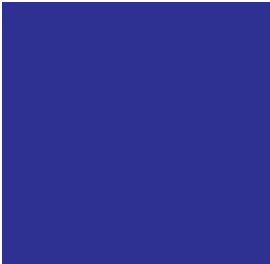
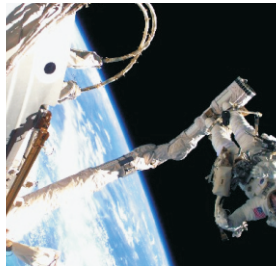


sasolmed

your wellness, our priority



sasolmed brochure

Important contact numbers

0860 00 2164



For authorisations and extensions of hospitalisation

Monday to Friday: 08:30 - 16:00 • fax: 0860 21 2223

e-mail: authorisations.cpt@medscheme.co.za • website: www.medscheme.co.za

Before you go to hospital, you, the doctor or the hospital must phone for a pre-authorisation reference number.

An automated voice system is available 24 hours a day, 7 days a week.

0860 10 0646



Aid for AIDS (all calls are totally confidential)

083 410 9078



SMS (call me)

fax: 0800 60 0773 • e-mail: afa@afadm.co.za • website: www.aidforaids.co.za

Register on the aids programme as soon as you have been diagnosed as HIV-positive

0800 01 6017



Ethics Hotline

0800 11 2811



Fraud Hotline

0860 00 2134



Sasolmed Customer Services

All queries: Monday to Friday 08:30 - 16:00 • e-mail: sasolmed@medscheme.co.za

Post claims to: Sasolmed, PO Box 2462, Vereeniging 1930

Fax: 0860 66 5357

0860 10 0608



Chronic Medicine Management

e-mail: cmm@medscheme.co.za • website: www.medscheme.co.za

0860 10 6155



Beneficiary Health Risk Management Programme

e-mail: membercare@medscheme.co.za • website: www.medscheme.co.za

0860 10 1306



Disease Management

e-mail: diseasemanagement@medscheme.co.za • website: www.medscheme.co.za

0860 10 0572



Oncology

fax: 021 466 2303 • e-mail: cancerinfo@medscheme.co.za

• e-mail: sasolmedoncology@medscheme.co.za

Medscheme Client Service Centers

Bloemfontein	Suite 13, Westdene Office Park, Pres. Reitz Ave Westdene, Bloemfontein
Exxaro (Pretoria)	Exxaro Corporate Centre, c/o Roger Dayson & Voortrekker Road, Pretoria West
Kathu	6 Rietbok Street, Kathu, Northern Cape
Lephalale	Onverwacht Business Mienie Building, Block C Walter Sisulu Avenue, Ellisras

Polokwane	Ground floor, Bonitas House, 22 Hans van Rensburg Street, Polokwane
Pretoria	Benstra Building, Ground Floor, 473B Church Street, Arcadia
Roodepoort	37 Conrad Avenue, Florida North, Roodepoort
Rustenburg	Femina Building, Kerk Straat 148, Rustenburg
Secunda	Shop 1, Sanlam Plaza, Horwood Street, Secunda
Vereeniging	36 Merriman Avenue, 2nd Floor, Vereeniging
Cape Town	Medscheme 15th Floor, Atterbury House No 9 Riebeek Street, Cape Town
Durban	67 Old Fort Road, Durban
East London	BSB Building, MBSA G Site, 7 Settlers Way Gately Township, East London
Port Elizabeth	Block 6, Greenacres Office Park, 2nd Avenue Newton Park, Port Elizabeth

THIS BENEFIT GUIDE PROVIDES YOU WITH AN OVERVIEW OF YOUR BENEFITS

KEEP IT IN A SAFE AND ACCESSIBLE PLACE

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Sasolmed Vision

To offer Sasol employees a medical scheme that is holistic, integrated and sustainable that improves the quality of life of all beneficiaries through balanced contributions and equitable benefits.

Objectives

- Provide comprehensive, non-discriminatory, private, medical cover to beneficiaries at a contribution rate that balances costs and benefits
 - Provide ease of administration
 - Deliver sustainable financial results
- Support the Employee Value Proposition (EVP) of Sasol

Membership

Who is eligible for membership?

Membership of a registered medical scheme is compulsory for all Sasol employees, either as principal members of Sasolmed or as a registered dependant of a spouse's or partner's medical scheme. Employees retiring from Sasol's service, or being declared medically disabled, are also eligible for membership.

Who can be registered as dependants?

- **A member's spouse(s)** - to whom the member is married (including customary wife/husband).
- **A member's partner** - which means a person with whom the member has a 2 - year or longer committed relationship akin to marriage, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.
- **Surviving spouse members** are entitled to continuation of membership of Sasolmed provided that they were registered as dependants at the time of the member's death.
- **A child under the age of 25** (full and part time students, persons unemployed) **who is not in receipt of a regular remuneration** of more than the maximum social pension per month, or a child of any age who, due to mental or physical disability, is dependent on the member. For extension as dependants over the age of 19, the following documentation is required and is subject to annual approval:
 - **if unemployed:** an affidavit is required, stating that the child is unemployed and financially dependant on the principal member.
 - **full-time student:** confirming registration as a student of a recognised tertiary institution or receipt of payment is required.
 - **part-time student:** an affidavit is required, stating that the child is unemployed and financially dependent on the principal member. Confirming registration as a student of a recognised tertiary institution or receipt of payment is required.

Who is not eligible for membership?

An employee who is registered as a dependant of his/her spouse's medical scheme may not be admitted to Sasolmed, as the Medical Schemes Act does not permit membership of more than one medical scheme at a time.
ex spouses.

A surviving spouse who:

- remarries and on remarriage is registered as a dependant on the new spouse's medical scheme,
- terminates membership in writing, will not be allowed to rejoin at a later stage, or register any new dependants.

A pensioner who:

- terminates membership. He/she will not be allowed to rejoin at a later stage.

A copy of the full membership eligibility document is available from Sasolmed Customer Services.

Membership applications or change of membership details

All membership application forms, or any changes, must be submitted directly to your HR department and not to Medscheme, except for pensioners or direct paying members of Sasolmed.

Proof of membership

Your membership card is proof of membership of Sasolmed and reflects the following information:

- your membership number
- your initials, surname and ID number
- the names of your registered dependants and their birth dates
- the dates from which you are entitled to benefits

Please look after your membership card. Do not provide it to anyone other than your registered dependants. Fraudulent use of membership cards will lead to suspension or termination of your membership.

