gems
Government Employees Medical Scheme

DISCOVER THE BRILLIANCE OF GEMS

YOUR 2023 MEMBER GUIDE

Working towards a healthier you

TABLE OF CONTENTS

WELCOME

Thank you for choosing and trusting GEMS to take care of your healthcare needs in 2023. 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 explains how to utilise and access your benefits and the various services that are available to you.

GEMS takes care of your health, giving you more time to focus on what is important to you and your family.

Please see note that this is a summary of the Scheme's benefits and rules, not a replacement for the registered rules. If there is a conflict between this guide and the rules, the Scheme Rules registered with the Council for Medical Schemes (CMS) will take precedence. The Scheme Rules are available at **www.gems.gov.za,** or you can request a copy by emailing **enquiries@gems.gov.za** or calling **0860 00 4367**.

ACCESS

- With the goal of achieving universal health coverage in mind, our 2023 benefit enhancements prioritise vulnerable groups such as children, women and the elderly.
- GEMS provides greater access to quality healthcare through a wide range of Healthcare Provider 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' flagship options, Tanzanite One and EVO are richer in benefits than other similar priced products in the market.
- GEMS understands the needs of the South African family and we provide greater access to quality healthcare through a wide range of networks. The South African definition of family extends far beyond the immediate family and GEMS understands this. We cover up to 5 generations, so no family member is left uncared for.
- GEMS assures members that it remains committed to providing excellent health plans that will see our members and dependants through any challenges they may face this year.

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

gems Tanzanite One

gems Emerald Value

gems Beryl

gems Emerald

gems Ruby

gems 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

MANAGING YOUR MEMBERSHIP

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

- When a main member joins the Scheme, changes their benefit option, or removes or adds a dependant, they receive a membership card and certificate. Each registered adult dependant is also given a card (i.e. a dependant older than 21 years of age).
- You and the registered dependants listed on the back of your membership card are the only people who can use the card to claim benefits. Giving your membership card to someone who is not your registered dependant and having them use it to claim benefits is considered fraud.
- If you resign, you cannot use the membership card. Using the card after your resignation is considered fraud.
- Please include your membership number in all correspondence with the Scheme so that we can assist you as quickly as possible.
- When you visit your doctor, dentist, pharmacist, specialist, and all other allied healthcare service providers (as listed in your benefit guide), remember to show your membership card.

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

Why is it important to manage your GEMS membership?

To get the most out of your GEMS membership, make sure you understand and adhere to the Scheme Rules and Procedures. To learn more about your membership, visit www.gems.gov.za and read Rule 10 of the Scheme rules. You can also request a copy by sending an email to **enquiries@gems.gov.za** or by calling **0860 00 4367.**

Protecting your personal information

The Protection of Personal Information Act 4 of 2013 (POPIA), which came into effect on 1 July 2021, provides a guideline on the minimum standards regarding the accessing and processing personal data. The purpose of POPIA is to protect your right to privacy and to regulate how personal information is processed. GEMS adheres to the highest standards in terms of safeguarding the personal data of our members and only relevant personal information is collected for our operations, to provide you with excellent service.

Help us to protect your personal information

GEMS' goal is to help public service employees and their families to get the best possible healthcare at the most affordable rate. We must therefore comply with POPIA by verifying member details in every interaction we have with you:

- When you contact the call centre, you will be asked verification questions and will only be assisted once your identity is validated.
- During face-to-face interactions, for example when you visit a walk-in centre, you will need to produce valid physical proof of identification.
- For third party enquiries, you need to complete and submit the Authorisation to Disclose Information Form, authorising GEMS to disclose personal information to a third party. This form can be downloaded from our website at www.gems.gov.za.

Change of banking details: FICA

To protect your benefits and ensure efficient claim refunding, please send us the following if your banking information needs to be updated:

- A copy of your Identity Document (ID)/Smart ID (with commissioner of oaths stamp not older than 3 months);
- A bank account statement, crossed cheque, or signed or stamped bank letter (not older than 3 months);
- Proof of address, such as a utility bill, a signed bank statement, or a certified affidavit confirming proof of address (not older than 3 months).

Any documents older than 3 months will be rejected, potentially delaying your refund. It is crucial to submit these documents, as GEMS prescribes to the FICA (Financial Intelligence Centre Act 38 of 2001), which combats money theft and fraud by assisting in the identification of 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 passes 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**
- Sending a fax to **0861 00 4367**
- Visiting a GEMS **Walk-in Centre** or Client Liaison Officers **(CLO'S)** at member engagement events

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 in Centres. You can also complete an online application.

The following supporting documents are required upon submission of a membership application:

For member:

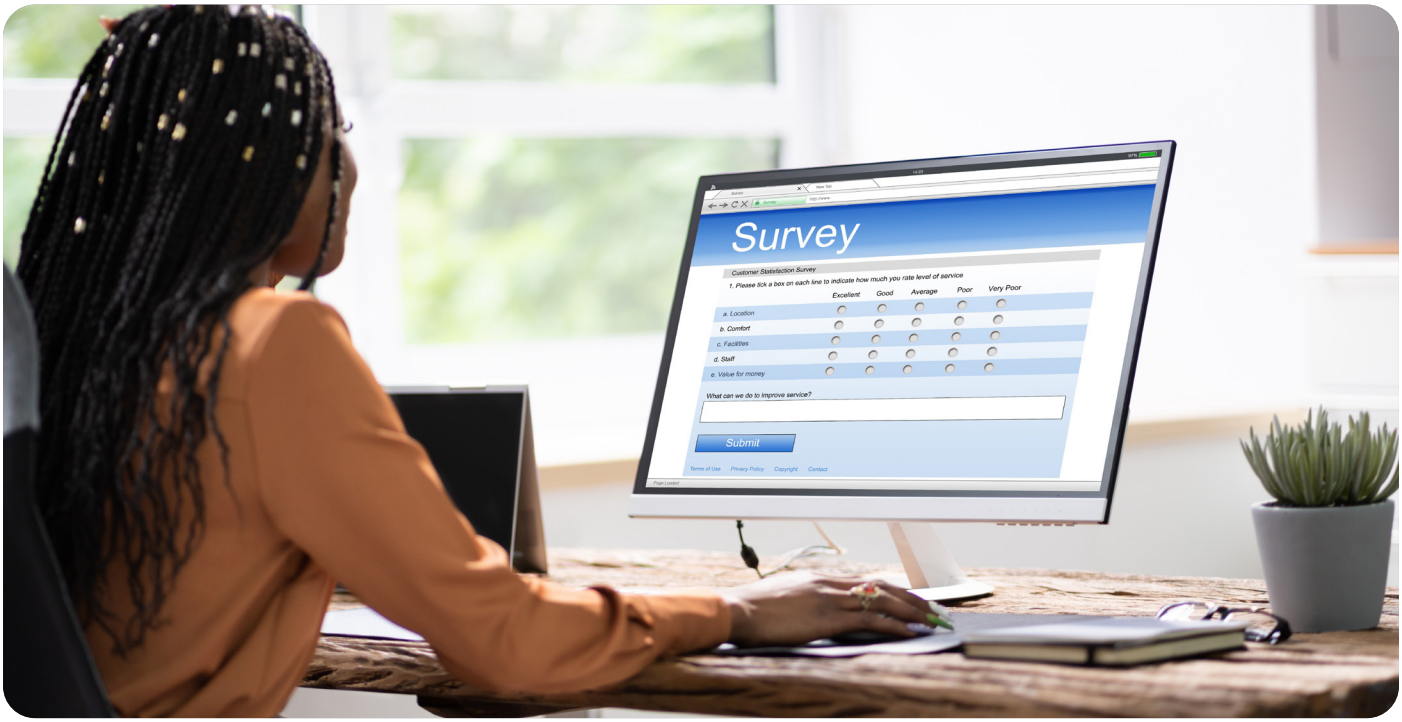
- Clear copy of Green ID book/Smart ID with both sides/SA Passport
- Latest salary advice or letter of appointment (not older than 3 months)
- Bank statement with stamp (not older than 3 months)
- Previous medical aid certificate with resignation date (if applicable)

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 (certified by Commissioner of Oaths)
- Previous medical aid certificate with resignation date (if applicable)



ABOUT YOUR DEPENDANTS

Registration of 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
  - 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.
- 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 at the same time. 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 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; and
- Declaration letter, email or telephone call from the main member confirming factual dependency.

If the child is 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); and
- 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.
- Important to note: adult rates will be applicable in this instance.

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 the Scheme a completed newborn registration form and a certified copy of the child's birth certificate within 60 days of birth so that they can be registered as a dependant on the Scheme from the date of birth. If your child is adopted, please provide the final adoption letter. We will then cover any medical expenses incurred as a result of the newborn's birth. If the surname of your newborn differs from yours, you must provide the Scheme with a declaration letter, email, or phone call confirming that the child is yours.
- You can download the newborn registration form from our website by visiting **www.gems.gov.za.**

When the baby is registered with the Scheme within 60 days of birth or adoption, the full monthly contribution is due from the month of birth or adoption, regardless of the newborn's registration date. This ensures that the newborn and/or adopted child has medical aid coverage from the date of birth or adoption. If the newborn/adopted baby is registered to the Scheme after 60 days, medical coverage will begin on the first day of the following month from the date of registration. The baby's registration to the Scheme after 90 days of birth or adoption will be subject to underwriting under the Medical Schemes Act.

Yearly review of dependants

Every year, the Scheme determines whether dependants are still eligible to receive benefits under the Scheme Rules. This means that each year, main members must provide us with proof of factual dependency for all dependants aged 21 to 28.

The main member only needs to provide supporting documents to the Scheme once for disabled dependants.

Eligibility review – implementation of Rule 4.9.5

- 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.
- 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 "Membership to 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 re-joining 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 a payment arrangement with the Scheme before a new membership period is effected.

Continuation of membership

The dependants of a GEMS member can 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 a risk management tool that medical funders implement as per the Medical Schemes Act.

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 and non-disclosure.

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:

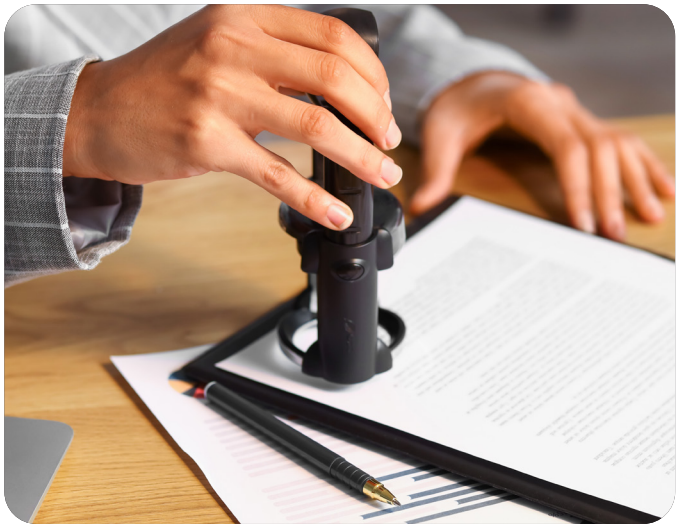
- A General Waiting Period (GWP) of up to 3 months; and/or
- A Condition-Specific Waiting Period (CSWP) of up to 12 months.

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

A CSWP 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. A monitoring process is in place to identify a pre-existing condition that was not disclosed by the member on application for membership. An investigation will be conducted if non-disclosure is suspected, and this can happen at any time during the admission or claims process.

If it is found that the beneficiary failed to disclose a pre-existing condition, GEMS will apply a CSWP for that condition, and will not cover any costs associated with such condition. Claims that may have been paid may also be reversed if they were paid prior to the outcome of the non-disclosure investigation. This would mean that the member is liable for such reversed claims.

GEMS has a process for members to make an informed decision regarding their underwriting status by signing an acceptance letter or using the USSD functionality. The acceptance letter will be sent to members who are to be underwritten, to review their waiting periods, then sign and return the acceptance letter to the Scheme to finalise the application process. This form must be returned within seven (7) days. Members who have underwriting imposed can use the USSD functionality by dialling *134*20018# on their mobile to accept or reject their waiting periods.



