises of Obstetricians and Gynaecologists, Paediatricians, Psychiatrists, Anaesthetists, Surgeons and Physicians, which also includes Pulmonologists (lung specialists), Gastroenterologists, Cardiologists and Rheumatologists, Ophthalmologists and Orthopaedic surgeons. A Network specialist has agreed to charge a contracted rate so that you will not have to pay co-payments, but claims will be paid subject to available benefits.

Members on the Tanzanite One and Emerald Value options need to keep the following in mind:

- Tanzanite One and Emerald Value members will not require an authorisation if the Specialist referral is requested by their nominated FP.
- Make sure that your FP, Specialist, Pharmacy, Optometrist or Dental Provider is on the GEMS Network before you visit them. This will ensure that you do not have to pay out of your pocket for the consultation or treatment.
- All medicine is subject to formularies regardless of prescribing doctor's discipline.
- FPs must form part of the GEMS Network to avoid any out-of-pocket costs.
- Ask your FP whether they can dispense medicine. If they can dispense medicine, you don't need to obtain your acute medicine from a pharmacy as you may have to make a co-payment or even pay the entire claim yourself.
- All medicines are subject to the Comprehensive Acute and Chronic Formulary lists which are accessible on the GEMS website at **www.gems.gov.za**. All FPs have a copy in their Family Practitioner (FP) Guide.
- Pathology and radiology tests must be in line with the GEMS Formulary (list of approved tests or services) for Tanzanite One and Beryl options.

Medicine: Know the difference

Chronic medicine

Prescribed for the long term management of chronic illnesses and covered under the chronic medicine benefit, subject to pre-authorisation on the relevant disease management programmes and managed care rules.

Acute medicine

Acute medicines are prescribed for the treatment of a disease or disorder that lasts for a short period of time. For members on the Tanzanite One and Beryl options, you can get acute medicine from a GEMS dispensing doctor (a doctor who is licensed to supply medicine from their practice rooms) or from a GEMS Network Pharmacy, subject to the GEMS Tanzanite One and Beryl acute formulary. Medicines not listed on the formulary will not be covered. Products listed on the acute out-of-formulary list **will** attract a 30% co-payment if claimed on the acute medicine benefit for the Ruby, Emerald, Emerald Value and Onyx options.

Please note that the GEMS Tanzanite One and Beryl acute formulary is product specific, each listed product has an indicator **or** formulary status (in formulary / out of formulary).

The acute formulary applicable to the Tanzanite One and Beryl options, as well as the Acute Out-of-Formulary list applicable to the Ruby, Emerald, Emerald Value and Onyx options can be found under '**Tools'** on the GEMS website at **www.gems.gov.za.**

Self-medicine

Also known as over-the-counter (OTC) medicine, self medication does not require a prescription from your doctor. For example, medicine for ailments such as a headache, cold or an upset stomach. For members on the Ruby, Emerald, Emerald Value and Onyx options, these medicines may be obtained from any pharmacy. For members on the Tanzanite One and Beryl options, you can make use of a GEMS Network dispensing doctor or a GEMS Network Pharmacy. Your pharmacist will be able to tell you if your medicine will be covered by the Scheme.

The chronic, acute and self-medicine benefits above are subject to Formularies, the use of Designated Service Providers (DSPs), generic utilisation (MPL) and option-specific Scheme Rules such as benefit limits. It is therefore important to also consult your option-specific Scheme Rules for more information on where these apply to your option. Visit the GEMS website at **www.gems.gov.za**

Chronic Medicine Programme

Chronic medicine is used on an ongoing basis to treat long-lasting (chronic) illnesses that can be disabling and/or potentially life-threatening, such as diabetes or high blood pressure. These illnesses have a negative effect on your and quality of life. Chronic medicines need to be taken regularly, over a long period, to manage the symptoms or control the effects of the chronic illness.

You, your doctor or your pharmacist may call **0860 004 367** or email **chronicauths@gems.gov.za** to obtain authorisation for new chronic conditions. Medicines will be paid from the chronic medicine benefit only if your condition has been pre-authorised. The Chronic Disease List (CDL) lists conditions covered as PMBs on all GEMS options, according to legislation and subject to managed care protocols, processes and formularies.

There is no need to email or fax documentation unless it specifically requested. When calling to authorise a new chronic condition have a copy of the prescription available, detailing the doctor's details (name and practice number), the diagnosis or ICD10 codes and the medicine details, such as strength and directions for use.

Once you have been registered for a chronic condition that is on the PMB CDL, you will have access to a care plan, which is a list of out-of-hospital services relevant to the condition(s). The care plan lists a mix of services such as doctor's visits, blood tests (pathology) and x-rays (radiology) which are available to you to ensure that you receive sufficient benefits to proactively manage and monitor your condition. No care plans are allocated for non-PMB chronic conditions. The conditions for which chronic medicine will be authorised are listed below:

Chronic Disease List (CDL) for all options

All options cover the following list of chronic condition which are PMB (subject to managed care protocols, processes and formularies)

Addison's Disease; Asthma; Bipolar Mood Disorder; Bronchiectasis; Cardiac Failure; Cardiomyopathy; Chronic Renal Disease; Coronary Artery Disease; COPD; Crohn's Disease; Diabetes Insipidus; Diabetes Mellitus Type 1; Diabetes Mellitus Type 2; Dysrhythmias; Epilepsy; Glaucoma; Haemophilia; HIV/AIDS; Hyperlipidaemia; Hypertension; Hypothyroidism; Multiple Sclerosis; Parkinson's Disease; Schizophrenia; Ulcerative Colitis; Rheumatoid Arthritis; Systemic Lupus Erythematosus.