Important

Please inform Sasolmed immediately of any changes in your personal details (for example address, contact numbers, marital status and number of dependants) by completing the relevant “Member Record Amendment” form, available from your HR department or the Sasol Pension Fund.

Membership ceases when you leave the service of your employer. Please return your membership card to your employer or the Sasol Pension department upon termination of membership.

Waiting periods

Sasolmed reserves the right to impose **waiting periods**.

When will they apply?

A 3-month general **waiting period**

- for all principal members or dependants who have not had cover for more than 90 days, and whose period of membership of his/her previous medical scheme is less than 24 months.

A 12-month medical condition-specific **waiting period**

- for all principal members and dependants who have not had cover for more than 90 days, and whose period of membership of his/her previous medical scheme is less than 24 months.

A 3-month general **waiting period** and 12-month condition-specific **waiting period**

- for an existing employee (and his/her dependants) who join Sasolmed more than 90 days after becoming eligible for membership, and whose gap in medical cover exceeds 90 days,
- for the dependant of an existing member who joins after the member, and whose gap in medical cover exceeds 90 days, and
- for all principal members and dependants whose gap in medical cover exceeds 90 days.

When will they not apply?

- No **waiting period** will apply to registered child dependants born during the period of membership.
- No 3- or 12- month **waiting period** will apply if you are forced to transfer membership because of change of employment.
- If your employer changes schemes and this changeover is made within a 90-day period, no 3- or 12- month **waiting periods** will apply. Any outstanding portion of a **waiting period** imposed by a former scheme will apply and PMB's will be available to you or your dependants during such periods.

Problem-free administration*How to submit your accounts?*

- Your healthcare provider will give you an invoice. If you have paid the service provider up-front, you will also be given a receipt.
- Mail or deliver your original invoices and receipt to us, as soon as possible.
- Only claims received within 4 months of treatment will be paid, so:
 - send the first account you receive,
 - do not send statements,
 - if you have already paid the account and have attached the receipt, clearly mark the account "paid by member", and
 - do not submit accounts marked "for your information only", or accounts showing only a balance brought forward. Such accounts are for your records, and should be used to check against payments reflected on your statements.
- The Medical Schemes Act requires that the healthcare providers give full details on all accounts. Please check that your account shows:
 - your name and initials,
 - your medical aid number,
 - the treatment date,
 - name of patients (as indicated on the membership card, not nickname),
 - the amount charged, and
 - tariff and ICD-10 codes where applicable (see page 24 for explanation of ICD-10 codes)

Tips on claiming

Check that prescriptions for medicine show all your details. Also check that the correct quantity of medication dispensed is reflected on the claim. If the pharmacy omits any of these details, Sasolmed will not be able to process your claim, and this may lead to delays.

Dental treatment often requires additional work by a dental technician. He bills the dentist who adds this to your account and attaches a copy of the technician's account. Please submit both accounts and ensure that your name and membership number are reflected on each account.

When can you expect payment?

Sasolmed has a regular payment cycle - 2 payment runs per month to members and healthcare providers. The payment runs will happen in the second and last week of that particular month. Remember that some months have 5 weeks. All valid claims received by Medscheme will be processed on this basis. After we receive your claim, we will process it and either refund you, or pay your healthcare provider by direct transfer to a bank account, depending on the payment method that has been chosen.

If the healthcare provider charges the Sasolmed tariff

The healthcare provider will submit the account to Medscheme. Sasolmed will pay the provider directly, subject to the benefits available.

Should the member pay the healthcare provider directly?

The member must submit the account to Medscheme and Sasolmed will refund the member, up to the Sasolmed tariff limit, deducting co-payments where applicable. Any refunds will offset against member portions owing to Sasolmed, if applicable.

How will you know what was paid?

A monthly statement will be mailed or e-mailed to you. This statement is compiled each month end. Member's will receive a single statement with the following information:

- tax amount for the current and previous year on claims paid
- member's beneficiary status
- benefit summary
- member's portions and providers claims processed, and
- claims refund to member.

As your e-mail address and cellphone number will be loaded on the Medscheme system, you will receive confirmation of every claim that has been paid or rejected.

You will receive:

- an e-mail to acknowledge that the claim has been processed, and
- an SMS message indicating the amount that will be credited to you or the service provider in the next payment run.

Please check regularly to ensure that all your personal details, including your bank account details, are correct for the electronic payment of refunds.

Follow these easy steps:

- Access the Medscheme website on www.medscheme.co.za.
- Click on the registration link.
- Enter your membership number without any spaces or hyphens and your ID number. If you get an error message **“incorrect ID number”** please contact the call centre on 0860 00 2134 to update your ID number before trying to register again.
- Complete the registration form and click on the **“submit”** button. It is imperative that your e-mail address and telephone contact details are 100% correct.
- When choosing a username and password remember that the password is case sensitive.
- The confirmation of registration details screen will pop-up to confirm that the entered information is correct. If correct, click on the **“submit”** button.
- The second screen will appear, to confirm that the entered information has been submitted to Medscheme.
- As part of the registration process, you will be sent an e-mail within 24 hours confirming your registration on the Medscheme website.
- You can then use your username and password to logon.
- Type your username and password into the relevant boxes on the top left and click on the **“go”** button.
- Now you will have two-way communication for all medical aid queries, so read on...

Statements

You can obtain your **statements** from the Medscheme website or send an e-mail to webmail@medscheme.co.za to obtain the following:

- all your membership details
- your claims history
- benefit details
- contribution details - for direct paying members

Claims against the Road Accident Fund

In the case of a third party accident claim, Sasolmed will require a third party indemnity form to be completed, enabling the scheme to recover any medical expenses from the **Road Accident Fund**. Should this form not be received within 3 months after the accident, a R500 penalty will be raised by Sasolmed, as a member's portion.

If you are unsure of the benefits offered by Sasolmed or if you sustain injuries as a result of an accident, an assault or an injury on duty, please contact Sasolmed on **0860 00 2134** to discuss what you should do.

Contact Details - Benefit and Claims

tel: 0860 00 2134

e-mail: webmail@medscheme.co.za (statements only) or

website: www.medscheme.co.za

Sasolmed Managed Care

Managed Care

What is managed care?

Managed care is a holistic approach that aims to:

- Promote health and prevent disease.
- Treat existing diseases appropriately and cost-effectively whilst ensuring high quality care.

Sasolmed uses a dedicated **managed care** company, Medscheme, to provide managed healthcare services to its members.

