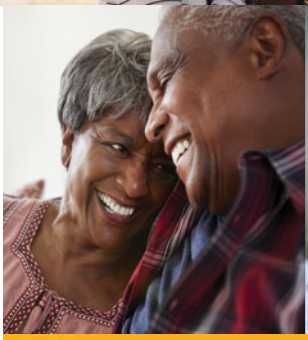
gems
Government Employees Medical Scheme

With GEMS
AFFORDABLE means **RICH** in benefits.



YOUR 2020 MEMBER GUIDE

Table of Contents

Welcome

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

This guide provides more information on how to use your benefits and the many services that are available to you. It is a summary of the Scheme's benefits and rules and does not replace the registered Scheme Rules registered with the Council for Medical Schemes (CMS). If there is a difference between what is in the guide and the rules, the Scheme Rules apply. View these at **www.gems.gov.za,** request a copy via **enquiries@gems.gov.za** or call us on **0860 00 4367**.

With GEMS AFFORDABLE means RICH in benefits.

Ensuring the best healthcare cover for your family at an affordable rate does not mean you have to compromise on cover, or on value. GEMS options are affordable and ensure that the most precious things in life – your health and your family – are taken care of.

That's because all of our options are tailored to fully support you and ensure that you are rich in all the ways that really matter:

- Rich in health
- Rich in love for your family
- Rich in the security of knowing you are taken care of, and
- Rich in the quality of care you receive

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

- Tanzanite One
- Beryl
- Ruby
- Emerald Value
- Emerald
- Onyx

About GEMS

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 wellbeing.

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 listed in Schedule 1 of the Public Service Act.
- A Provincial Department listed in Schedule 2 of the Public Service Act.
- A Provincial Administration listed in Schedule 2 of the Public Service Act.
- Organisational 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

- As the main member, you receive a membership card when you join GEMS, change your benefit option, or remove or add a dependant. A card is also issued to each registered adult dependant (i.e. a dependant older than 28 years of age).
- Only you and the registered dependants reflected on the back of your membership card may use the card to claim for benefits. It is fraud if you give your membership card to someone other than your registered dependant and he or she uses it to claim for benefits.
- It is fraud if you use the card after your resignation.
- Please use your membership number as a reference on all correspondence with GEMS so that we can help you as quickly as possible.
- Remember to show your membership card to your doctor, dentist, pharmacist and specialist when you visit them.

For more information on membership cards and certificates, visit www.gems.gov.za and read Rule 10 of the Scheme Rules. You may also request a copy by sending an email to enquiries@gems.co.za or by calling 0860 00 4367.

Why is it important to manage your GEMS membership?

To derive the most out of your GEMS membership, you need to understand and follow the Scheme Rules and procedures.

Change of banking details

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

- A copy of your identity document (ID).
- A bank account statement, crossed cheque or signed or stamped bank letter (not older than three months).
- Proof of residence (not older than three months).

Documents older than three months will be rejected, which may delay your refund.

These documents are essential, as GEMS subscribes to the Financial Intelligence Centre Act (FICA) 38 of 2001, which fights money theft and fraud by helping to identify individuals who engage in such activities.

Stay informed

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

Let us know if:

- You want to add or remove dependants.
- A registered dependant passes away (we must also be informed if the main member passes away).
- You resign from the public service or a GEMS participating employer.
- You or your dependant(s) are not going to live in 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.
- Monthly income.

You can update your details by:

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

NOTE: Neither you nor a dependant is allowed to belong to more than one medical scheme simultaneously.

About your dependants

You and your dependants are at the heart of all our efforts. The following family members qualify as 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. A child dependant is:
  - Under the age of 21;
  - Under the age of 28 and registered as a bona fide student at an educational institution recognised by the Board, within South Africa or abroad; or
  - Totally dependent on the main member and who is deemed by the Board to be permanently disabled, irrespective of age.
- Parents, parents-in-law, step-parents, step-parents-in-law, grandparents and grandparents-in-law, if they are factually dependent on the main member.
- Grandchildren and great-grandchildren, if they are factually dependent on the main member.
- Siblings (brothers and sisters), half-siblings, step-siblings and in-law siblings, if they are factually dependent on the main member.
- Nephews and nieces, if they are factually dependent on the main member or the main member's spouse.
- A person, other than family, who is dependent on the main member for family care and support.
- Neither you nor any of your dependants may be a beneficiary of more than one medical scheme; belonging to more than one medical scheme is a criminal offence.

How to register your dependants

To register a dependant, we need:

- The application form with the dependant section fully completed.
- ID copies and birth certificates of the dependants, ID copies and marriage certificates of the spouse. Relevant pages of the application form must be initialled and signed.
- For most of the dependant categories outlined, a declaration letter, email or telephone call that proves factual dependency should be lodged with the application form.

Factual dependency means to be financially dependent. A factual dependant depends on the main member for family care and support.

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 marriage certificate if married and the surname of the husband or wife is different from the main member's surname.

Ex-husband or ex-wife

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

Partner

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

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

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

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

If the child is a student and not yet 28 years old, we need the following annually:

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

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

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

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

- A declaration letter, email or telephone call from the main member confirming factual dependency. Please note that you will pay adult rates for this dependant.

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

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

Grandchildren and great-grandchildren

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

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.

Nephews and nieces (including in-laws)

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

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

- A completed 'Addition of dependants' form and a copy of the dependant's ID.
- A declaration letter, email or telephone call from the main member confirming factual dependency.

Registering your newborn or newly adopted child

You are required to send a completed newborn registration form and a certified copy of the child's birth certificate to the Scheme within 60 days of birth so that he or she can be registered as a dependant from date of birth. Provide the final letter of adoption if your child is adopted. We will then also cover medical expenses related to the newborn's birth. If your newborn's surname is different from yours, provide a declaration letter, email or make a telephone call confirming that the child is yours.

You can get the newborn registration form by clicking on 'Forms' under 'Members' on the GEMS website **www.gems.gov.za.**

The full monthly contribution will be due from the month of birth or the adoption date, regardless of the newborn's registration date with the Scheme. This will ensure that the newborn and/or adopted child has medical aid cover from birth or adoption date.

Yearly review of dependants

Every year, the Scheme reviews whether dependants still qualify to receive benefits according to the Scheme Rules. Each year, main members must give us proof of factual dependency for all dependants who are 21 years or older.

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

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 register your dependant for child rates only if he or she was a full-time student.
- Rule 4.9.5 allows for the review of student's eligibility throughout the year, triggered by his or her study completion dates.
- The new short course rule allows a main member to pay a child rate for a dependant for the duration of his or her registration on a short course. The child rate will revert to an adult rate after the completion date of the short course. For example, if a student is studying a three-month diploma course, the main member will pay a child rate during that period.

Age	Rates to be paid	Review period
Under 21 years old	Child rates	
21 years and older, but under 28 years	Child rates as long as you have submitted proof that the student is studying at a recognised tertiary institution You also need to provide a declaration letter, email or make a telephone call stating factual dependency	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

NOTE: If the dependant is not a student, but is factually dependent on the main member, he or she may continue as a dependant at adult contribution rates, if all relevant documents are submitted.

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 South Africa.' According to Rule 6.2: 'The membership of the Scheme is limited to those members and their dependants who are ordinarily resident within the Republic of South Africa, or who are stationed abroad on or by virtue of instructions, requirements or obligations of the member's employer, or who are studying abroad.'

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

We need to receive all required documentation and supporting documents requested in the eligibility review letters, so that your dependant can continue to receive benefits at child dependant rates. 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 pay the hospital costs of the newborn.

Underwriting

Underwriting is the assessment of the risk profile of a new member or beneficiary to determine whether waiting periods should be imposed to reduce GEMS' risk exposure.

A waiting period is a period during which a member pays contributions without having access to all or certain benefits.

There are two types of GEMS waiting periods:

- A general waiting period (GWP) of up to 3 months.
- A condition-specific waiting period (CSWP) of up to 12 months.

A GWP is a period during which a beneficiary is not entitled to claim any benefits, or in certain circumstances, may claim for only prescribed minimum benefit (PMB) conditions.

A CSWP is a period during which a beneficiary is not entitled to claim benefits for a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months prior to the application for membership.