ADDITIONAL **CHRONIC DISEASE LIST**

Payable from the chronic medicine benefit (subject to managed care protocols, processes and formularies)

In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Acne				✔	✔	✔
Allergic rhinitis				✔	✔	✔
Alzheimer's disease				✔	✔	✔
Ankylosing spondylitis				✔	✔	✔
Anorexia nervosa				✔	✔	✔
Anxiety	✔	✔	✔	✔	✔	✔
Attention deficit and hyperactivity disorder	✔	✔	✔	✔	✔	✔
Barrett's oesophagus				✔	✔	✔
Benign prostatic hyperplasia			✔	✔	✔	✔
Bulimia nervosa				✔	✔	✔
Delusional disorder				✔	✔	✔
Dementias, including (but not limited to), multi-infarct, sub-cortical vascular and alcohol				✔	✔	✔

In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Depression	✔	✔	✔	✔	✔	✔
Dermatitis				✔	✔	✔
Eczema				✔	✔	✔
Gastro-oesophageal reflux disease (GORD)				✔	✔	✔
Generalised anxiety disorder				✔	✔	✔
Gout				✔	✔	✔
Huntington's disease				✔	✔	✔
Hypoparathyroidism				✔	✔	✔
Hyperthyroidism				✔	✔	✔
Interstitial lung disease				✔	✔	✔
Meniere's disease			✔	✔	✔	✔
Menopause				✔	✔	✔
Myasthenia gravis				✔	✔	✔
Narcolepsy				✔	✔	✔
Neuropathies				✔	✔	✔
Obsessive compulsive disorder				✔	✔	✔
Osteoarthritis			✔	✔	✔	✔
Osteopenia				✔	✔	✔
Osteoporosis				✔	✔	✔
Paget's disease				✔	✔	✔
Post-Traumatic Stress Syndrome				✔	✔	✔
Psoriasis			✔	✔	✔	✔
Stroke*				✔	✔	✔
Systemic Sclerosis				✔	✔	✔
Thrombocytopenic Purpura*				✔	✔	✔
Thrombo-Embolic Disease*			✔	✔	✔	✔
Tourette's Syndrome				✔	✔	✔
Valvular Heart Disease*				✔	✔	✔
Zollinger-Ellison Syndrome				✔	✔	✔

HOW TO OBTAIN CHRONIC MEDICINES WITH DISEASE AUTHORISATIONS

Your doctor has prescribed chronic medicine for you to manage your chronic condition. What next?

↓

Have you registered for chronic medicine for this condition before?

NO →

To access your Chronic Medicine Benefits, you must register a new condition. To register, you, your doctor or your pharmacist can contact us telephonically on **0860 00 4367**.

Your FP can call us on **0860 436 777**

YES

↓

Go straight to your pharmacy with your new script. You will have access to a list of pre-approved medicines for that condition, called a basket. This means if your doctor prescribes a new medicine for the condition within the basket, **you will already be approved for it.**

→

Your pharmacist will process your claim and provide you with feedback from the system.

↓

What if my medicine is declined?

↓

If your medicine is declined, it means your medicine is not part of the defined basket of medicines for that condition or your chronic medicine benefit (if not PMB) has been exceeded for the year.

←

You can choose to pay for the medicine from your own pocket.
OR
You can discuss the reasons for the decline with your doctor. If possible they may change to an alternative medicine within the basket.
OR
You may obtain a letter of motivation from your doctor and/or additional test results if required to support the choice of medicine by your doctor.

↓

If your doctor changes the medicine on your prescription, start at the pharmacy again.

↑

Your chronic diagnosis must be pre-authorised by the Chronic Medicine Management department to ensure that the prescribed medicine is reimbursed from the chronic medicine benefit. Some medicines are not paid in full if they are not on the Scheme's formulary or within the Scheme's reimbursement rate known as the Medicine Price List (MPL). Sometimes, medicine will not be authorised when it does not fall within the reimbursement guidelines for a specific condition. Always check with your doctor to see if the most cost effective medicine is prescribed according to the MPL and the GEMS Formulary so that you do not need to pay out of your own pocket.

We will review your application and check it against the Scheme Rules to see if we can cover the medicine under the chronic medicine benefit.

- If we approve your application, you will receive a Medicine Access Card, listing the chronic conditions and/or medicine that we have agreed to pay for from your chronic medicine basket.
- If the chronic conditions and or medicine that we have agreed to pay for differs from the medicine your doctor has prescribed, we will attach a letter to your Medicine Access Card that will explain the reasons for this. We will also send a copy of the letter to the doctor who prescribed the medicine.
- If we do not approve your application for a chronic condition or medicine, you and your doctor will both receive a letter explaining this decision.

Please note that the duration of authorisation varies from medicine to medicine; some medicines may be authorised on an ongoing basis, whilst others may only be authorised for a limited period. The Medicine Access Card will indicate the duration for which the medicine has been approved.

What if my chronic medicine authorisation request has been declined?

If your chronic medicine authorisation request has been declined, GEMS will send you a letter and send a copy to your prescribing doctor. If further clinical information is required, your request will be reconsidered once all the relevant information has been received from your doctor. Your doctor may call 0860 436 777 for assistance.

Can I appeal a medicine authorisation?

Yes, you can appeal the decision to either reject your application for chronic medicine or to provide you with alternative medicine to the one prescribed by your doctor. To appeal, you must ask your doctor to write a clinical motivation and email it to **chronicauths@gems.gov.za** Your doctor can also call us on **0860 436 777.**

The clinical motivation will be considered carefully by the medical advisor and the outcome of the appeal will be communicated to you.

How do I obtain my approved chronic medicine?

You have a choice of receiving your medicine through either our Courier Pharmacy or your nearest GEMS Network Pharmacy. Once you have indicated your choice, you will either collect your medicine at your nearest GEMS Network Pharmacy or the Courier Pharmacy will contact you to make medicine delivery arrangements. If you choose to obtain your approved chronic medicine from a supplier that is neither the GEMS Courier Pharmacy or a GEMS Network Pharmacy, you will be liable for a 30% co-payment, which must be paid directly to the pharmacy or dispensing doctor.

Can I change my registered chronic medicine pharmacy at any time?

After a member has been contacted by the Chronic Medicine Manager and registered with either the Courier Pharmacy or a specific GEMS Network Pharmacy, they will be expected to remain with that pharmacy for at least six months before they are allowed to change.