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 2023. 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 **page14 .**

TANZANITE ONE OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 – R10 170.00	R1 245	R984	R536
R10 170.01 - R14 272.00	R1 305	R1 046	R578
R14 272.01 - R24 449.00	R1 388	R1 099	R612
R24 449.01 +	R1 624	R1 374	R778

BERYL OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 – R10 170.00	R1 405	R1 401	R788
R10 170.01 - R14 272.00	R1 524	R1 512	R869
R14 272.01 - R24 449.00	R1 663	R1 663	R933
R24 449.01 +	R1 997	R1 997	R1 133

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 - R15 316.00	R2 903	R2 179	R1 124
R15 316.01 - R26 451.00	R3 234	R2 431	R1 260
R26 451.01 +	R3 581	R2 699	R1 386

EMERALD VALUE OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R15 316.00	R2 717	R2 076	R1 010
R15 316.01 - R26 451.00	R3 007	R2 331	R1 133
R26 451.01 +	R3 369	R2 590	R1 262

EMERALD OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R15 316.00	R3 246	R2 472	R1 205
R15 316.01 - R26 451.00	R3 592	R2 777	R1 350
R26 451.01 +	R4 027	R3 088	R1 506

ONYX OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R15 316.00	R5 627	R4 309	R1 692
R15 316.01 - R32 635.00	R5 857	R4 459	R1 838
R32 635.01 +	R6 323	R4 860	R2 051

HOW THE SUBSIDY WORKS

Approved medical scheme subsidy

One of our goals as GEMS is to keep member contributions affordable, and the medical scheme subsidy provided by your employer plays an important role in keeping your medical benefits affordable. Please consult your employer for information on the subsidy and how it applies to you as an individual. Employees on salary level 1 to 5 on the Tanzanite One option will continue to be fully subsidised, up to the maximum amounts specified below. In-service GEMS employees will receive a 75% subsidy on their total contribution, up to the maximum amount shown below. Please keep in mind that your subsidy eligibility is determined by your employment conditions; therefore, your employer will be able to confirm the subsidy you qualify for. If you add more dependants and have exhausted your employer's maximum subsidy, you will be required to pay the amount not covered by the subsidy as a member contribution.

The subsidy policy for pensioners is as follows:

- Pensioner members on GEMS will receive 75% of their monthly contribution as a subsidy up to a maximum of R1 701 for a member without dependants.
- Pensioner members will receive 75% of their monthly contribution as a subsidy up to a maximum of R3 402 for a member with dependants.

If you have any questions about your subsidy, you should discuss them with the Government Pensions Administration Agency (GPAA), telephone no. (012) 319 1911 or email to medical@gpaa.gov.za. Please note that eligibility for pensioner members is determined by the Government Pensioner Administration Agency.

Please note: Pensioner members who were on salary level 1 to 5 and on the Tanzanite One option while they were in employment (in-service), and retire on the same option, will now continue to receive a 100% subsidy to a maximum of R3 402.

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

Please visit the 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 2023.

Please note that the subsidy is calculated as 75% of the total contributions up to a maximum as indicated in below table:

MEMBER PROFILE	1 JANUARY 2022 MONTHLY EMPLOYER SUBSIDY	1 JANUARY 2023 MONTHLY EMPLOYER SUBSIDY
Single Principal Member	R1 624	R1 701
Principal Member with one dependant	R3 248	R3 402
Principal Member with two dependants	R4 241	R4 442
Principal Member with three dependants	R5 234	R5 482
Principal Member with four dependants	R6 227	R6 522

GPAA subsidy for retired employees effective from 1 January 2023.

Please note that the subsidy is calculated as 75% of the total contributions up to a maximum as indicated in below table:

MEMBER PROFILE	MAXIMUM EMPLOYER MONTHLY SUBSIDY	MAXIMUM EMPLOYER MONTHLY SUBSIDY FOR TANZANITE ONE OPTION SALARY LEVEL 1-5
Principal Member without a dependant	**R1 701**	**R1 701** or limited to Tanzanite One contribution of a single member.
Member plus dependant/s	**R3 402***	**R3 402**** or limited to Tanzanite One contribution of member plus dependant/s.

*Maximum post-retirement medical subsidy calculated at a maximum of a single principal member plus dependant/s.

**Maximum post-retirement medical subsidy calculated at a maximum of a single principal member plus dependant/s for former employees on salary level 1 to 5 who belonged to the Tanzanite One option.

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

Contribution statements

Each quarter, we send a contribution statement to all members. Members who owe GEMS money will receive a monthly contribution statement outlining their monthly contribution payments as well as any money owed to GEMS. This statement assists you in ensuring that your contributions are always up to date.

Managing arrear contributions

You might be behind in your payments to GEMS if:

- Your monthly contribution costs have not been deducted from your salary by your employer. This can happen to new members if their membership start date is captured after the PERSAL cut-off date for that month's monthly deductions. This could also happen if you switch departments.
- You added a dependant, but the additional contribution for the new dependant was not applied to the next contribution payment on time.
- 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 GPAA subsidy approval.	Submit your GPAA approval letter to **premiums@gems.gov.za.** You will be refunded when subsidy is applied and payments received from GPAA.
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 proof of study to GEMS.

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

Personal Medical Savings Account

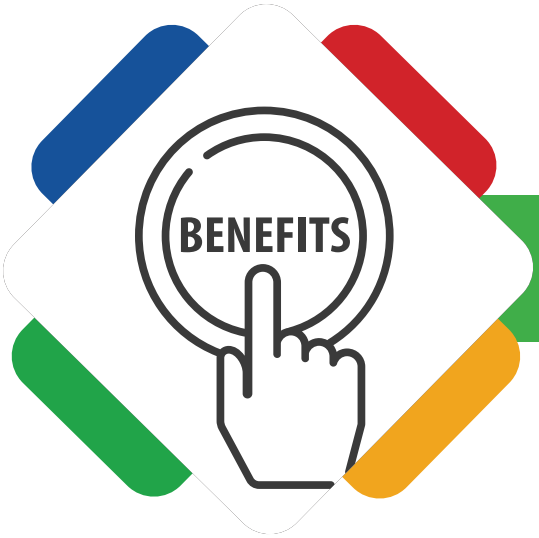
A Personal Medical Savings Account (PMSA) is only available to our Ruby option members. The PMSA is a savings account in the name of the primary member that receives 20% of the total contribution. The amount allocated to the PMSA is determined by the main member's salary and the number of beneficiaries. The PMSA covers out-of-hospital and daily medical expenses. When the PMSA is exhausted, out-of-hospital claims will be paid from the limited Block Benefit, which includes 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 following year or paid out to you (or to your new medical scheme) five months after you have terminated your membership or changed to a non-medical savings account option. Please keep in mind that this payment is taxable. In the event that a refund is owed to you, make sure the Scheme has your most recent banking information.

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 271 medical conditions (the Diagnostic Treatment Pairs);
- Any emergency medical condition; and
- 26 chronic conditions that are listed on the Chronic Disease List (CDL) and are provided for in the Regulations to the Medical Schemes Act.

More information on PMBs, as well as the list of Diagnostic Treatment Pairs and Chronic Disease List is available on the Council for Medical Schemes website (https://www.medicalschemes.co.za/resources/pmb/).

What you need to know about PMBs

- Qualifying for PMBs is not only based on the condition or diagnosis (ICD-10 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 first be covered from your day-to-day available benefits. Once these benefits have been 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 (ICD-10 code) and the treatment given (Tariff code or NAPPI code) are required to ensure GEMS identifies and pays PMBs correctly.
- Please remind your healthcare provider to use the relevant ICD-10 codes on all claims to ensure that your claim is processed correctly. Read more about submitting claims to the Scheme on pages 21 to 24.
- 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. This means you may be liable for part of the full amount of the claim

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:

- Hospitals: The State, as well as hospitals included in the GEMS Hospital Network for certain options, are GEMS' DSPs, for the treatment of in-hospital PMBs.
- Chronic medicine DSPs: Members should use a GEMS Medicine Provider Network Pharmacy or a Chronic Medicine Courier Pharmacy (Medipost or Marara) to obtain their authorised chronic medicine, including medicine for HIV.
- All chronic medicine (even if it is on separate prescriptions) must be collected from your allocated pharmacy. If you use a pharmacy that is not on the Pharmacy Network (or a Network Pharmacy to 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 one of the Courier Pharmacies 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 20 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 medicine 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 that precluded the beneficiary from obtaining such treatment from a DSP.
- The DSP was not within reasonable distance of the beneficiary's ordinary place of business or personal residence.

Except in the case of an emergency medical condition, pre-authorisation must be obtained before the voluntary 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, otherwise a co-payment of R1 000 per admission shall apply.

WHAT GEMS DOES NOT PAY FOR

Every Medical Scheme has a list of medicine, treatments, and procedures that they do not cover. These are known as Scheme exclusions, and they help to keep medical aid options affordable and sustainable.

Rule 16 and Annexure E of the Scheme Rules detail all Scheme exclusions. You must ensure that the procedures, treatments, or medicine you receive will be paid for before obtaining them, as GEMS will not pay for excluded services or items, and you will be responsible for these costs. GEMS also applies the Medicine Exclusions List (MEL) to all medicine benefits specified in Annexure C of the Scheme Rules. This list can be found on **www.gems.gov.za** and contains:

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

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 that even if a treatment is not excluded by the Scheme and is approved or authorized, it will still be denied or paid in part if the Scheme Rate/Tariff and benefit limits are exceeded. Claims may also be denied if they do not adhere to managed care guidelines. You can find the Scheme Rules by visiting www.gems.gov.za, or you can request a copy by calling us on 0860 00 4367. No exclusions on PMBs

Some complications resulting from Scheme exclusions may be considered as a PMB. 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 of a condition, irrespective of the cause of the condition.

HOW TO AVOID CO-PAYMENTS

There are many ways to avoid co-payment on your medical claims, simply by following the recommended GEMS processes.

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, or when benefits have been depleted for a service that is not a PMB entitlement.

How can co-payments be avoided?

Use Designated Service Providers (DSPs)

A DSP is a healthcare provider or group of providers chosen and contracted by GEMS to provide members with medical condition diagnosis, treatment, and care, including PMB conditions. A co-payment will be imposed if a GEMS DSP is not used (where required).

For example, if you receive chronic medicine from a pharmacy other than your designated DSP pharmacy, you will be charged a 30% co-payment, even if the medicine is on the formulary (see more about in-formulary medicines later in this section). However, you are only permitted one out-of-network pharmacy visit per benefit year.

How to avoid non-DSP co-payments

Follow these guidelines in order to avoid non-DSP co-payments:

Tanzanite One	Beryl	Emerald Value
• Obtain your acute and **over-the-counter (OTC) medicines** either from your network dispensing doctor or from a network pharmacy. • Only consult with your **nominated FP** (Family Practitioner). You 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.	• Obtain your **acute** and **over-the-counter (OTC) medicines** either from your network dispensing doctor or from a network pharmacy. • Only consult with a **GEMS Network FP.** You have unlimited network FP visits. Visits to a non-network FP are limited to three visits per family (and subject to limits), and include a 30% co-payment.	• Only consult with your **nominated FP** (Family Practitioner). You have unlimited nominated FP visits subject to the block benefit. • You may obtain authorisation for three (3) out-of-hospital (OH) non-nominated network FP visits per family per benefit year, 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.

Give birth naturally, if possible

An elective Caesarean section delivery (in other words, where Caesarean section is by choice, and not due to a medical condition or an emergency situation) will incur a R10 000 co-payment. In addition, if you are required to make use of a Network hospital and choose instead to make use of a Non-Network facility, you will be liable for a R12 000 Non-Network co-payment.

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, and Chronic Back and Neck Rehabilitation Providers.

These GEMS Network healthcare providers have committed to provide 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.

Please keep in mind that GEMS will not pay claims for services rendered by a healthcare provider who is not registered under the applicable law. Examples include doctors who are not registered to practise medicine in South Africa, doctors who have restrictions imposed by GEMS, and doctors who do not have written permission to perform remunerative work outside the Public Service. Before using the provider's services, consult with your doctor to ensure that your claims meet the necessary requirements before submitting them to the Scheme.