If it is found that the member did not disclose a condition and is admitted to hospital, the member will be liable for the account.

Any beneficiary added to the membership after the start date will be subject to underwriting in line with GEMS Rules to determine whether any waiting period(s) should be imposed.

When a member joins the Scheme and the medical history is not disclosed in full, an underwriting waiting period (UWP) of up to 12 months may be imposed so that the Scheme can monitor for non-disclosure. This implies that when a member is admitted during an active UWP, investigations will be conducted to ensure that the condition for which the member is admitted is newly diagnosed. If the condition is found to be pre-existing, a CSWP will be imposed on the condition and no benefits will be available for that admission (the member will be liable for the account).

Underwriting protects GEMS and its members against abuse by persons who join GEMS only to claim for certain, usually pre-existing, medical conditions with no intention of contributing for a longer term, and resign from the Scheme once their claims have been paid.

Cost of membership

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

These are the monthly contributions (how much you pay each month to be a member of GEMS) for 2020. They do not show how much you will pay when the employer subsidy is included. Where an employee qualifies for a subsidy, the employer will pay a part of the contribution and the employee will pay the balance. Read about how the subsidy works on page 12.

TANZANITE ONE (Network Option)			
Salary			
R0 - R9 728.00	1 116	882	480
R9 728.01 - R13 651.00	1 169	936	517
R13 651.01 - R23 386.00	1 243	984	549
R23 386.01 +	1 455	1 231	696

BERYL			
Salary			
R0 - R9 728.00	1 235	1 231	692
R9 728.01 - R13 651.00	1 339	1 329	764
R13 651.01 - R23 386.00	1 462	1 462	821
R23 386.01 +	1 755	1 755	996

RUBY			
Salary			
R0 - R14 650.00	2 550	1 915	990
R14 650.01 - R25 301.00	2 840	2 135	1 105
R25 301.01 +	3 150	2 370	1 220
Please Note: 20% of Ruby contributions go towards the Personal Medical Savings Account (PMSA).			

EMERALD VALUE (Network Option)			
Salary			
R0 - R14 650.00	2 434	1 859	905
R14 650.01 - R25 301.00	2 694	2 087	1 015
R25 301.01 +	3 018	2 320	1 130

EMERALD			
Salary			
R0 - R14 650.00	2 852	2 172	1 059
R14 650.01 - R25 301.00	3 157	2 440	1 187
R25 301.01 +	3 539	2 713	1 323

ONYX			
Salary			
R0 - R14 650.00	4 875	3 733	1 466
R14 650.01 - R31 216.00	5 074	3 863	1 592
R31 216.01 +	5 478	4 211	1 776

MEMBER	ADULT	CHILD
Refers to a 'Member' (i.e. a principal member)	Refers to any 'Adult Dependant'	Refers to any 'Child Dependant'

How the subsidy works

New approved medical scheme subsidy

GEMS ensures that member contributions remain affordable and the medical scheme subsidy provided by employers plays an important role in ensuring the continued affordability of medical benefits. Please consult your employer about the subsidy and for information on how it applies to you.

Employees on salary levels 1 to 5 on the Tanzanite One option continue to be subsidised at 100% up to the maximum amounts indicated below. In-service employees on GEMS receive a subsidy of 75% of their contribution up to the maximums indicated below. Eligibility for subsidy is dependent on employment conditions and will be confirmed by the employer.

Pensioner members who were on a salary level from 1 to 5 and on the Tanzanite One option while they were active employees, and who retire on the same option, continue to receive a 100% subsidy for the main member and up to one dependant, up to a maximum of R2 812, as indicated in the table below.

Pensioner members on GEMS receive 75% of their monthly contribution as a subsidy up to a maximum of R1 406 for a member without dependants and R2 812 for a member with dependants. Discuss questions about your subsidy with the Government Pensions Administration Agency, which determines eligibility for pensioner members.

GEMS is committed to ensuring that member contributions remain affordable.

Please use the contribution calculator at **www.gems.gov.za** to work out your monthly contributions.

Family Structure	January 2019	January 2020
Main member without dependants	R1 301	R1 406
Main member with one dependant	R2 602	R2 812
Main member with two dependants	R3 397	R3 671
Main member with three dependants	R4 192	R4 530
Main member with four or more dependants	R4 987	R5 389

Contribution statements

We send a contribution statement to all members once a quarter. Members who owe money to GEMS receive a monthly contribution statement that helps them to check that their contributions are always up to date.

Managing arrear contributions

You might be behind in your payments to GEMS if:

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

We will send you a letter confirming the amount you owe the Scheme. You may contact the Scheme or ask your human resources department to help you with the repayment terms.

Different types of debt, what causes it and how to prevent it:

Type of Debt	Causes	Prevention
Change of paypoint or department	Transfer of employment between bureaus	Provide the letter of appointment to premiums@gems.gov.za to change your contribution requests to the new paypoint
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
Retired	Pensioners are responsible for the full contribution while awaiting Government Employees Pension Fund (GEPF) subsidy approval	Submit your GEPF approval letter to premiums@gems.gov.za. You will be refunded for the months you contributed without subsidy approval
Short-payment of contributions for dependants	Dependants registered after payroll cut-off date and over-age dependants still studying, but without proof having been submitted to GEMS	Notify your employer or department as soon as you register a dependant so that your contributions are adjusted in time via Persal. Provide GEMS with documentation on your dependant's study

NOTE: Members must make payments for their arrears using their membership number as a reference.

Personal Medical Savings Account

A Personal Medical Savings Account (PMSA) applies only to members who select the Ruby option. The PMSA is 20% of the member's contribution allocated to a personal medical savings account in the main member's name. The amount allocated to the PMSA depends on the main member's salary and how many beneficiaries he or she has. It pays for out-of-hospital and day-to-day medical expenses. Once the PMSA is depleted, out-of-hospital claims are paid from the limited block benefit, which covers family practitioner services, pathology and medical technology, optical services, allied health services, other professional health services, physiotherapy, audiology, occupational therapy and speech therapy.

Funds in the PMSA that are not used during the year are carried over to the next year, or paid out to you (or to your new medical scheme) five months after you have terminated your membership or changed to an option that does not have a medical savings account. This payment amount is taxable.

PMSA statements

Ruby members receive an annual PMSA statement that shows all transactions and entries made on the savings account and balances at each month-end. This is a separate statement from the normal claims and contribution statements sent quarterly. It is distributed to members once a year when tax certificates are issued. No interest is earned on a PMSA.

A PMSA applies only to members who select the Ruby option.

Prescribed Minimum Benefits (PMB)

PMBs are minimum benefits that GEMS provides for in accordance with the Medical Schemes Act.

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

- A list of 270 medical conditions.
- Any emergency medical condition.
- 26 chronic conditions on the chronic disease list (CDL) on page 33, provided in the Regulations to the Medical Schemes Act.

What you need to know about PMBs

- Qualifying for PMBs is based not only on the condition or diagnosis (ICD10 code) but 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 or it cannot be claimed as a PMB.
- PMBs will be covered from your available benefits. When your benefits are depleted, the Scheme will continue to pay for PMBs above the benefits.
- PMBs may not be covered from your PMSA if you are on the Ruby option.
- Codes used by healthcare providers to identify the condition (ICD10 code) and the treatment given (Tariff code or National Pharmaceutical Product Index - NAPPI - code) are required to ensure GEMS identifies and pays PMBs correctly.
- Please remind your doctor to provide the relevant codes to you or include them on the claim to ensure that your claim is processed correctly. Read about submitting claims to the Scheme on pages 24-28.
- Healthcare providers who treat you for a PMB condition while you are in hospital should include the hospital pre-authorisation number when they claim. As it is not always possible for the Scheme or healthcare provider to know the diagnosis or treatment when authorisation is obtained, 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 for these measures, claims may not be paid as PMBs.

What is a Designated Service Provider (DSP)?

A DSP is a healthcare provider or group of providers that has been selected by and has a contract with GEMS to provide members with diagnosis, treatment and care of medical conditions, including PMB conditions, according to an agreed fee schedule.