However, if a member on the chronic medicine programme changes their home or work address, they may contact the Chronic Medicine Manager to change their registered pharmacy accordingly. Patients registered on the chronic medicine programme will be contacted by the Chronic Medicine Manager twice a year to confirm or reconsider whether they want their medicine delivered by the courier or collected at the GEMS Network Pharmacy.

Am I required to only use my registered GEMS Network Pharmacy or can I use any GEMS Network Pharmacy for my chronic medicine?

- Once you have been allocated to your nominated pharmacy, you must only obtain your medicine from that pharmacy for a minimum period of six months before you change.
- You will be allowed to obtain your authorised chronic medicine from a non-nominated pharmacy only once during the benefit year, except where the Courier Pharmacy is the non-nominated pharmacy. Once this allocation is exceeded, the patient will be liable for a 30% co-payment.
- However, you can request to be re-allocated when:
  - You have changed employers, or your employment address.
  - You have changed your residential address.
  - Six months has passed since the initial allocation.
  - Your preferred pharmacy is no longer part of the network.
  - If for whatever reason, you are unhappy with your allocated pharmacy.
- Should you wish to change your allocated pharmacy, please contact us to facilitate the change.

How often do I need to supply the GEMS Courier or GEMS Network Pharmacy with a repeatable prescription?

You need to supply the Courier Pharmacy or your GEMS Network Pharmacy with a valid doctor's prescription before they can supply you with your chronic medicine. Prescriptions have to be renewed every six months, which is a legal requirement. Scripts for schedule 6 medication must be renewed monthly. A prescription cannot be repeated for more than six months. The Chronic Medicine Manager will send you an SMS to remind you to obtain a new prescription before your old one expires. Whether you are obtaining your medicine from the Courier Pharmacy or a GEMS Network Pharmacy, you will need to send a new prescription when this is due. Your chosen pharmacy will not send or provide you with medicine if your prescription has expired, you will have to submit a new one.

HIV/AIDS Disease Management Programme (DMP)

Any member or beneficiary diagnosed or living with HIV/AIDS can enrol on the HIV/AIDS DMP for the support and education needed to lead a healthy and productive life.

Confidentiality guaranteed

This programme is managed by a team of healthcare professionals separate from other Scheme programmes and your employer. Confidentiality is always maintained.

The HIV/AIDS DMP has its own confidential contact channels, which are:

- Telephone: **0860 436 736**
- Fax: **0800 436 732**
- Send a 'please call me' to: **083 843 67 64**
- Email: **hiv@gems.gov.za**

What HIV/AIDS benefits are available?

Enrolees on the HIV/AIDS DMP will have access to the following benefits:

- Medicine (antiretroviral therapy) can be started soon after diagnosis and once you are ready to start and commit to lifelong treatment Test and Treat (TAT).
- Medicine to treat and prevent opportunistic infections related to HIV/ AIDS, including multi-vitamins where appropriate (a doctor's prescription and pre-authorisation is required for all medicines, including multi-vitamins).
- All pathology tests related to monitoring the disease.
- Regular monitoring of your condition to ensure you start treatment at the right time and that it is effective.
- Clinical support and guidelines for treating doctors.
- Access to a professionally trained medical team who will review your details and consult with your doctor to ensure that you receive the most appropriate treatment for your condition.
- Reminders for the enrolee and treating doctor to do regular check-ups and tests to monitor the patient's health status and update treatment where necessary.
- Treatment to prevent the transmission of the virus from mother to child (including treatment for the baby).
- Treatment to prevent the transmission of the virus from accidental exposure to infected bodily fluids (sexual assault, needle stick injury). Please call **0860 436 736** if you have had accidental exposure to HIV so that appropriate treatment called (Post-exposure Prophylaxis) can be arranged.
- Treatment to prevent transmission of the virus from a HIV-positive partner to a HIV-negative partner Pre-exposure prophylaxis (PrEP) treatment.

How do I register on the HIV/AIDS DMP?

1. Know your HIV status by requesting a doctor or clinic to perform a HIV test. GEMS will pay for this test.
2. If you have tested HIV-positive, obtain an application form by calling **0860 436 736** or use our 'please call me number' **083 843 6764** from Monday to Friday between 8am and 5pm and Saturday from 8am to 12pm; alternatively send an email to **hiv@gems.gov.za** or download the form from **www.gems.gov.za**.
3. Visit your treating doctor who will examine you and complete your application form. You will need to sign the application form and submit it to GEMS.
4. Fax your completed form to the confidential toll-free fax number **0800 436 732** or email it to **hiv@gems.gov.za**
5. We will contact you to discuss the outcome of your application.

How do I get my HIV/AIDS medicine?

The HIV/AIDS DMP enrols, manages and supports members while the Scheme's Chronic Medicine DSP – the Courier Pharmacy and the GEMS Network Pharmacies – provide all chronic medicine (including HIV medicine) to members. If you get your anti-retrovirals (ARVs or medicine to treat HIV) from any other pharmacy not contracted to the Scheme's Network, you will pay 30% of the cost of medicine and dispensing fees.

If you choose to use the Courier Pharmacy your medicine is delivered to your chosen address without anyone seeing what is inside. Beneficiaries who choose to make use of a GEMS Network Pharmacy will also be guaranteed confidentiality when collecting their medicine. Should you need medicine for other chronic conditions (for example, high blood pressure), it can be delivered or collected together with your HIV medicine.

Your chosen Chronic Medicine DSP will also remind you to get a new repeat prescription 21 days before your current prescription is due to expire. Schedule 1 – 5 prescriptions expire after six months according to the law. Schedule 6 scripts need to be renewed monthly.

Oncology (Cancer) Management Programme

If you or a member of your family is diagnosed with cancer, it is important to register on the Oncology Management Programme as soon as possible, all oncology treatment require pre-authorisation and case management.

How to register on the Oncology Management Programme

1. Your doctor must fax your treatment plan to the Oncology Management Programme on **0861 00 4367** or email **oncologyauths@gems.gov.za**. You can also contact the GEMS Call Centre on **0860 00 4367**.
2. Once the Oncology Management team has received the treatment plan from your doctor, we will record your details, disease information and proposed treatment.
3. Your treatment plan will be reviewed and, if necessary, a member of the clinical team will contact your doctor to discuss more appropriate or cost-effective treatment alternatives.
4. After the treatment plan has been assessed and approved, authorisation will be sent to your treating doctor. You will also receive an authorisation letter. The letter will show the treatment that GEMS has authorised, the approved quantities and how long the authorisation is valid for.

