self med

medical scheme

Members Guide 2011

Simplicity • Sincerity • Security • Service

www.selfmed.co.za

Content

The Selfmed Medical Scheme was formally registered on 19 November 1974.

The members of the Board of Trustees of the Selfmed Medical Scheme are:

Barry Reide (Chairman)

Mel Bartlett (Vice-chairman)

Willem Boshoff

Reg. No: 1446

FSP No: 15494

1. Membership

1.1 Who qualifies as a dependant of a member?

- Spouse (not an ex-spouse)
- Life partner of principal member
- Children
- Brothers, sisters and parents if dependent on the principal member for care and support

1.2 What proof is required by the Scheme in respect of a dependant's reliance on the member?

- In the case of a spouse, a marriage certificate
- In the case of a common-law spouse, an affidavit
- In the case of a companion, a sworn affidavit that the principal member and the dependant share a communal household akin to marriage
- In the case of children:
  - legal documents in respect of adoption (in the case of an adopted child)
  - a court order for a foster child
- In respect of brothers, sisters and parents of the principal member, a sworn affidavit confirming the relationship to the principal member and stating that the family member is financially dependent on the principal member for care and support, as determined by a Court of Law

1.3 How do I add a new dependant to my existing membership?

By completing an amendment form, which can be obtained from the Scheme or downloaded from the website (www.selfmed.co.za). Fax the completed amendment form to **0860 288 363**. Should you have any enquiries regarding your application, please contact us on **0860 787 372**

1.4 What happens in the event of the death of the principal member?

The Scheme will notify the eldest dependant of his/her right to continue with the membership, with the status of the other dependants remaining unchanged, provided that the Scheme receives a copy of the death certificate. Unless such person informs the Scheme of his intention not to become a member the person will be admitted as a member to the Scheme. Bank details should be furnished to the Scheme to avoid any interruption in the payment of contributions.

1.5 When will the Scheme have the right to cancel my membership or that of any of my dependants?

If you or any of your dependants:

- joined another scheme and neglected to give the Scheme one month's advance notice, in which case no more than two months' contributions will be refunded
- provide false information, or fail to disclose material information when applying for registration
- provide false information upon submission of a claim, submit a fraudulent claim, or intentionally allow a service provider to do so on your behalf
- allow any other person to use your membership card
- without a good explanation, neglect to inform the Scheme that it has paid for services or supplies that were not delivered or received
- commit any other fraudulent act
- fail to pay contributions within 28 days
- fail to repay an advance within 28 days

1.6 When am I entitled to benefits?

You are entitled to benefits from the inception date of your membership, provided that no general waiting period or condition specific waiting period is applicable.

1.7 Waiting Period

1.7.1 What is a general waiting period?

The Scheme may impose a general waiting period of three months on all benefits in respect of all new applicants and dependants who:

- Have never belonged to a medical scheme; and/or
- Have not belonged to a medical scheme for 90 days or more, prior to joining the current scheme; and/or
- Were members of another medical scheme for a period of more than 2 years and have not had a break of 90 days or more between leaving the previous scheme and joining the new scheme

Please note that a certificate of previous membership may be required

1.7.1.1 Can I opt to make a payment in lieu of this waiting period, in order to have it waived?

No

1.7.2 What is a condition specific waiting period?

The Scheme may further impose a condition specific waiting period of up to 12 months from the inception date of your membership, in respect of any pre-existing condition, in respect of any beneficiaries who:

- Have never belonged to a medical scheme
- Have not belonged to a medical scheme for 90 days or more, prior to joining the current scheme
- Have belonged to a previous medical scheme for a period of less than 2 years and have not had a break of 90 days or more between leaving the previous scheme and joining the new scheme

Please note that a certificate of previous membership and medical report may be required

1.7.3 No waiting periods will be imposed on:

- A beneficiary changing option within a scheme
- A child dependant born during the period of membership

1.8 Inception Date

1.8.1 What is an inception date?

This is the date on which a person becomes a member of the Scheme or on which a dependant's registration becomes available.

1.8.2 What is the inception date in respect of dependants?

- If the application is received within 30 days of the new dependant becoming eligible for registration (e.g. through marriage, birth or adoption), the inception date will be the date on which the dependant became eligible
- If the application is received after 30 days of the new dependant becoming eligible for registration, the inception date will be the 1st of the month following the one in which the application was received,

OR the 1st of the month following the one in which the Scheme receives all the information it may need in respect of such application

1.8.3 Will benefits be pro-rata?

Yes, if membership or dependant membership commences after 1 January. This is applicable to all benefits that are subject to an annual limit.

1.9 When do my dependants become entitled to benefits?

Your dependants are entitled to benefits from the inception date, unless a waiting period is applicable.

2. Contributions

2.1 How is my contribution calculated?

As a principal member, you will pay a fixed amount, regardless of your age and income, together with a fixed amount for each adult dependant (21 years or older) and each minor dependant (younger than 21 years) registered under your membership.

Example:

This table applies to the Selfmed MEDXXI Option.

Principal member's contribution	R970
One additional adult dependant	R950
One additional minor dependant	R454
Total contribution	R2 374

2.2 When are contributions payable?

Contributions are payable monthly in advance, due from the first day of your inception month.

2.3 At what stage does my contribution increase when a minor dependant turns 21?

The increased contribution for an adult dependant becomes due on the first day of the month following the month in which the dependant turns 21. A dependant, who is registered as a full-time student, on the Selfmed 80% and Selfsure options, will qualify for minor dependant contributions up to the age of 25, on receipt of annual proof of studies.