Health Policy Unit

Medscheme's **Health Policy Unit** collates the clinical policies that underpin all managed care programmes. Such policies are based on the scientific evidence of medical practices, economic considerations that include efficiencies of healthcare interventions and their budgetary impacts, as well as the relevant legal framework. The **Health Policy Unit** further supports all managed care programmes and the Scheme on day-to-day issues that require clinical expertise. This ensures that all special payment requests and appeals by beneficiaries are duly considered.

Medicine Management

Medicine Price List (MPL)

Medicines are an important aspect of healthcare expenditure and as such necessitate careful management by Sasolmed. In order for members to continue enjoying affordable contribution increases without quality of care being compromised, Sasolmed adopted the **Medicine Price List (MPL)** for acute and chronic medication.

MPL is a reference pricing system that uses a benchmark (reference) price for generically similar products. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicine, but instead limits the amount that will be paid. MPL reference prices are set in such a way as to ensure availability of medicines without co-payments (outside of the scheme rules) being necessary. In other words, you will be able to afford the medicine you need without paying from your own pocket, but you may have to select a generic over a brand name product. However, should you prefer the more expensive product, Sasolmed will only pay up to the MPL reference price. You will have to pay the difference to the pharmacy.

Given that medicines within a specific MPL group are either identical to one another (except for their appearance or their packaging) or otherwise very similar (for example, only the inactive ingredients of products differ slightly), a given illness can be treated with any one medicine within such a group. Thus, to avoid unnecessary co-payments, ask your doctor and pharmacist to prescribe and dispense medicines that are fully reimbursed within the MPL.

Co-payments are levied in accordance with the Scheme rules.

For more information on MPL please visit www.medscheme.co.za

Medicine Exclusion List (MEL)

The **Medicine Exclusion List (MEL)** is a list of medicines which are excluded for payment from the Acute/Chronic Medicine benefit for various reasons. These include:

- medicines not proven to have the relevant clinical value,
- medicines more expensive compared to equally effective and as safe alternatives,
- medicines prone to abuse,
- some expensive chronic medicines that require pre-authorisation,
- some combination products, where it is more appropriate to use single ingredient products,
- newly registered products under review.

For more information on MEL please visit www.medscheme.co.za

Chronic Medicine Management

Chronic medicines are indicated for prolonged illnesses that are often life-long. To ensure that the most appropriate and cost-effective treatment is prescribed, payment of medicines of such conditions must be approved by your medical scheme.

The **Chronic Medicine Management Programme** authorises payment of appropriate, high quality and cost-effective medicine from the Chronic Medicine benefit. Diseases for which such medicines are authorised are determined by your scheme, as well as medical scheme legislation. Medicines for illnesses listed on the government Chronic Disease List (CDL) have to be paid irrespective of the scheme option to which a member belongs.

Each application for authorisation of medicine from the Chronic Medicine benefit is subject to the current **Chronic Medicine Management's** Clinical Guidelines and Protocols.

Authorisation and payment of medication from the Chronic Medicine benefit is also subject to scheme rules, waiting periods, exclusions and available benefits, as amended from time to time.

How to apply for the Chronic Medicine Management Programme

To ensure you get the most appropriate, high quality and cost-effective treatment for your chronic condition, you need to apply and be authorised for chronic medication through the Chronic Medicine Management (CMM) Programme, subject to the CMM Clinical Guidelines and Protocols. The prescribed medication that will be authorised is determined by your scheme and medical scheme legislation and is subject to scheme rules, waiting periods and exclusions. Payment for the medicine is taken from your available Chronic Medicine Benefit.

To Apply for chronic authorisation, you, your doctor, pharmacist or broker can contact the call centre or log onto the Medscheme website as described below, with the following information on hand:

- Membership number
- Beneficiary date of birth
- Clinical examination date e.g. weight, height BP readings
- ICD 10 code
- Medicine details
- Test results e.g. lipogram results, Hba1c, lung function tests
- Motivations

Kindly note: paper applications are no longer accepted.

Applying Online

1. Log onto the Medscheme website <https://www.medscheme.co.za>, available 24 hours a day.
2. A login username and password will be requested. If you are registered for online access you will be prompted to register as a first time user.
3. Access an easy to use guide on completing the online application on the Medscheme login home page.

Applying Telephonically

1. Call the Chronic Medicine Management department between 8am and 4pm on 0860 100 608 to speak to a consultant.

The registration process is then completed and the user may receive an immediate response from both of these processes. Where more clinical information is required, members of the clinical team will review the information supplied and correspond with the doctor and the member, either telephonically or in writing, on the status of the medication requested.

Our consultants will confirm your consent after completion to ensure that you are aware of and agree to the application. Your application may be delayed up to 5 days should there be

outstanding information or further feedback needed from your doctor. You will receive SMS notifications of the status thereof. You may also follow up on the progress of your application by calling the CMM Call Centre.

Please note that each beneficiary needs to have their own separate application but you only need to complete this application form once.

Once your application has been approved

- Once registered and your application has been approved, you will receive a Medicine Access Card, listing the medicines to be paid from your Chronic Medicine benefit.
- The Access Card will also indicate which medicines are on the Medicine Price List (MPL) and medicines that will attract formulary co-payments (if applicable).
- If the medicine authorised differs from the medicine requested, a letter of explanation will be attached to your Access Card and a copy will be sent to the prescribing doctor.
- You will need a repeat script from your doctor for the medicines listed on the card. The Access Card is not a prescription and cannot be used to have medicines dispensed.
- Your doctor determines the number of repeats and will advise you how often he needs to see you to monitor your condition.
- Whenever you need to have your medicine dispensed, produce a valid doctor's prescription together with the Access Card.
- The duration of authorisation varies from medicine to medicine - some medicines may be authorised ongoing, whilst others may only be authorised for a limited period. The Access Card will indicate the duration for which the medicine has been authorised.
- Please note that even if the medicine is authorised as "ongoing", you still need to provide the pharmacy with a new prescription every 6 months, as required by law.

What if your medicine request has been declined

- If any medicine request has been declined, e.g. requesting a less costly alternative, a letter of explanation will be sent to you and a copy will be sent to the prescribing doctor.
- Please ensure that the appropriate doctor provides the requested clinical information (where relevant).
- For on-line clinical decisions, your doctor should contact the Chronic Medicine Management Call Centre.
- Your request will be reconsidered once all the relevant information has been received.