Please make sure that your doctor informs the Oncology Management team of any change in your treatment, as your authorisation will need to be re-assessed and updated. If your doctor does not inform the Oncology Management team about a change in your treatment, GEMS may reject your claims or pay them from an incorrect benefit.

You need pre-authorisation

You will need pre-authorisation for any hospitalisation, specialised radiology (for example, MRI scans, CT scans and angiography), stoma requirements or private nursing or hospice services.

Chronic Back and Neck Rehabilitation (CBNR) Programme

GEMS offers you a back and neck rehabilitation programme to provide you or your dependants with appropriate treatment to manage your back and neck pain.

The focus of the programme is on functional rehabilitation with major components being controlled exercises, biopsychosocial support and pain education. Clinical measurements are taken and recorded which are used to evaluate the progress of treatment over time. The treatment is delivered by reputable Service Providers, such as Physiotherapists and Biokineticists, utilising protocols and interventions based on international standards. Members are referred to a facility closest to them in order to be assessed and a treatment plan formulated to assist rehabilitation. The treatment can be extended over 6 weeks, depending on the assessment done at the centre.

Positive outcomes include improved flexibility, reduced pain and stiffness leading to a more productive life. The programme consists of carefully planned exercises and guidance on how to deal with your back problem and live a normal life.

The intervention entails:

- A comprehensive assessment.
- Based on your risk profile identified during the assessment, a tailored treatment programme – ranging from 1 to 12 active treatment sessions – is prescribed.
- Physiotherapy for pain management and muscle relaxation.
- A progress assessment with the doctor.
- A comprehensive outcome assessment to assess progress and measure improvement over the course of the programme.
- Tailored home-based exercises and stretches to ensure results are maintained long term.
- Follow-up visits to track improvement following the completion of the programme.

How the programme works:

- Members identified or referred for the programme will be contacted by the Scheme and a short questionnaire will be completed.
- Members will be referred to the nearest centre and appointments will be managed by the centre.
- The centre will perform an assessment which will determine the treatment. Treatment will need to be completed in order for the member to benefit from the programme.

What benefits will be used?

The Orthopedic Disease Management Programme benefit will be used for members receiving treatment at the centres.

How can you access the programme?

There are a number of ways to access the programme:

- Telephone: **0860 00 4367**
- Email: **enquiries@gems.gov.za**
- Your Scheme may contact you if you have had back problems in the past and received related treatment.
- Your FP or Specialist may refer you to the programme.

Renal Dialysis Network

GEMS established a Renal Dialysis Network in 2018 to contain the cost of care whilst enhancing the quality of care and maintaining access to treatment.

The use of the Renal Dialysis Network is compulsory for patients who are newly diagnosed with chronic renal failure and require treatment.

All new requests for chronic renal dialysis treatment from 1 January 2018 are subject to the GEMS Renal Network. We encourage members to use a network provider to prevent paying a co-payment of 30% per event, as per the benefit schedule and Scheme Rules.

Co-payment will not be applied to:

- Members admitted to hospitals who are receiving acute dialysis. Once discharged, the beneficiary is to be referred to a network provider for chronic dialysis.
- Existing beneficiary changing membership details for any reason, but no break in membership.
- Members who were registered on the programme and accessed their treatment at a non-network provider prior to 1 January 2018.
- Patients transferred to the following types of facilities requiring dialysis:
    1. Sub-acute facilities (Step-down facility)
    2. Private rehabilitation facilities
    3. State hospitals
- Out of area visits: Beneficiaries who are not able to receive treatment from their regular provider due to travelling, are to obtain an authorisation in advance to continue their treatment at a network provider at their destination, for example holiday dialysis.
- In cases where there is no network provider within a 50 km radius of the GEMS member's place of residence or work.

A list of GEMS Network providers can be found at **www.gems.gov.za**

IN-HOSPITAL BENEFITS

The Hospital benefits Management team ensures that you receive appropriate, quality healthcare while you are in hospital. The pre-authorisation process ensures that the planned procedure is both necessary and appropriate before you are admitted to hospital. The case management team is responsible for updating your hospital authorisation details and communicating with your hospital case managers and treating doctor where necessary during your admission.

OTHER GEMS PROGRAMMES

Maternity Programme

Pregnant members and dependants have access to the Maternity Programme. This programme is specifically designed to give you support, education and advice through all stages of your pregnancy, the confinement and post-natal (after birth) period.

To access maternity benefits, pregnant members or dependants must register on the programme as soon as their pregnancy is confirmed.

The Maternity Programme is managed by experienced health professionals. These practitioners will help you register on the Maternity Programme and you can contact them on **0860 00 4367** for advice and information.

Benefits of joining the Maternity Programme

- Added maternity vitamins to the value of R165 per script each month for a maximum of 9 months.
- A GEMS pregnancy, birth and early parenting book when you register.
- A free maternity bag during your third trimester.
- Free access to all services offered by the Maternity Programme.
- Information about the benefits offered by GEMS during your pregnancy and after the birth of your child.
- A Care Plan to guide your doctor in the appropriate treatment necessary for the duration of your pregnancy.
- You will be assigned a dedicated midwife who will provide you with telephonic support and information during each trimester of your pregnancy.
- Support from your healthcare practitioner and a workplace support colleague (HR practitioner or manager) if you choose to nominate one, providing them with the necessary tools to support you along this journey.
- If you have a high-risk pregnancy you will receive additional telephonic support from midwives to help you manage and reduce the risks to you and your baby.
- Access to healthcare information that will make it possible for you to make informed decisions with your midwife or doctor about your health and birth choices.
- Continued telephonic support and advice if you experience problems during the first six weeks of parenthood.
- If you can't get online, your midwife on the GEMS Maternity Programme can access the information for you if you call into the Call Centre on 0860 00 4360.
- You, your healthcare practitioner and your nominated workplace colleague will also receive regular electronic newsletters covering topics relevant to your pregnancy, your birth experience and early parenthood.