2.4 When do increased contributions become due in respect of a new dependant?

The first increased contribution becomes due:

- on the member's inception date, if the dependant's addition was indicated on the member's application form; or
- from the first day of the month following the admission date of dependants registered within 30 days of marriage or date of birth; or
- from any other date determined by the Scheme

2.5 What happens if my contributions fall in arrears?

Member contributions are payable on the 1st of each month. If the Scheme does not receive your contribution three days after it becomes due, payment of all benefits in terms of your membership is suspended until such time as any amounts in arrears are received. If your contributions fall in arrears for more than a month, your membership will be terminated immediately without further notice.

2.6 What is a late joiner?

The section on "Definitions" describes a late joiner.

2.7 How do late joiner penalties work?

The Scheme may increase the contributions of a late joiner in accordance with the stipulations of the Medical Schemes Act. The number of years with no medical cover is converted into a percentage as prescribed by the Act. The late joiner penalty amount is therefore the prescribed percentage of the normal monthly contribution.

3. Operation of Selfmed Options

3.1 Options Available

3.1.1 What is an Option?

An Option is a product registered under the Scheme, which offers a specific structure of benefits.

3.1.2 What Options are offered by the Scheme?

- Selfmed MEDXXI
- Selfmed Selfsure
- Selfmed Med Elite
- Selfmed 80%

3.1.3 What are my Chronic Medicine Benefits?

Notwithstanding the chronic medicine benefits that are part of the Prescribed Minimum Benefits (see part 5), Chronic Medicine Benefits are available under Selfmed 80% and Med Elite Options. Please refer to the list of Chronic Conditions in this Members' Guide, to the Summaries of Benefits for limits on chronic medicine, and point 4.2 for information on the application process.

3.1.4 When may I change my Option?

You may change your Option on the 1st day of January each year, after giving the Scheme at least 30 days' written notice.

3.1.5 How do I change my Option?

By returning a completed Option Form to the Scheme, which can be obtained from the Selfmed offices or website (www.selfmed.co.za)

4. Medicine

4.1 Who should apply for the Chronic Medicine Benefit?

To qualify as an applicant, you must use the medicine for an uninterrupted period of at least three months. The medicine must be prescribed by a medical practitioner and should be prescribed for the treatment of conditions as listed on the Scheme's list of approved chronic conditions. Your option should also provide a chronic medicine benefit.

4.1.1 List of Chronic Conditions

- Addison's Disease
- Alzheimer's Disease
- Angina
- Ankylosing Spondylitis
- Asthma
- Attention Deficit Disorder
- Benign Prostatic Hyperplasia
- Bronchiectasis
- Cancer
- Cardiac Arrhythmias
- Cardiomyopathy
- Chronic Renal Failure
- Congestive Cardiac Failure
- Conn's Syndrome
- Chronic Obstructive Pulmonary Disorder (COPD)
  - Emphysema
  - Chronic Bronchitis
- Coronary Artery Disease (incl. Angina)
- Crohn's Disease
- Cushing's Syndrome
- Cystic Fibrosis
- Deep Vein Thrombosis
- Dermatomyositis
- Diabetes Insipidus
- Diabetes Mellitus
- Epilepsy
- Gastro-oesophageal Reflux Disease (GORD)
- Glaucoma

- Gout
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypoparathyroidism
- Hypothyroidism
- Ischaemic Heart Disease
- Menopause (Hormone Replacement Therapy)
- Motor Neuron Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Narcolepsy
- Organ Transplants (maintenance therapy)
- Osteoporosis
- Paget's Disease of Bone
- Paraplegia/Quadriplegia (associated medicine)
- Parkinson's Disease
- Polyarteritis Nodosa
- Psoriasis, incl. Psoriatic Arthritis
- Psychiatric Disorders
  - Anorexia Nervosa
  - Bipolar Mood Disorder
  - Bulimia Nervosa
  - Major Depression
  - Narcolepsy
  - Obsessive Compulsive Disorder
  - Panic Disorder, if diagnosed and treated by psychiatrist
  - Post-traumatic Stress Disorder
  - Schizophrenia
  - Tourette's Syndrome
- Pulmonary Interstitial Fibrosis
- Rheumatoid Arthritis
- Sarcoidosis
- Scleroderma
- Stroke
- Systemic Lupus Erythematosus
- Thromboangitis Obliterans
- Thrombocytopaenic Purpura
- Ulcerative Colitis
- Zollinger-Ellison Syndrome

4.2 Application Process

4.2.1 How to register for Chronic Medication?

Your healthcare provider (doctor or pharmacist) can apply for chronic medicine authorisation on your behalf by phoning **0860 247 288**. A member may contact the Scheme on **0860 787 372** and request approval for chronic medicines to be paid from the chronic medicine benefit. It may be necessary to fax a prescription and other information required, such as pathology tests, to the Scheme. If any additional information is required, a pharmacist will contact the doctor.

Please make sure that you supply the following information as part of the prescription:

- membership number
- your contact details

4.2.2 What must I do if my Chronic Medicine changes, authorisation expires or if I am diagnosed with another chronic ailment?

The quickest and simplest way to address the above would be for your healthcare provider to contact us and inform the Scheme's pharmacist on **0860 247 288** of the change. The other option is to fax your new or updated prescription to **0860 633 277**. Please remember to include your Selfmed membership number and contact details.

4.3 What is a Generic Reference Price?

It represents the maximum benefit payable by the Scheme for specific chronic medicine or a class of medicine used in the treatment of the chronic conditions as per the Scheme's list in 4.1.1. The generic reference price differs per option and if the cost of the medicine exceeds this price, a co-payment will apply. The reference price applies over a 30-day period and complies with the prescribed treatment of PMB conditions, as dictated by legislation. Since the generic reference price is applied on a monthly basis, a member retains more control over his/her chronic medicine purchases during the approved period.