Consult renal facilities on the GEMS Renal 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 GEMS Hospital Network facilities for Emerald Value and Tanzanite One members

Members on the Tanzanite One and Emerald Value plans are required to use GEMS Hospital Network facilities.This network is made up of private hospitals (057/058), day clinics (076/077), and mental health institutions (055). If a member is admitted to a Non-Network hospital, a R12 000 co-payment will be charged to the member's account, unless the admission was an emergency or the services were unavailable at the nearest Network hospital. A list of these Network providers 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 centers can also assist members with locating a GEMS Healthcare Network Provider.

Use in-formulary medicine

GEMS has two medicine formularies:

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 these options. 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 Ruby, Emerald, Emerald Value and Onyx options
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 here, 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 at **www.gems.gov.za** under Individuals > Formulary Lists > Select formulary files for the relevant benefit year.

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 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.

The MPL can be found on the GEMS website at **www.gems.gov.za.**

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, get pre-authorisation at least 48 hours before you go to hospital, or you will incur a co-payment. For example, if you do not get pre-authorisation for your maternity admission, you will pay a R1 000 co-payment.

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); and
- 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 rendered by a healthcare provider who is not registered under the applicable law. For example, doctors who are not registered to practice medicine in South Africa, doctors who are subject to GEMS restrictions, or doctors who do not have written permission to perform remunerative work outside the Public Service. Speak with your doctor to ensure that your claims meet the necessary requirements before submitting them to the Scheme or using the provider's services.

WHAT TO DO BEFORE GOING TO HOSPITAL

Get pre-authorisation first!

You need to get a pre-authorisation number (PAR) from GEMS no later than 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 can request authorisation by calling **0860 00 4367.** Alternatively your healthcare provider can create an authorisation online, or request one by calling **0860 436 777** or sending an email to Hospitalauths@gems.gov.za together with all the required information.

What happens in an emergency if I cannot pre-authorise a treatment?

If you need emergency treatment or are admitted to hospital on a weekend, public holiday, or at night, you or a family member must contact GEMS on the first working day following the incident. Failure to request authorisation will result in a R1 000 co-payment, which the member must pay out of pocket, according to the Scheme Rules.

Discuss costs with the doctor

Obtaining pre-authorisation does not guarantee payment, nor does it imply that the event will be fully covered by the Scheme. The Scheme Rules will govern the payment of all benefits. For example, if the benefit is covered at 100% of the Scheme Rate but the doctor charges 200% of the Scheme Rate, you must pay the difference.

Speak with your doctor to find out if they will be charging Scheme Rates and if any non-covered items will be used during your stay, procedure, or treatment. You can plan better and be aware of all payments that you may need to make out of your own pocket this way.

Note: It is your responsibility as a member/beneficiary to check whether there will be charges above Scheme Rates, or procedures that are excluded or not covered. More information on this is included in the 'What GEMS does not pay for' section on page 18.

What happens if I do not preauthorise and it is not an emergency?

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.

How to avoid fraud, waste and abuse when admitted to a hospital

Being over-serviced means that a provider conducts tests that are not necessary or medically required for your condition. This is an example of waste.

Fraudulent claims means that a provider bills you for services not rendered. Always check your claims and codes billed. If you suspect that there has been either over-servicing or fraudulent billing, please contact the Scheme's fraud hotline on **0800 21 2202.**

The most common examples of fraud by a service provider include:

- Charging the (higher) initial consultation tariff for both initial and follow-up visits, which is incorrect as the cost of an initial consultation and a follow-up consultation is not the same.
- Using code 0011 for 'emergency for after-hours consultations', even when it is not an emergency, and/or the doctor was in theatre for the day.

It is important to be mindful of the following to minimise 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 exceedingly 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 before 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 exclusions that the Scheme would not cover with your service providers.
7. Ensure that you get a copy of the authorisation, codes, and approved length of stay for your hospital admission.
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 have been updated.
10. Check that the claim reflects the treatment that you have received, and report it if you have been charged for treatment not received.

Tip: Avoid being charged for an extra day's stay by asking your doctor about ythe discharge items. If your doctor discharges you in the morning, ensure that you are discharged from the hospital by midday (12H00). Staying longer without being discharged by the hospital, for example while waiting for transport, will result in an aditional 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 is important to bear in mind that at the time of service, membership must be active and valid before a 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 (practice number) 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 ICD-10 code (condition);
- Main member signature to confirm that the account is valid; and
- 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. ICD-10 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: one in the middle and one at the end. Your claim can be settled at either of these runs, depending on when it is received. After a claim is processed, you will receive a claims statement that will allow you to evaluate how the claim was paid. Rejection codes that explain why a claim was underpaid will be displayed next to the service. The claims statement, if applicable, also includes information on what is required to correct a short-payment.

Are medicine claims processed immediately?

At the point of sale, your pharmacy can electronically submit medicine claims to us. The Scheme Rules will be applied immediately, so you will know whether GEMS will pay for the medicine right away. If there are sufficient funds available, you will receive your medicine without having to pay for it in cash.

If the medicine is not on the Scheme's formulary, you may be required to pay a co-payment or have your claim denied. If you are rejected, please consult with your provider about prescribing a medicine from the formulary.

The Scheme will also send you one of the following SMSs when you are about to incur a co-payment:

Non-network provider

GEMS: Dep. XXX has obtained medicine from a non-network pharmacy. Use a GEMS Network Pharmacy to avoid 30% non-DSP co-payments, call 0860 00 4367

MPL Reference Price Exceeded

GEMS: Dep. XXX claimed medicine higher than the listed GEMS Medicine Price (MPL) by R1000,00. Ask the pharmacist for a generic within MPL to avoid this cost.

Off-formulary Acute/Dental Product Claimed

GEMS: Dep. XXX has obtained medicine that is not on the formulary list. To avoid 30% co-payments, ask your doctor to prescribe medicines from the formulary.

Acute to Chronic Conversion SMS

GEMS: Dep. XXX has been obtaining medicine which is potentially for a chronic condition. Call 0860 00 4367 for chronic registration or authorisation update.

Please note that the "XXX" in the SMS will be populated with the dependant code.

Members can opt for available generics to aid the prolonging of medicine benefits, as generics are less costly.

Claims refunds

If you have paid a healthcare provider for a service, you may be eligible for a refund from the Scheme if the service is covered by the Scheme. Your available benefits, the applicable Scheme Rules, and the Scheme Rate will all determine whether and how much of a refund you will receive. When submitting a claim, make sure to include all supporting documents, such as a valid proof of payment and the actual healthcare provider invoice.

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

Each time GEMS processes a claim, you may receive a claims alert SMS or email. The SMS and email notify you when a claim is processed, but they do not guarantee payment. Your claims statement reflects the payment guarantee. Please call 0860 00 4367 and ensure that we have your current cellphone number to receive a claim alert SMS.

Your claims statement

When a claim is settled, you will receive a claims statement. Please review your claims statement to determine whether your claims were paid. If a claim was not paid, the rejection reason code will be displayed on your claims statement. If the rejection reason indicates that an action is required, please resubmit the claim with the necessary information. The statement's rejection reason is also shared with the healthcare provider. Members can thus confirm whether the healthcare provider has taken corrective action to correct the claim submission.

Paying a healthcare provider directly

GEMS has processes in place to validate the submission and payment of claims in order to protect your benefits from fraudulent claims submitted to the Scheme.

One of these processes is the suspension of direct payments to certain healthcare providers who have received sanctions from the Scheme. The claims of these healthcare providers will be denied. You must pay the provider directly, and the Scheme will reimburse you at the applicable scheme rate 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 recieve 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**. Claims submitted to GEMS should only be for service actually rendered to GEMS members.

International Claims

GEMS does not cover travel claims when a member goes on holiday. For that kind of claim, a member going on holiday must take travel insurance for medical cover abroad.

When a member is stationed abroad, international claims are covered, subject to GEMS funding rules and tariff rates. The exchange rate difference, the type of service billed or type of medicine billed may differ from the South African benefits and therefore would result in a shortfall. Should you have any enquiries on how international claims work and if you are eligible to claim, please contact GEMS on **0860 00 4367** where your personal profile can be assessed.

Top 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 it from the incorrect benefit
   - Physiotherapy treatment in hospital must also be authorised.
   - Pre-authorisations on medicine claims not approved on chronic benefits.

3. **To get the authorisation on medicine claims you must have a copy of the following:**

   - Valid prescription available detailing the doctor's details (name and practice number)
   - Diagnosis or ICD-10 codes
   - Medicine details (strength and directions for use).

Note: You, your doctor, or your pharmacist can register your condition immediately, by calling the Chronic authorisation department on **0860 00 4367.**

4. **No benefits are available**
   When your benefits have reached the benefit limits or sub-limits, GEMS will not pay any more claims.

5. **When a member or dependant does not keep a doctor's appointment**
   GEMS will not pay penalties for that missed doctor's visit.

6. **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.

7. **Claims sent to us too late (stale claim)**

8. **Claims must be received by the Scheme by the end of the fourth month following the month in which the service was provided.**
   For example, if the service is provided on February 15, 2023, the claim must be received by us by June 30, 2023. (i.e. 120 days). GEMS will not pay claims made after this time period. This is in accordance with the Medical Schemes Act Regulations. You will be charged for claims that are not submitted to us within four months of the treatment date. To avoid stale claims, confirm with your healthcare provider whether a claim will be submitted directly to the Scheme or whether you should submit the claim yourself. 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.

9. **Scheme exclusions**

10. **Specific conditions and treatment facilities are not paid for in accordance with the Medical Schemes Act for all GEMS options.**
    Scheme exclusions are items or procedures that are not covered by the Scheme. Before undergoing any procedures, treatments, or medications, you must ensure that they are covered by GEMS. GEMS will not pay for excluded services or items. Those expenses will be your responsibility. Exclusions from medicines are listed in the Medicines Exclusion List (MEL), which is also available on the GEMS website at www.gems.gov.za.The ICD-10 codes on the claim are not correct

    Ensure that the ICD-10 code provided on the claim correctly identifies the condition the patient is being treated for. An ICD-10 code is the code that the treating provider will document as a diagnosis code.

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

12. **Collecting your chronic medicine within 28 days.**
    Every 28 days, GEMS allows you to pick up your chronic medicine prescription from the pharmacy. If you go to the pharmacy too soon to fill your prescription, your claim will be denied because it is too early to collect your chronic medicine.

    You can manage this by noting your collection date and making sure it is 28 days after your last claim. You can also inquire with your pharmacist about the next collection date. This will help you ensure that your medicine is collected on time, saving you time and money on travel. Note: For international travel exceptions, please contact us to arrange for an advance supply one month before travelling outside South Africa.

Remember: Incorrectly submitted claims will not be paid. You will be sent a claims statement explaining why your claim was not paid. Your claim will be returned for correction, and you or your healthcare provider must provide the correct information and resubmit the claim within 60 days of the date the claim was returned.

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 that includes Family Practitioners (FPs), Specialists, Pharmacies, Dental Providers, Optometrists, Emergency Medical Services, Hospitals, Renal Dialysis Providers, and Chronic Back and Neck Rehabilitation providers. These GEMS Network healthcare providers have committed to providing you with excellent quality healthcare at Scheme rates with no co-payments or additional costs.

All GEMS Network FPs and specialists are given a GEMS Network logo or sticker to display on their window or door to help you identify them. You can also locate a GEMS Network provider by dialing 0860 00 4367 or going to www.gems.gov.za.

Family Practitioner (FP) nomination

Your Family Practicioner (FP) is critical to providing you with high-quality care. Consulting the same FP allows them to gain a thorough understanding of your health and treatment history, allowing them to make informed healthcare decisions, such as determining whether you need to be referred to a specialist. As a result, you will receive the best possible care from the right person who has the necessary skills and knowledge about your condition. This also means you'll have more say over how your benefits are managed.

Due to these advantages, GEMS encourages you and your dependents to nominate a GEMS Network FP (see next section) if you haven't already.

How members on the various options are affected by FP nominations

- **Tanzanite One** members have unlimited consultations with a nominated FP, as well as three (3) consultations with a non-nominated network provider. A 30% co-payment will apply once these have been depleted.