To view a comprehensive brochure about the Maternity Programme, visit **www.gems.gov.za** and click under **Members > Programmes > Maternity Programme**.

Registering on the Maternity Programme

You can complete your registration telephonically and or obtain a copy of the registration form by calling **0860 00 4367**. Alternatively, you can complete the registration form by downloading the form at **www.gems.gov.za.**

Please fax the completed registration form to **0861 00 4367**, email it to **enquiries@gems.gov.za** or post it to the **GEMS Maternity Programme Private Bag X782, Cape Town 8000**. You may also SMS **'please call me'** to **32377** for assistance.

Dental Benefit

The GEMS dental benefit ensures that members have access to cost-effective, quality dental healthcare. It is important for you and your registered dependants to have regular dental check-ups.

Network service providers

GEMS dental network providers charge the agreed Scheme tariffs. If you have benefits available for the treatment, you will not pay anything out of your pocket.

If you are on Tanzanite One or Beryl, dental services must be provided by a dentist, dental therapist or oral hygienist who are part of the GEMS dental network. You can find a network provider at **www.gems.gov.za** or by calling **0860 00 4367.**

Root canal treatment

Root canal treatment is covered on all options.

For Beryl and Tanzanite One members, this benefit is limited to one root canal treatment per beneficiary per year, and services must be provided by a dentist who is part of the GEMS dental network.

For all other options, this benefit is subject to the annual limit for out-of-hospital dental services.

Dental treatment in hospital

If you are on Tanzanite One or Emerald Value, use a GEMS network hospital to avoid any out-of-pocket expenses. Consult the list at www.gems.gov.za or by calling 0860 004 367.

Voluntary use of a non-network hospital will result in a R12 000 co-payment.

Pre-authorisation for specialised dentistry

Members and dependants need pre-authorisation for the following treatment types:

- Sedation or conscious sedation,
- Dental hospitalisation,
- Maxillofacial surgery,
- Crown and bridge treatment,
- Periodontal treatment,
- Orthodontics and
- Dentures (on some options).

Read the benefit schedule in the option-specific benefit guide for details of your dental benefits and pre-authorisation requirements.

Under certain circumstances and for certain procedures, your doctor may inform you that your dental procedure will be performed under either general anaesthetic or sedation. When general anaesthetic is administered, you will be asleep throughout the procedure. This is generally done in a hospital environment. Sedation means you are partially awake, but you are relaxed during the procedure.

Dental hospitalisation is allowed only for impacted teeth, severe trauma (PMBs) or patients younger than six years. Contact us for pre-authorisation for hospitalisation at least 48 hours before treatment, unless it is an emergency. If due process is not followed, you will be liable for a penalty of R1 000.

Benefits for treatment under general anaesthetic or sedation are not available for members or dependants older than six years, unless for impacted teeth or severe trauma. The treating dentist or dental specialist must provide GEMS with the medical reason for anaesthetic or sedation before the procedure is performed. In an emergency, pre-authorisation may not be required, but we advise that you contact us as soon as possible to avoid paying a penalty.

Registering on the Periodontal Programme

Tanzanite One and Beryl members must register on the Periodontal Programme in order to qualify for benefits for periodontal treatment. The Periodontal Programme is a disease management programme for patients with moderate periodontal disease. Once the treatment plan is authorised, the enhanced benefits for dental cleaning and specialised treatment (i.e. root planing) with your cooperation will help prevent loss of teeth.

Your GEMS Dental Network Provider has to complete the periodontal pre-authorisation form and forward it to GEMS along with the supporting documentation to enquiries@gems.gov.za or fax to 0861 00 4367. The “Dental report for periodontal pre-authorisation” form is available at www.gems.gov.za/healthcare/tools/forms.

Dental exclusions

Check your option-specific benefit schedule for details on excluded dental procedures. There are specific age criteria for certain dental procedures and for the number of dental procedures allowed per beneficiary in a defined period to avoid unnecessary out of pocket expense.

Elective cosmetic procedures

Elective cosmetic procedures and complications arising from them are not covered by the Scheme.

Optometry Benefit

The GEMS Optometry Benefit provides you with clinically essential optometry benefits. This means that GEMS only covers expenses for optometry that is necessary for your health and your sight.

Not all items prescribed by your provider may be covered. Some of the items not covered include:

- Plano (zero power) and low power lenses for both eyes.
- Sunglasses and spectacles with lens tints exceeding 35%, except in cases of albinism.
- GEMS covers either spectacles or contact lenses in an Optical Appliance Cycle of 24 months, not both.
- Bifocal or multifocal lenses for persons of a younger age, unless properly motivated by your optometrist.
- No contact lenses for children under the age of 16 unless motivated.
- Clinically non-essential additions, such as coatings.

When you read the benefit schedule in the option-specific mini-guide, you will notice that there is a limit for your family, as well as a sub-limit for each beneficiary or dependant registered on the Scheme. Each beneficiary can claim only up to a maximum of each sub-limit, and the total that the family can claim for is limited to the ‘family limit’

If you are on Emerald, there is a family limit of **R5 094** and a beneficiary limit of **R2 548** for every 24 months. If two members of the family need glasses to the value of **R3 500** in total, it means that there is only **R1 594** left of the benefit for the rest of the family. GEMS will only pay **R1 594** of the next beneficiary’s account. The rest will be for your own account.

Wellness Programme

The GEMS Health and Wellness Screening Services (HWSS) was introduced to reduce the rising negative impact of ill-health on public servant productivity.

The service is designed to be a positive experience, focusing on preventative measures by helping employees with lifestyle changes. The GEMS HWSS has proved to be very beneficial and the results so far have been encouraging.

It is only by testing the current health and well-being of employees that you have the knowledge to plan and implement meaningful and targeted interventions. We encourage you to make the most of the GEMS Wellness days you have access to.