4.3.1 What will happen if the quantity of medication purchased in a specific 30-day period exceeds the quantity that was approved?

The reference price for the approved medication will be exceeded resulting in a co-payment by the member. If, however, a medical practitioner prescribed a higher dosage, this must be motivated to the Scheme, whereafter the reference price will be increased accordingly.

4.4 How does the Generic Reference Price differ from the generic MMAP price?

The MMAP price represents a form of generic reference pricing. A generic equivalent is a medicine that contains exactly the same active ingredients compared to the branded product. These medicines are manufactured by the same or another company once the patent on the branded product expires. As a result, the generic equivalent normally cost less than the branded version. A co-payment will also apply if the cost of the prescribed (branded) product exceeds that of a generic equivalent. The generic reference price is based on a medicine class that includes therapeutic equivalents. A therapeutic equivalent is a product that may not share the same active ingredients, yet can be used to treat the same condition and render the same therapeutic outcome. An example would be the use of Panado (containing paracetamol) and Disprin (containing asprin) that are both used to enable pain relief.

4.5 When is a co-payment on medicine payable?

Any co-payment, regardless of whether it results from the generic reference price being exceeded, and/or a medicine limit being exhausted, and/or the pharmacy or doctor charging a dispensing fee that is higher than the Scheme's tariff, will be payable at the point of purchase.

4.6 Take-home Medicine (TTOs)

A maximum of seven days' supply of medicine will be allowed on discharge from hospital. This benefit is payable from a member's hospital benefit, provided the medicine is purchased on the date of discharge.

4.7 Non-prescribed Medicine (PAT)

Most common ailments can be treated effectively by medicines available at a pharmacy without a doctor's prescription. These medicines may be claimed from your PAT benefit. Please ask your pharmacist for advice. PAT is available on Selfmed 80% and Selfmed Selfsure options only.

5. Prescribed Minimum Benefits

5.1 What are the Prescribed Minimum Benefits (PMB)?

These are benefits contemplated in the Medical Schemes Act in respect of which medical schemes are compelled to provide cover for the diagnosis, treatment and care associated with these conditions, and without any co-payment or use of deductibles, providing that services are obtained from a designated service provider. In the case of PMB chronic medicine, the Scheme's formulary and protocol must be complied with.

NOTE: These benefits are available on application to all members in addition to the benefits already offered by their chosen Option.

5.2 What is a Designated Service Provider (DSP)?

It is a healthcare provider or group of healthcare providers whom the Scheme has selected as its preferred supplier in terms of rendering treatment and care for the Prescribed Minimum Benefits (PMB) conditions. These providers are:

- Public Healthcare System (state facilities)
- Clicks Direct Medicines Courier Pharmacy
- Script-Wise Courier Pharmacy

Clicks Direct Medicines can be contacted on **0861 444 405**

Script-Wise Courier Pharmacy can be contacted on **0860 102 622**

NOTE: Even though these services are covered in full, the Scheme's healthcare priniples will still apply. You will still be required to obtain pre-authorisation for hospitalisation whilst admitted for a PMB condition and/or PMB chronic medicine and a relevant treatment plan.

5.3 What happens if these services are obtained from a provider other than a DSP?

A member will then be liable for an upfront co-payment in respect of PMB which are voluntarily obtained from a provider, other than the Public Healthcare System, Script-Wise Courier Pharmacy or Clicks Direct Medicines Courier Pharmacy.

5.4 What happens in case of the following:

- The required service was not available from the DSP or would not be provided without unreasonable delay, OR
- There was no DSP available in a reasonable proximity from where the beneficiary resides or conducts business, OR
- Immediate emergency care was required under circumstances or at locations, which precluded the beneficiary from obtaining the treatment from the DSP?

If any of the above circumstances apply, the co-payment described under 5.3 will not apply, provided that the following documentation is submitted to and approved by the Scheme:

- Written communication proving the need – in case of all three of the above
- Comprehensive clinical report supporting the need for the emergency care

5.5 Which conditions and treatments are covered under the PMB's?

Approximately 270 conditions are covered under PMB in the event of complications which require hospital treatment. A list of all these conditions is available from the Scheme, on request.

As from 1 January 2004 provision has been made to provide for medical management, diagnosis and medicine of the following chronic conditions:

- Addison's Disease
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac Failure
- Cardiomyopathy
- Chronic Renal Disease
- Coronary Artery Disease
- Crohn's Disease
- Chronic Obstructive Pulmonary Disorder
- Diabetes Insipidus
- Diabetes Mellitus
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythromatosis
- Ulcerative Colitis

5.6 If you are already in possession of a chronic authorisation for treatment of a specific condition, will you be able to retain this authorisation?

Yes, however, benefits will be subject to the Scheme Rules of the specific Option. Kindly note that should you belong to an Option with specific sub-limits, both PMB and non-PMB treatment will accumulate to this specific limit until it is reached, whereafter only the PMB benefit will qualify for further benefits, provided the prescribed criteria is met.

6. Pre-Authorisation

6.1 What is Pre-authorisation (PAR)?

Pre-authorisation (PAR) is the prior approval of any planned admission to a hospital, including an associated treatment or procedure (including a dental procedure) performed during hospitalisation.

MRI/CT-scans and radio-isotope studies, whether during hospitalisation or not, also require specific Pre-authorisation as well as certain endoscopic procedures. However, the following procedures do NOT require a PAR, and benefits in respect thereof will be paid from your Option's radiology benefits:

- Dexa scans
- CT bone mineral density studies

If you are unsure if the procedure falls within the above categories, it is recommended that you call the Pre-authorisation Centre for advice on **0860 104 974**.