GEMS has selected the following DSPs for PMB care:

- State hospitals: The state is GEMS' DSP for the treatment of in-hospital PMBs.
- Chronic medicine DSPs: Members should use the chronic medicine courier pharmacy (Medipost Pharmacy) or contracted pharmacies in the chronic medicine pharmacy network to obtain all chronic medicine, including medicine for HIV.
- Use of another pharmacy may attract a co-payment. Members may choose the courier pharmacy or any network pharmacy within 10 kilometres of their workplace or home as their chronic medicine DSP. Also refer to 'How to avoid co-payments' on page 19.

Members are required to remain with the pharmacy they have chosen for six months, which is in line with the six-month prescription validity cycle as per regulations.

Using non-DSPs

If a healthcare provider other than the DSP is used 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 for PMB treatment provided, the Scheme will find out whether the beneficiary voluntarily or involuntarily used 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 reasonably precluded the beneficiary from obtaining such treatment from a DSP.
- The DSP was not within a reasonable distance from the beneficiary's place of business or residence.

Except for an emergency medical condition, pre-authorisation must be obtained before involuntary use of a non-DSP. For an emergency hospital admission, a pre-authorisation must be obtained within one working day of the admission, after which a co-payment of R1 000 per admission shall apply.

What GEMS does not pay for

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

All GEMS Scheme exclusions are listed in detail in Rule 16 and Annexure E of the Scheme Rules. Ensure that the procedures, treatments or medicine you receive will be paid for or you will be responsible for payment.

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

- Medicine exclusions on acute and chronic medication.
- Medicines for which pre-authorisation is required.
- New products still under review.

The list can be found at www.gems.gov.za under Members > Tools > ICD10 codes.

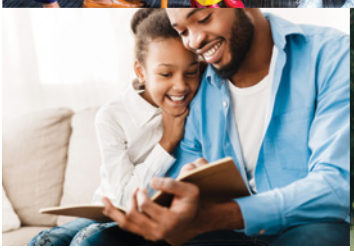
Examples of exclusions – items that GEMS does not pay for:

- All costs for operations, medicines, treatments and procedures for cosmetic purposes (cosmetic refers to procedures such as liposuction).
- Holidays taken for recovery.
- Medicines not registered with the South African Health Products Regulatory Authority.
- Toiletries, beauty products, slimming products, homemade remedies and alternative medicines.
- Household products such as disinfectants, soaps, food and fitness-related nutritional supplements.
- Treatments by a healthcare provider who is not registered with a recognised professional body or any healthcare facility that is not legally registered.
- 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 paid to a healthcare provider for failure to keep an appointment.

Even if a treatment is not excluded by the Scheme and is approved or authorised, it will not be paid or not be paid in full if it exceeds the Scheme rate/tariff and benefit limits. Claims may also be declined if they do not comply with managed care rules. Refer to the Scheme Rules at **www.gems.gov.za** or call **0860 00 4367** to request a copy.

No exclusions on PMBs

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



How to avoid co-payments

What is a co-payment?

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

How can co-payments be avoided?

Use DSPs

A DSP is a healthcare provider or group of providers selected and contracted by GEMS to provide members with the diagnosis, treatment and care for medical conditions, including PMB conditions. For example, chronic medicine obtained from a pharmacy other than a DSP pharmacy will attract a 30% co-payment, even if the medicine claimed for is on the formulary.

Tanzanite One members can prevent a co-payment by visiting their nominated general practitioner (GP). These members have unlimited nominated GP visits with three non-nominated visits. A 30% co-payment will apply once the three visits have been made.

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

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

Tanzanite One and Beryl members can avoid a co-payment on acute medicines if they always get their medication from a **network pharmacy.**

Consult healthcare providers on the GEMS network

GEMS has a network of healthcare providers consisting of GPs, specialists, pharmacies, dentists and optometrists who have promised to deliver quality healthcare to GEMS members. Network healthcare providers have committed to providing excellent quality care at Scheme rates and will not charge co-payments or additional costs. If a healthcare provider in the GEMS network asks that you pay upfront or from your pocket, contact GEMS immediately on **0860 00 4367**. Report any irregularities relating to GEMS network healthcare providers to the Scheme.

Consult renal facilities on the GEMS network

GEMS has a network of renal facilities. If you do not use a network facility for chronic dialysis subject to authorisation, a 30% co-payment will apply.

Use network facilities for Emerald Value and Tanzanite One members

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

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

Use in-formulary medicine

The comprehensive chronic formulary is a list of cost-effective medicine for which GEMS pays in full according to Scheme Rules. If your doctor prescribes medicine not on the GEMS formulary, there will be a 30% co-payment.

The acute formulary applies to acute medicine claims on the Tanzanite One and Beryl options. These medicine rules can include out-of-formulary medicine (which will attract a 30% co-payment), in-formulary medicine (which will not attract a formulary co-payment) and prescription limits. It is important that your prescribing doctor refers to the acute formulary for your option when prescribing acute medicine.

The acute out-of-formulary list applies to acute medicine claims on the Ruby, Emerald, Emerald Value and Onyx options. Medicines on this formulary will always attract a 30% co-payment. If the medicine is not listed on this formulary, it will not attract a co-payment, but this is subject to the MEL and the use of generic medicines.

Formularies, exclusions and medicine price lists can be found at www.gems.gov.za under Members > Tools > ICD10 codes.

Use generic medicine

Generic medicines contain the same active ingredients as branded medicine and achieve the same therapeutic results, at a lower cost. Ask your pharmacist for generic medicine where possible.

Obtain pre-authorisation

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

Pre-authorisation is also required for:

- Certain out-of-hospital procedures, e.g. where a member obtains dialysis on an out-patient basis.
- In-hospital physiotherapy.
- Specialised radiology investigations (e.g. CT, MRI, angiogram, radio-isotope scans).

Use registered doctors

GEMS will not pay claims for services provided by healthcare providers who are not registered by law. These include doctors not registered to practise medicine in South Africa, doctors with restrictions placed against them by GEMS or doctors without written permission to perform remunerative work outside the public service. Ensure that your claims meet the requirements before you send them to the Scheme or before you make use of the provider's services.

What to do before going to hospital

Obtain pre-authorisation first

48 hours before you are admitted to a private hospital, make an out-patient visit to a hospital (excluding emergencies), or have a CT scan, MRI scan or radio-isotope study, obtain a pre-authorisation number (PAR) from GEMS by contacting 0860 00 4367.

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

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

Discuss costs with the doctor

Obtaining pre-authorisation does not guarantee payment, nor does it mean that GEMS will cover the event in full.

All benefits will be paid according to Scheme Rules. For example, if the benefit is covered at 100% of Scheme rate and the doctor charges 200% of Scheme rate, you will be liable for the difference in cost. Find out if your doctor will charge Scheme rates or use any non-covered items during your stay, procedure or treatment.

It is your responsibility as a member/beneficiary to ensure that there will not be charges above Scheme rates or excluded or non-covered procedures. Refer to 'What GEMS does not pay for' on page 17 for a list of Scheme exclusions.

What happens if I do not apply for a PAR?

If you fail to obtain 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 R1 000 co-payment. Refer to 'In-hospital benefit management programme' on page 42 for more information on pre-authorisation.

How to avoid being over-serviced when admitted to hospital

Being over-serviced means that a provider conducts tests that are not necessary or medically required for your condition. Fraudulent claims result when a provider bills you for services not rendered. Always check your claims and codes billed. If you suspect that there is either over-servicing or fraudulent billing, contact the call centre on 0860 00 4367.

The most common scenarios include:

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

Reduce the risk of fraud, waste and abuse by:

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

TIP: Avoid being charged for an extra day's stay by asking your doctor about the discharge times. If your doctor discharges you in the morning, ensure that you are also discharged by 12:00. Staying longer, for example to wait for transport without being discharged by the hospital, will result in an additional half day's stay charged on the hospital account, which will not be covered by the Scheme.

Claims simplified

Who can claim?

The registered member or dependants can claim from the Scheme. The healthcare provider can submit a claim on behalf of the registered member or dependant.

What information must be on your claims?

- Your membership number
- The Scheme's name (i.e. GEMS)
- Your benefit option (e.g. Tanzanite One, Beryl, Ruby, Emerald Value, Emerald or Onyx)
- Your surname and initials
- The patient's date of birth and dependant code, as it appears on your membership card
- The name of the healthcare provider
- The valid practice code of the healthcare provider
- The date of service
- The type and cost of treatment
- The pre-authorisation number, if applicable
- The tariff code (treatment)
- The ICD10 code (condition)
- Your signature to confirm that the account is valid
- If you paid for the service, proof of payment highlighting this. 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 Scheme Rules. If the Scheme Rules allow, the claim will be paid.