The objectives of GEMS HWSS are aligned to creating a strong culture of well-being within the Government Departments and includes the following:

- Providing Health Screenings for all Public Service employees
- Early identification of lifestyle diseases (Diabetes, Hypertension), including HIV
- Referral to GEMS Disease Management Programmes
- Providing support and guidance to maintain your well-being (mental, psychological and social) for optimal functioning in the workplace
- Raising awareness of the importance of well-being and healthy living

GEMS provides the following screening tests and services at Wellness events:

- Body Mass Index (BMI) Assessment
- Random Blood Glucose Testing
- Blood Pressure Testing
- Total Cholesterol Testing
- HIV Counselling and Testing (HCT)
- Oral Health Education
- TB Screening questionnaire
- Lifestyle questionnaire
- Head, Neck and Shoulder massages

Test results are discussed with participants who will receive advice on what further steps to take to prevent or minimise health problems.

It is important to note that these are random screening tests, and participants are referred to their Family Practitioner for final diagnoses.

Preventative care and screening benefit

All members have access to a separate preventative care and screening benefit payable from risk. The tables below list the benefits available from FPs and Pharmacies.

SCREENING SERVICES – OBTAINABLE FROM YOUR FP		
Procedure	**Accessed from FPs**	**Eligible beneficiaries**
Cholesterol Screening	Once per annum	20 years and older
Osteoporosis Screening (Bone Densitometry Scan)	Once per annum	Females 65 years and older
Cytology Screening (Pap smears)	Once per annum	Females 12-65 years old
HIV / AIDS pre-test counselling with no test	Once per annum	All beneficiaries
HIV / AIDS (Screening test, post-test counselling, confirmatory test and condoms)	Once per annum	All beneficiaries
Mammography Screening	Once per annum	Females 40 years and older
Prostate Screening (PSA)	Once per annum	Males 45-69 years old
Faecal Occult blood test	Once per annum	50-75 years old
Glucose Screening	Once per annum	20 years and older
Glaucoma Screening	Once per annum	40 years and older
Neonatal Hypothyroidism	Single Screening	Up to 28 days old
Childhood Hearing Screening	Once per beneficiary	≥1 - 7 years old
Childhood Hearing Screening for infants	Once per beneficiary	Birth - 1 year (excluding first x3 months of life)
Childhood Optometry Screening	Once per beneficiary	Birth - 7 years (excluding first x3 months of life)
Syphilis Screening	Once per beneficiary per annum	All beneficiaries
Chlamydia / Gonorrhoea Screening	Once per beneficiary per annum	All beneficiaries
TB Screening	Once per beneficiary per annum	All beneficiaries

SCREENING SERVICES – OBTAINABLE FROM PHARMACIES		
Procedure	**Accessed from pharmacies**	**Eligible beneficiaries**
Cholesterol Screening	Once per annum	20 years and older
Blood pressure monitoring	Once per annum	18 years and older
HIV / AIDS pre-test counselling with no test	Once per annum	All beneficiaries
HIV / AIDS (Screening test, post-test counselling, confirmatory test and condoms)	Once per annum	All beneficiaries
Peak flow measurement	Once per annum	4 years and older
Glucose Screening	Once per annum	20 years and older
Pregnancy Screening	Once per month to a maximum of 6 per year	Female beneficiaries ≥12 years
Urine analysis	Once per annum	All beneficiaries

VACCINATION SERVICES – ACCESSED FROM FPs AND PHARMACIES		
Procedure	**Frequency**	**Eligible beneficiaries**
Influenza vaccination	Once per annum	All beneficiaries ≥6 months of age*
Pneumococcal vaccination	Once every 5 years	High risk beneficiaries: ≥65 years 2-64 years with a chronic registration / relevant hospital admission**
HPV vaccination (1 course = 3 doses)	One course per beneficiary per lifetime	Females 9-14 years
All other vaccinations	Subject to an annual limit of R780 pbpa.	All beneficiaries

* Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)

** Chronic Heart Disease, including Congestive Heart Failure and Cardiomyopathies; Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease, Emphysema and Asthma (smokers with Chronic Lung Disease secondary to smoking); Diabetes Mellitus; Cerebrospinal Fluid Leaks; Cochlear Implant(s); Alcoholism; Chronic Liver Disease; Congenital or Acquired Immunodeficiencies (includes B- (humoral) or T-lymphocyte Deficiency, Complement Deficiencies), and Phagocytic Disorders (excluding Chronic Granulomatous Disease); HIV infection; Chronic Renal Failure or Nephrotic Syndrome; Leukaemia or Lymphoma; Hodgkin Disease; Generalised Malignancy; Latrogenic Immunosuppression (diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy); Solid Organ Transplant; Multiple Myeloma.

EMERGENCY MEDICAL SERVICES

The Scheme has an Emergency Medical Services (EMS) Network that provides emergency medical assistance to GEMS members.

How the GEMS EMS Network works

When you call the emergency telephone number – **0800 44 4367** – the Emergency Medical Evacuation Dispatch (EMED) Centre will assign the appropriate EMS provider to the incident. The EMED Centre can be contacted 24 hours a day, seven days a week.

Emergency medical services include:

- Help given over the phone if there is an emergency.
- Emergency medical response (ambulance and emergency personnel) by road or air to the scene of a medical emergency.
- Transfer by road or air to the closest, most appropriate medical facility.
- Transfer of a patient from one hospital facility to another where medical intervention is required.

Follow these steps when you are faced with an emergency:

1. Dial **0800 44 4367** to contact the EMED Centre.
2. Give your name and the telephone number that you are calling from.
3. Give the address or location of the incident to help paramedics get there.
4. Provide a brief description of what has happened and how serious the situation is, for example:
    - Age of the patient
    - Is the patient male or female?
    - Is the patient breathing?
    - Is the patient conscious?
    - Brief details on the current condition of the patient.
5. Confirm the patient's membership number and details
6. Do not put the phone down until the person on the other side has disconnected.

Alert: Please ensure that all your registered dependants are aware of this service. Inform your child's school that your child is a member of GEMS and make sure your child and the school knows the emergency medical service number. Should you need to be transferred from one hospital facility to another, please inform the hospital you are admitted to that you are a GEMS member and that any hospital transfers must be authorised by calling the EMED Centre on 0800 444 367.