What if your authorised chronic medication changes

- If your chronic medication changes in any way, Chronic Medicine Management needs to be advised.
- The quickest and simplest way would be for the prescribing doctor or dispensing pharmacist to contact the call centre and advise the clinical staff of the change. The change is then processed (as per the current Chronic Medicine Management Clinical Guidelines and Protocols) within 24 hours.
- If approved, a temporary Access Card can be faxed to the dispenser, enabling them to dispense the medicine without delay.
- An updated Access Card will be mailed to you and if the medicines authorised differ from the medicines requested, you will need a valid doctor's prescription which matches the new Access Card to enable your pharmacy to dispense the medication.
- Should you wish to fax through an updated script to Chronic Medicine Management, the toll-free fax number may be used. These requests will take approximately 7 working days to process.

Contact Details

call centre number: 0860 10 0608

fax number: 0800 22 3670/80

e-mail address: cmm@medscheme.co.za

website: www.medscheme.co.za

Prescribed Minimum Benefits (PMBs)

Specific hospital procedures and chronic diseases

The Medical Schemes Act lists a number of conditions for which a minimum level of treatment must be made available to members. These conditions are contained in the Chronic Disease List (CDL) below.

How do you access these specific benefits?

You need to use the same pre-authorisation process for hospitalisation or chronic medication, as explained under Hospital Benefit Management on page 16 and Chronic Medicine Management sections on pages 10-14.

How can healthcare providers ensure payment of claims for PMB?

The hospital, doctor, pharmacist, etc, must indicate on their accounts that the treatment was for a condition qualifying for **Prescribed Minimum Benefits**.

Specified codes (ICD-10) must be used by the healthcare providers to ensure that claims will be processed correctly - see page 30.

Chronic Disease List

Prescribed Minimum Benefits (PMB's) were introduced for specified chronic conditions from 01/01/2004

This list is known as the Chronic Disease List or CDL. The 25 conditions are the following:

- Addison's disease (hormone imbalance)
- Asthma
- Bi-polar mood disorder
- Bronchiectasis (lung and airway disease)
- Cardiac failure (heart disease)
- Cardiomyopathy (heart failure)
- Chronic obstructive pulmonary disease
- Chronic renal failure (kidney disease)
- Coronary artery disease (artery obstruction)
- Crohn's disease (intestinal inflammation and obstruction)
- Diabetes insipidus (metabolic dysfunction of pituitary gland)
- Diabetes mellitus - type 1 (non-insulin dependent) and type 2 (insulin dependent)
- Dysrhythmia (heartbeat out of rhythm)
- Epilepsy
- Glaucoma (high pressure in the eye)
- Haemophilia (bleeding)
- Hyperlipidaemia
- Hypertension (high blood pressure)
- Hypothyroidism (subnormal activity in thyroid)
- Multiple sclerosis (neurological disease)
- Parkinsons disease
- Rheumatoid arthritis
- Schizophrenia (psychiatric disease)
- Systemic lupus erythematosus (skin and organ disease)
- Ulcerative colitis (inflammation and ulceration of the colon and rectum)

Treatment of these 25 chronic conditions will be covered 100% by the medical scheme. Legislation specifies, however, that reimbursement will be subject to the application of a formulary (a defined list of medicine that Sasolmed will cover) and requires registration as specified by the Managed Care Programme of Sasolmed.

The revised benefits can be summarised as follows:

25 chronic diseases (CDL) now defined as PMB's	• In formulary:	<ul style="list-style-type: none"> • 100% benefit • unlimited, MPL applies • all associated costs
	• Out of formulary:	<ul style="list-style-type: none"> • 60% benefit (40% co-payment) • unlimited, MPL applies • all associated costs
All other REGISTERED chronic diseases (non-PMB's)	Applicable to cost of medication only	
	<ul style="list-style-type: none"> • approved by Chronic Medicine Management • not approved by Chronic Medicine Management 	<ul style="list-style-type: none"> • 80% benefit • (20% co-payment) MPL applies • no benefit (100% own cost)

How does this affect the chronic medicine benefit?

- The Chronic Medicine Management clinical protocols and guidelines (formulary) will apply as before.
- However, non-formulary products authorised by Chronic Medicine Management for PMB conditions (according to Medical Council Protocols) will be subject to a 40% co-payment.
- In the formulary, PMB medicines authorised by Chronic Medicine Management will be covered 100% (subject to the MPL where applicable).
- Once the chronic limit is reached, only medicines used to treat PMB diseases authorised by Chronic Medicine Management, that fall within the protocols specified by the Council, will continue to be reimbursed.
- Out-of-formulary medicines for PMB conditions will be subject to a 40% co-payment.
- Medicines authorised by Chronic Medicine Management to treat non-PMB conditions will be subject to the current 20% co-payment.

If you are unsure in which category your medication is classified, please contact Chronic Medicine Management.

Contact Details - Chronic Medicines

tel: 0860 10 0608

fax: 0800 22 3670/80

e-mail: cmm@medscheme.co.za

website: www.medscheme.co.za

Hospital Management

The pre-authorisation process ensures added value for the member and the scheme, by assessing the medical necessity as well as the appropriateness of the planned intervention prior to the hospital event or admission. This process can be initiated by the member, medical practitioner or the hospital. The request can be submitted telephonically, electronically (e-mail and via the web) and by fax.

Contact Details - Authorisations

pre-authorisation on the web: www.medscheme.co.za

e-mail: authorisations.cpt@medscheme.co.za

fax: 0860 21 2223

Send hospital accounts to:

The Claims Management Department

Medscheme Hospital Claims

PO Box 38625

Pinelands, 7430

Contact Details - Hospital claims:

e-mail: claimsmanagement@medscheme.co.za

hospital claims call centre: 0860 00 2148

(from 08:00 - 16:00 Mon - Fri)

Pre-authorisation of hospital admission forms a key component of the management of hospital costs and includes:

- confirmation of membership
- evaluation of the request against scheme rules
- evaluation of the request against clinical guidelines and protocols
- authorisation of hospital admission where appropriate

Medscheme guidelines for admissions, length of stay and level of care are continuously updated, and drawn on international and local best practice.

Extensive use is made of evidence based guidelines and protocols which are impartial, reliable and generally accepted.

Why are some requests declined?

Some of the pre-authorisation requests will be declined and there are various reasons for this, for example:

- The planned intervention is not covered by the medical scheme as specified in the scheme rules.
- The planned intervention is not in line with the acceptable treatment standards for a particular medical condition.
- Inactive membership status, etc.