Sometimes additional information is required from you or your healthcare provider, e.g. ICD10 code, clear copy of account, detailed account or proof of payment. If this information is not available, claims may not be paid.

When does GEMS pay claims?

There are two claims payment runs each month; mid-month and month-end. Payment depends on timing of claim submission.

Are medicine claims processed immediately?

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

If the medicine is not on the Scheme's formulary, you may have to make a co-payment or your claim may be rejected. If rejected, please speak to your provider to prescribe a medicine that is listed on the formulary.

Claims refunds

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

The proof of payment can be a valid receipt from the healthcare provider, an electronic fund transfer (EFT) slip or bank deposit slip.

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

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

Fax this information to **0861 00 4367** or email it to **enquiries@gems.gov.za**, using your membership number as a reference. You can also deliver the information to one of the GEMS walk-in centres 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 a utility bill such as your municipal account (not older than three months).

Claims alert SMS

You may receive a claims alert SMS or email each time GEMS processes your claims. The SMS and email inform you when a claim has been processed, but it is not a guarantee of payment. Guarantee of payment is reflected on your claims statement.

To receive a claim alert SMS, please call 0860 00 4367 and make sure that we have your current cellphone number.

Your claims statement

You will receive a claims statement when a claim has been settled. Please read your statement to see if your claims were paid or not. If a claim was not paid, your statement will detail the reason. If the reason indicates an action, resubmit the claim with the applicable information.

Paying a healthcare provider directly

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

One of these processes is the termination of direct payments to healthcare providers who have had sanctions placed against them by GEMS. These healthcare providers' claims will be rejected. You will have to pay the provider directly and GEMS will reimburse you.

Your claim submission must include corresponding details and valid proof of payment, signed by the main member, in the form of a valid stamped receipt from the provider, an electronic funds transfer (EFT) slip or a bank deposit slip.

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

Top 10 reasons why claims are rejected (not paid)

1. Member or dependant information is not correct

- 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 their details appear on the claim. Refer to 'Claims simplified' on page 24 for more information on what should be included in your claims submission.

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 do this, GEMS may reject your claims or pay them from the incorrect benefit.

3. No benefits are available

When your benefits have reached the benefit limits or sub-limits, GEMS will not pay any more claims.

4. Not keeping an appointment

GEMS will not pay penalties for missed appointments.

5. Healthcare provider is not registered correctly

GEMS will not settle claims for services provided by a healthcare provider who is not registered in terms of law - for example, if a doctor is not registered to practise medicine in South Africa or has restrictions placed against him or her by GEMS (indirect payment) or if a doctor does not have written permission to perform remunerative work outside the public service. Speak to your doctor to ensure that your claims meet requirements before you send the claims to GEMS or before you use the provider's services.

6. Claims sent too late (stale claims)

Claims must reach GEMS by the last day of the fourth month after the month in which the service was rendered - for example, if the service is rendered on 15 February 2020, the claim must reach us by 30 June 2020 (i.e. 120 days). GEMS will not pay claims received after this period. This is according to the Regulations of the Medical Schemes Act. To prevent claims from becoming stale, double check with your healthcare provider if a claim will be submitted directly to GEMS or whether you should submit the claim yourself.

7. Claims we received after a member has resigned from the public service or from GEMS

If you resign, you cannot use your GEMS membership card for healthcare services. If you or a healthcare provider claim for services after your resignation date , you will have to pay back this money to GEMS.

8. Scheme exclusions

- Specific conditions and treatment facilities are not paid for, in line with the Medical Schemes Act. These are called Scheme exclusions. You will be responsible for the costs for these procedures, treatments and medicines.
- Scheme exclusions are listed in detail in Rule 16 and Annexure E of the Scheme Rules, at www.gems.gov.za.

9. ICD10 codes on the claim are not correct

Ensure that the ICD10 code provided on the claim correctly identifies the condition for which you were treated.

10. Duplicate claims

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

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

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

The GEMS network of healthcare providers

GEMS has a network of healthcare providers consisting of GPs, specialists, pharmacies, dentists and optometrists who have promised to deliver quality healthcare at Scheme rates to members.

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

GP nomination

Your GP plays a vital role in providing you with quality healthcare. Consulting the same GP allows him or her to develop a good understanding of your health and treatment history on which to make informed decisions about your care, such as determining if you need to be referred to a specialist. You will, therefore, receive the best possible healthcare from the right person with the necessary skills and knowledge about your condition. Thus you will have better control over how your benefits are managed.

GEMS encourages you and your dependants to nominate a GEMS network GP in 2020 if you have not already done so, although failure to nominate a GP will not result in any penalties for members on the Ruby, Emerald and Onyx options.

Members on Tanzanite One have unlimited nominated GP visits with three non-nominated visits at a network provider. A 30% co-payment will apply once the three visits have been made.

Members on Beryl have unlimited network GP visits. Visits to a non-network GP are limited to three per family, subject to limits including a 30% co-payment.

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

GP nomination for Emerald Value/Tanzanite One members

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

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

What happens if my nominated GP is not available?

- Beryl members may consult with any other GEMS network GP. Should the member need to visit a non-network GP, the visit will be reimbursed from the out-of-network benefit subject to available benefits.
- Ruby, Emerald or Onyx members may consult with any other Ruby, Emerald or Onyx network GP. Non-network GP consultations will be reimbursed at Scheme rates and might result in a co-payment to the member.
- Emerald Value/Tanzanite One members need to consult their nominated GP.
- Emerald Value members may obtain authorisation for three voluntary OH non-nominated network GP visits per family, with no co-payment, subject to available benefits and limits. Once the three visits have been exhausted, a 30% co-payment will apply to claims for any additional non-nominated network GP visits, subject to available benefits and limits.
- Tanzanite One members have a limit of three non-nominated GP consultations per beneficiary. Once these are depleted a co-payment of 30% will apply.
- You can update your nominated GP every six months.
- You are allowed to nominate two GPs per beneficiary to your profile.

If you want to report any irregularities about healthcare providers on the GEMS network, or need more information on GP nomination or nominating an additional GP, please contact GEMS on **0860 00 4367** or email **enquiries@gems.gov.za.**

Coordination of specialist care

Specialist referral is effective for the Tanzanite One, Beryl and Emerald Value options. Members on Tanzanite One and Emerald Value need a referral letter. Referrals from a non-nominated GP require a specialist referral authorisation number. If the visit is not approved, a 30% co-payment will be applied.

The Beryl network GP must obtain a referral number for his or her Beryl patient before making an appointment to see a specialist. This can be done by calling the GEMS provider call centre on 0860 436 777.

We encourage our Ruby, Emerald and Onyx members to consult their network GP before making an appointment with a specialist to ensure that an appropriate specialist is selected.

Types of specialists requiring a referral from a nominated GP:

- Cardiologists
- Cardiology paediatricians
- Dermatologists
- Gastroenterologists
- Gynaecologists
- Neurologists
- Neurosurgeons
- Orthopaedic surgeons
- Otorhinolaryngologists (ear, nose and throat)
- Paediatricians
- Physicians
- Plastic and reconstructive surgeons
- Psychiatrists
- Pulmonologists
- Rheumatologists
- Surgeons
- Urologists

The GEMS specialist network comprises obstetricians and gynaecologists, paediatricians, psychiatrists, anaesthetists, surgeons and physicians, which include pulmonologists (lung specialists), gastroenterologists, cardiologists and rheumatologists, ophthalmologists and orthopaedic surgeons. A network specialist has agreed to charge a contracted rate so that you will not have to pay co-payments, but claims will be paid subject to available benefits.