NOTE: A PAR is not a guarantee of payment of a claim. Payment is at all times subject to available benefits and co-payments may apply (full detail in Summaries of Benefits).

6.2 When must I apply for a Pre-authorisation Reference Number (PAR)?

Application for a PAR should be made as soon as possible, preferably upon confirmation of admission by your doctor. However, it is recommended that application be made at least three working days ahead of a planned procedure, in case more information is required from your doctor. In the event of an emergency admission to hospital over a weekend or at night, you may apply for a PAR from the Pre-authorisation Centre within two working days of the admission or scan. In the case of pregnancy, it is recommended that pre-authorisation be obtained by the 28th week.

6.3 How do I contact the Pre-authorisation Centre to obtain a PAR?

Send an e-mail to: authorisations@selfmed.co.za, fax **0860 467 727** or telephone **0860 104 974**.

6.4 What information should I furnish when applying for a PAR?

- Membership number and dependant code
- Patient's full name and date of birth
- Date of admission PLUS the date of procedure (This is particularly important, as we do not routinely authorise pre-operative procedures the day prior to planned surgery – this must be applied for and motivated)
- Surname and initials of attending doctor or service provider and practice number
- Name and telephone number of admitting doctor or in the case of MRI- and CT-scans, the details of the radiologist
- Name of hospital to which the patient will be admitted
- The reason for the admission to hospital or the planned diagnostic procedure and ICD-10 code
- To assist with your PAR-application, ask your doctor for a full description of:
  - The diagnosis, and
  - the planned procedure as well as the procedural codes he/she intends to use

6.5 What happens if I fail to apply for a PAR?

If you do not apply for a PAR in advance or within two working days (in the case of an emergency) of receiving treatment, the claim will not be paid.

6.6 Treatment of out-patients at the casualty department of a hospital

Please note that visits to the doctor at a hospital's out-patient or casualty department will not always be funded from your hospital benefit. For this reason, some hospitals may require that you pay cash for these visits. In this event, you may send the account to the Scheme and you will be refunded according to your day-to-day, out-of-hospital benefits.

IMPORTANT: Whilst every effort is made to establish member eligibility and availability of funds any authorisation given may be excluded in terms of the Scheme Rules and payment is therefore not guaranteed.

7. Managed Healthcare

Managed healthcare is defined as any effort to promote the rational, cost-effective and appropriate use of healthcare resources. The philosophy of the Scheme is to work with members and service providers in achieving these aims.

7.1 Protocol

The Scheme's Managed Healthcare provider uses funding guidelines and protocols in respect of certain services and supplies for which the Scheme allows benefits. Beneficiaries will only qualify for benefits in respect of those services and supplies if the guidelines and protocols have been complied with.

The Scheme or its Managed Healthcare provider reserves the right to request a second opinion, at the Scheme's cost and with a doctor nominated by the Scheme, in respect of any elective hospital procedure. A fitness report will also be required in respect of any requests for spinal or joint surgery. The Scheme or its managed healthcare provider may also, in its discretion, limit the cost of any laparoscopic surgery to the cost of the equivalent conventional (open) surgery.

7.2 Disease Management

Disease Management is a treatment approach that focuses on the patient's disease, using all the cost elements involved. The intervention takes place by means of patient counselling and education, behaviour modification, therapeutic guidelines, and case management.

7.2.1 Oncology Benefit Management

It is important that, prior to starting active treatment for cancer, you are registered on the Oncology Disease Management programme.

7.2.1.1 How do you register?

In order to be registered, your treating doctor needs to complete a treatment plan and forward this to the clinical team, as all oncology treatment is subject to Pre-authorisation and Case Management. If you are given cancer-related treatment and your treatment has not been Pre-authorised by the Oncology Disease Management Programme, no oncology benefit will be paid by the Scheme. Note that members on the MEDXXI and Selfsure options are required to make use of the Scheme's preferred provider oncology network. Once the Oncology Disease Management team receives your disease information, treatment plan and your membership details, your 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 treatment alternatives. An authorisation will be sent to your doctor after the assessment and approval of the treatment plan. You will also be issued with an authorisation letter.

Please ensure that your doctor advises the Oncology Disease Management team of any change in your treatment, as your authorisation will then need to be re-assessed and updated.

NOTE: In addition to authorisation from the Oncology Disease Management team, you will need to get Pre-authorisation from the Hospital Management department for any hospitalisation, specialised radiology, stepdown facilities and stoma therapy.

7.2.1.2 Who does your treating doctor contact to register your treatment?

Phone **0860 104 974**, e-mail oncology@selfmed.co.za or send a fax to **0860 467 727**

7.2.1.3 Do any limits apply to Oncology Benefits?

Yes. The Scheme allows an insured benefit for the oncology treatment, including the associated pathology and radiology, during the active stage of the disease but subject to an overall annual limit. If hospitalisation is required as part of the oncology treatment such hospital costs will not accumulate to the oncology limit.

7.2.2 HIV/AIDS

Specific benefits are available with regard to antiretroviral therapy, related medicine and pathology tests and will be handled and managed in the strictest confidence, when members register on the Scheme's HIV/AIDS Management Programme. Support and counselling is available to the relevant member and family, if required. Any member or dependant who has tested positive for HIV must join the HIV/AIDS Management Programme in order to access benefits.

Contact numbers are reflected at the back of this guide.

7.3 Breast Reconstruction

Benefits are allowed in respect of reconstructive surgery after mastectomy of proven breast cancer. Benefits will be paid once only for full reconstruction by whichever method, as well as for reduction surgery on the unaffected side for symmetry, where indicated, as per motivation. Only complications of a true medical nature will be considered for benefits and not failed cosmesis.