CHANGING YOUR BENEFIT OPTION

You can only change your benefit option at the end of every year. For option changes at any other time, you will need special permission from the Scheme. A notice period will be applied.

Please refer to Scheme Rules 16.2.2 and 16.2.3 at **www.gems.gov.za** for more information. To help you decide if you want to change options during the annual Option Selection period, you will receive information from GEMS about new benefits, as well as an Option Selection form. If you decide to change your option during the specified election period, your membership of the new option will start on 1 January of the next year.
You do not need to complete an option selection form if you choose to stay on the same option. However, if your personal details have changed, the option form is a handy way of making sure that we have your most recent contact details. It is important that you submit your option change request by the deadline provided.

GOVERNANCE OF THE SCHEME

In addition to the Scheme's Board of Trustees and Executives, there are seven committees of the Board that oversee the work done in various areas.

These committees perform their duties with your interests in mind and ensure the decision-making processes and structures are effectively governed. They are:

Audit Committee (AC)

The Board of Trustees, in terms of section 36(10) of the Medical Schemes Act 131 of 1998, are required to appoint an audit committee of at least five (5) members, of which at least two (2) shall be members of the Board of Trustees. The remaining three (3) members must be independent of the Board, including the Chairperson. An Audit Committee Charter that provides guidance to its members determines its authority and duties. The AC's primary responsibilities include assisting the Board of Trustees to evaluate the adequacy and efficiency of the Scheme's internal controls, accounting practices, financial reporting processes and risk management. The committee's other responsibilities include overseeing the Scheme's information systems, providing oversight on external reports (other than financial statements) and guiding the combined assurance processes applied by the Scheme and its service provider network. The Audit Committee considers and recommends the appointment of the external auditors, monitors them and reports on their independence to the Board. The committee is also responsible for appointing and assessing the performance of the Chief Audit Executive. They also approve the internal audit plan, the annual review and the approval of the Internal Audit Charter.

Clinical Governance and Administration Committee (CGAC)

The primary responsibility of this committee is to assist the Board of Trustees in ensuring that the operations of the Scheme are efficient by providing oversight and assessment and review processes of all the administrative aspects of the Scheme. The committee assists the Board of Trustees to ensure that there is a seamless interaction between the various service providers to meet the operational objectives of the Scheme. The committee also assists the Board to expand the Scheme's membership, and is involved in overseeing communication and marketing activities, stakeholder relations and managing the complaints management function to:

- Assess and report on the approval of ex gratia applications and payments to members of the Scheme. The committee has a mandate to approve ex gratia payments in excess of R50 000.00 and to intervene in matters where a patient cannot obtain treatment/therapy (due to insufficient cover), or may be facing a life-threatening condition or the treatment prescribed for a patient will result in them leading an improved quality of life. Members will be assisted if the treatment/therapy prescribed for their condition is clinically safe, is supported by internationally-recognised medical evidence and meets the treatment guidelines. The Scheme may also assist in cases where the patient has a proven inability to afford the required treatment. However, these cases are dealt with on a case by case basis and depends on the financial allocation for such projects.
- Assist the Board to ensure that the Healthcare Management Strategic Objectives are implemented, specifically: To improve the Scheme's clinical risk profile and limit fraudulent claims; and
- Oversee the Scheme's product development process.

Risk Social and Ethics Committee (RSEC)

This committee has been mandated by the Board of Trustees to ensure sound corporate governance controls by providing oversight, assessment and review of the risk management policy, maintaining ethics and compliance within the Scheme. The committee must comply with the Medical Schemes Act's regulations, patent and trademark legislation and deal with any legislative matters in the Scheme.

Finance and Investment Committee (FIC)

The committee was established by the Board in December 2013 and their primary responsibility is to assist the Board to fulfil its mandate to deal with the Scheme's investment activities and to consider issues relating to GEMS' investment activities. This committee monitors the Scheme's organisational and financial performance. The Scheme's responsibility to review the contracts of its service providers on a regular basis lies with the

committee. The committee monitors the Scheme's cash flow position, performance of investments and GEMS' compliance with the regulatory framework in respect of Medical Scheme investments. The committee also oversees the Scheme's Information and Communication Technology (ICT) infrastructure, communication function and monitors the performance of asset consultants and managers contracted to the Scheme.

Dispute Committee (DC)

The primary responsibility of this committee is to consider and preside over any disputes referred by the Principal Officer (PO) to the DC for adjudication. The DC provides independent advice to the Board of Trustees on how to handle disputes within the Scheme.

On 29 April 2019 the GEMS Board of Trustees approved a recommendation to move away from the current DC structure to an alternative dispute resolution body (e.g. an Ombud).

Human Resources and Remuneration Committee (HRRC)

This committee seeks to ensure professional and sound people management within the Scheme by assessing and reviewing relevant HR and remuneration policies in the Scheme. The committee advises the Board about the annual cost of living adjustment for the Scheme's employees. The committee formulates the criteria used to benchmark annual remuneration surveys, the applicable remuneration rates for employee levels, trustees and independent committee members. The committee also implements the remuneration survey results or recommendations, performance review measures for the Scheme's employees and discloses the remuneration earned by trustees, independent committee members and members of the GEMS Executive Committee in the Scheme's annual integrated report.

Benefit Design Committee (BDC) (complements the Standing Committee)

This committee deals with the benefit design for the Scheme, its annual contribution rates and meets at least twice a year. The work commences with a product development process which runs throughout the year, in preparation for the GEMS BDC recommendation.

GEMS SERVICE PROVIDERS

We have contracted a network of service providers from administrative and operational services, to quality healthcare.