- **Beryl** members have unlimited consultations with network FPs. Consultations with a non-network FP are limited to three (3) visits per family, subject to limits. A 30% co-payment will apply once these have been depleted.

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

- **Ruby, Emerald**, and **Onyx** members will not incur penalties for not having nominated an FP.

FP nomination for Emerald Value and Tanzanite One

- Emerald Value and Tanzanite One members must nominate an FP to coordinate their care.
- If you are on one of these options, you can nominate up to two different FPs for each of your dependants, should you need to.
- Failure to nominate an FP will result in any application to join one of these options to be placed on hold, in accordance with 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 Tanzanite One and Emerald value options to nominate a FP to coordinate their care.

What happens if my nominated FP is not available?

- Members on the Ruby, Emerald and Onyx options can consult with any other Ruby, Emerald and Onyx network FP. Non-Network FP consultations will be reimbursed at Scheme Rates and may result in a co-payment by the member.
- Members on the Emerald Value option may obtain authorisation for three (3) voluntary out-of-hospital consultations with a non-nominated network FP per family, with no co-payment subject to available benefits and limits. Once the three visits have been depleted, a 30% co-payment will apply to claims for any additional consultations with a non-nominated network FP, subject to available benefits and limits.
- Members on Tanzanite One will have a limit of three (3) consultations with a non-nominated FP 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 may 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 have any queries about FP nomination or nominating an additional FP or wish to report any irregularities relating to healthcare providers on the GEMS Network, please contact GEMS on **0860 00 4367** or send an email to enquiries@gems.gov.za.

Coordination of Specialist Care

Specialist referral is in place for **Tanzanite One**, **Beryl** and **Emerald Value options.**

- Members on the **Tanzanite One** and **Emerald Value** options need a referral letter before consulting with a specialist. Referrals from a non-nominated FP will also require a specialist referral authorisation number. In the event of the visit not being approved, the member will incur a 30% co-payment.
- The **Beryl** network FP must obtain a referral number for their Beryl patient before making an appointment for their patient to see a Specialist. This can be done by calling the GEMS Provider Call Center 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
- Paediatric Cardiologist
- Dermatologist
- Gastroenterologist
- Gynaecologist (excluding maternity cases)
- Neurologist
- Neurosurgeon
- Orthopaedic surgeon
- Otorhinolaryngologist (ENT
- Paediatricians (excluding children under 2 years of age)
- Physician
- Plastic and reconstructive surgeons
- Psychiatrist (excluding renewal of prescription)
- Pulmonologist
- Rheumatologist
- Surgeon
- Urologist

The GEMS Specialist Network comprises Obstetricians and Gynaecologists, Paediatricians, Psychiatrists, Anaesthetists, as well as Surgeons and Physicians, including sub-disciplines such as Neurologists, Cardiologists, Ophthalmologists, Urologists, Neurosurgeons, ENT surgeons, Cardiac and Thoracic surgeons, and Orthopaedic surgeons.Network specialists have agreed to charge a contracted rate so that you will not incur unnecessary co-payments (although you need to keep in mind that claims will be paid subject to your available benefits).

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

- You will not require an authorisation if the Specialist referral is requested by your nominated FP.
- Make sure that your FP, Specialist, Pharmacy, Optometrist and Dental Provider are 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 for you as a member to avoid out-of-pocket costs.
- Ask your FP whether they can dispense medicine. If they can do so, you do not need to obtain your acute medicine from a pharmacy (in which case you may have had 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.**
- Pathology and radiology tests must be in line with the GEMS Formulary (list of approved tests or services) for **Tanzanite One** and **Beryl** options.

GEMS MEDICINE BENEFIT

Medicine: Know the difference

Acute medicine

Acute medicines are prescribed for the treatment of a disease or disorder that lasts for a short period of time.

- Members on the **Tanzanite One** and **Beryl** options can obtain 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. Please note: The GEMS Tanzanite One and Beryl acute formulary is product specific and each listed product has an indicator or formulary status (in formulary/out-of-formulary).
- 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.

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 on the GEMS website at **www.gems.gov.za** (For Individuals > Formulary Lists > Select the formulary file for the relevant benefit year).

Self-medicine

Also known as over-the-counter (OTC) medicine, self-medicine does not require a prescription from your doctor. Examples of these would be 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.
- Members on the **Tanzanite One and Beryl** options 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), the use of generic alternatives (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 you and your quality of life. Chronic medicines need to be taken regularly, over an extended period, to manage the symptoms or control the effects of chronic illnesses.

To obtain authoriation for new chronic conditions, you, your doctor, or your pharmacist can call **0860 004 367 or email chronicauths@gems.gov.za.** Only if your condition has been pre-approved will medicine be paid from the chronic medicine benefit. According to legislation and subject to managed care protocols, processes, and formularies, the Chronic Disease List (CDL) lists conditions covered as PMBs on all GEMS options.

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 ICD-10 codes, and the medicine details, such as strength and directions for use.

When your doctor has issued a new prescription, email a copy of the new prescription to **chronicdsp@gems.gov.za** or fax it to **0861 004 367** to ensure non-interruption of your chronic medicine.

GEMS will remind you to visit your doctor for a new prescription before the current one expires. This is also an opportunity for your doctor to review the outcome of your current treatment and perform relevant tests to monitor your chronic condition, if necessary.

You will have access to a care plan, which is a list of out-of-hospital services relevant to the chronic condition, once you have been registered for a chronic condition on the PMB Chronic Disease List (CDL) (s). The care plan includes a variety of services available to you, such as doctor's visits, blood tests (pathology), and x-rays (radiology), to ensure that you receive enough benefits to proactively manage and monitor your condition. There are no plans for non-PMB chronic conditions.

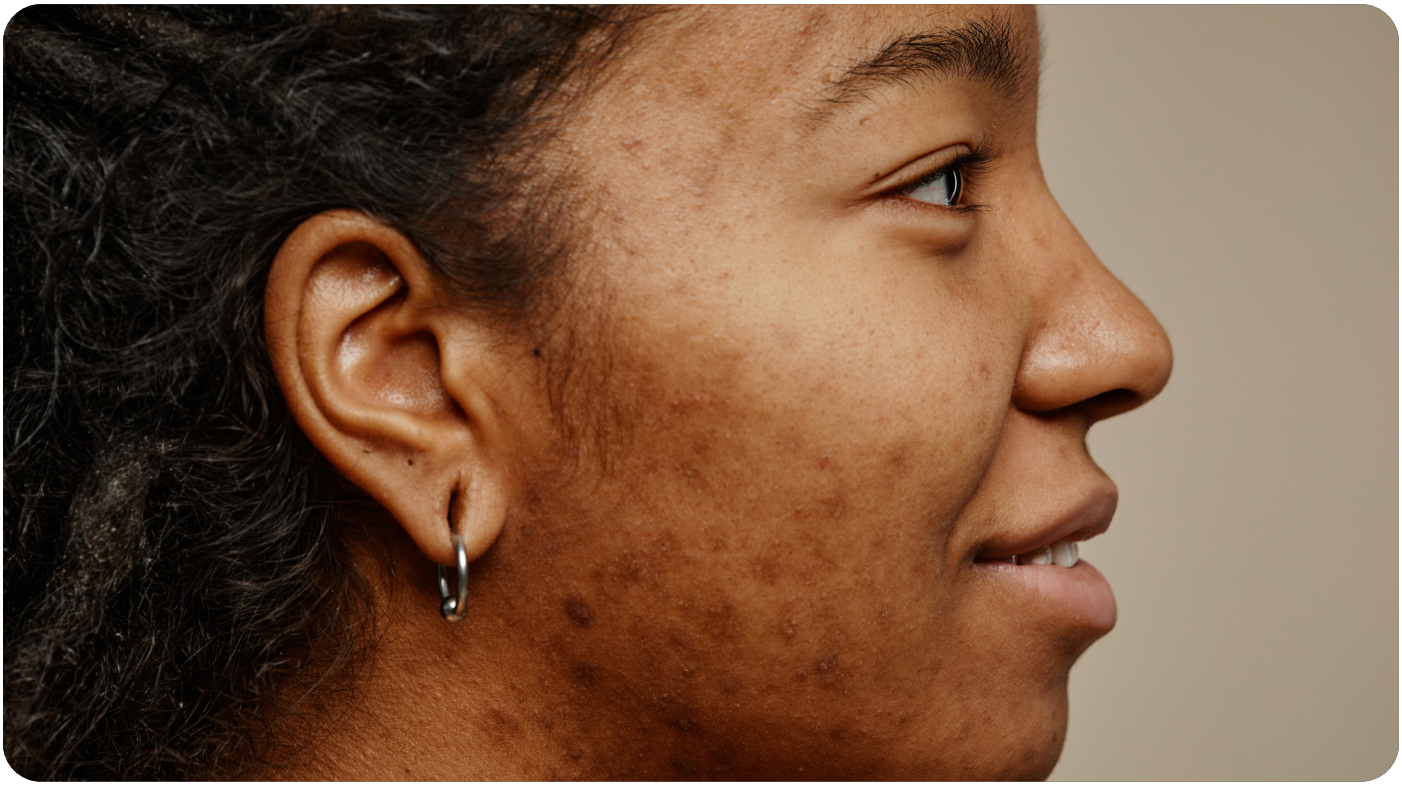
Chronic Diesease List (CDL) for all options

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

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

ADDITIONAL CHRONIC DISEASE LIST

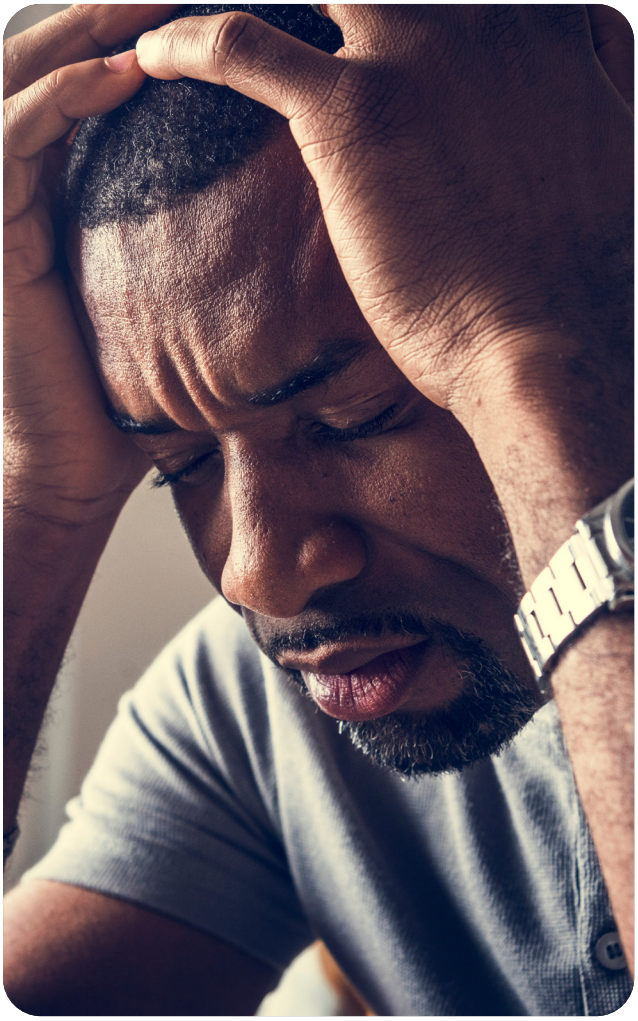
In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Acne				✔	✔	✔
Allergic rhinitis				✔	✔	✔
Alzheimer's disease				✔	✔	✔
Ankylosing spondylitis				✔	✔	✔
Anorexia nervosa				✔	✔	✔
Anxiety	✔	✔	✔	✔	✔	✔
Attention deficit and hyperactivity disorder	✔	✔	✔	✔	✔	✔



In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Barrett's oesophagus						
Benign prostatic hyperplasia			✔	✔	✔	✔
Bulimia nervosa				✔	✔	✔
Delusional disorder				✔	✔	✔
Dementias, including (but not limited to), multi-infarct, sub-cortical vascular and alcohol				✔	✔	✔
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				✔	✔	✔

In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
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				✔	✔	✔

* Pays above chronic limits
** PMB DTP condition; Annexure G of Scheme Rules applies
*** As per Annexure D of Scheme Rules



HOW TO OBTAIN CHRONIC MEDICINES WITH DISEASE AUTHORISATIONS

Your doctor has prescribed chronic medicine for you to manage your chronic condition. What comes 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 you pharamacist can contact us telephonically on 0860 00 4367 and email your script to chronicdsp@gems.gov.za. Your FP can call us on 0860 436 777 and email your script to chronicdsp@gems.gov.za.