We need the following information to authorise your treatment

- membership number
- member or beneficiary name and date of birth
- contact details
- reason for admission and applicable tariff codes for the proposed treatment
- date of admission and date of the operation if applicable
- name of the doctor and his/her practice and telephone number
- name of the hospital, their practice and telephone number
- ICD-10 codes

Once the above information has been captured we will supply you with an authorisation number. However, should all the information not be supplied or should further clinical information be needed you will be given a reference number. We will request the outstanding information from the treating doctor. Once all the required information has been obtained and it meets with the clinical protocols, your authorisation number will be supplied.

The main values of pre-authorisation can be seen as follows:

- An opportunity to educate and empower the member. For example, should a member not know what procedure a doctor was planning to do, a nurse would assist the member to establish what is planned - in that way, starting to encourage the member to take more responsibility for his/her own health care.
- The opportunity to pro-actively start ensuring that any proposed admission is handled in the most appropriate and cost effective way.
- The opportunity to pro-actively start planning for discharge. For example, an elderly patient living alone might require home-nursing post discharge - wherever possible, Medscheme starts making these arrangements from day one.
- The opportunity to gather excellent information - this not only facilitates the subsequent case management process, but provides the database for Managed Care profiling and risk management tools.
- The opportunity to inform the member about specified limited benefits, co-payments and non-covered services where applicable.
- The opportunity to pro-actively manage the funds of the scheme and the member's benefits.

For problem-free admissions

- Notify Medscheme in advance i.e. 48 hours before admission.
- The authorisation nurse will give you an authorisation number which you need to provide to the hospital clerk.
- The Hospital Benefit Management department will then be able to manage your admission and monitor the quality of care you receive during your stay in hospital.
- If you do not get authorisation before going to hospital, or on the first working day following a medical emergency, your treatment may not be covered and you could be held liable for all costs associated with your admission.
- Only procedures which are covered in terms of the rules of your scheme will be authorised.

Oncology Disease Management Programme

It is important that, on diagnosis of cancer, you are registered on the **Oncology Disease Management** programme and that your treatment plan is forwarded to the clinical team, as all oncology treatment is subject to pre-authorisation and case management.

Once the **Oncology Disease Management** team has received your treatment plan, your details, disease information and proposed treatment will be captured. The treatment plan is then reviewed and, if necessary, a member of the clinical team will contact your doctor to discuss more appropriate or cost-effective treatment alternatives. After the treatment plan has been assessed and approved, an authorisation will be sent to your treating doctor. You will also be issued with an authorisation letter. This letter will indicate the treatment authorised, the approved quantities and the period of validity of authorisation.

Please make sure that your doctor advises the **Oncology Disease Management** team of any change in your treatment, as your authorisation will need to be re-assessed and updated. Failure to do so may result in your claims being rejected or paid from the incorrect benefits as there will be no matching oncology authorisation.

Note: In addition to the authorisation from the **Oncology Disease Management** team, you will need to get pre-authorisation from Hospital Benefit Management for any hospitalisation, specialised radiology (e.g. MRI scans, CT scans, angiography) or private nursing/hospice services.

Who should register on the programme?

Only patients who have been diagnosed with cancer.

What steps do I follow in order to register on the programme?

Your treating doctor should fax or e-mail a copy of your treatment plan to below. An oncology case manager will then take the process forward.

Contact Details

contact number: 0860 10 0572

facsimile: 021 466 2303

e-mail: cancerinfo@medscheme.co.za

sasolmedoncology@medscheme.co.za

Beneficiary Health Risk Management Programme

Sasolmed cares about you

Sasolmed has invested in an initiative that will:

- support you with educational information, enabling you to make informed and empowered decisions regarding your health and possible healthcare requirements, and
- work with your doctor (with your consent) to promote your best health interests.

This initiative is known as **Beneficiary Health Risk Management**. You can access the available services directly or you may, from time to time be contacted by someone from the **Beneficiary Health Risk Management** team who will offer to provide you with assistance and support.

Informed healthcare decisions are now possible through the advice on disease prevention and management provided by **Beneficiary Health Risk Management**. Advice given to you is tailored to your personal needs. **Beneficiary Health Risk Management** can help you with expert and experienced guidance on:

- keeping healthy,
- lifestyle changes that can reduce risks of developing diseases and limiting the impact of existing diseases,
- managing the effects and side-effects of treatment,
- the importance of adhering to prescribed treatment,
- rehabilitation after disease events (like a stroke or an operation) and,
- setting personal healthcare targets.

Beneficiary Risk Management

Formal disease management programmes are provided for members that have chronic conditions such as asthma, diabetes and ischaemic heart disease. If you are identified as being at risk of suffering complications or advancement of your health conditions you will be asked to register on the programme to help you to control, manage and monitor your conditions effectively. The programme offers support and education to assist in managing your chronic conditions with the ultimate goal being to improve your quality of life and promote cost-effective treatment empowering you to take responsibility for your own health and wellness.

Many medical conditions can lead to life threatening complications that can be avoided with the correct care and advice. A good example would be high cholesterol levels, which can lead to a number of cardiac related problems that can pose a serious health risk to you. By providing information and advice relating to nutrition, exercise and the importance of adhering to treatment guidelines and medication, the programme assists you to manage your conditions effectively.

A whole team of qualified medical personnel is available to discuss possible challenges; provide you with relevant information and advice; and help you in dealing with your condition. In some cases, where applicable, the programme also works together with your GP or specialist, with your prior consent, to ensure that the correct support is provided to you and to regularly discuss your condition and treatment.

Please note that all information regarding your medical condition is kept strictly confidential and is only known to the team and your treating doctors. During your registration on the programme you will be asked to provide consent for your scheme to use your medical information to assess your health status, to exchange information with your treating doctor and pathologist and to possibly use your medical information anonymously for data analysis and reporting. You have the right to withdraw your consent at any time by informing the scheme in writing.

Members have access to things like telephonic health advice during office hours on 0860 106 155; educational material that is distributed either on request or to specific identified members; and reminders to specific members on the importance of adhering to treatment.

There is no need to apply for participation in this programme as your scheme automatically identifies and contacts members that would benefit from the programme.

All healthcare discussions are kept strictly confidential

All Sasolmed members have access to:

- a health line contactable on **0860 10 6155** during office hours,
- educational material distributed on request and/or to specific identified members,
- telephonic support of specific identified members, often in collaboration with their doctors, and
- reminders to specific members on the importance of adhering to treatment.

The health line (telephone number 0860 106 155)

This confidential health advisory service is managed by experienced registered nurses and provides beneficiaries with immediate access to appropriate healthcare advice. The service is available in four official languages: English, Afrikaans, Xhosa and Zulu.