7.4 Organ Transplants and Dialysis

Benefits in respect of organ transplants and dialysis are subject to treatment forming part of a Case Management Programme.

Benefits are allowed in respect of kidney dialysis and the following organ transplants: heart-, lung-, heart-and-lung, bonemarrow-, kidney- and liver transplants.

Benefits are further subject to the recipient being a beneficiary of the Scheme in which case limited benefits will be applicable.

7.5 Ambulance Services ER24

7.5.1 Who should I call for ambulance services?

ER24 is the Scheme's Preferred Provider for any ambulance services. If services are not rendered by (or through the intervention of) ER24, benefits will be limited to a specified maximum (please refer to the Summaries of Benefits for details).

7.5.2 How do I contact ER24

For clinical advice or to request medical emergency transport, phone **084 124** if you are in the RSA For claims enquiries phone **011 319 6580**.

7.5.3 How much time do I have to inform ER24 that I have made use of another ambulance service as a result of an emergency?

In the event of an emergency, you should inform them within 24 hours of the date on which the service was rendered to qualify for unlimited benefits.

Note: The services of this preferred provider are only available in the RSA, Swaziland and Lesotho.

Note: If you need to contact ER24 from one of the above neighbouring countries, their contact number changes to: **011 541 1218**

8. Internal Prosthesis

8.1 What is an Internal Prosthesis?

It is a device implanted during an operation into the body as an internal supporting mechanism and/or which for functional medical reasons are implanted as a prosthesis to replace parts of the body.

8.2 What benefits are allowed in respect of Internal Medical and Surgical accessories?

The following limits apply based on the type of prosthesis:

Cardiac Stents, limited to R31 500 and a maximum of 2 stents per Beneficiary per Year
Cardiac Pacemakers, limited to R36 700 per Beneficiary per Year
Cardiac Valves, limited to R26 200 per Beneficiary per Year
Hip Replacement, limited to R36 700 (Selfmed 80% and Med Elite only) per Beneficiary per Year or in the case of simultaneous bilateral hip replacement, limited to R73 400 (Selfmed 80% and Med Elite only) per Beneficiary per year
Total Elbow Replacement, limited to R26 200 per Beneficiary per Year (Selfmed 80% and Med Elite only)
Knee Replacement, limited to R36 700 (Selfmed 80% and Med Elite only) per Beneficiary per Year or in the case of simultaneous bilateral knee replacement, limited to R73 400 (Selfmed 80% and Med Elite only) per Beneficiary per year
Total Shoulder Replacement, limited to R26 200 per Beneficiary per Year (Selfmed 80% and Med Elite only)
Total Ankle Replacement, limited to R26 200 per Beneficiary per Year (Selfmed 80% and Med Elite only)
Spinal Plates and Screws, limited to R31 500 (Selfmed 80% and Med Elite only) per Beneficiary per Year
Bone Lengthening Devices, limited to R26 200 per Beneficiary per Year
Carotid Stents, limited to R12 600 per Beneficiary per Year
Aorta Stent Grafts, limited to R36 700 per Beneficiary per Year
Peripheral Arterial Stent Grafts, limited to R26 200 per Beneficiary per Year
Embolic Protection Devices, limited to R31 500 per Beneficiary per Year
Internal Sphincters and Stimulators, limited to R31 500 per family per Year
Internal Fixation Devices for Fractures, limited to R21 000 per Beneficiary per year (MedXXI and Selfsure) limited to R25 200 (Selfmed 80% and Med Elite) per Beneficiary per Year
Cerebral Aneurysm Coils, limited to R31 500 per Beneficiary per Year
Spinal Implantable Devices, limited to R31 500 (Selfmed 80% and Med Elite) per Beneficiary per Year
Intraocular lens post cataract removal, limited to R1 900 per Beneficiary per Year if procedure was performed on one eye only, or R3 800 per Beneficiary per Year for both eyes
Any other internal prosthesis not listed above, limited to R21 000 per Beneficiary per Year

9. Co-payments Applicable to Hospital Procedures

Where any of the following elective procedures are performed in hospital, the co-payment specified will be payable upfront, unless treatment is funded as a Prescribed Minimum Benefit:

Procedure	Co-payment on MEDXXI and Selfsure options	Co-payment on Med Elite option
Arthroscopy	R5 300	R2 700
Cholecystectomy	R5 300	R2 700
Colonoscopy and/or Sigmoidoscopy and/or Proctoscopy	R2 100	R1 100
Conservative Back Treatment	R2 100	R1 100
Diagnostic Cystoscopy	R2 100	R1 100
Diagnostic Laparoscopy and/or Hysteroscopy and/or Endometrial Ablation	Procedure funded as PMB treatment	R2 700
Gastroscopy	R2 100	R1 100
Hysterectomy (not applicable to pre-operatively diagnosed cancer)	R3 200	R1 600
Incisional Hernia	R5 300	R2 700
Incontinence Repair	R5 300	R2 700
Joint Replacements	Procedure funded as PMB treatment	R5 300
Nissen Fundoplication (reflux surgery)	R10 700	R5 300
Spinal Surgery	Procedure funded as PMB treatment	R5 300

10. Payment of Claims

10.1 What information should be contained in a claim in order for it to be processed?

Type of claim	Requirements
Medical Practitioners	• membership number • name • date of birth of the patient • the doctor's practice number • the nature of service • relevant code, including ICD-10 code • service date • cost of each service rendered or item supplied
Medicine	the name, quantity, dosage and net amount payable by the member in respect of the medicine dispensed, as well as the relevant national pharmaceutical product interface (NAPPI) code and ICD-10 code Non-electronic accounts payable by the member must also be accompanied by a copy of the original prescription made out by a person legally authorised to prescribe the medicine (if applicable), and proof of payment must be attached
Dental	the details of each tooth treated
Surgical	the name, practice code and registration number issued by the relevant registering authority of every medical practitioner or dentist who assisted in the performance of that operation
Advanced Dentistry Services	the first account must contain the treatment plan showing the expected duration and total cost of the treatment, as well as the initial and monthly amounts payable
Please note: Although orthodontic treatment is generally funded from the specialised dentistry benefit, certain parts of the treatment plan are classified under your Option's benefits for basic dentistry. Please consult Selfmed to ascertain whether you will be responsible for certain costs in respect of your and your family's orthodontic treatment	

10.2 When must I submit a claim for payment?

A claim must be submitted within four months from the end of the month in which the service was rendered. If not submitted within this period, the account will NOT be paid.