YES

Get 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.

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.

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.

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

The Chronic Medicine Management department must pre-authorise your chronic diagnosis in order for the prescribed medicine to be reimbursed through the chronic medicine benefit. Some medicines are not fully reimbursed if they are not on the GEMS formulary or fall outside of the Scheme's reimbursement rate, which is known as the Medicine Price List (MPL). When a medicine does not meet the reimbursement guidelines for a specific condition, it may be denied. Always consult your doctor to ensure that the most cost-effective medicine is prescribed in accordance with the MPL and the GEMS Formulary, so that you do not have to pay out-of-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 Chart, 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 Chart that will explain the reasons for this. We will also send a copy of the letter to the doctor who prescribed the medicine.

Please keep in mind that the duration of authorisation varies by medicine, some medicines may be authorised on an ongoing basis, whereas others may only be authorised for a limited time. The Medicine Access Chart will show how long the medicine has been approved for.

What if my chronic medicine authorisation request has been declined?

If your chronic medicine authorisation request is declined, GEMS will send you a letter, with a copy sent to your prescribing doctor, explaining why. If additional clinical information is required, your request will be reconsidered once your doctor has provided all relevant information. Your doctor can get help by dialing 0860 436 777.

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** or your doctor can 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 can get your medicine from either one of our Courier Pharmacies or your nearest GEMS Network Pharmacy. Once you've indicated your preference, you can either pick up your medicine at your nearest GEMS Network Pharmacy or the Courier Pharmacy will contact you to arrange for medicine delivery. If you choose to obtain your approved chronic medicine from a supplier who is not a GEMS Courier Pharmacy or a GEMS Network Pharmacy, you must pay a 30% copayment to the pharmacy or dispensing doctor.

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

After being contacted by the Pharmacy Network Manager and registering with either the Courier Pharmacy or a specific GEMS Network Pharmacy, members are expected to stay with that pharmacy for at least six months before being allowed to change.

However, if a chronic medicine programme member changes their home or work address, they may contact the Pharmacy Network Manager to update their registered pharmacy. The Pharmacy Network Manager will contact patients enrolled in the chronic medicine programme twice a year to confirm or reconsider whether they want their medicine delivered by a Courier Pharmacy or collected at the GEMS Network Pharmacy.

Am I required to use only 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 obtain your medicine from that pharmacy only 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 a Courier Pharmacy is the nominated pharmacy. Once this allocation is exceeded, you will be liable for a 30% co-payment.

- You can however request to be re-allocated when:

    - You have changed employers, or your employment address;

    - You have changed your residential address;

    - Six months have passed since the initial allocation;

    - Your preferred pharmacy is no longer part of the network; or

    - 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 Pharmacy or GEMS Network Pharmacy with a repeatable prescription?

You must provide a valid doctor's prescription to the Courier Pharmacy or your GEMS Network Pharmacy before they can provide you with your chronic medicine. Prescriptions must be renewed every six months, as required by law. Schedule-6 medication prescriptions must be renewed monthly.

A prescription cannot be renewed for a period of more than six months. GEMS will text you a reminder to get a new prescription before your current one expires. Whether you get your medicine from the Courier Pharmacy or a GEMS Network Pharmacy, you must send in a new prescription when it is due. If your prescription has expired, your preferred pharmacy will not send or provide you with medicine.

Email a copy of the new prescription to **chronicdsp@gems.gov.za** or fax it to **0861 00 4367**. Ensure that your GEMS membership number is clearly indicated on all documents, and in the email subject line.

GEMS MEDICAL APPLIANCES

GEMS has designed it's medical appliance benefit in such a way as to ensure that all beneficiaries have access to cost-effective, quality medical devices and appliances, prostheses and associated professional services, irrespective of their benefit option.

The following tyes of appliance require pre-authorisation from GEMS:

- Braces (knee and back)
- Hearing devices
- Nebulisers
- Orthotic shoes
- Prosthetics Oxygen concentrattors
- Sleep apnoea devices
- Specialised beds
- Wheelchair

Your healthcare provider can help you with obtaining pre-authorisation before any custom prostheses are made.

Two medical appliance categories

When prescribing a medical device or appliance, your healthcare professional may select from a wide range of GEMS covered devices and appliances. These medical devices and appliances are divided into two categories: those that do not require pre-authorisation and those that require pre-authorisation from GEMS.

Certain devices and appliances are also specifically excluded in the Scheme rules, and thus are not covered by GEMS. It is important to care for your medical devices and appliances as costly medical appliances such as wheelchairs, hearing aids, CPAP machines etc., are expected to last for a reasonably long time. For this reason, their benefits are made available over longer cycles than a single benefit year. For example, the Scheme rules make provisions for GEMS beneficiaries to claim a maximum of one wheelchair within a 24-month cycle and one hearing aid per ear within a 36-month cycle.

Some appliance benefits such as shoe orthotics, wheelchairs and crutches etc., have a sub-limit and claims will be paid accordingly. Please make you provider aware to avoid you paying from your pocket.

It is your responsibility as a member to ensure that all claims submitted on your behalf are valid as the misuse of membership details in order to submit fraudulent claims or refund requests to GEMS may result in the termination of Scheme membership, criminal prosecution, and/or disciplinary action by your employer.

Some of the costs of these appliances and devices may be above your benefit limit. Always ask your healthcare practitioner upfront to prescribe appliances that will avoid you paying from your pocket.

When your healthcare provider prescribes appliances or medical devices, make sure you ask your healthcare provider to use the correct NAPPI code, and that it is on the appliances list, otherwise your claim may be rejected. Access to the Appliance list is discussed below.

Benefits available for medical and surgical appliances and prostheses in 2023

Option	Prosthesis Benefit Limit	Appliances Benefit Limit
Tanzanite One	R33 831	R7 962
Beryl	R39 825	R13 274
Ruby	R51 010	R19 903
Emerald Value	R51 010	R19 903
Emerald	R51 010	R19 903
Onyx	R68 906	R23 036

You and your healthcare practitioner can access more information about covers for various appliances here or use the following path: www.gems.gov.za > Healthcare Providers > Medical Appliance List, and more about the Scheme Rules that apply to such cover here or under Information > Scheme Rules on our website.

The availability of Ex gratia funding

Ex gratia funding is a concession exercised at the sole discretion of the Ex Gratia Committee, and not a right to which you are entitled. You or your provider may apply to the Scheme for Ex gratia consideration if your benefits are depleted or insufficient. You may request application forms by calling **0860 436 777 or emailing enquiries@gems.gov.za**, or you can collect an application form at any of the GEMS walk-in centers.

Complementary GEMS benefits

In cases where your appliances provider is considering orthoses or prostheses for spinal pathology, please remember that GEMS has established a Chronic Back and Neck Rehabilitation (CBNR) programme that should be explored as a complementary option to increase your wellbeing. Read more about this Programme on page 42.

DISEASE MANAGEMENT PROGRAMMES

HIV Management Programme

All HIV-positive members have access to the comprehensive and effective HIV Management Programme. If you or one of your dependents has HIV, it is critical that you register on the HIV Programme so that GEMS can provide you with the support you need to live a healthy and productive life.

Confidentiality guaranteed.

GEMS takes great care to protect the privacy of all HIV-positive members and dependents who enroll in the GEMS HIV Management Programme. The programme is managed by a separate team of healthcare professionals from the rest of the Scheme's programmes, and no confidential information is shared with your employer, dependants, or family members.

The HIV Management Programme has its own confidential contact channels:

- Telephone: **0860 436 736** (Monday to Friday between 8:00 and 17:00 and Saturday from 8:00 to 12:00)
- Send a 'please call me' to: **083 843 67 64**
- Email: **hiv@gems.gov.za**
- Fax: **0800 436 732**

What HIV benefits are available?

Members on the HIV DMP will have access to the following benefits:

- Medicine to treat HIV/AIDS (antiretroviral therapy).
- Medicine to treat and prevent opportunistic infections related to HIV/AIDS, including multivitamins where appropriate. Please note that a doctor's prescription and pre-authorisation is required for all medicines, including multivitamins.
- All pathology tests required to assess your condition.
- Regular monitoring of your condition to ensure you start treatment at the right time and that it is effective.
- Clinical support and guidelines for your doctors.
- Access to a professionally trained medical team who will review your clinical information and consult with your doctor to ensure that you receive the most appropriate treatment for your condition.
- Reminders for you and your doctor to ensure that all regular check-ups and tests to monitor are done to optimise your treatment where necessary.
- Treatment to prevent the transmission of the HIV virus from mother-to-child (including treatment for the baby).
- Treatment to prevent the transmission of the HIV virus after accidental exposure to infected bodily fluids (sexual assault, needle stick injury, etc.). Please call **0860 4367 36** if you have had accidental exposure to HIV so that Post-exposure prophylaxis (PreP) treatment can be arranged.
- PreP treatment to prevent transmission of the virus from an HIV-positive to an HIV-negative partner.

GEMS has dedicated,user friendly HIV Member Guide that contains important information to help you and answer many of your questions.

How do I register on the HIV 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 4367 36** or use our 'please call me number' **083 843 6764** (Monday to Friday between 8:00 and 17:00 and Saturday from 8:00 to 12:00). 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. The completed form can be emailed in confidence to **hiv@gems.gov.za.** You can also fax it to the confidential toll-free fax number 0800 436 732.
5. We will contact you to discuss the outcome of your application.

How do I get my HIV medicine?

1. The HIV Management Programme enrolls, manages, and supports members living with HIV, whereas the Chronic Medicine Management team assists members living with all other chronic conditions.
2. Members can obtain all chronic medicine (including HIV medicine) from the Courier Pharmacies and the GEMS Network Pharmacies. If you get your antiretroviral (ARVs or HIV medicine) from a pharmacy other than the one you've chosen, you'll have to pay a 30% co-payment.
3. When you use a Courier Pharmacy, your medicine is delivered to your specified address without anyone knowing what is inside. Beneficiaries who choose to collect their medicine from a GEMS Network Pharmacy will also be guaranteed confidentiality.
4. If you require medicine for another chronic condition (such as high blood pressure), it can be delivered or collected along with your HIV medicine.
5. GEMS will send you a reminder to get a new repeat prescription 21 days before your current prescription is due to expire.
6. Schedule 1-5 prescriptions expire after six months according to the law.
7. Schedule 6 scripts need to be renewed monthly.

Oncology (Cancer) Management Programme

GEMS offers a comprehensive set of oncology benefits that cover diagnosis, treatment, and palliative care. If you or a family member is diagnosed with cancer, it is critical that you enroll in the Oncology Management Programme as soon as possible because all oncology treatments require pre-authorisation and case management.

How to register on the Oncology Management Programme

1. Your doctor must email a copy of your treatment plan and histology which confirms the presence of cancer to **oncologyauths@gems.gov.za.**
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 detail the treatment that GEMS has authorised, the approved quantities and how long the authorisation is valid. Oncology medicine may be obtained from any Pharmacy that has stock of the medicine required.

Please notify the Oncology Management team if your treatment changes, as your authorisation will need to be re-evaluated and updated. If your doctor fails to notify the Oncology Management team of a change in your treatment, GEMS may reject your claims or pay them from the wrong benefit.

When do you need pre-authorisation?

Even if you are registered on the Oncology Programme, you will need a separate 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 provides you with a back and neck rehabilitation programme to help you or your registered dependents manage your back and neck pain. Positive outcomes include increased flexibility, decreased pain and stiffness, and a more productive lifestyle. The programme consists of carefully planned exercises and advice on how to deal with your back problem while still living a normal life.