- ASI – Financial Advisory Consultancy
- Denis - Ambulatory Dental management services
- Europ Assistance – Emergency Medical Evacuation Dispatch (EMED) contact centre
- Healthi Choices – Wellness screening services
- MediKredit – Pharmacy benefit management
- Medipost Pharmacy – Chronic medicine courier pharmacy
- Medscheme – Contributions and debt management services
- Medscheme Health Risk Solutions (MHRS) – Managed care services
- Metropolitan Health – Correspondence services
- Metropolitan Health – Membership and claims services
- Opticlear – Optometry management services
- Universal Healthcare – Medicine Management Programme (MMP) and Strategic Managed Care

GLOSSARY (WORD LIST)

Acute medicine
Medicine prescribed to relieve symptoms of a temporary illness or condition, for example, an infection or a sprain.

Additional Chronic Disease List (aCDL)
An additional list of chronic diseases that the Scheme provides chronic medicine benefits for. GEMS covers these diseases for some of its options, in addition to the 26 diseases that it must cover by law (the 26 diseases are given in the chronic disease list).

Beneficiary
A person who can receive benefits from GEMS. A beneficiary is either the main member on GEMS or one of their registered dependants.

Benefit
The amount of money allocated by GEMS to a member or dependant to spend on medical treatment and medicine, according to the relevant Scheme option: Tanzanite One, Beryl, Ruby, Emerald Value, Emerald or Onyx.

Chronic
A chronic condition is any condition which needs ongoing treatment, or a treatment for a period of at least three months. Examples of chronic conditions are Asthma or Diabetes.

Chronic Disease List (CDL)
A list of the 26 specific chronic diseases all medical schemes need to provide a minimum level of cover for, as stated by law.

Conscious sedation
A combination of medicine to help you relax and to block pain during a medical or dental procedure, during which you will probably stay awake but may not be able to speak.

Consultation
A visit to your doctor, surgeon or other healthcare provider to get a diagnosis or treatment. This also includes the times when your healthcare provider visits you while you are in hospital.

CT and MRI scans
Specialised and more advanced type of ‘X-rays’.

Designated Service Provider (DSP)
A healthcare provider or group of providers chosen by the Scheme to provide diagnosis, treatment and care to members for one or more PMB conditions. This includes doctors, pharmacies and hospitals. When you choose not to use a DSP, you will have to pay a 30% portion of the cost of the consultation of treatment from your own pocket. GEMS has a network of renal facilities as their DSP for renal dialysis. When you choose to use a non-network facility for chronic renal dialysis, a 30% co-payment will apply.

Formulary
The list of approved medicine, tests or services.

GEMS Tariff
The rate at which healthcare providers will be paid for services rendered to GEMS members.

GEMS Network
The GEMS Network is a network of healthcare providers consisting of Family Practitioners (FPs), specialists, pharmacies, dentists and optometrists who have promised to deliver quality healthcare at Scheme rates to our members.

General anaesthesia
A treatment with certain medicine that puts you into a deep sleep so you do not feel pain during a procedure. When you receive these medicines, you will not be aware of what is happening around you.

Family Practitioner (FP)
FPs are doctors who provide general healthcare services. It is important to always consult the same FP so that your FP can develop a good understanding of your health and treatment history. They can then make informed decisions about your care, such as if you need to be referred to a specialist.

Generic medicine
Medicine that has the same chemical ingredient, strength and form (such as a tablet or syrup) as the original brand name product. Generic medicine is as safe and effective as the original brand name product, but usually cheaper.

ICD-10 code
These are codes that appear on healthcare provider accounts. The codes are used to inform medical schemes about what conditions their members were treated for so that claims can be settled correctly.

Main member
The main/principal member registered on the Scheme.

Medicine list or formulary
A list of cost-effective medicine that guides the doctor in the treatment of specific medical conditions.

Medicine Exclusion List (MEL)
A list of medicines that GEMS does not cover for various reasons.

Medicine Price List (MPL)
A reference pricing system we use to work out the prices of groups of medicine. The medicines are grouped according to how similar they are in ingredients, strengths and form. If a member and healthcare provider chooses to use medicine that costs more than the reference price, the member pays the difference.

NAPPI code
The National Pharmaceutical Product Index (NAPPI) is a comprehensive database of medical products used in South Africa. The NAPPI code is a unique code for medicine, surgical or consumable products and medical procedures that allows you to claim a refund from GEMS.

Personal Medical Savings Account (PMSA)
The portion of your monthly contribution that is allocated to a savings account held in your name. The money in this account is used to pay for your out-of-hospital medical expenses on the Ruby option.

CONTACT DETAILS

SERVICE	PURPOSE		
GEMS Contact Centre	General queries related to GEMS	**0860 004 367**	**enquiries@gems.gov.za**
GEMS Website	View GEMS Products and Services		**www.gems.gov.za**
GEMS Tariff File, Formularies and Forms	To view GEMS Tariff file, Formularies and Forms		**www.gems.gov.za, select Healthcare Providers > Tools > Select either Tariff file, ICD10 Codes or Forms from the menu.**
Chronic Medicine Management - New registrations and updates	Chronic registrations	**0860 004 367**	**chronicdsp@gems.gov.za**
Chronic Medicine Authorisation Queries	Queries related to the authorisation of chronic medicines	**0860 004 367**	**chronicauths@gems.gov.za**
GEMS MPN Pharmacy Nomination	To nominate a GEMS Network Pharmacy for chronic medicine	**0860 004 367**	**chronicdsp@gems.gov.za** Lists of Pharmacies can be found by following these links: **www.gems.gov.za/members/providers/REO-Providers** **www.gems.gov.za/members/providers/T1B-Providers**
Fraud Hotline	Fraud-related matters	**0800 212 202**	**gems@thehotline.co.za** **office@thehotline.co.za**
Hospital Pre-Authorisation	All hospital pre-authorisations for non-emergency events	**0860 004 367**	**hospitalauths@gems.gov.za**
Submission of claims	Submissions of claims for GEMS beneficiaries		
Queries of claims	Queries relating to a claim for GEMS beneficiary		
Oncology Services	Oncology-related queries	**0860 004 367**	**oncologyauths@gems.gov.za**
Ambulatory PMB	Ambulatory PMB queries	**0860 004 367**	**enquiries@gems.gov.za**
HIV/Aids Management	HIV/AIDS related queries	**0860 436 736**	**hiv@gems.gov.za**