10.3 How will I know when my claim has been settled?

After your claim has been processed, you will receive a claim statement reflecting the payments made.

Note: If you received discount on an account, you will only be entitled to the lower benefit amount after discount was taken into consideration.

10.4 Are benefits allowed in respect of foreign claims?

No benefits are allowed in respect of foreign claims, with the exception of claims originating in Namibia. Namibian claims will be processed and refunded to members in South African rands.

11. Exclusions

The following are exclusions on all options:

11.1 Exclusions applicable to Basic and Specialised dentistry:

- Resin bonding of metal fillings
- Mouth guards for sport purposes
- Metal inlays in dentures
- Bleaching of vital teeth
- Metal inlays in front teeth
- Costs associated with professional reports
- Electrognathographic recording – with or without computer analysis

11.2 Exclusions applicable to Prescribed Medicine:

- Medicines used in clinical trials and medicines not registered with the Medicine Control Council, patent preparations and household remedies
- Patent food-stuffs, including baby-food and special formulae, except if mother is HIV-positive
- Slimming preparations
- Anti-smoking preparations
- Surgical appliances and devices
- Diagnostic agents and appliances, except diabetic accessories
- Medicine used specifically to treat alcoholism, except if used as part of a Beneficiary's rehabilitation treatment at a recognised facility
- Aphrodisiacs
- Anabolic steroids
- Sun screens and tanning agents including emollients and moisturisers
- Cosmetic preparations, soaps, shampoos and other topical applications medicated or otherwise except for the treatment of psoriasis, lice, scabies, and other parasitic and fungal infections, except for PMB's
- Single or combined mineral preparations, except for calcium preparations with 300mg or more of elemental calcium used for the prevention and treatment of osteoporosis and potassium when used in conjunction with a diuretic and haematinics and iron supplements for anaemia
- Contact lens preparations
- Preparations not easily classified
- Stimulant laxatives
- Treatment of erectile dysfunction, e.g. Sildenafil and/or similar remedies
- Products used for incontinence, except if resulting from complications of a PMB-condition in hospital
- Immunoglobulins

NB: No faxed claims wil be accepted!

- Injection material, except diabetic injection material
- Nebulisers, unless part of an asthma management programme
- Blood pressure monitors
- Glucometers, unless part of a disease management programme

The following medicines, unless they form part of the public sector protocols and are authorised by the relevant managed healthcare programme:

- Maintenance Rituximab (or other monoclonal antibodies) for haematological malignancies – such as Mabthera
- Fungal infections: liposomal amphotericin B
- Septic shock and septicaemia: protein C inhibitor-such as Xigris
- Bevacizumab for colorectal cancer – such as Avastin

11.3 Exclusions applicable to Acute Medicine:

- Medicine not offering proven clinical value
- Medicine that is more expensive than equally effective and safe alternatives
- Medicine prone to abuse, e.g. Benzodiazepines
- Expensive chronic medicine requiring Pre-authorisation
- Combination products where a single ingredient would be more appropriate
- Newly registered medicine under clinical review

11.4 Exclusions applicable to Optical benefits:

- Adjustment of frames
- Fitting of contact lenses
- Coloured contact lenses
- Sunglasses
- Refraction corrective eye surgery

11.5 General

- Examinations for testing of eyes or vision by somebody other than an eye specialist or registered optometrist, and the cost of any instrument other than spectacles or contact lenses
- Travel costs – except for transporting of the patient to and from a Hospital
- Applicators, toilet preparations and cosmetics
- Holidays for recuperative purposes
- Accommodation in old-age homes and similar institutions, frail care and long-term care
- Costs rejected by the Scheme, due to it being fraudulent or not clinically indicated or medically necessary, as indicated by the Scheme's clinical auditing company
- Bandages, cotton wool, plasters and other household first-aid items – unless these are supplied during a stay in Hospital
- Examinations for assurance, employment, lawsuits and similar purposes
- Cosmetic and reconstructive surgery, including for protruding ears, according to the Member's or Dependant's own choice, or recommended for psychological reasons only – and any complications resulting from such surgery
- Where more than one Clinical Procedure, that requires a PAR, is performed at the same time and a PAR was not granted for both, no Benefits will be granted for complications arising from any of the procedures, except if a PMB
- Beauty treatments and beauty preparations and cosmetics
- Examinations and/or treatment where no real or supposed illness exists and/or recommended for psychological reasons only
- Examinations, treatment or medicine for sterility or erectile dysfunction
- Artificial insemination
- Marriage therapy
- Birth control, excluding oral-, injectable- and IUD contraceptives, vasectomies and sterilisations