The CBNR programme focuses on functional rehabilitation, with controlled exercises, biopsychosocial support, and pain education as key components. Clinical measurements are taken and used to track the progression of your 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 to be assessed and for a treatment plan formulated to assist their rehabilitation. The treatment can be extended over 6 weeks, depending on the assessment done at the center.

How the programme works:

- Members who are identified for or referred to the programme will be contacted by the Scheme to complete a short questionnaire.
- Members will be referred to the nearest center and all appointments will be managed by the center.
- The center will perform an assessment, which will determine the treatment required. Treatment will need to be completed for the member to benefit from the programme.

The intervention entails:

- A comprehensive assessment.
- Based on your risk profile identified during the assessment, a tailored treatment programme is prescribed. This ranges from 1 to 12 active treatment sessions.
- At each treatment session, physiotherapy and exercise is done to assist with pain management and muscle relaxation.
- A progress assessment with the healthcare provider is completed.
- On completion of the programme, a comprehensive outcome assessment to evaluate progress and measure improvement over the course of the programme is done.
- Tailored home-based exercises and stretches to ensure that results are maintained in the long term are discussed and shared.
- Follow-up visits to track improvement following completion of the programme may be included.

What benefits will be used?

The Chronic Back and Neck Rehabilitation Programme benefit will be used for members receiving treatment at the centers. This means that day-to-day benefits are not depleted.

How can you access the programme?

There are several ways to access the programme:

- Telephone: **086 000 4367**
- Email: **enquiries@gems.gov.za**
- The Scheme may contact you if you have had back problems in the past and received related treatment.
- Your Family Practitioner (FP) or Specialist may refer you to the programme.

Renal Dialysis Network

GEMS has contracted a Renal Dialysis Network to provide chronic dialysis to all benefit options members. Members who require chronic dialysis must therefore use Network providers; otherwise, an out-of-network co-payment of 30% will be charged for each treatment session.

Members who have recently been diagnosed with chronic renal failure and require treatment must also use the Renal Dialysis Network.

The co-payment will not be applied to:

- Members admitted to hospitals who are receiving acute dialysis (Once discharged, however, chronic dialysis will be covered in full if received from a Network provider).
- 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 and requiring dialysis:

    1. Sub-acute facilities (Step-down facility);
    2. Private rehabilitation facilities; and
    3. State hospitals.

- Out-of-area visits: Beneficiaries who are unable to receive treatment from their regular provider due to travel must obtain prior authorisation to continue treatment at a Network provider at their destination, such as holiday dialysis.
- 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.

To manage the admission, GEMS at times makes use of case managers that are located within the actual hospital. These specialised case managers support the other teams and may engage with you during your admission.

ALTERNATIVE TO HOSPITALISATION BENEFIT

GEMS offers the 'alternative to hospitalisation' benefit for members who require medical care but do not necessarily need to be admitted to the hospital.

Who has access to the 'alternative to hospitalisation' benefit and who pays for it?

All members have access to the 'alternative to hospitalisation' benefit and it is paid from the overall annual limit, separate from the day-to-day benefit.

What services are covered?

- Hospital at Home

What is provided under this service?

- Real-time hospital-grade monitoring at home – through collection of vital signs data (usually monitored in the hospital) wirelessly and automatically, and this data is closely monitored by a team of healthcare professionals in their 24-hour medical command center;
- Intravenous therapy;
- In-person and virtual visits;
- Skilled nursing;
- Access to laboratory services, allied healthcare services e.g. physiotherapy, and short-term oxygen, as required; and
- Rapid response protocols – if a patient's condition should worsen during treatment, the clinical team will identify such changes and make the necessary arrangements, which may include an increase in visits, early review by the treating doctor and if required, transfer to hospital.

Which patients are eligible for the Hospital at Home service?

- The patients who would ordinarily require admission in a hospital general ward are eligible, as this service brings hospital-level care to the home;
- Consent is required from both the patient and the treating doctor; and
- Benefit management protocols are applied to ensure safety.

This includes the different services provided by a nurse in the home environment. Examples are:

- Stoma care;
- The care of long-term ventilated patients;
- Neonatal care; and
- Assistance with mobilisation following a long-term illness.

- Home oxygen

- Hospice care

This is available for terminally ill members that require end-of-life care such as pain management. It can be provided in a hospice or at home.

- Physical rehabilitation
- This is the care that may be required after an acute traumatic episode (e.g. post-surgery, physical trauma, or amputation), or medical episode (e.g. after a stroke) to help members recover as fully as possible.
- There is a special physiotherapy benefit available for post hip, knee, or shoulder replacement.

- Stepdown/Sub-acute care
- Wound care
- Other Medical care
- This includes prescribed treatments such as intravenous (IV) therapy, Outpatient Antibiotic Treatment (OPAT) and home dialysis.

What is not covered as an alternative to hospitalisation benefit?

The benefit does not cover frail care or general assistance with recuperating following any illness. The request must be medically necessary for the benefit to apply.

How do members access this benefit?

To access this benefit, the treating healthcare provider must email their clinical view in a referral or letter of motivation with the request for outpatient care to homebasedcare@medscheme.co.za. The healthcare team will review the request and provide an authorisation number if this is approved.

There is also the option of contacting the GEMS Call Center on **0860 436 777** or sending an email to hospitalauths@gems.gov.za to enquire further.

OTHER GEMS PROGRAMMES

Maternity Programme

The GEMS Maternity Programme is available to pregnant members and their dependants. This programme is specifically designed to provide you with support, education, and advice throughout your pregnancy, confinement, and post-natal (after birth) period.

The Maternity Programme is overseen by an experienced and passionate team of administrators as well as healthcare professionals who are registered nursing sisters with a specialisation in midwifery. The team will assist you in registering for the Maternity Programme, after which you can contact them at 086 000 4367 for advice and information about your pregnancy and maternity benefits.

To access the maternity benefits pregnant members or dependants must register on the Programme as soon as their pregnancy has been confirmed.

Benefits of joining the Maternity Programme

- You will be assigned a **dedicated midwife** who will provide you with telephonic support and information during each trimester of your pregnancy. You will continue to receive this support, should you experience challenges in your first six weeks of parenthood.
- If you have a **high-risk pregnancy**, you will receive additional telephonic support from your midwife to help you manage and reduce the risks to you and your baby.
- You will receive a GEMS pregnancy handbook, as well as a Maternity programme guide.
- Access to healthcare information through telephonic correspondence with your midwife and brochures enabling you to make informed decisions with your midwife or doctor about your health and birth choices.
- A Maternity Care Plan **Utilisation Guideline** will be shared with you, to inform you what is covered by the Scheme and how to best optimise your benefits.
- You will qualify for added maternity **vitamins**. For more information on the maternity vitamins, contact the GEMS Maternity call center on 086 000 4367 or visit www.gems.gov.za. Additional vitamins that are not part of the formulary list may incur additional out of pocket costs.
- We will send you a **maternity bag** during your third trimester. This is our gift to you filled with goodies for you and your baby.

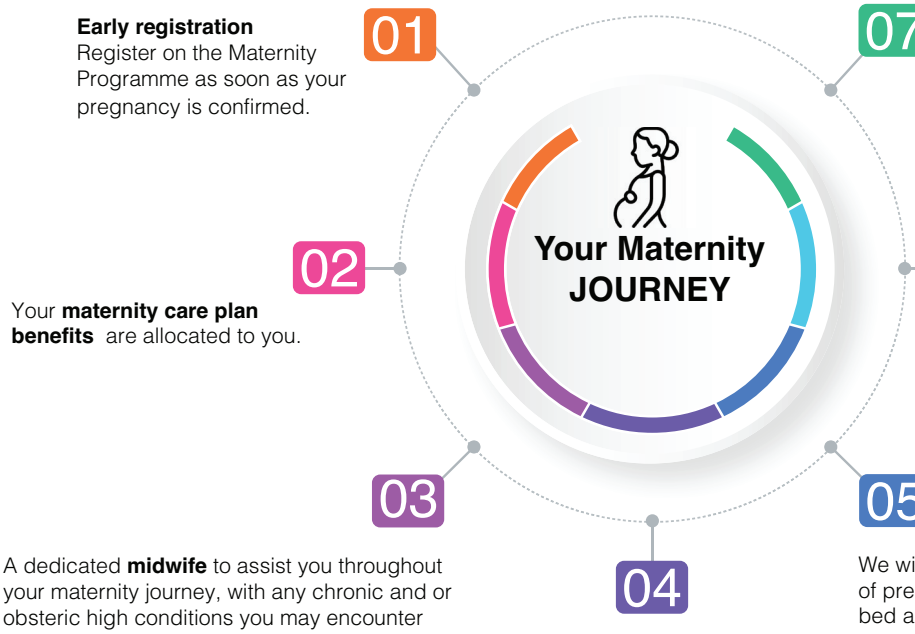
To view a comprehensive brochure about the Maternity Programme, visit **www.gems.gov.za** and navigate to Healthcare Providers > Healthcare Programmes > Maternity Programme.

Registering on the Maternity Programme

Telephonic registration:
You can complete your registration telephonically by contacting us on **086 000 4367.**

Registration form:

Visit **www.gems.gov.za** to download and complete the registration form or call us on **0860 00 4367** to obtain a copy of the form. Once completed, please email the form to enquiries@gems.gov.za, fax it to 0861 00 4367, or post it to, Private Bag X782, Cape Town, 8000.



01

Early registration
Register on the Maternity Programme as soon as your pregnancy is confirmed.

02

Your **maternity care plan benefits** are allocated to you.

03

A dedicated **midwife** to assist you throughout your maternity journey, with any chronic and or obsteric high conditions you may encounter with psychosocial support.

04

We will send you a welcome SMS and a **welcome pack** with a Pregenancy Handbook and a Maternity Programme Guide.

05

We will send you a **Maternity** bag from 27 weeks of pregnancy and you will need to book a hospital bed and receive pre-authorisation.

06

You will continue to receive **support from the midwife** and psycosocial team after the delivery of your baby.

07

Don't forget to register your newborn as a **GEMS dependant** within 60 days of birth.

		1st trimester	2nd trimester (13-26 weeks)					3rd trimester (27-40 weeks)			Post Natal
Benefit / Tariff Codes	**Services**	≤12 Weeks	13-15 Weeks	16 Weeks	20 Weeks	20-24 Weeks	26 Weeks	27-28 Weeks	32 Weeks	38 Weeks	41-42 Weeks
0000190/ 0000191, 000192, *88420	**GP/Midwife/Gynae-cologist Consultation** (Blood-Pressure, Weight, Height, Urine test) Two of the five second-trimester consultations can be used for gynaecological consultations	✔	✔	✔	✔	✔	✔				
0003755	Blood test: Full blood count-Haemoglobin test	✔				✔					
0003764	Blood test: Blood group with Rhesus	✔									
0003932	Blood test: HIV (Elisa or other screening test)	✔									
0003949	Blood test: Venereal Disease Research Laboratory (VDRL)	✔									
0004188	Macroscopic Urinalysis	✔	✔	✔	✔	✔	✔	✔	✔	✔	
As per the maternity vitamins list	Vitamins Supplements script	✔	✔	✔	✔	✔	✔	✔	✔	✔	
0003615	2D Ultrasound: **10 - 14 weeks** + nuchal trans-lucency assessment The member has the option of the following scans that will be paid to the value of a 2D scan: 3D Ultrasound: **10 - 14 weeks** + nuchal translucency assessment	✔									
0003617	2D Ultrasound: **20 - 24 weeks** + detailed ana-tomical assessment The member has the option of the following scans that will be paid to the value of a 2D scan: 3D Ultrasound: **20 - 24 weeks** + nuchal translucency assessment				✔						
0000190/ 0000191, 000192, *88420	**Gynaecologist/ Obstetrician Consultation** (Blood Pressure,Weight, Height, Urine test)										
Maternity Support	Trimester Calls	Expect 1st Trimester call	Expect 2nd Trimester call					Expect 3rd Trimester call			Expect Postnatal call
Maternity Info & Content	Welcome Pack, Trimester Brochure and SMSs	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Disclaimer

Every effort has been made to ensure that all information provided to you is factual and accurate. However, in the event of a dispute, the Scheme Rules shall apply. You can view the Scheme Rules on our website at www. gems.gov.za in the 'Information' section under Scheme Rules. The information provided on this correspondence is for information purposes only and cannot replace medical advice from your professional healthcare provider. The welcome letter that is received in the Welcome Pack supersedes the maternity care plan infographic.

