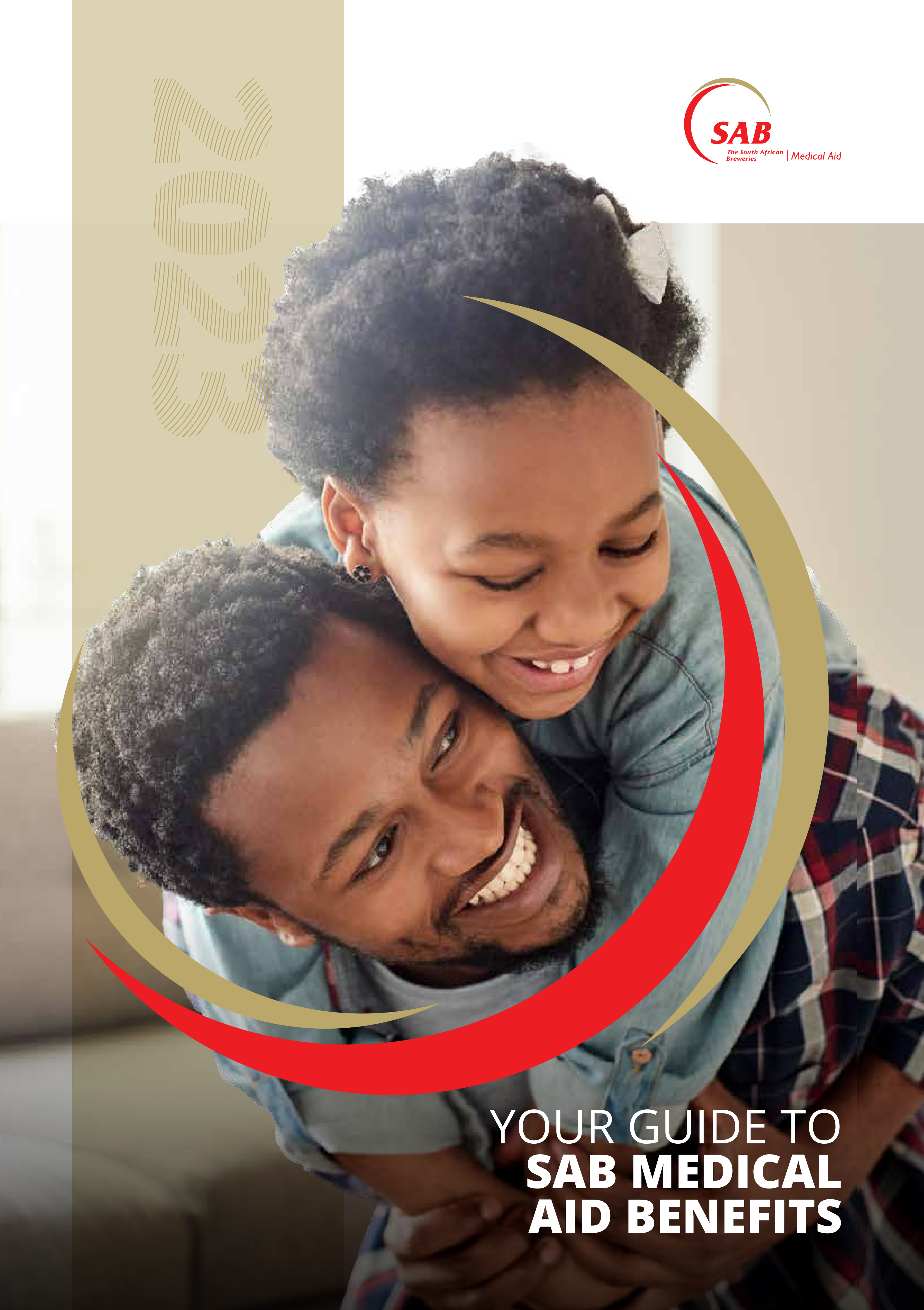
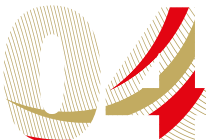

2023
SAB
The South African Breweries
Medical Aid
YOUR GUIDE TO
SAB MEDICAL
AID BENEFITS

CONTENTS

HOW THE SCHEME WORKS

What's the difference between traditional medical schemes and new-generation medical schemes?
And where does SAB Medical Aid fit into the mix? We explain it all.



ESSENTIAL VS COMPREHENSIVE

SAB Medical Aid offers two Options: Essential and Comprehensive. But how do you choose the right Option? Our comparison table can help you make an informed decision.

WHAT WE COVER

Medical schemes are complex by nature, but that doesn't mean they have to confuse you. Here we unpack all of the benefits available to you.

