Oncology benefit 2023

Who we are

Retail Medical Scheme (referred to as 'the Scheme"), registration number 1176, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as "the Administrator"), is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd administers the Scheme.

Contact us

You can call us on **0860 101 252** or visit www.retailmedicalscheme.co.za for more information.

Overview

This document explains how the Scheme covers you for cancer treatment on the Oncology Programme for 2023. It gives you details about:

- What you need to do when you are diagnosed with cancer
- What you need to know before your treatment
- How this benefit will cover your approved cancer treatment.

It also explains the allocated 12-month cycle limit for approved cancer treatment and what you'll need to pay once your allocated limit is reached.

We also provide information about your benefits for cancer treatment under Prescribed Minimum Benefits (PMB) and how we cover consultations with cancer-treating GPs and specialists, when you are treated in- or out-of-hospital.

What you need to do before your treatment

Tell us if you're diagnosed with cancer and we'll register you on the Oncology Programme.

If you are diagnosed with cancer you need to register on the Oncology Programme to have access to the Oncology Benefit. To register, you or your treating doctor must send us details of your histology results that confirm your diagnosis. Call us on **0860 101 252** for assistance.

Understanding some of the terms we use in this document

There are a number of terms we refer to in the document that you may not know. We give you the meaning of these terms.

Terminology	Description
Above Threshold Benefit	The Above Threshold Benefit is included on the Essential Comp plan has been removed and the Essential Plus Option. The Scheme starts paying for non-hospital expenses once the member has reached a certain accumulated amount. The benefit is limited on the Essential Plus Option.
Centres	Medical facilities that the Scheme has chosen to partner with. We will refer you to your nearest centre for treatment. You can choose not to go to our centres but then your cover will be limited and you may have co-payments.
Co-payment	The portion that you have to pay yourself, like when the amount the Scheme pays is less than what your doctor charges.
Day-to-day benefits	The funds available in the Medical Savings Account or Above Threshold Benefit.
Deductible	The amount that you must pay upfront to the hospital or day clinic. You must pay this amount from your own pocket.
Scheme rate	The rate that Scheme sets for paying claims from healthcare professionals.
ICD-10 code	A clinical code that describes diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases as classified by the World Health Organization (WHO).
Morphology code	A clinical code that describes the specific histology and behaviour and indicates whether a tumour is malignant, benign, in situ, or uncertain (whether benign or malignant) as classified by the World Health Organization (WHO).
Payment arrangements	We have payment arrangements in place with specific specialists and GP's to pay them in full at a higher rate. When you use these providers you won't need to make a co-payment.
Prescribed Minimum Benefits	A set of conditions for which all medical schemes must provide a basic level of cover. This basic level of cover includes the diagnosis, treatment and costs of the ongoing care of these conditions.
12-month cycle limit	A 12-month benefit period that is individualised depending on when a member is diagnosed with cancer. For example, if a member is newly diagnosed and registered on the 1st,the member's 12-month cycle benefit threshold will refresh 12 months later (1st April the following year).
Histology Results	A report that confirms the diagnosis of a disease after a specimen of tissue from the body (biopsy) is examined in a laboratory under a microscope to spot the signs and features of a disease.

The Oncology Benefit at a glance

We cover the first portion of your treatment over a 12-month cycle in full up to 100% of the Scheme Rate. Depending on your benefit option, the Oncology Programme covers the first R200 000 of your approved cancer treatment over a 12-month cycle in full up to the Scheme Rate.

Once your treatment costs go over this amount the Scheme will pay 80% of the Scheme Rate of all further treatment for non-PMB cancer treatment and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate. PMB treatment is paid in full from the Scheme's DSPs.

All costs related to your approved cancer treatment including Prescribed Minimum Benefit treatment during the 12-month period, will add up to the 12-month cycle cover amount.
We cover all cancer-related healthcare services up to 100% of the Scheme Rate from health professionals who do not have a payment arrangement with the Scheme. You might have a co-payment if your healthcare professional charges more than this rate. Health professionals who have a payment arrangement with the Scheme will be funded at the agreed rate.

Treatment provided by your cancer specialist and other healthcare providers that add up to the 12-month limit include:

- Chemotherapy and radiotherapy
- Technical planning scans
- Implantable cancer treatments, including brachytherapy and Gliadel® wafers
- Hormonal therapy related to your cancer
- Consultations with your cancer specialist
- Fees charged by accredited facilities
- Specific blood tests related to your condition
- Materials used in the administration of your treatment, for example drips and needles
- Medicine on a medicine list (formulary) to treat pain, nausea and mild depression as well as other medicine used to treat the side effects of your cancer treatment (except schedule 0, 1 and 2 medicines)
- External breast prostheses and special bras
- Stoma products
- Oxygen (rental of home oxygen concentrators)
- Radiology requested by your cancer specialist, which includes:
    - Basic x-rays
    - CT, MRI and PET-CT scans related to your cancer
    - Ultrasound, isotope or nuclear bone scans
    - Other specialised scans, for example a gallium scan.
- Scopes such as bronchoscopy, colonoscopy and gastroscopy that are used in the management of your cancer. Please note that we will fund up to a maximum of two scopes from your Oncology Benefit for the management of your condition if you are enrolled on the Oncology Programme.

We pay certain treatments from your day-to-day benefits. Other needs related to your condition and treatments that are not covered from the Oncology Benefit will be paid from the available funds in your day-to-day benefits. This includes, for example, wigs.