DENTAL BENEFIT

The GEMS dental benefit ensures that members have access to cost-effective, quality dental healthcare.

Network providers

GEMS recommends seeing your dentist every six months for a dental check-up and oral preventative care. Consider visiting a dental provider who is a member of the GEMS dental network to avoid unexpected out-of-pocket expenses. The agreed-upon Scheme tariffs are charged by GEMS dental network providers. If you have benefits for treatment at a network provider, you will not have to pay anything out of pocket. If any dental work is required that is not covered by GEMS, the network provider will first obtain your permission before proceeding with the treatment, with a cost discussion. This way, you'll always know what dental bills to expect. If you are on the Tanzanite One or Beryl option, dental services must be provided by a dentist, dental therapist or oral hygienist who is part of the GEMS dental network. You can find a network provider at www.gems.gov.za or by calling 0860 00 4367. Choose option 4; your preferred language; then option 2 for Dental, and option 3 for General Enquiries.

Emergency out-of-network visit for members on the Tanzanite One and Beryl options

Benefits on the Tanzanite One and Beryl options are subject to the use of a GEMS dental network provider. Members are allowed one emergency out-of-network visit per year for pain and sepsis treatment.

If there is no network provider in your area, call GEMS at 0860 00 4367 before going to the doctor to see if the visit is covered. This will assist you in avoiding unexpected co-payments. Option 4 is your preferred language, followed by Option 2 for Dental and Option 3 for General Enquiries.

Dental fissure sealants

Enquire with your dentist about fissure sealants for your child's permanent teeth. Fissure sealants are a simple and effective way to prevent tooth decay, and they are covered by your GEMS dental benefits*.

Dental fissure sealants are included in the list of approved services at your dental network provider on the Tanzanite One and Beryl options. Dental fissure sealants are covered by the Preventative Care Services benefit on the Ruby, Emerald Value, Emerald, and Onyx options if they are obtained from a network provider.

*Kindly note that managed care protocols do apply for this treatment.

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 available shared dental sub-limit.

Pre-authorisation for specialised dentistry

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

- Any treatment in hospital,
- Conscious sedation,
- Crown and bridge treatment,
- Maxillofacial surgery,
- Orthodontics,
- Periodontal treatment, and
- Plastic dentures (Tanzanite One and Beryl options).

To request pre-authorisation, ask your dental provider to complete and submit the 'Periodontal' form (for Periodontal treatment) or the 'Dental Report' form (for all other treatment). The forms are available on **www.gems.gov.za** under Forms on the GEMS Information Center page.

Dental treatment under general anaesthesia or conscious sedation

Your dental provider may inform you that your dental procedure will be performed under general anaesthesia or conscious sedation in certain circumstances and for certain procedures. You will be asleep throughout the procedure if you are given general anaesthesia. This is usually done in a hospital setting. Conscious sedation means that you are awake but relaxed during the procedure. This procedure is carried out in the dental chair.Benefits for treatment under general anaesthesia or conscious sedation are not available for members or dependants over the age of six, unless they have impacted teeth or have suffered severe trauma. Before the procedure, the treating dentist or dental specialist must provide GEMS with the medical reason for general anaesthesia or conscious sedation.

All procedures requiring general anaesthesia or conscious sedation require pre-authorisation. Pre-authorisation may not be required in an emergency, but we recommend that you contact us as soon as possible to avoid paying a penalty.

Dental treatment in hospital

Dental hospitalisation is only permitted for patients under the age of six, for impacted teeth, or for severe trauma (PMBs). Unless it is an emergency, contact us at least 48 hours before treatment to request pre-authorisation for hospitalisation.

If a patient is admitted to a private facility for an emergency dental condition, the Scheme must be notified within one working day of the admission, otherwise, a co-payment of R1 000 per admission will apply. If you are on the **Tanzanite One** or **Emerald Value** options, you are subjected to the use of a State or GEMS Hospital Network facility; failing which, the Scheme shall not be liable to fund the first **R12 000** of the other facility's bill. Use a GEMS network hospital to avoid any out-of-pocket expenses. View the list at **www.gems.gov.za** or by call **0860 00 4637.**

Registering on the Periodontal Programme

Periodontal (gum) disease treatment is limited to local anaesthesia, with no coverage for in-hospital care.

To be eligible for periodontal treatment benefits, Tanzanite One and Beryl members must enroll in the Periodontal Programme. The Periodontal Programme is a disease management programme for patients with mild periodontitis. Once the treatment plan is approved, the enhanced benefits for dental cleaning and specialised treatment (such as root planning) will help prevent tooth loss. Your GEMS dental network provider must 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 "Periodontal" form is available at www.gems.gov.za under For Individuals > Forms.

Orthodontic treatment

The benefit for orthodontic treatment is available to GEMS beneficiaries under the age of 21 on the Ruby, Emerald Value, Emerald, and Onyx options only. GEMS does not have a separate benefit limit for orthodontic treatment; all claims are payable from the available shared dental sub-limit.

Authorisation and a treatment plan are required, and approval is subject to prior evaluation according to the Index of Complexity, Outcome and Treatment Need (ICON) criteria. Fixed orthodontic treatment ranges from 9 to 36 months, depending on the complexity as explained in the treatment plan. The approval for the orthodontic treatment plan is valid for one year. An updated authorisation is required on an annual basis for the remainder of the treatment.

Valid claims will be covered only if the beneficiary's GEMS membership is active and valid throughout the treatment period. Once approved, GEMS will pay the provider an initial amount and the balance in monthly instalments, subject to the beneficiary's shared dental sub-limit funds. If a case is transferred to another provider, only the remaining balance under the original treatment plan is covered.

Please request records from the first service provider when relocating or seeking second opinions to avoid duplication of costs or overexposure to radiation. Orthodontic treatment is a once in a lifetime benefit per beneficiary, and retreatment is not funded.

Dentures

Tanzanite One and Beryl options:

- The GEMS dental benefit allows for one set* of plastic dentures per beneficiary every four years.
- Only members and beneficiaries over the age of 21 qualify for this benefit.
- The benefit is subject to pre-authorisation, use of a GEMS dental network provider and limited to the approved 2023 Scheme tariff.
- No benefit available for metal frame dentures.

Ruby, Emerald Value, Emerald, and Onyx options:

- All denture-related claims are payable from the available shared dental sublimit at 100% of the Scheme rate.
- Members are allowed one set* of plastic dentures per beneficiary every four years, with rebase and relines of the soft base every two years.
- Metal frames for partial dentures are limited to one per jaw, once every five years.

*A set of dentures is defined as follows:

- A complete upper and/or a complete lower denture, or
- A partial upper and/or partial lower denture.

Appeals process

If your application for pre-authorisation has been declined an appeal may be lodged at **enquiries@gems.gov.za.** The appeal process can take up to five working days before a decision is sent to you. Kindly await the outcome of the decision before proceeding with the treatment.

Ex gratia process

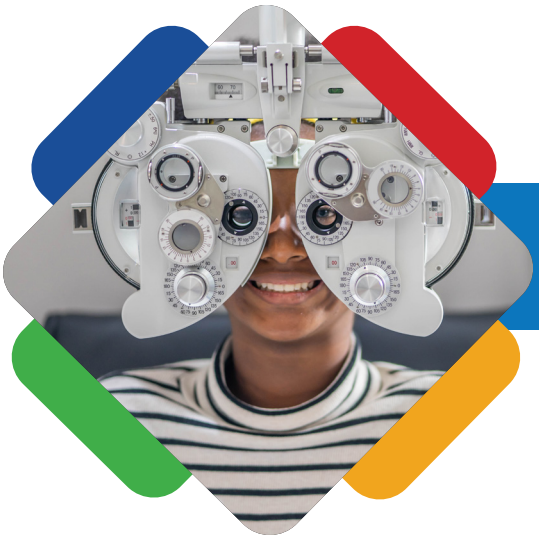
As a GEMS member you are eligible for ex gratia assistance for dental treatment. Kindly await the outcome of the decision before proceeding with the treatment.

Dental exclusions and limitations

More information on Dentistry and Maxillofacial Surgery Exclusions can be found in Annexure E of the GEMS Scheme Rules. Certain dental procedures have age requirements, and the number of dental procedures allowed per beneficiary in each time period is limited. These restrictions are detailed in the GEMS Dental Provider Guide, which can be found at www.gems.gov.za under Healthcare Providers> Healthcare Provider Guides.

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.

You can choose either glass or plastic lenses. The Scheme will pay a specific rate for the spectacles and lenses in line with industry funding guidelines.

When you read the benefit schedule in the option-specific mini-guide, you will notice that there is a family limit as well as a sub-limit for each beneficiary or dependant registered on the Scheme. The benefit limits represent the maximum amount available for your optical benefits. Please keep in mind that sub-limits and rules may apply to your optical benefits, so your available benefit may be less than the overall optical limit. Each beneficiary is entitled to a 12-month optometric examination, one pair of standard lenses, and a frame or contact lenses (every 24 months). Each beneficiary may only claim a maximum of one sub-limit, and the total amount that the family may claim is limited to the 'family limit.' The below table indicates the limits applicable per option:

Benefit Option	Limit Available
Tanzanite One	Limit of **R1 380** per beneficiary every two (2) years
Beryl	Limit of **R1 748** per beneficiary every two (2) years
Ruby	Limited to PMSA and Block Benefit Frame is limited to **R 1 497**
Emerald Value	Annual family limit available of **R5 400** Limit of **R2 817** per beneficiary every two (2) years Frame is limited to **R 1 497**
Emerald	Annual family limit available of **R5 400** Limit of **R2 817** per beneficiary every two (2) years Frame is limited to **R 1 497**
Onyx	Annual family limit available of **R6 392** Limit of **R3 325** per beneficiary every two (2) years. Frame is limited to **R2 404**

For Example

To illustrate how the benefit for a family works, let us explain the Emerald Option:

Claim received	2023 Overall Annual Family Limit: R5 400 (As at 1 January 2023); 2023 Beneficiary/dependant limit R2817
Beneficiary/dependant 1: Claim comes through for **R2400** beneficiary/ dependant.	Beneficiary/dependant limit for 2023 is **R2 817** therefore **R417** remains after **R2400** claim is processed, Family limit remaining after the **R2400** claim is processed will be **R3000.**
If beneficiary/dependant 2 has a claim for **R2 817.**	Family Limit of **R3000** after Dep 01's claims was processed is sufficient to cover the Dep 02 claims with a balance of **R183** that will be left in the family benefit.
Dep 03 has a claim for **R2000.**	This will be processed from available family benefit (in this example **R183**) with the balance of **R1817** due by the main member as beneficiary/dependant out of pocket as the family limit (**R5400**) will be depleted for the year given that 3 members had claims for the year and within the benefit cycle.

The family limit is available each year on the Emerald Option for beneficiaries who did not claim in the previous year.

The GEMS Optometry Network and how it works

GEMS members receive discounted optometry services and materials, such as spectacles and contact lenses, from any GEMS Network optometrist. This means that by visiting a GEMS Network optometrist, you will receive discounted services and items. Because the GEMS Optometry Network includes 98% of all optometry providers in South Africa, your optometrist is very likely a network provider. To find your nearest GEMS Network optometrist, please visit the GEMS website at www.gems.gov.za and use the following path: Healthcare Providers > Designated Service Providers.

Items that may not be covered by GEMS:
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 members living with 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.
- In some instances, an Optometrist may prescribe certain medications that GEMS does not cover. This may be excluded and therefore may not be paid/ short-paid by GEMS.

Prior to receiving services, members should always confirm their available benefits with their optometrist and the GEMS Optometry Team. If you have any questions about your benefits, please call the GEMS Optometry Team at 086 000 4367 and select option number 4 for optometry benefits.