- Vasovasostomy (reversal of vasectomy)
- Group exercises or fitness tests
- Obesity – surgical treatment with the exception of certain bariatric surgical procedures performed for life threatening morbid obesity by a multidisciplinary team in accordance with agreed protocol in an accredited centre of excellence when pre-authorised, but not including post-operative plastic and reconstructive surgery
- Hyperbaric oxygen treatment
- Telephone consultations
- Services of social workers
- Fees for medical reports
- ALCAT allergy tests
- Sclerotherapy treatment, unless a vascular surgeon is responsible for the treatment where it forms part of the surgical removal of vascular veins
- Reduction: Mammoplasty, unless due to medical reasons
- Treatment of kelloids (except in the case of burns, dependent on a PAR)
- Refractive surgery
- Functional reconstruction of palate and uvula (uvulopalatopharyngoplasty)
- All costs of whatsoever nature incurred for treatment of injuries sustained as result of participation in activities on a regular basis, except if PMB's. (Contact the Scheme to enquire about a specific activity)
- Injuries due to professional sports, except if PMB's.
- Acupuncture
- Reflexology
- Aromatherapy
- PET-scans, except if part of an approved oncology treatment plan
- Haemapure blood products
- Artificial hearts (e.g. Berlin heart)
- No benefits for any treatment where Beneficiaries take part in clinical trials
- No benefits for the storage of fetal stemcells
- Pectus excavatum/carinatum
- All monoclonal anti-bodies, except where specified as part of an option's oncology benefit or in the case of Beta-Interferon for the treatment of Multiple Sclerosis as per the PMB algorithm
- Medicines not approved by the Medicine Control Council, unless section 21 approval obtained and authorisation has been obtained from the relevant managed health care programme
- HIV resistance testing unless registered and pre-authorised on the relevant managed healthcare programme
- Food and nutritional supplements, including baby food and specific milk preparations, unless prescribed for life threatening malabsorptive disorders and for HIV mother to child transmission (MTCT) prophylaxis if registered on the relevant managed healthcare programme
- Intra-ocular lens implant, unless implanted post cataract removal
- Medical stockings, unless obtained from a dispensing doctor or pharmacy in which case benefits will be paid from the external accessories benefit, where applicable
- Sleep studies and CPAP, if body mass index is 30 or higher, provided treatment will be granted at providers, for a period of up to 6 months, to assist a beneficiary in achieving a favourable BMI
- Joint replacement surgery, if body mass index is 35 or higher and/or the risks of surgery outweigh the benefits

12. Definitions and Abbreviations

12.1 Act

The Medical Schemes Act, 1998, as amended or replaced from time to time, and the regulations promulgated thereunder.

12.2 Acute Medicine

Medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short

course of medicine treatment, as well as medicines that qualify for benefits but have not been classified as chronic medicine by the Scheme.

12.3 Adult

A dependant who is 21 years or older, excluding full-time students on Selfmed 80% and Selfsure options who are younger than 25.

12.4 Agreed Tariff (AT)

A tariff as agreed upon, and amended from time to time, by or on behalf of the Scheme and its preferred providers and/or for medicine: the single exit price (Medicines and Related substances Act No 101 of 1965) plus dispensing fee and/or MMAP, whichever is lesser.

12.5 Artificial Prosthesis

Any prosthesis used to replace a part of the body, e.g. leg or arm.

12.6 Basic Dentistry

Examinations; and/or X-rays; and/or plastic and soft-based dentures, limited to one set per jaw per annum; and/or simple corrections to all teeth; and/or preventative dentistry including scaling and polishing of teeth, fluoride treatment, sealing teeth to prevent tooth decay, oral hygiene education in respect of the brushing of teeth, as well as flossing techniques; and/or root canal therapy to front teeth, including premolars; and/or sedation; and/or local anaesthetics; and/or sterilised instrumentation; and/or occlusal guard.

12.7 Beneficiary

Each individual member and dependant.

12.8 Biologicals

a Substance that is made from a living organism or its products and includes vaccines therapeutic proteins (e.g. insulin) and monoclonal anti-bodies.

12.9 Case Management Programme

A process whereby clinically indicated, appropriate and cost-effective healthcare, as an alternative to hospitalisation, or otherwise, is offered to individual beneficiaries with specific healthcare needs - whether the Scheme prescribes it, or approves it on application by a beneficiary.

12.10 Chemotheraphy

Medication used in the cure and containment of cancer. This includes cytostatics and hormone inhibitors and excludes medication not directly related to the treatment of cancer (e.g. antidepressants) and medication used in the treatment of long-term conditions that may develope as a result of the cancer treatment.

12.11 Chronic Medicine

Medicine that meets all the following requirements:

- prescribed by a medical practitioner for an uninterrupted period of at least three months; and
- for a condition appearing on the Scheme's list of approved chronic conditions, as amended from time to time; and
- which has been applied for in the manner and at the frequency prescribed by the Scheme from time to time, and which application has been accepted by the Scheme

12.12 Clinical Procedure

A procedure categorised as such by the Scheme.

12.13 Dependant

The following persons for whom the member is liable for care and support, who are not members or dependants of members of any other medical scheme, and, if applicable, who are duly registered as dependants by the Scheme:

- a spouse; and/or partner (NOT an ex-spouse)
- a child - including an adopted child, stepchild or foster child; and/or
- the member's parents (including adoptive parents), sisters and brothers; and/or
- any other person approved by the Scheme

12.14 Disease Management

A holistic approach focusing on the patient, using all the cost elements of the disease to identify the patient eligible for a disease management programme. The intervention takes place by means of:

- Patient counselling and education
- Behaviour modification
- The application of therapeutic guidelines; and
- Case management

12.15 Effective Date

The date on which a beneficiary becomes entitled to benefits.

12.16 Elective Dental Surgery

Dealing with the cause and treatment of malposition of the jaw-bones, and/or alveolar ridge augmentation.

12.17 Family

A member and his/her dependants.