CHRONIC BENEFITS

If there's medicine you need to take every day, you may have a chronic condition. Find out if your condition is on our list and if so, how to register, which service providers to use, what reference pricing means and how to choose a pharmacy.

- Prescribed Minimum Benefits (PMB) and the Chronic Disease List (CDL)
- Chronic Care Management
- Reference pricing and medicine management
- Choosing a pharmacy
- Treatment baskets for Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) Conditions.

DAY-TO-DAY BENEFITS

We explain more about your Day-to-day Benefits, which relate to all out-of-hospital benefits such as consultations with doctors, dentists, specialists, optometrists, and acute medication.

BENEFIT CHANGES FOR 2023

PATIENT ADVOCACY

As a consumer and a member of SAB Medical Aid, you're allowed to negotiate prices with your Healthcare Providers – and to shop around if they're unaffordable. We show you how and explain why.

SAB MEDICAL AID PROVIDER NETWORKS

Getting the right treatment is critical, but so is getting it at the right cost – otherwise you're wasting the money you need for other things. We explain about the Provider Networks, the group of medical service providers whose fees we've already negotiated on your behalf.

CONTENTS

BENEFIT OPTIONS

Find out how your Benefit Option has you covered for day-to-day and Major Medical Benefits.

THE WELLNESS BENEFIT

Here we show you how to proactively manage your health (via the Early Detection Programmes and Immunisations) and make your benefits last longer.

OTHER AREAS WE CAN HELP WITH

We want to help you if you're pregnant, undergoing cancer treatment, are HIV-positive or if you're faced with a medical emergency. Find out how we can support you.

- Maternity Management Programme
- Oncology Management Programme
- Netcare 911
- Aid for AIDS Programme
- Out-of-Hospital DTP PMB.

BENEFIT EXCLUSIONS

As with all medical schemes, there are certain procedures and treatments we do not cover. Find out what these are so that you're a well-informed member.

ADMIN HOW-TO'S

How to claim? You've seen a doctor and now you'd like to be refunded for your claim. But what's claimable? And when will the money be reimbursed? We'll explain.

ADMIN INFORMATION

Who's covered? And how do you get cover? Like all medical schemes, we have to be firm about who we cover and when, so that we can keep your contributions as low as possible. You can find all the details here.

Q & A: PROVIDER NETWORKS

These Networks consist of providers who charge pre-negotiated rates. Learn about these Networks.

CONTACT US

This is where you can find the info to contact us, compliment us or complain about us. Hopefully more of the first two; less of the last. Either way, we're at your service

- Complaints and Appeals
- Contact Information.

REMEMBER

Benefits and contributions for 2023 are subject to approval by the Council of Medical Schemes.

SOUTH AFRICAN MEDICAL SCHEMES

There are two types of medical schemes, differentiated as follows:

TRADITIONAL

These are usually closed corporate medical schemes. Contributions from all members are pooled and all medical claims are paid using funds from the medical scheme's pool of money. The size of the pool determines what benefits can be covered for all members.

Limits start fresh each year, so if you don't use a particular benefit in a particular year, it doesn't carry over to the next year.

In essence, traditional cover generally means that most of your medical expenses are covered from the medical scheme's pool of money within the rules and benefits of the medical scheme and up to certain limits.

NEW GENERATION

These are open medical schemes like Discovery Health Medical Scheme, Momentum Health, Bonitas Medical Scheme and others. They generally cover major medical costs like hospitalisation and chronic medicine from the medical scheme's pool of money, but day-to-day expenses, like visits to a GP, dentist, optometrist, X-rays, and medicine come out of the member's own savings account. If savings aren't fully used, they carry over to the next year.

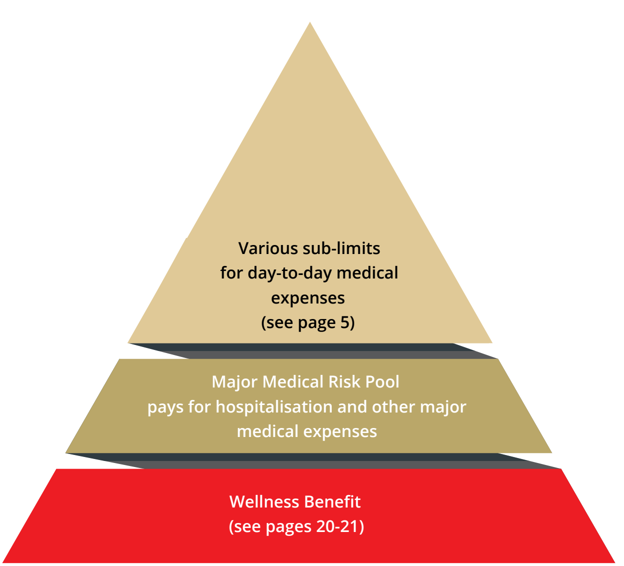
HOW THE SCHEME WORKS

As you know, health is unpredictable and the costs of quality healthcare in South Africa are rising all the time. Even if you take good care of yourself and your health, you don't want to be caught off guard by an accident, an unforeseen illness or even the high costs of a pregnancy, appendectomy or X-rays.