Wellness Programme

The GEMS Health and Wellness Screening Services (HWSS) were created to combat the growing negative impact of illness on public servant productivity.

The service is intended to be a positive experience, with a focus on preventative measures such as assisting employees with lifestyle changes. The GEMS HWSS has proven to be extremely beneficial, with encouraging results thus far.

Only by testing employees' current health and well-being will you be able to plan and implement meaningful and targeted interventions. We encourage you to take advantage of the GEMS Wellness days that are available to you. 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 conditions (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

Screening services are tests that are performed to aid in the early diagnosis of a condition so that it can be treated and managed effectively from the beginning. Preventative healthcare services are actions taken to prevent disease and improve the quality of life for members and beneficiaries.

GEMS is constantly improving the benefits provided by the separate Preventative Care and Screening Benefit, which is available on all options. The tables below detail the various screening services and vaccinations available from providers and pharmacies

SCREENING SERVICES – OBTAINABLE FROM YOUR FP		
Procedure	**Accessed from FPs**	**Eligible beneficiaries**
Cholesterol Screening	Once per benefit year	20 years and older
Osteoporosis Screening (Bone Densitometry Scan)	Once per benefit year	Females 65 years and older
Cytology Screening (Pap smears)	Once per benefit year	Females 12-65 years old
HIV / AIDS pre-test counselling with no test	Once per benefit year	All beneficiaries
HIV / AIDS (Screening test, post-test counselling, confirmatory test, and condoms)	Once per benefit year	All beneficiaries
Mammography Screening	Once per benefit year	Females 40 years and older
Prostate Screening (PSA)	Once per benefit year	Males 45-69 years old
Faecal Occult blood test	Once per benefit year	50-75 years old
Glucose Screening	Once per benefit year	20 years and older
Glaucoma Screening	Once per benefit year	40 years and older
Neonatal Hypothyroidism	Once per beneficiary	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 benefit year	All beneficiaries
Chlamydia / Gonorrhoea Screening	Once per beneficiary per benefit year	All beneficiaries
TB Screening	Once per beneficiary per benefit year	All beneficiaries

SCREENING SERVICES – OBTAINABLE FROM PHARMACIES		
Procedure	**Accessed from FPs**	**Eligible beneficiaries**
Cholesterol Screening	Once per benefit year	20 years and older
Blood pressure monitoring	Once per benefit year	18 years and older
HIV / AIDS pre-test counselling with no test	Once per benefit year	All beneficiaries
HIV / AIDS (Screening test, post-test counselling, confirmatory test, and condoms)	Once per benefit year	All beneficiaries

SCREENING SERVICES – OBTAINABLE FROM PHARMACIES		
Procedure	**Accessed from FPs**	**Eligible beneficiaries**
Peak flow measurement	Once per benefit year	4 years and older
Glucose Screening	Once per benefit year	20 years and older
Pregnancy Screening	Once per benefit year	Female beneficiaries ≥12 years
Urine analysis	Once per benefit year	All beneficiaries

VACCINATION SERVICES – ACCESSED FROM FPs AND PHARMACIES		
Procedure	**Accessed from FPs**	**Eligible beneficiaries**
Influenza vaccination	Once per benefit year	All beneficiaries ≥6 months of age*
Pneumococcal vaccination	Once per benefit year	• All beneficiaries 65 years and older
		• High risk beneficiaries: 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 • Ages between 9-14 years of age: 1 course = 2 doses (Initial single dose, then follow-up dose to be given at 6 or 12 months). • Ages between 15-45 years of age: 1 course = 3 doses (Initial single dose, then follow-up doses given at 2 and 6 months, respectively.
All other vaccinations	Subject to an annual limit of R863 per beneficiary per benefit year	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 444 367 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 know 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.

For more information, please see our Scheme Rules 16.2.2 and 16.2.3 at www.gems.gov.za. GEMS will send you information about new benefits as well as an Option Selection form to help you decide whether to change options during the annual Option Selection period. If you change your option during the specified election period, your membership for the new option will begin on 1 January of the following 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 of more than 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.

- DENIS - Ambulatory dental managed care services
- Europ Assistance - Emergency Medical Evacuation Dispatch (EMED) contact center
- Health Calibrate – Provider network management
- MediKredit - Pharmacy benefit management
- Medipost Pharmacy and Marara Pharmacy - Chronic medicine courier pharmacies
- Medscheme - Contributions and debt management services
- Medscheme - Managed care services
- Metropolitan Health - Correspondence services
- Metropolitan Health - Membership and claims services
- Medscheme - HIV management
- Opticlear - Optometry management services
- Tshela Healthcare - Maternity services
- Universal Healthcare - Pharmacy Network Management Provider (PNMP)
- Universal Healthcare - 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).

Appliance List
The appliance list is a list of medical appliances and devices which are funded by GEMS. Your provider may select the appropriate appliance or device from this list for your healthcare needs.

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, 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 may have to pay a 30% portion of the cost of the consultation of treatment from your own pocket, depending on your option. For example, 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 Networks
GEMS has contracted with various providers to deliver quality healthcare to members at Scheme rates. Members on the Tanzanite One and Emerald Value options must make use of network providers for their healthcare needs in order to avoid co-payments.

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 is usually more cost effective.

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.

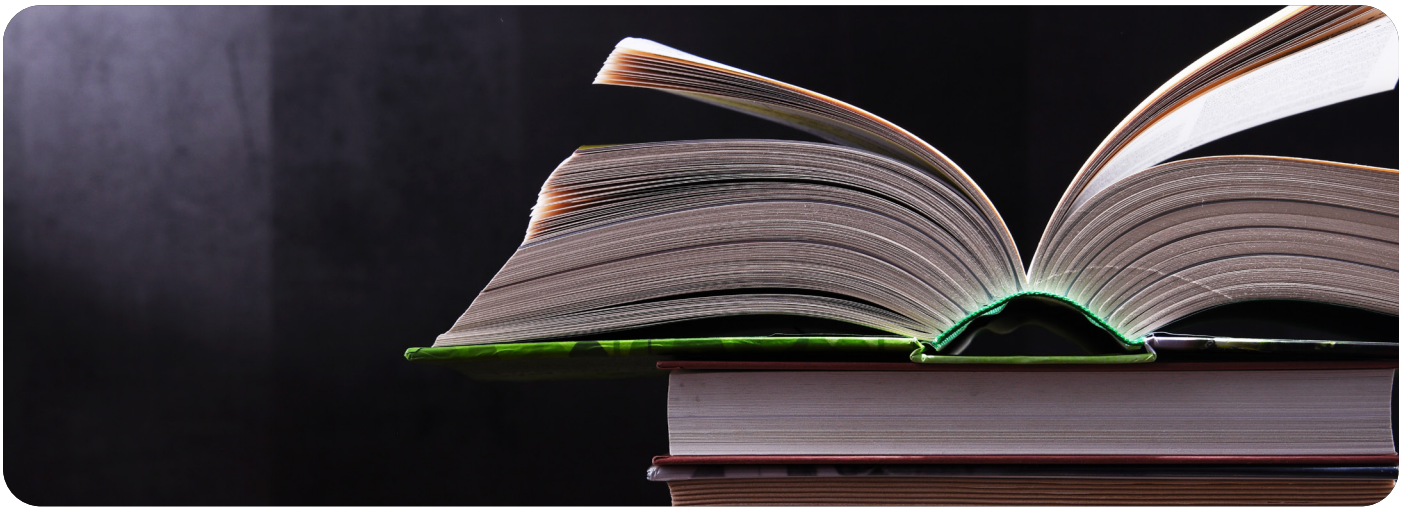
Medicine list or formulary
A list of cost-effective medicine that guides the doctor in the treatment of specific medical conditions.

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

Medicine Price List (MPL)
A reference pricing system used 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 medicines, medical appliances and consumable products. Your healthcare provider must include this code on all claims as it enables GEMS to identify what has been supplied.

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

GEMS Contact Centre
General queries related to GEMS
0860 00 4367
enquiries@gems.gov.za

GEMS Website
View GEMS Products and Services
0860 00 4367
www.gems.gov.za

GEMS Tariff File, Formularies and Forms
To view GEMS Tariff file, Formularies and Form
www.gems.gov.za, For Individuals > Formulary Lists > select the formulary list for the relevant benefit year

Chronic Medicine Management - New registrations and updates
Chronic registrations
0860 00 4367
chronicdsp@gems.gov.za

Chronic Medicine Authorisation Queries
Queries related to the authorisation of chronic medicines
0860 00 4367
chronicdsp@gems.gov.za

GEMS Pharmacy Network Management - Pharmacy Nomination
To nominate a GEMS Network Pharmacy for chronic medicine
0860 00 4367
enquiries@gems.gov.za **www.gems.gov.za, For Individuals > Designated Service Providers > Pharmacies**

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 00 4367
hospitalauths@gems.gov.za

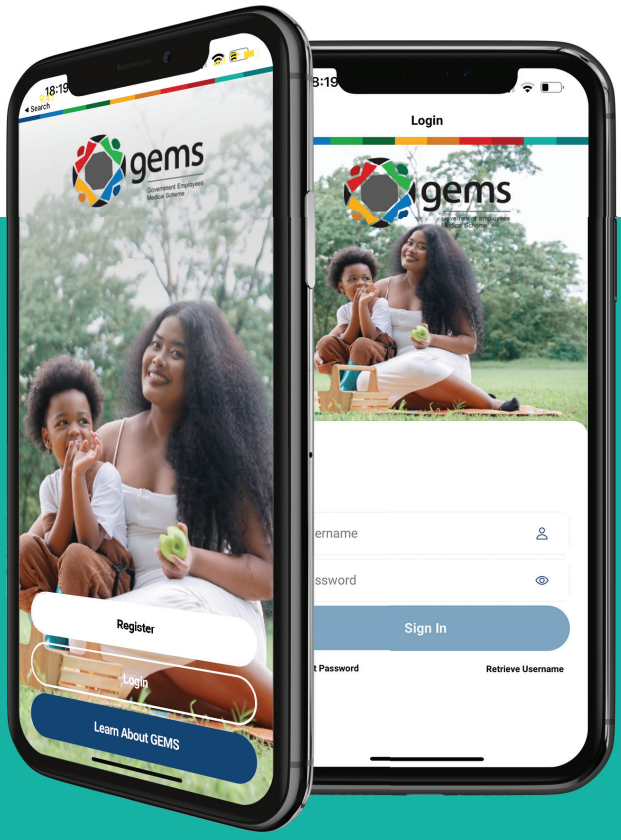
Submission of claims
Submissions of claims for GEMS beneficiaries
0860 00 4367
hospitalauths@gems.gov.za

Queries of claims
Queries relating to a claim for GEMS beneficiary
0860 00 4367
enquiries@gems.gov.za

Oncology Services
Oncology-related queries
0860 00 4367
oncologyauths@gems.gov.za

Ambulatory PMB
Out-of-Hospital PMB queries
0860 00 4367
enquiries@gems.gov.za

HIV Management
HIV related queries
0860 436 736
hiv@gems.gov.za



Stay Connected with GEMS:

Enhancing Your Healthcare Experience Through Multiple Platforms

Make use of the multi-function **GEMS Member App** to interact with the Scheme at home or on the go to make your life easier.

Use the QR Code to download the **GEMS Member App**

ANDROID APP ON Google play

Download on the App Store

CONTACT DETAILS:

GEMS CONTACT CENTRE
0860 00 4367

WEB
www.gems.gov.za

FAX
0861 00 4367

EMAIL
enquiries@gems.gov.za

POSTAL ADDRESS
GEMS, Private Bag X782
Cape Town, 8000

GEMS FRAUD HOTLINE
0800 212 202
gems@thehotline.co.za

PROVIDER LIAISON OFFICERS
plo@gems.gov.za

GEMS EMERGENCY SERVICES
0860 44 4367

Social media pages

FACEBOOK
@GEMS1GEMOFASCHEME

TWITTER
@GEMS_Number1

INSTAGRAM
gems_sa_official

LINKEDIN
Government Employees Medical Scheme

Council for Medical Schemes

CMS CONTACT CENTRE
0861 123 267

EMAIL
information@medicalschemes.co.za

WEB
www.medicalschemes.co.za