Educational material is provided on request for most healthcare related topics. Information is distributed to members via e-mail, fax or post. More formal dissemination of educational material is initiated by Beneficiary Health Risk Management and provided to selected beneficiaries who have specific risk factors or health needs.

Telephonic support, initiated by Beneficiary Health Risk Management, is provided by appropriately qualified and experienced nurses. These nurses will provide counselling, education and assistance in order to empower members to better manage their health.

Adherence reminders are alerts sent when members are not claiming for their chronic medication as prescribed and/or where irregular medicine claims are highlighted by our system. When regular tests form part of treatment, members may also receive reminders that a particular test is due. These reminders are crucial as they assist members avoid unnecessary complications that may arise due to non-adherence to treatment, even when there are no symptoms.

You are encouraged to participate in this programme as you will be empowered to manage your condition optimally and improve your quality of life.

Dental Management

Preventative dentistry

Sasolmed has designed the dental benefit to ensure cost-effective, quality dentistry for those who care for their teeth. It is important to your overall health to have regular dentist check-ups!

If you need dental treatment under general anaesthetic

Benefits are not available for dental treatment under general anaesthetic or conscious sedation for anyone over the age of 8 years. The only exception is when impacted wisdom teeth need to be removed.

Pre-authorisation is necessary for all other procedures that require general anaesthetic or conscious sedation. Before undergoing this type of treatment, you must provide a motivation explaining the medical necessity for general anaesthetic or sedation.

Please obtain authorisation for hospitalisation at least 72 hours before treatment, where possible.

When you need special dentistry

Contact a Sasolmed customer service agent on **0860 00 2134** before undergoing any special dentistry, to confirm that you have benefits available and that the procedure will be covered. A written treatment plan and cost estimate from your dentist will assist in determining your available benefit.

All orthodontic treatment must be pre-authorised

Please note: orthognathic (jaw) surgery is an exclusion on Sasolmed. There may be some dental procedures which cannot be covered because of academic, cosmetic, financial or other reasons. Orthodontic treatment is subject to a 20% co-payment and approval from the scheme.

Dental accounts management

Medscheme **Dental Management** audits your dental claims before the dentist is paid. The programme examines claims according to treatment specifications laid down by the SADA and dentists must use the correct treatment codes according to these rules.

Claims will not be paid for treatment which was done outside the SADA rules, or if your scheme rules do not allow certain procedures. In a case such as this, your dentist will be asked for a motivation, an amended account, or be sent a reason for the non-payment of the claim.

Optometry Management

Medscheme **Optometry Management** is an optical benefit management programme that provides you with clinically essential optometric benefits that are financially validated. You have access to optical benefits and products as detailed in your scheme rules and according to the approved optometric tariffs.

Benefits available

According to Sasolmed Rules, Medscheme Optometry Management will provide:

- benefits for eye examinations and also Glaucoma tests (comprehensive eye examination),
- benefits per beneficiary for single vision, bi-focal and multi-focal (vari-focal) spectacle lenses in glass and plastic. Plano (zero power) lenses for both eyes will NOT be covered by Sasolmed,
- hard contact lenses, conventional soft contact lenses and disposable contact lenses, according to the benefits available,

NB: all benefits are subject to availability of funds.

Aid for AIDS

HIV/AIDS

For most people HIV/AIDS is a frightening disease, but today effective treatment is available that allows the majority of people living with HIV to lead healthy and productive lives for many years.

Action and information

The first step is to find out whether you have been infected with HIV and what you can do to protect your loved ones and stay healthy. Medicines are available to suppress the virus, while vitamins, good nutrition and exercise can play a critical role in keeping your body strong and healthy. Starting treatment at the right time ensures the effectiveness of the medicines, improves quality of life and decreases the risk of serious infections and other complications. Our **Aid for AIDS** programme can help you access benefits that assist you in managing HIV/AIDS.

We can help you manage your condition

Sasolmed has a benefit specifically for HIV/AIDS related medicines and tests. This benefit is used to pay for medicines to suppress the virus (antiretrovirals) and to protect against illnesses such as TB and serious pneumonia, vitamins to boost your immune system and regular monitoring tests.

Your condition will stay confidential

HIV is a sensitive matter and every effort is made to keep your condition confidential. The staff members at **Aid for AIDS** have all signed confidentiality agreements and work in a separate area away from the medical scheme. They use separate telephone, fax and private mailbag facilities. Patients need to use these facilities to maintain confidentiality.

You must register on the Aid for AIDS programme

If your test shows you are HIV positive you must register with **Aid for AIDS** as soon as possible. Telephone them in confidence on **0860 10 0646** and ask for an application form. Your doctor can also contact Aid for AIDS on your behalf and may also contact the medical team for advice.

After you have registered

After you receive the application form, you and your doctor must complete it and return it to the **Aid for AIDS** programme by using the confidential, toll-free faxline number on the form. A highly qualified medical team will review the information provided and, if necessary, discuss cost-effective and appropriate treatment with your doctor.

Once treatment has been agreed upon, you and your doctor will be sent a detailed treatment plan, which lists the approved medicines and how to take them, as well as the regular tests that need to be done to ensure that the drugs are working correctly and safely.

What the Aid for AIDS programme offers you

Aid for AIDS is a comprehensive and confidential HIV disease management programme that offers both members and beneficiaries:

- medicine to treat HIV (including drugs to prevent mother-to-child transmission and infection after sexual assault or occupational exposure) at the appropriate time,
- treatment to prevent opportunistic infections like certain serious pneumonias and TB,
- regular monitoring of disease progression and response to therapy,
- regular monitoring tests to pick up possible side-effects of treatment,
- ongoing patient support via Nurse-line,
- best practice clinical guidelines and telephonic support for doctors by a team of acknowledged clinical experts, and
- help in finding a registered counsellor for emotional support.

If you are exposed to HIV infection through sexual assault or needle-stick injury, please ask your doctor to contact **Aid for AIDS** to authorise special antiretroviral medicine to help prevent possible HIV infection.

It is best to take this medicine as soon as possible (within hours) after exposure. If the incident putting you at risk occurs over the weekend, make sure you get the necessary medication on time.

You or your doctor can contact the Aid for AIDS programme on the Monday morning to arrange authorisation of the drugs for payment by Sasolmed.

