



# Naspers Oncology Benefit 2011

## **Naspers Medical Fund Oncology Benefit**

This document summarises the benefits offered by the Naspers Medical Fund's Oncology Programme.

It explains the flexible range of options available for Naspers Medical Fund members who have been diagnosed with cancer. You'll find information about the cover for cancer treatments under the Prescribed Minimum Benefits, including how we cover cancer-treating GP and specialist consultations for out-of-hospital cancer treatment as well as the in-hospital treatment of cancer. It also explains about the annual limit for approved cancer treatment and what you'll need to pay once your allocated rand limit has been reached.

This summary of benefits is applicable to both N Option Plus and N Option Basic.

### **Cover for cancer**

The Oncology Benefit provides members cover for approved cancer treatment.

To offer you a flexible range of options to fund your cancer treatment, we have structured the benefit to include an amount of R182 900 for each family for each benefit year for all your approved cancer-related treatment up to the Fund Rate. You may be responsible for a co-payment if your healthcare provider charges more than the Fund Rate.

The rand amount covers the following treatments that are provided by your cancer specialist and other healthcare providers, up to the specific rand amount of R182 900:

- Chemotherapy and radiotherapy
- Brachytherapy
- Hormonal therapy relating to your cancer
- Consultations with your cancer specialist
- Fees that are charged by the treatment facility
- Specific blood tests related to your condition
- Materials that are used in the administration of your treatment, for example drips, needles, syringes, pumps and hydration
- Medicine to treat pain, nausea and depression as well as other medicine used to treat the side effects of your cancer treatment (except schedule 0, 1 and 2 medicine)
- Radiology requested by your cancer specialist, which includes:
  - Basic black and white x-rays
  - Four CT and MRI scans related to your cancer (this includes the limit of two CT and MRI scans available for in-hospital and day-to-day benefits)
  - PET CT scans (subject to benefit confirmation and approval according to clinical entry criteria)
  - Nuclear scans
  - Ultrasound, isotope or bone scans
  - Other specialised scans, for example a gallium scan
- External breast prostheses and special bras
- Stoma products
- Oxygen

Once this rand limit has been reached, we will continue funding for cancer treatment defined by SAOC Tier 1. Alternatively, you can apply to continue to have your approved cancer treatment covered by Naspers Medical Fund. This is subject to approval.

This does not apply to the Prescribed Minimum Benefits treatment, which is covered in full on with our clinical guidelines (defined as SAOC Tier 1).

Other needs related to your condition and treatments that are not listed may be funded from your day-to-day benefits, for example wigs.

**All cancer treatments, whether in- or out-of-hospital, must be approved beforehand and will be subject to managed care criteria**

## How to get the most out of the benefits available to you

### Prescribed Minimum Benefits

The Prescribed Minimum Benefits are guided by a set list of medical conditions as defined in the Medical Schemes Act of 1998. These conditions include 270 defined diagnoses and their associated treatments, as well as 27 chronic conditions.

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from the Prescribed Minimum Benefits. The three requirements are:

1. The condition must be part of the list of defined PMB conditions
2. The treatment needed must match the treatments in the defined benefits
3. Members must use a doctor, specialist or healthcare provider in the Fund's network

Your condition may be classified as a Prescribed Minimum Benefit condition, however, only certain treatment protocols are available for funding as a PMB.

Only when a member chooses to receive treatment outside of the designated service provider network, protocols and formularies, does the scheme have the right to apply co-payments.

We will pay the claims as a Prescribed Minimum Benefit if it has a valid ICD-10 code.

You can choose where to have your cancer treatment. However, if you choose to see a cancer specialist (or oncologist) who is not part of our designated service provider network, you may be responsible to pay any shortfall on the accounts.

**Cancer-treating specialists:** Any oncologist participating in our direct payment arrangement

**Cancer-treating GPs:** Any GP who is on the Discovery Health GP Network and is a member of the South African Oncology Consortium (SAOC)

#### **Medical and surgical management**

When you are admitted to hospital for medical or surgical treatment for your cancer, you need to ensure that your surgeon or treating doctor, anaesthetist **and** the hospital are within the Fund's networks.

#### **Diagnostic work-up as part of a Prescribed Minimum Benefit**

This refers to the out-of-hospital tests and investigations you need to have done for the diagnosis of your condition.

If your plan option does not cover the costs of the diagnostic work-up adequately and you require these to be covered as a Prescribed Minimum Benefit, you may appeal for this by completing and sending us an out-of-hospital PMB appeal form (OH PMB form).

### **What you need to know before your treatment**

1. We will only fund your cancer treatment from the Oncology Benefit if your treatment plan has been approved by Naspers Medical Fund.
2. If your cancer specialist charges more than the Fund Rate, you may be responsible for paying the difference from your pocket for professional services such as consultations.
3. All costs related to your approved cancer treatment will count towards the annual amount of R182 900 for each family. This includes chemotherapy, radiotherapy and other treatment prescribed by your cancer specialist as well as pathology , radiology, medicine and other cancer-related treatment that is provided by healthcare professionals other than your cancer specialist.
4. We will cover any costs that are more than the rand amount if requested and approved. You may need to pay the rest of the costs yourself.
5. The rand amount is allocated for each year and any funds left will not be carried over into the following year.
6. Certain items such as Brachytherapy and Gliadel<sup>®</sup> wafers that are administered in hospital will add up to your rand amount of R182 900.
7. Certain items such as wigs will be paid from your day-to-day benefits, if available.
8. Newly registered medicine and treatments usually enter the market at a high price. The high cost of these treatments poses a significant financial challenge to healthcare funders. Any newly registered medicine and treatment will be funded up to rand amount and subject to approval.
9. Certain treatments, scans and procedures are subject to our funding protocols and clinical entry criteria.
10. Treatment for osteoporosis is paid from the day-to-day benefits and not from the Oncology Benefit.
11. All claims must have a relevant and correct ICD-10 code for us to pay it from the Oncology Benefit.

### **What you need to do**

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 diagnosis and the test results that confirm your diagnosis. If you need cancer treatment, your cancer specialist should send us your treatment plan for approval before starting with the treatment.

Please remember that have a set rand amount available for your cancer treatment. It is important that you understand and are aware of any personal financial implications before the costs are incurred.