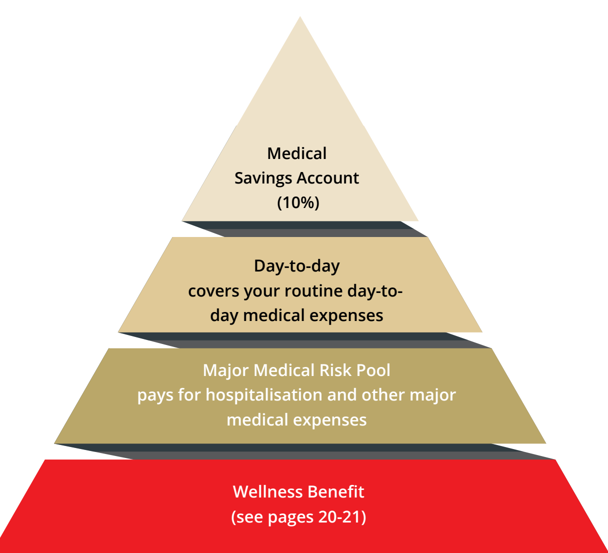
In our country, the Medical Schemes Act (131 of 1998) regulates all medical schemes. Since the healthcare industry is constantly evolving and undergoing changes, so does SAB Medical Aid undergo changes to ensure that it stays abreast of industry developments. This allows members to make the most informed and most appropriate choices possible within SAB Medical Aid.

WHAT ABOUT SAB MEDICAL AID?

SAB Medical Aid is a closed corporate medical scheme. We aim to give our members the best of both worlds. The Essential Option is considered a traditional medical scheme option. The Comprehensive Option is also a traditional medical scheme option with a savings element. These savings are used for co-payments and discretionary medical spend (such as over-the-counter medicine and fees higher than the Scheme Rate). We also offer our members something unique: both Options have a wellness component to them, which encourages health awareness and provides peace of mind via preventative care and early detection. Review the Option comparison on page 5 so that you can easily identify the Option with the benefits that will suit you and your budget.



Essential Option



Comprehensive Option

ESSENTIAL VS COMPREHENSIVE

CHANGING BETWEEN OPTIONS

Please note that you can only change between the Comprehensive and Essential Options at the end of the year for the following year. Specific dates for the Option change window period are published online at **www.sabmas.co.za.** During this time, you can change either from Essential to Comprehensive, or vice versa. Please remember that Option changes take effect on 1 January each year.

CHOOSING THE RIGHT BENEFIT OPTION

The table below gives you a brief summary of the different benefits and inclusions we offer on the Essential and the Comprehensive Options. See at a glance the benefits offered for each Option to help you make an informed decision.

	ESSENTIAL	COMPREHENSIVE
Overall Annual Limit	▪ An overall annual limit applies R471 050 per family*	▪ Unlimited
Medical Savings Account	▪ No savings	▪ 10% savings ▪ This always remains the members'
Major medical benefits	▪ Acute Hospital Network ▪ Specialist Network (if you use a non-network specialist, you may have to pay for out-of-pocket expenses)	▪ Hospital of choice ▪ Specialist Network (if you use a non-network specialist, you may have to pay for out-of-pocket expenses) ▪ Refractive surgery ▪ Specialised dentistry benefits, subject to limits
	Subject to pre-authorisation, limits and patient advocacy	
Chronic Benefit	▪ 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions ▪ Network Providers – SABMAS Pharmacy Network (20% co-payment if you use a non-Network Provider)	▪ 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions + 28 additional non PMB CDL conditions ▪ Network Providers – SABMAS Pharmacy Network (20% co-payment if you use a non-Network Provider)
	Subject to medicine reference pricing and approval	
Day-to-day Benefit	▪ Subject to overall annual limit with certain sub-limits (GPs, specialists, dentists, acute medicine, physiotherapy and biokinetics, remedial and other therapies) ▪ No Routine Benefit ▪ No savings ▪ 20% co-payment deducted from salary, or is deducted by debit order if you are a self-paying member ▪ Limited Optical Benefit ▪ Unused benefits are not carried over to the next year	▪ Subject to Routine Benefit ▪ Subject to certain sub-limits (GPs, specialists and dentists) ▪ 10% savings ▪ 20% co-payment payable from savings or deducted from salary, or is deducted by debit order if you are a self-paying member ▪ Enhanced Optical Benefit ▪ Unused savings balances are carried over each year ▪ Unused benefits are not carried over to the next year
Consultations and visits with a GP (out-of-hospital)	▪ For your chosen GP or 3 consultations with a different GP: 100% of the lower of cost or Scheme Rate R2 436 per beneficiary including minor procedures and consumables. For a GP who has not been chosen, where 3 consultations have been depleted: 60% of the lower of cost or Scheme Rate	▪ 100% of the lower of cost or Scheme Rate R5 370** per beneficiary including minor procedures and consumables.
Consultation and visits with specialists (out-of-hospital)	▪ If referred by GP: 80% of the lower of cost or Scheme Rate R2 374 beneficiary. If not referred by GP: 60% of the lower of cost or Scheme Rate. R2 374 per beneficiary	▪ If referred by GP: 80% of the lower of cost or Scheme Rate R5 370** per beneficiary. If not referred by GP: 60% of the lower of cost or Scheme Rate. R5 370 per beneficiary
Wellness Benefit	A basket of early detection and preventative tests paid from the Scheme's risk pool, which helps your Day-to-day Benefit last longer and keeps you on track with your health status	
Prescribed Minimum Benefits (PMB)	▪ 100% of the agreed rate for the diagnosis, treatment and care costs of PMB conditions, if those services are obtained from a Network Provider. Benefits may be subject to pre-authorisation and/or managed care protocols	▪ 100% of the agreed rate for the diagnosis, treatment and care costs of PMB conditions, if those services are obtained from a Network Provider. Benefits may be subject to preauthorisation and/or managed care protocols
Monthly contributions	▪ Lower, as there are limited benefits and restricted access	▪ Higher, as there are richer benefits and more freedom of choice