Contact Details

contact number: 0860 10 0646

fax: 0800 60 0773

e-mail address: afa@afadm.co.za

website: www.aidforaids.co.za

sms (call me): 083 410 9078

General

Selection of a Preferred General Practitioner (PGP)

The key to good healthcare is the development of a strong relationship with a General Practitioner (GP) that you trust and respect. A family doctor who knows your medical history and background is important to ensure appropriate hospitalisation, medical testing and specialist interventions that you may require.

To deliver quality healthcare to Sasolmed members, the Board of Trustees has decided that all Sasolmed members and their beneficiaries should each select one GP as the PGP (since 2005).

This has become necessary as an increasing number of Sasolmed members have been visiting more than one GP on a regular basis. This practice has major disadvantages for both members and Sasolmed such as:

- conflicting diagnosis and treatments resulting from visiting more than one GP,
- additional costs being incurred where similar diagnostic tests are repeated or medicines are duplicated by different GPs,
- the opportunity for fraud is greatly increased by members allowing their Sasolmed membership cards to be used by other persons not known to the different GPs being visited.

The selection of a PGP is a further milestone in our drive to provide quality healthcare to all Sasolmed members and also to ensure the long-term financial sustainability of Sasolmed.

Important Process:

- new members/beneficiaries must complete a PGP selection form to load a PGP,
- to update your PGP members/beneficiaries, contact the Sasolmed call centre at **0860 00 2134** or alternatively e-mail: Sasolmed@medscheme.co.za to update,
- when updating your PGP, please ensure that you provide Sasolmed with your valid membership number and the 7 digit practice number per member/beneficiary, and
- a PGP may be changed at the principal member's discretion once every 6 months by contacting Sasolmed.

General conditions for the selection of a Preferred General Practitioner (PGP)

Please study carefully.

It is permissible for dependants to select different PGPs, subject to the following provisions:

- adult dependants (e.g. spouses) may select a PGP of their choice,
- for child dependants under the age of 16 years, a PGP is to be selected by the parent registered as the principal member of Sasolmed,
- child dependants over the age of 16 years may select their own PGP, with the consent of the parent registered as the principal member of Sasolmed,
- where a PGP is part of a group practice of general practitioners (practice under one pr no.), members may visit any doctor who is part of the group practice, provided the account/claim is submitted under the group practice number,
- when the PGP is not available, the doctor standing in (known as the locum) will automatically be considered as the PGP,
- when the PGP is unable to consult for any reason e.g. he is fully booked for the day, the PGP can refer you to the alternative secondary PGP,

- when a Sasolmed member is on holiday and needs to visit a doctor, such visits would be covered by the “Out of Town” benefit of 3 visits per family to a doctor other than the selected PGP,
- as soon as the 3 Out-of-Town visits are exhausted or if the member makes use of a GP other than his selected PGP, the GP will be paid, but the full consultation amount will be debited against the member,
- in the event of emergencies, the PGP rules will not necessarily apply. However, Sasolmed needs to be informed of the circumstances within 3 working days to ensure that claims arising from the event are allocated to the appropriate benefit.

Who can register an additional Preferred General Practitioner?

- member residing and working in different towns,
- children studying/ in boarding schools,
- children of divorced parents,
- migrant workers (living in hostels) with family living in a different town, or
- member travelling for work or involved in special projects away from home.

Qualifying criteria

- member must submit proof of residence VS work place when working away from home by means of affidavit or written confirmation from employer,
- member to submit letter from school for children in boarding schools,
- member involved in special projects away from home to submit confirmation from employer of the duration of the project, and
- migrant workers to submit affidavit/proof of temporary (hostel) and permanent (spouse and children) residence.

Specialist co-ordination of care programme

To create a specialist referral, your PGP needs to access the Medscheme interactive voice system on **086 111 2666**. Your PGP has been briefed on the simple procedure to be followed.

The referral number will apply to either a type of specialist (for example, a dermatologist) or a specific specialist for a period of time that your GP decides on, which can be up to 6 months. Ultimately the patient still has the choice of which specialist to visit.

There are some exceptions to this rule and you will not need a specialist referral number in the following instances:

- 1 visit per year to a gynaecologist for a gynaecological check-up and pap smear for female patients,
- visit to a paediatrician for children under 2 years of age,
- visits to optical and dental specialists,
- maternity consultations by a gynaecologist.

In case of an emergency, where a patient had to consult a specialist without prior authorisation, a referral number can be obtained after the visit. The patient would need to contact his/her GP to obtain the referral number within 72 hours of the emergency.

The Scheme also takes cognisance of the fact that there might be unique cases where a member has to see a specialist on a more regular basis due to a specific condition. Members can apply to the Ex-gratia Committee for an exclusion from the Specialist Co-ordination of Care Programme. The committee will consider this request on medical and clinical evidence, assisted by the Sasolmed Medical Advisor.

Members should remember that obtaining a referral number from a PGP is not a guarantee of payment - specialist consultations will still be paid only up to the Scheme tariff.

Please Contact Sasolmed Customer Services on **0860 00 2134** for assistance.



Your Medical Scheme, Sasolmed has taken the decision to appoint ER24 as your Emergency Medical Service Provider. Below is a brief introduction to ER24, your emergency medical care network. ER24 is a proudly South African, emergency medical response company, operating in the pre-hospital environment. ER24 strives to be the first call in any medical emergency and to respond in a way that reflects **realhelprealfast**. ER24 supports all hospitals throughout the country, which makes it one of the most widespread medical emergency networks in South Africa. If you are involved in a medical emergency, one call to the emergency telephone number, **084 124**, will activate assistance through their 24 hour national emergency contact centre.

As a member you will have access to additional ER24 benefits such as

- 24 Hour activation in the event of a medical emergency by calling **084 124**,
- 24 Hour emergency medical advice e.g. CPR, choking, bleeding control while paramedics respond,



- 24 Hour emergency response using Advanced Life Support paramedics in rapid response vehicles by road and where necessary by air ambulance,
- treatment and stabilisation at the scene of the emergency,
- medical transportation to the closest most appropriate hospital,
- **note that you have access to medically justified transfers only, non medical justified transfers will be for your own account.**

Members also have access to the following Medical Advice and Assistance Hotlines

- general medical advice
- medical practitioner & facilities referrals
- trauma advice & counselling
- suicide hotline
- domestic & child abuse
- generic medication assistance
- poison advice
- rape counselling
- substance abuse
- HIV/Aids counselling

What to do in an event of a medical emergency

1. Always call **084124**.
2. If someone is calling on your behalf, tell them to call **084 124**.
3. Tell the ER24 operator you are an ER24 member through your medical scheme, Sasolmed. The call taker will prompt you or the caller through all the information they need to get help to you.
4. You will receive stickers which need to be placed on your vehicles.
5. Save **084 124** under “**emergency**” on your mobile phone.