Guidelines for Tanzanite One and Emerald Value members:

- No authorisation is needed if the specialist referral is requested by the nominated GP.
- Ensure that your GP, specialist, pharmacy, optometrist or dentist is on the GEMS network before you visit them to ensure that you do not have to pay out of your pocket for the appointment or treatment.
- All medication is subject to formularies regardless of prescribing doctor's discipline.
- GPs must be part of the GEMS network to avoid any out-of-pocket costs.
- Ask your GP whether he or she can dispense medicine. If yes, you don't need to obtain your acute medicine from a pharmacy as this may result in a co-payment or full payment of the claim yourself.
- All medicines are subject to the comprehensive acute and chronic formulary, or lists of approved tests and services, which may be found at www.gems.gov.za. All GPs have a copy in their GP guide.
- Pathology and radiology tests must be in line with the GEMS formulary (for Tanzanite One and Beryl).

GEMS medicine benefit

Medicine: Know the difference

Chronic medicine

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

Acute medicine

Acute medicines are prescribed for the treatment of a disease or disorder that lasts for a short time. Tanzanite One and Beryl members can obtain acute medicine from a GEMS dispensing doctor (a doctor licensed to supply medicine from his or her practice rooms) or from a GEMS network pharmacy, subject to the Tanzanite One and Beryl acute formulary. Medicines not listed on the formulary will not be covered. The acute comprehensive out-of-formulary list applies for Ruby, Emerald, Emerald Value and Onyx members and attracts a co-payment.

Self-medicine

Also known as over-the-counter medicine, self-medication such as that for a headache, cold or stomach ailment does not require a prescription from your doctor. Ruby, Emerald, Emerald Value and Onyx members may obtain these medicines from any pharmacy. Tanzanite One and Beryl members must 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 DSPs, generic utilisation (medicine price list - MPL) and option-specific Scheme Rules such as benefit limits. Consult your option-specific Scheme Rules for more information on where these apply to your option.

Chronic medicine programme

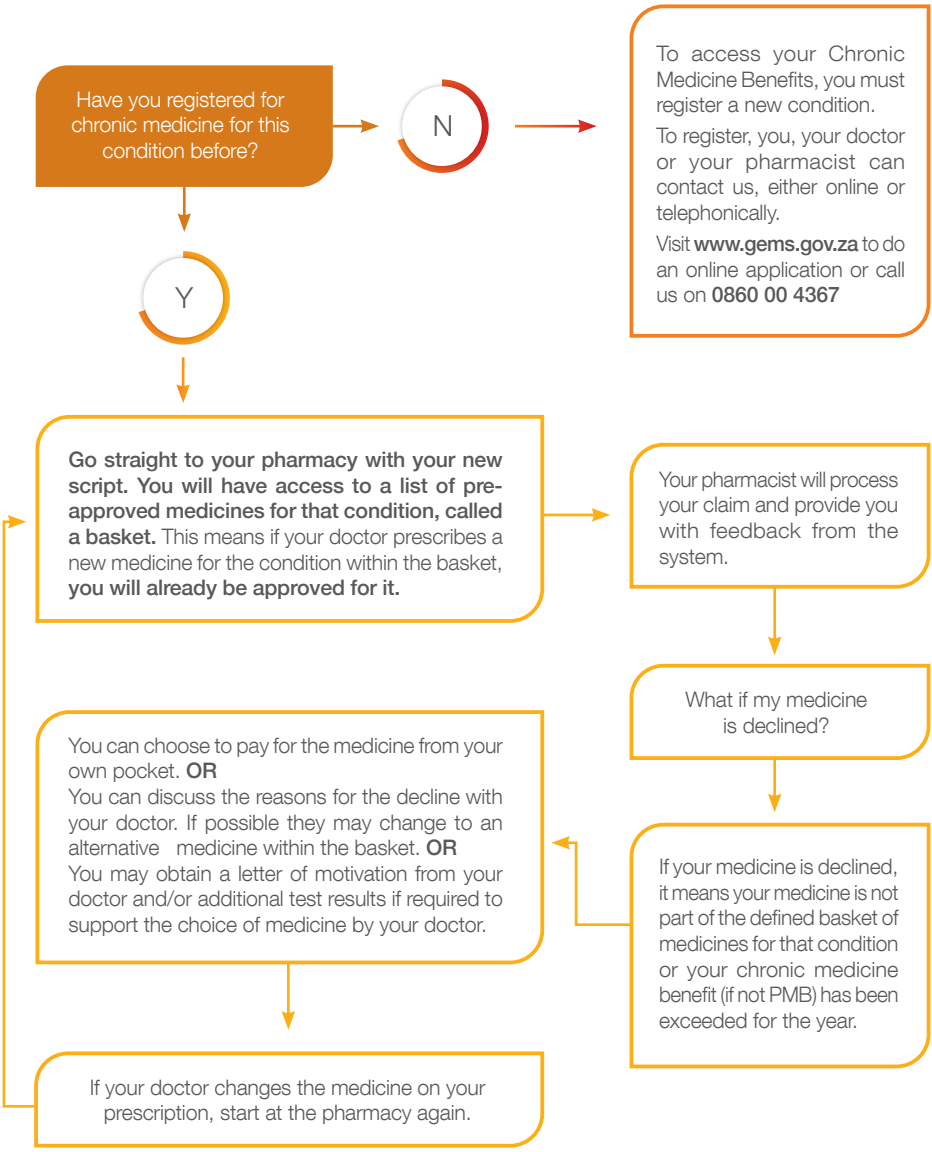
Chronic medicine is used on an ongoing basis to treat disabling and/or potentially life-threatening illnesses such as diabetes, which affect health and quality of life negatively. The conditions for which chronic medicine will be authorised are listed on the next page.

Chronic disease list 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 disease, asthma, bipolar mood disorder, bronchiectasis, cardiac failure; cardiomyopathy, chronic renal disease, coronary artery disease, chronic obstructive pulmonary disease, Crohn's disease, diabetes insipidus, diabetes mellitus type 1, diabetes mellitus type 2, dysrhythmias, epilepsy, glaucoma, haemophilia, HIV/Aids, hyperlipidaemia, hypertension, hypothyroidism, multiple sclerosis, Parkinson's disease, schizophrenia, ulcerative colitis, rheumatoid arthritis, systemic lupus erythematosus.

Additional chronic disease list	
Payable from the chronic medicine benefit (subject to managed care protocols, processes and formularies):	
Tanzanite One and Beryl	Anxiety, attention deficit and hyperactivity disorder, depression
Ruby	Anxiety, attention deficit and hyperactivity disorder, benign prostatic hyperplasia, depression, Meniere's disease, osteoarthritis, psoriasis, thromboembolic disease
Emerald Value, Emerald and Onyx	Acne, allergic rhinitis, Alzheimer's disease, ankylosing spondylitis, anorexia nervosa, anxiety, attention deficit and hyperactivity disorder, Barrett's esophagus, benign prostatic hyperplasia, bulimia nervosa, delusional disorder, depression, dermatitis, eczema, gastro-oesophageal reflux disease, generalised anxiety disorder, gout, Huntington's disease, hypoparathyroidism, hypothyroidism, interstitial lung disease, Meniere's disease, menopause, myasthenia gravis, narcolepsy, neuropathies, obsessive compulsive disorder, osteoarthritis, osteopenia, osteoporosis, Paget's disease, post-traumatic stress syndrome, psoriasis, stroke, systemic sclerosis, thrombocytopenic purpura, thromboembolic disease, Tourette's syndrome, valvular heart disease, and Zollinger-Ellison syndrome

How to obtain chronic medicines with Disease Authorisations

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



Your chronic diagnosis must be pre-authorised by the chronic medicine management department to ensure that the prescribed medicine is reimbursed from the chronic medicine benefit. Some medicines are not paid in full if they are not on the Scheme's formulary or MPL. Sometimes, medicine will not be authorised when it does not fall within the reimbursement guidelines for a specific condition. Ask your doctor to prescribe the most cost-effective medicine according to the MPL and the GEMS formulary so that you do not need to pay out of your own pocket.

We will check your application against Scheme Rules to see if the medicine is covered under the chronic medicine benefit.

- If we approve your application, you will receive a medicine access card listing the chronic conditions and/or medicine that we will pay for from your chronic medicine basket.
- If the chronic conditions and/or medicine that we will pay for differs from the medicine your doctor has prescribed, we will explain in a letter accompanying your medicine access card. We will also send a copy of the letter to the prescribing doctor.
- If we do not approve your application for a chronic condition or medicine, you and your doctor will both receive an explanatory letter.