12.18 Foreign Claims

Claims originating from countries outside the borders of the Republic of South Africa.

12.19 Generic Reference Price

The maximum price payable for generic equivalents or therapeutic equivalents.

12.20 Hospital

Includes a mental health institution, registered unattached theatre and day clinic, but excludes an institution for rehabilitation for substance abuse.

12.21 Implantology

All stages of treatment required to achieve the end result of placing an implant supported tooth or teeth into places left by previous removal of natural teeth. This includes the surgical augmentation of the jaw bone, surgical placement and exposure of implant(s).

12.22 Inception Date

The date on which a person becomes a member of the Scheme or on which a dependant's registration becomes effective.

12.23 Late Joiner

An applicant or the adult dependant of an applicant who, on the Application Date, is 35 years or older. This excludes any beneficiary who enjoyed cover with one or more medical schemes prior to 1 April 2001, and who did not have an interruption in cover of more than 90 days since 1 April 2001. A certificate of previous membership may be required.

12.24 Major Medical Benefits

Insured benefits for services such as hospitalisation and the treatment/procedures performed whilst a beneficiary is hospitalised.

12.25 Medical Auxiliary Services

A person or entity

- whose discipline is explicitly covered by the Scheme rules; or
- with a practice code beginning with 090 (issued by the Board of Healthcare Funders), whose type of service rendered has been approved (in writing) by the Scheme

12.26 Medical Scheme Rate

The Selfmed Tariff is based on the National Health Reference Price List (NHRPL) published in 2006, adjusted by an inflationary factor determined by the Board, as well as a set of in-house tariffs for tariffs not defined by the 2006 NHRPL schedule, as determined by the Board.

12.27 Medicine

A substance registered under the Medicines and Related Substances Control Act, 1965, as amended or replaced from time to time.

12.28 Member

A person who has been registered as a member by the Scheme.

12.29 Minor

A dependant who is not yet 21 years old, and, under the Selfmed 80% and Selfsure Options, a dependant who is over the age of 21 but not over the age of 25 years, who is studying full time at a recognised institution.

12.30 Non-elective Dental Surgery

The treatment of cysts and tumours of the jaw, as well as conditions of the saliva glands; and/or the treatment of abscesses of the jaw (with the exception of periodontal therapy); and/or the treatment of all traumas to the bone and soft tissue of the face; and/or extractions or the surgical removal of teeth.

12.31 Orthopaedical Appliances

External spinal and/or major joint appliances with the explicit function to provide stability after operative procedures, e.g. cervical and lumbar spine supports, knee and ankle braces and shoulder support.

12.32 Pre-authorisation Reference Number (PAR)

A number allocated by the Scheme's managed healthcare agent, which is required before certain services qualify for benefits.

12.33 Preferred Provider

A Service Provider with whom preferential rates were negotiated by or on behalf of the Scheme, or who is part of a preferred provider network contracted for or on behalf of the Scheme.

12.34 Prescribed Minimum Benefits

The minimum benefits that the Scheme is obliged to provide under the Act.

12.35 Prosthesis

A device that replaces a missing or nonfunctioning body part or organ.

12.36 Registrar

The Registrar of Medical Schemes appointed under the Act.

12.37 Service Date

In the event of:

- hospitalisation - the date of each admission to a hospital; or
- any other service or supplies - the date on which the service was rendered or the supplies obtained, whether for the same illness or not

12.38 Service Provider

A medical practitioner, dentist, pharmacist, nurse, clinical psychologist, medical auxiliary or hospital duly registered or licensed as such with a statutory council or relevant state department – or if practising in a territory outside South Africa, registered or licensed as such with a similar body in that territory.

12.39 Specialised Dentistry

Metal frames for full or partial sets of dentures; and/or root canal therapy for molars; and/or resin, porcelain or metal inlays in teeth for which simple corrections are not adequate, with the exclusion of metal inlays in front teeth and dentures. Periodontal treatment; and/or crown and bridge work; and/or the bleaching of root-canal-treated teeth that have discoloured as a result of the removal of nerves; and/or orthodontic treatment; and/or components bonded to previously placed implants. All services, except for hospitalisation, qualify for dental benefits, if these are provided or rendered in respect of conditions related to dentistry.

12.40 Spouse

A person to whom a member is married under a system recognised by South African law.

12.41 Year

A period of 12 months beginning on 1 January and ending on 31 December.

13. Contact Numbers

Service Excellence Centre (for all your enquiries and requests)	Tel: **0860 787 372** (SUPERB) Fax: **0860 288 363** (ATTEND) E-mail: expert@selfmed.co.za
Hospital Pre-authorisation	Tel: **0860 104 974** Fax: **0860 467 727** E-mail: authorisations@selfmed.co.za (This includes authorisation requests for confinements, MRI-scans, CT-scans and radio-isotope studies as well as case management)
Chronic Medicine	To apply for chronic medicine benefits your service provider can phone: **0860 247 288**, OR if you have enquiries about your chronic medicine you can phone: **0860 787 372** Fax: **0860 633 277** E-mail: chronicmed@selfmed.co.za
Disease Management (HIV/AIDS)	Tel: **0860 906 090** Fax: **0865 579 168** E-mail: selfmed@optipharm.co.za
Oncology	Tel: **0860 104 974** Fax: **0860 467 727** E-mail: oncology@selfmed.co.za
ER 24 Ambulance Services	For emergency transport – in RSA = **084 124** For emergency transport – in Swaziland or Lesotho = **011 541 1218**
Fraud Line	**0861 299 999**
Submission of claims (only original claims will be accepted)	Selfmed Medical Scheme PO Box 5543 Tygervalley 7536

Visit our website at www.selfmed.co.za

connect with us on Facebook