ER24 hopes that this benefit will help with “peace of mind” and if the unexpected should occur you can trust ER24 to provide “**realhelprealfast**”.

Resilience Health Services Chronic Back and Neck Rehabilitation Programme

Although Back and Neck pain is a common condition that afflicts four out of five people at least once in their lifetime, a proportion of these people experience chronic (long term) back and neck pain, which leading healthcare experts believe to be a chronic disease. This potentially debilitating condition can result in you experiencing pain as well as reduced mobility, thus affecting your quality of life. As your medical scheme, your well-being is of great importance to us. Sasolmed partnered with Resilience Health Services (DBC) from 2010 and is proud to present the Chronic Back and Neck rehabilitation Programme as part of Sasolmed’s disease management strategy for chronic diseases.

The purpose of the Programme is to form a partnership with you and various healthcare providers in the treatment of your condition. An inter-disciplinary approach greatly increases the success rate in restoring normal functionality to an individual without which surgery might be the only alternative. While surgery may be appropriate in some cases, it is only a component of the long treatment disease management programme. Post-surgical functional rehabilitation is critical in managing the condition in the longer term. This Programme will therefore cater for members who have had back and neck surgery to assist with rehabilitation.

As part of the Programme, members who suffer from chronic back and neck pain will have access to treatment at Resilience Health Services Musculo-Skeletal Treatment Centre. When your Doctor (GP) refers you to a Resilience Health Services Musculo-Skeletal Treatment Centre, an assessment will be done which includes the completion of standard questionnaires as well as a physical evaluation. The information is then analysed and an individualised exercise program is presented to you, should your condition require such intervention. The duration of the programme will be dependent on a number of factors and can vary from 3 weeks to 12 weeks and could include further maintenance subsequent to that. It is important to note that this treatment is funded by Sasolmed and will not affect your other medical aid benefits in any way.

If you are currently experiencing chronic back or neck pain or if you have previously been hospitalised for this condition or had surgery for back and neck conditions, you are encouraged to join the Programme. This can be done in the following ways:

- Contact your chosen GP to refer you to Resilience Health Services Musculo-Skeletal Centre for treatment;
- Contact Resilience Health at 012 471 1507 or e-mail info@resiliencehealth.co.za to register you on the programme and make suitable arrangements for an appointment at a Resilience Health Services Musculo-Skeletal Centre;

Province	Area
Gauteng	Centurion Parkview(Pretoria East) Silver Oaks(Pretoria East) Boksburg (Eastrand) Illovo(Johannesburg)
Free State	Sasolburg
Mpumalanga	Nelspruit Secunda

Resilience Health Services will be establishing centres throughout the country in time. However should you reside outside these areas, you are welcome to contact Resilience Health to obtain telephonic advice regarding chronic back and neck pain.

As mentioned previously, the intention of the Programme is to provide members with the most appropriate treatment for their condition in the form of a disease management programme. If you suffer from chronic back and neck pain, your engagement with the Programme is vital. Should your specialist plan surgery and you wish to proceed, you should follow the standard Sasolmed procedures for Hospital Pre-authorisation. Resilience Health Services Medical Advisor may contact you and your specialist in these cases to discuss potential treatment options and alternatives.

Please note that should you undergo non-emergency back and neck surgery for a chronic back and neck condition without having joined the Programme, you could be liable for a co-payment of R5000-00, even if the surgery is clinically appropriate.

Although this co-payment will be waived if you reside and work in excess of 30km from the nearest Resilience Health Services Musculo-Skeletal Treatment Centre, you (and your Doctor) are encouraged to contact Resilience Health Services to discuss your treatment options.

For a copy of the Resilience Health Services Back and Neck guide please visit the following website address: www.resiliencehealth.co.za

ICD-10 Codes

ICD-10 codes appear on healthcare provider accounts and are used to inform medical schemes of the conditions for which members sought healthcare services so that claims can be settled correctly.

ICD-10 stands for International Classification of Diseases and Related Health Problems (10th revision). It is a coding system developed by the World Health Organisation (WHO), that translates the written description of medical and health information into standard codes, e.g. J03.9 is an ICD-10 code for acute tonsillitis and G41.0 denotes epilepsy (unspecified).

ICD-10 codes provide accurate information on the condition you have been diagnosed with. These codes help medical schemes to determine what benefits you are entitled to and how these benefits should be paid.

This becomes very important if you have a PMB condition, as these can only be identified by the correct ICD-10 codes. Therefore, if the incorrect ICD-10 codes are provided, your PMB-related services might be paid from the wrong benefit or it might not be paid at all if your benefits limits have been exhausted.

ICD-10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers (e.g. Pathologists and radiologists) who are not all able to make a diagnosis. Therefore, they require the diagnosis information from your referring doctors so that their claim to your medical scheme can also be paid out of the correct pool of money.

Management of fraud and abuse

Fraud continues to be a major concern to medical aid companies and schemes lose millions of Rands as a result of paying fraudulent claims. As you know, the greater the losses through fraud, the higher your contributions will be to help cover this loss. Sasolmed has measures in place to detect and manage fraud and abuse of benefits.

You can help to combat fraud by anonymously contacting our Fraud Hotline if you are aware of any practitioner or patient abusing the system.

Glossary

All those acronyms and abbreviations are enough to make you need our stress management assistance - look them up here

AFA	Aid for AIDS
ARB	Annual Routine Benefit
ARM	Alternative Reimbursement Mechanism
CDL	Chronic Disease List
DOH	Department of Health
DUR	Drug Utilisation Review (clinical evaluation of medicines prescribed)
GP	General Practitioner
ICD-10	International Classification of Diseases version 10
MCC	Medicine Control Council
MEL	Medicine Exclusion List
MPL	Medicine Price List (sets a price limit on what your Scheme will pay for any group of medicines that has a similar clinical effect)
PAR	Pre-authorized Reference Number
PAT	Pharmacy Advised Therapy
PGP	Preferred General Practitioner
PMB	Prescribed Minimum Benefits (The Medical Schemes Act lists a number of chronic diseases for which a minimum level of care must be provided)
SADA	South African Dental Association
Sasolmed Tariff	The tariff of fees that the scheme has agreed to pay healthcare providers



Sasolmed Customer Services : 0860 00 2134

Line open Monday to Friday 08:30 - 16:00

The 0860 number ensures that you are only charged at local call rates.

sasolmed