The duration of authorisation varies from medicine to medicine - some medicines are authorised on an ongoing basis and others for a limited period. The medicine access card will detail the duration.

What if my chronic medicine authorisation request has been declined?

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

Can I appeal a medicine authorisation?

Yes, you can appeal a decision to either reject your application for chronic medicine or provide you with an alternative to the prescribed medicine.

Ask your doctor to write a clinical motivation and email it to chronicauths@gems.gov.za. He or she can also call us on 0860 436 777.

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

How do I obtain my approved chronic medicine?

Through either our courier pharmacy or your nearest GEMS network pharmacy. Once you have indicated your choice, you will either collect your medicine at your nearest GEMS network pharmacy or the courier pharmacy will contact you to make medicine delivery arrangements. If you choose to obtain your approved chronic medicine from a supplier that is neither the GEMS courier pharmacy nor a GEMS network pharmacy, you will be liable for a 30% co-payment, which must be paid directly to the pharmacy or dispensing doctor.

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

After you have been contacted by the chronic medicine manager and registered with either the courier pharmacy or a specific GEMS network pharmacy, you will be expected to remain with that pharmacy for at least six months before changing.

However, if you are on the chronic medicine programme and change your home or work address, you may contact the chronic medicine manager to change your registered pharmacy. You will be contacted by the chronic medicine manager twice a year to confirm or reconsider whether you want your medicine delivered by the courier or collected at the GEMS network pharmacy.

Am I required to use my registered GEMS network pharmacy for my chronic medicine or can I use any GEMS network pharmacy?

Once you have been allocated to your nominated pharmacy, you must obtain your medicine only from that pharmacy for a minimum of 6 months before you change.

- You are allowed to obtain your authorised chronic medicine from a non-nominated pharmacy once only during the benefit year, except where the courier pharmacy is the non-nominated pharmacy. Once this allocation is exceeded, then you will be liable for a 30% co-payment.

However, you can request to be re-allocated when:

- You have changed employers or employment address.
- You have changed residential address.
- 6 months has passed since the initial allocation.
- Your preferred pharmacy is no longer part of the network.
- If for whatever reason, you are unhappy with your allocated pharmacy.
- Should you wish to change your allocated pharmacy, please contact us to facilitate this.

How often do I need to supply the GEMS courier or GEMS network pharmacy with a repeatable prescription?

A valid doctor's prescription must be presented before the pharmacy supplies you with your chronic medicine. Prescriptions then have to be renewed every 6 months, which is a legal requirement. Scripts for Schedule 6 medication must be renewed monthly. The chronic medicine manager will SMS you a reminder to obtain a new prescription before your old one expires. Whether you are obtaining your medicine from the courier pharmacy or a network pharmacy, you need to send a new prescription when due or you will not receive your medication.

Disease management programmes

HIV/AIDS disease management programme (DMP)

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

Confidentiality guaranteed

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

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

- Telephone: 0860 436 736
- Fax: 0800 436 732
- Send a 'please call me' to: 083 843 6764
- Email: hiv@gems.gov.za

What HIV/AIDS benefits are available?

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

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

How do I register on the HIV/AIDS DMP?

1. Know your HIV status by requesting a doctor or clinic to perform a HIV test. GEMS will pay for this test.
2. If you have tested HIV-positive, obtain an application form by calling 0860 436 736 or use our 'please call me number' 083 843 6764 from Monday to Friday between 08:00 and 17:00 and Saturday from 08:00 to 12:00. Alternatively, send an email to hiv@gems.gov.za or download one from www.gems.gov.za.
3. Your treating doctor will examine you and complete your application form. Sign the application form and submit it to GEMS.
4. Fax your completed form to the confidential toll-free fax number 0800 436 732 or email it to hiv@gems.gov.za
5. We will contact you to discuss the outcome of your application.

How do I get my HIV/AIDS medicine?

The HIV/AIDS DMP enrols, manages and supports members while GEMS chronic medicine DSP – the courier pharmacy and GEMS network pharmacies – provide members with all chronic medicine, including for HIV. If you get your antiretrovirals or other medicine from a pharmacy not contracted to GEMS network, you will pay 30% of the cost of medicine and dispensing fees.

When you use our allocated GEMS network pharmacy or courier pharmacy, discussions about your medicine are confidential. If you use the courier pharmacy, your medicine is delivered in a package that does not reveal the contents. If you collect from a GEMS network pharmacy, you are also guaranteed confidentiality. Medicine for other chronic conditions, such as high blood pressure, can be delivered or collected with your HIV medicine.

Your chronic medicine DSP will remind you to obtain a new repeat prescription 21 days before your current prescription expires. Schedules 1 to 5 prescriptions expire after 6 months according to law. Schedule 6 scripts must be renewed monthly.

Oncology (cancer) management programme

If you or a member of your family is diagnosed with cancer, register on the oncology management programme as soon as possible, as all oncology treatment requires pre-authorisation and case management.

1. Your doctor must fax your treatment plan to the oncology management programme on 0861 00 4367 or email oncologyauths@gems.gov.za. You can also contact the GEMS call centre on 0860 00 4367.
2. Once the oncology management team has received the treatment plan from your doctor, it 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 alternatives.
4. After the treatment plan has been assessed and approved, an authorisation will be sent to your treating doctor. You will also receive an authorisation letter that shows the treatment that GEMS has authorised, the approved quantities and authorisation duration.

Ensure that your doctor informs the oncology management team of any change in treatment, as your authorisation will need to be re-assessed and updated. Without this notification, GEMS may reject your claims or pay them from an incorrect benefit.

You need pre-authorisation

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

Chronic back and neck rehabilitation programme

The GEMS back and neck rehabilitation programme provides you or your dependants with treatment to manage back and neck pain.

The programme focuses on functional rehabilitation, with major components being controlled exercises, biopsychosocial support and pain education. Clinical measurements are taken and recorded to evaluate the progress of treatment over time. The treatment is delivered by reputable service providers such as physiotherapists and biokineticists, using international standard protocols and interventions. Members are referred to the facility closest to them to be assessed and a treatment plan is formulated, which can extend to six weeks depending on the assessment.

Positive outcomes include improved flexibility, reduced pain and stiffness, leading to a more productive life.

The intervention entails:

- A comprehensive assessment.
- A tailored treatment programme ranging from 1 to 12 active treatment sessions.
- Physiotherapy for pain management and muscle relaxation.
- A progress assessment with the doctor.
- A comprehensive outcome assessment to assess progress and measure improvement.
- Tailored home-based exercises and stretches to maintain results long term.
- Follow-up visits to track improvement following the completion of the programme.

How the programme works

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

What benefits will be used?

The orthopaedic disease management programme benefit will be used for members receiving treatment at the centres.

How can you access the programme?

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

Renal dialysis network

GEMS established a renal dialysis network in 2018 to contain the cost of care whilst enhancing the quality of care and maintaining access to treatment.

Use of the network is compulsory for patients who are newly diagnosed with chronic renal failure and require treatment.

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

Co-payment will not be applied to:

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

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

In-hospital benefit management programme

The in-hospital benefit management programme ensures that you receive appropriate, quality healthcare in hospital. Pre-authorisation ensures that the planned procedure is both necessary and appropriate before you are admitted to hospital.

Maternity programme

Pregnant members and dependants have access to the maternity programme, which gives support, education and advice through all stages of pregnancy, the confinement and post-natal (after birth) period.

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

The programme is managed by experienced health professionals who will help you register. Contact them on 0860 00 4367 for advice and information.

Benefits of joining the maternity programme:

- A GEMS pregnancy, birth and early parenting book when you register.
- A free maternity bag during your third trimester.
- Free access to all services offered by the programme.
- Information about the benefits offered by GEMS during your pregnancy and after the birth of your child.
- A care plan to guide your doctor in appropriate treatment for the duration of your pregnancy.
- Support for you at work by either your healthcare practitioner and a workplace support colleague (human resources practitioner or manager) if you choose to nominate one, providing them with the tools to support you along this journey.
- If you have a high-risk pregnancy, you will receive additional telephonic support from midwives to help you manage and reduce the risks to you and your baby.
- Access to healthcare information to make informed decisions with your midwife or doctor about your health and birth choices.
- Telephonic advice and support if you experience problems during the first six weeks of parenthood.
- Registration on the GEMS maternity programme website in your third trimester, providing information, tools, and resources for you, your family and your support network as your young family grows. If you can't go online, your midwife on the programme can access the information for you if you contact the call centre on 0860 00 4367.