You have full cover if your doctors have an agreement with us

You can benefit by using doctors and other healthcare providers like hospitals who we have an agreement with us because we will cover their approved procedures in full.

You have cover for bone marrow donor searches and transplants

Bone marrow transplant costs do not add up to the 12-month limit for cancer treatment.
The Scheme covers you for bone marrow donor searches and transplants up to the agreed rate if you adhere to our protocols. Your cover is subject to review and approval.

We need the appropriate ICD-10 and morphology codes on accounts

All accounts for your cancer treatment must have the relevant and correct ICD-10 and morphology code for us to pay it from the Oncology Benefit. To ensure there isn't a delay in paying your doctor's accounts it would be helpful if you double check to make sure that your doctor has included the ICD-10 and morphology codes.

Introduction of a Designated Service Provider (DSP) Pharmacy network for oncology medicines

Oncology medication significantly contribute to the total medication expenditure of the Scheme and the Trustees approved the implementation of a Designated Service Provider (DSP) for oncology to ensure that efficiencies can be achieved whilst ensuring sustainable access to a comprehensive oncology benefit offering. Through a DSP arrangement, the Scheme can work with the pharmacies to ensure that members are dispensed the most preferentially price products.

In 2023, the Scheme will introduce a Pharmacy DSP for the supply of approved oncology medicines

Please ensure that you use our pharmacy DSP for your oncology medicines. For treatment administered in the doctors' rooms (in-rooms) your treating doctor will need to use one of the following providers within the DSP:

- Dis-Chem's Oncology Courier Pharmacy
- Medipost Pharmacy
- Qestmed
- Olsens Pharmacy
- Southern Rx

Speak to you treating doctor if you have any concerns.

Where your treating doctor has provide you with a prescription (like supportive medicine, oral chemotherapy and hormonal therapy). Please use a MedXpress Network Pharmacy or one of the in-rooms pharmacies.

Please refer to Oncology Benefit brochure for 2023 for any additional information.

Understanding what is included in your cancer benefits

Prescribed Minimum Benefits (PMB)

PMBs is a set of conditions for which all medical schemes must provide a basic level of cover. This basic level of cover includes the diagnosis, treatment and costs of the ongoing care for these conditions.

The aim of the PMB treatment is to ensure that no matter what benefit option a member is on there is always a basic level of cover for these conditions.

Cancer is one of the conditions covered under PMB. We will cover your treatment in full as long as you meet all three of these requirements for funding.

Your condition must be part of the list of defined conditions for Prescribed Minimum Benefits (PMBs).	You may need to send us the results of your medical tests and investigations that confirm the diagnosis for your condition.
The treatment you need must match the treatments included as part of the defined benefits for your condition.	There are standard treatments, procedures, investigations and consultations for each condition.
You must use a doctor, specialist or other healthcare provider who the Scheme has an agreement with.	There are some cases where this is not necessary, for example a life-threatening emergency

Tests to confirm a diagnosis (diagnostic work-up)

This refers to the certain out-of-hospital pathology and radiology tests and investigations that are carried out in diagnosing your cancer. We may pay these from your day-to-day benefits upon request Once confirmed, you can request for us to review these diagnostic tests to be funded as a Prescribed Minimum Benefit. You can call us on 0860 101 252

You may apply for us to review this decision

We will review this decision if you or your doctor sends us new information about your condition or information that was not sent with the original application. We will review the individual circumstances of the case but please note this process does not guarantee funding approval.

The Oncology Programme at a glance

Tell us about your cancer treatment and we'll tell you how we will cover it

If you need cancer treatment, your cancer specialist must send us your treatment plan for approval before starting with the treatment. We will only fund your cancer treatment from the Oncology Benefit if your treatment plan has been approved and meets the terms and conditions of the Scheme.

You have cover from PMB but you must use a healthcare provider that has an agreement with us and your treatment must match the treatments included as part of the defined benefits for your condition or you will have a co-payment. Refer to page 4 for more information about the PMBs.

Use approved treatment methods and medicine

The Scheme does not pay for medicine and treatment that are not approved or registered by the Medicines Control Council of South Africa (MCC). This includes treatment that has not been sufficiently tested as well as herbal or traditional treatments.

We also do not cover PET-CT scans or any other cancer treatment that we have not approved.

Use doctors that have an agreement with us

If we have an agreement with your doctor, the Scheme will pay all your approved treatment costs. If we don't have an agreement with your doctor you will have to pay any difference between what is charged and what the Scheme pays.

Where there are no payment agreements for healthcare professionals such as radiologists (basic radiology), orthotists and prosthetists we pay these in full from the Oncology Benefit.

We cover you in full if you visit these healthcare providers who are in the Scheme's network:

Cancer-treating specialists: out of hospital	
All benefit options	Any cancer specialist who is part of our Premier Rate payment arrangement. (For specialists on other payment arrangements you may have a co-payment).

You can dispute our funding decisions in certain circumstances

If you disagree with our decision on the PMB cover you requested there is a formal disputes process that you can follow. Call us on **0860 101 252** or logon to www.retailmedicalscheme.co.za for more information.

Complaints process

You may lodge a complaint or query with Retail Medical Scheme directly on **0860 101 252** or address a complaint in writing to the Principal Officer at the Scheme's registered address. Should your complaint remain unresolved, you may lodge a formal dispute by following the Retail Medical Scheme internal disputes process.

You may as a last resort approach the Council for Medical Schemes for assistance.
Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / **0861 123 267** / complaints@medicalschemes.co.za / www.medicalschemes.co.za