- Access to a virtual online shopping mall from the third trimester and after your baby is born, offering discounts on a range of baby products.
- You, your healthcare practitioner and your nominated workplace colleague will also receive regular electronic newsletters covering topics relevant to your pregnancy, your birth experience and early parenthood.

To view a comprehensive brochure about the maternity programme, visit www.gems.gov.za and click on 'Maternity programme'.

Registering on the maternity programme

Complete a registration form obtainable from **www.gems.gov.za** or **0860 00 4367**.

Fax this to 0861 00 4367, email it to enquiries@gems.gov.za or post it to GEMS maternity programme Private Bag X782, Cape Town 8000. You may also SMS 'please call me' to 41773 for assistance.

Dental benefit

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

Network service providers

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

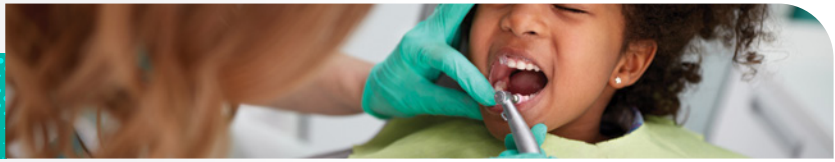
If you are on Tanzanite One or Beryl, dental services must be provided by a dentist or dental therapist who is part of the GEMS dental network. You can find a network provider at www.gems.gov.za or by calling 0860 00 4367.

Dental treatment in hospital: If you are on Tanzanite One or Emerald Value, use a GEMS network hospital to avoid any out-of-pocket expenses. Consult the list at www.gems.gov.za or by calling 0860 00 4367. If due process is not followed, you will be liable for a penalty of R12 000.

Pre-authorisation for specialised dentistry

Members and dependants need pre-authorisation for the following treatment types: Dental hospitalisation, maxillofacial surgery, crown and bridge treatment, periodontal treatment, orthodontics and dentures (on some options). Read the benefit schedule in the option-specific benefit schedule for details of your dental benefits and pre-authorisation requirements.

Dental hospitalisation is allowed only for impacted teeth, severe trauma (PMBs) or patients younger than six years. Contact us for pre-authorisation for hospitalisation at least 48 hours before treatment,



unless it is an emergency. If due process is not followed, you will be liable for a penalty of R1 000.

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

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

Dental exclusions

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

Elective cosmetic procedures

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

Optometry benefit

The GEMS optometry benefit covers expenses for clinically essential optometry necessary for your health and your sight.

Not all items prescribed by your provider may be covered. Exclusions include:

- Plano (zero power) and low-power lenses for both eyes.
- Sunglasses and spectacles with lens tints exceeding 35%, except for albinism.
- Both spectacles and contact lenses in an optical appliance cycle of 24 months (only one option is covered).
- Bifocal or multifocal lenses for youngsters, unless properly motivated by your optometrist.
- Contact lenses for children under the age of 16, unless motivated.
- Clinically non-essential additions, such as coatings.
- The benefit schedule specifies a limit for your family, and a sub-limit for each beneficiary or dependant registered with GEMS. Each beneficiary can claim only up to a maximum of each sub-limit, with the ‘family limit’ applying to the family’s claim.

Family limits

Emerald has a family limit of R4 656 and a beneficiary limit of R2 329 for every 24 months. If two members of the family need glasses to a total value of R3 500, GEMS will pay only R1 156 of the next beneficiary’s account. The balance will be for your own account.

Wellness and preventative screening benefit

Wellness programme

GEMS health and wellness screening service (HWSS) addresses the rising negative impact of ill-health on public servant productivity.

The service focuses on preventive measures, helping employees with lifestyle changes. It has proved very beneficial and results to date have been encouraging.

Testing the current health and wellbeing of employees provides knowledge to plan and implement meaningful and targeted interventions. We encourage you to make the most of the GEMS wellness days to which you have access.

The HWSS initiative aims to create a strong culture of wellbeing within government departments and include the following:

- Providing health screenings for all public service employees.
- Early identification of lifestyle diseases (diabetes, hypertension), including HIV.
- Referral to GEMS Disease Management Programmes (DMP).
- Support and guidance to maintain mental, psychological and social wellbeing for optimal functioning in the workplace.
- Raising awareness of the importance of wellbeing and healthy living.

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

- Body mass index assessments.
- Random blood glucose testing.
- Blood pressure testing.
- Total cholesterol testing.
- HIV counselling and testing.
- Oral health education.
- Tuberculosis screening questionnaires.
- Lifestyle questionnaires.
- Head, neck and shoulder massages.

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

As these are random screening tests, participants are referred to their GP for final diagnoses.

Preventive care and screening benefit

All members have access to a separate preventive care and screening benefit payable from risk in-hospital benefits. The tables below list the benefits available from GPs and pharmacies.

SCREENING SERVICES – OBTAINABLE FROM YOUR GP		
Procedure	**Frequency**	**Eligible beneficiaries**
Cholesterol screening	Twice a year	20 years and older
Osteoporosis screening (bone densitometry scan)	Once a year	Females 65 years and older
Cytology screening (pap smears)	Once a year	Females 12 to 65 years
HIV/Aids pre-test counselling with no test	Twice a year	All beneficiaries
HIV/Aids (screening test, post-test counselling, confirmatory test and condoms)	Twice a year	All beneficiaries
Mammography screening	Once a year	Females 40 years and older
Prostate screening	Once a year	Males 45 to 69 years
Faecal occult blood test	Once a year	50 to 75 years
Glucose screening	Twice a year	20 years and older
Glaucoma screening	Once a year	40 years and older
Neonatal hypothyroidism	Single screening	Up to 28 days old
Childhood hearing screening	Once per beneficiary	≥1 – 7 years
Infant hearing screening	Once per beneficiary	Birth - 1 year (excluding first three months of life)
Childhood optometry screening	Once per beneficiary	Birth - 7 years (excluding first three months of life)
Syphilis screening	Twice per beneficiary a year	All beneficiaries
Chlamydia/gonorrhoea screening	Twice per beneficiary a year	All beneficiaries
Tuberculosis screening	Twice per beneficiary a year	All beneficiaries

SCREENING SERVICES – OBTAINABLE FROM PHARMACIES		
Procedure	**Frequency**	**Eligible beneficiaries**
Cholesterol screening	Twice a year	20 years and older
Blood pressure monitoring	Twice a year	18 years and older
HIV/Aids pre-test counselling with no test	Twice a year	All beneficiaries
HIV/Aids (screening test, post-test counselling, confirmatory test and condoms)	Twice a year	All beneficiaries
Peak flow measurement	Once a year	4 years and older
Glucose screening	Twice a year	20 years and older
Pregnancy screening	Once a month to a maximum of six a year	Female beneficiaries ≥12 years
Urine analysis	Four a year	All beneficiaries

VACCINATION SERVICES – OBTAINABLE FROM GPS AND PHARMACIES		
Procedure	**Frequency**	**Eligible beneficiaries**
Influenza vaccination	Once a year	All beneficiaries ≥6 months of age*
Pneumococcal vaccination	Once every five years	High risk beneficiaries: ≥65 years 2 to 64 years with a chronic registration/relevant hospital admission**
HPV vaccination (1 course = 3 doses)	One course per beneficiary per lifetime	Females 9 to 14 years

* Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner 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

GEMS 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.

EMS include:

- Help given over the phone in 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 to another where medical intervention is required.

Follow these steps in an emergency:

1. Dial 0800 44 4367 to contact the EMED centre.
2. Give your name and the telephone number from which you are calling.
3. Give the address or location of the incident to help paramedics reach the scene.
4. Provide a brief description of what has happened and its seriousness, 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 other person has disconnected.

ALERT:

Ensure that all your registered dependants are aware of this service. Inform your child's school that your child is a member of GEMS and make sure your child and the school knows the emergency medical service number. Should you need to be transferred from one hospital to another, 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 44 4367**.

Changing your benefit option

You can change your benefit option only at year-end. Option changes at any other time need special permission from the Scheme. A notice period will be applied. Refer to Scheme Rules 16.2.2 and 16.2.3 at www.gems.gov.za for more information. To help you decide if you want to change options during the annual option selection period, you will receive information from GEMS about new benefits, and an option selection form, which must be submitted by the deadline provided. Should you decide to change your option, your membership of the new option will start on 1 January of the next year.

You do not need to complete an option selection form if you 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.

Governance of the Scheme

In addition to the Scheme's Board of Trustees and executives, seven committees of the Board oversee work 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

This committee assists the Board of Trustees to carry out its duties relating to the Scheme's accounting policies, internal control systems, financial and sustainability reporting and risk management practices.

Finance and Investment Committee

This committee assists the Board of Trustees to ensure efficient operations of the Scheme, such as the collection of contributions, claim payments and managing member records.

Clinical Governance and Administration Committee

This committee (previously called Ex Gratia Committee) considers member requests for ex gratia assistance. These are requests for financial assistance for beneficiary healthcare services that do not form part of their benefit entitlements. The Scheme's ex gratia function contributes to the health and wellbeing of members and their families by further enhancing access to healthcare services in a responsible manner.

Risk, Social and Ethics Committee

This committee ensures that sound corporate governance is applied in the Scheme's affairs by making sure that it complies with all laws and rules that affect its operations. The committee also makes sure that risks to the Scheme's business are identified and properly managed and that the interests of all Scheme stakeholders are properly protected.

Dispute Committee

The Dispute Committee independently considers and presides over any dispute raised by members.

Human Resources and Remuneration Committee

This committee's responsibilities include overseeing the maintenance and administration of the GEMS Remuneration Policy for employees, trustees and independent committee members, and reporting against the policy; overseeing the maintenance and administration of the GEMS Performance Management Policy for employees, and overseeing the annual employee and trustee salary surveys conducted on behalf of the Scheme.

Benefit Design and Strategy Development Committee

This committee develops recommended option changes considering proposals from members, GEMS service providers and the trustees.

GEMS service providers

We have contracted a network of service providers in 2020, from administrative and operational services to quality healthcare.

These include:

- ASI – Telemarketing and financial advisory consultancy
- DENIS – dental management services
- Europ Assistance – EMED contact centre
- Healthi Choices – Health and Wellness Screening Services
- Healthi Choices – maternity programme
- MediKredit – Pharmacy benefit management
- Medipost Pharmacy – chronic medicine courier pharmacy
- Medscheme – contributions and debt management services
- Medscheme Health Risk Solutions – managed care services
- Metropolitan Health – correspondence services
- Metropolitan Health – membership and claims services
- Opticlear – optometry management services
- Thebe Health Risk Management Joint Venture – HIV/Aids disease management services
- Universal Healthcare – medicine management programme and strategic managed care

Glossary

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

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

Beneficiary
A person who can receive benefits from GEMS. A beneficiary is either the main member on GEMS or one of his or her 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 Scheme option: Tanzanite One, Beryl, Ruby, Emerald Value, Emerald or Onyx.

Chronic
A chronic condition is one that needs ongoing treatment, or treatment for at least three months. Examples are asthma and diabetes.

Chronic disease list
The 26 chronic diseases for which all medical schemes need by law to provide minimum cover.

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

Consultation
A visit to your doctor, surgeon or other healthcare provider for a diagnosis or treatment. This includes hospital visits by your healthcare provider.

CT and MRI scans
Specialised and more advanced x-rays.

Designated service provider
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. They include doctors, pharmacies and hospitals. Should you choose not to use a DSP, you pay 30% of the cost of the consultation or treatment. Similarly, a 30% co-payment applies should you choose a facility not on the GEMS network of renal dialysis facilities.

Formulary
The list of approved medicine, tests or services.

GEMS tariff
The rate at which healthcare providers are paid for services rendered to GEMS members.

GEMS network
A network of healthcare providers consisting of GPs, specialists, pharmacies, dentists and optometrists who have promised to deliver quality healthcare at Scheme rates to members.

General anaesthesia
Administering of medicine that puts you in a deep sleep so you do not feel pain during a procedure. You are not aware of what is happening around you.

General practitioner
GPs are doctors who provide general healthcare services. Always consult the same GP so that he or she can develop a good understanding of your health and treatment history to make informed decisions about your care, including referral to a specialist.

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

ICD10 code
A code on a healthcare provider account that informs medical schemes of the conditions for which members are treated 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
A list of medicines that GEMS does not cover for various reasons.

Medicine price list
A reference pricing system used to work out the prices of groups of medicine. The medicines are grouped according to similarity of ingredients, strengths and form. If a member and healthcare provider use medicine more expensive than the reference price, the member pays the difference.

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

Personal medical savings account
The portion of your monthly contribution allocated to a savings account in your name. This money is used for your out-of-hospital medical expenses if you are a Ruby member.

Contact details

SERVICE	PURPOSE	TELEPHONE	EMAIL ADDRESS/ LINKS FOR QUERIES
GEMS contact centre	General queries related to GEMS	0860 00 4367	enquiries@gems.gov.za
GEMS website	View GEMS products and services	-	www.gems.gov.za
GEMS tariff file, formularies and forms	To view GEMS tariff file, formularies and forms	-	www.gems.gov.za, select Healthcare Providers > Tools > Select either Tariff file, ICD10 Codes or Forms from the menu.
Chronic medicine management – new registrations and updates	Chronic registrations	0860 00 4367	chronicdsp@gems.gov.za
Chronic medicine authorisation queries	Queries related to the authorisation of chronic medicines	0860 00 4367	chronicauths@gems.gov.za
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	enquiries@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	Ambulatory PMB queries	0860 00 4367	enquiries@gems.gov.za
HIV/AIDS management	HIV/AIDS related queries	0860 436 736	hiv@gems.gov.za

GEMS Walk-In Centres

REGIONAL OFFICE WALK-IN CENTRE	ADDRESS
Eastern Cape	**East London:** Gillwell Shopping Centre Shop LG36, Lower Level, Cnr Gilwell Road and Fleet Street. **Mthatha:** Savoy Complex Unit 11and 12A, Nelson Mandela Drive.
Free State	**Bloemfontein:** Bloem Plaza Shop 124, Charlotte Maxeke Street. **Welkom:** GoldFields Mall Shop 51A, Cnr Strateway and Buiten Street.
Gauteng	**Johannesburg:** Traduna House 118 Jorrisen Street, Ground Floor, Cnr Jorrisen and Civic Boulevard(opposite Civic Centre), Braamfontein. **Pretoria:** Sancardia Building, Shop 51, First Floor, c/o Beatrix & Church Streets, Acardia.
KZN	**Durban:** The Berea Centre Shop G18, Entrance 1, 249 Berea Road, Berea. **Pietermaritzburg:** Deloitte House Suite 3, Block A, 181 Hoosen Haffejee Street (Berg Street).
Limpopo	**Polokwane:** Shop 1, 52 Market Street **Thohoyandou:** Unit G3, Metropolitan Centre.
Mpumalanga	**eMalahleni(Witbank):** Safeways Crescent Centre, Shop S67, c/o President and Swartbos Streets. **Nelspruit:** Shop No. 18, Nedbank Centre, 30 Brown Street, Nelspruit CBD
North West	**Klerksdorp:** City Mall, Shop 101, c/o OR Tambo & President Street. **Mafikeng:** Mmabatho Megacity Shopping Centre, Shop 39, c/o Sekame & James Moraka Streets, Mmabatho.
Northern Cape	**Kimberley:** New Park Centre, Shop 14, Bultfontein Way & Lawson Street. **Upington:** 61A Market Street.
Western Cape	**Cape Town:** Constitution House, 124 Adderley Street. **Worcester:** Mountain Mill Shopping Centre Shop 125A and B, Mountain Mill Drive

Contact details

GEMS Contact Centre
0860 00 4367 for member queries
0860 436 777 for provider queries

Fax
0861 00 4367

Web
www.gems.gov.za

Email
enquiries@gems.gov.za

Postal address
GEMS, Private Bag
X782, Cape Town, 8000

GEMS Emergency Services
0800 444 367

GEMS Fraud hotline
0800 212 202
gems@thehotline.co.za

The digital membership card is available on the GEMS Member app and is convenient for members and their beneficiaries. 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.