* All claims accumulate to this limit. Once the available sub-limit and/or annual limit has been reached, you will only have cover for PMB treatment.

** This is a shared limit for GP and Specialist Out-of-hospital consultations.

WHAT WE COVER

DAY-TO-DAY BENEFITS

We are one of the very few medical schemes to offer you both a savings account (on the Comprehensive Option) and routine benefits. The value of the Routine Benefits will differ depending on your family size.

THERE'S AN 80/20 CO-PAYMENT STRUCTURE

When you claim for a specialist or dentist consultation, the Scheme pays 80% of the Scheme Rate. The other 20% is first paid from your available savings if you're on the Comprehensive Option, otherwise it comes off your salary, or is deducted by debit order if you are a self-paying member.

THERE ARE SET LIMITS AND SUB-LIMITS

Please refer to page 15, which will take you through the limits and sub-limits of certain benefits so that your savings
(if you're on the Comprehensive Option) can go further.

If you are on the Essential Option, and have depleted your limits, you will need to pay from your own pocket.

REMEMBER

If your doctor charges more than the Scheme Rate, you will need to pay the extra amount above the Scheme Rate. This amount above the Scheme Rate can be funded from your available savings (Comprehensive Option).

CHRONIC BENEFITS

Prescribed Minimum Benefits (PMB) and the Chronic Disease List (CDL)

All medical scheme members have access to a certain minimum level of health services. PMBs are defined in the Regulations to the Medical Schemes Act as the level of minimum benefits available to all members and their dependants.

To ensure that you have full cover for the treatment of your PMB condition in hospital, we have created a Hospital Network for PMBs. The Acute Hospital Network will serve as the Scheme's PMB Hospital Network for both the Comprehensive and Essential Option.

When you make use of the Acute Hospital Network along with a Healthcare Provider in the SABMAS Provider Network, your entire PMB hospital event will be covered in full.

Please refer to page 14 for the list of hospitals within the Acute Hopsital Network and visit www.sabmas.co.za to search for a Healthcare Provider.

As part of PMBs, 26 chronic conditions, excluding HIV/AIDS, on the CDL are covered, as well as any chronic condition included in the 270 PMBs. The 270 PMB conditions are linked to a specific diagnosis and treatment guideline known as Diagnosis and Treatment pairs. Members will receive treatment for conditions on this list, subject to registration, approval, formularies and use of a Network Provider.

To view the complete list of PMB conditions, please visit **www.medicalschemes.co.za**

The 26 CDL conditions, (excluding HIV/AIDS and Diabetes type 1 and type 2) covered on the Essential and Comprehensive Options are:

ESSENTIAL	COMPREHENSIVE
1. Addison's disease	14. Dysrhythmias
2. Asthma	15. Epilepsy
3. Bipolar mood disorder	16. Glaucoma
4. Bronchiectasis	17. Haemophilia
5. Cardiac failure	18. Hyperlipidaemia
6. Cardiomyopathy	19. Hypertension
7. Chronic renal disease	20. Hypothyroidism
8. Chronic obstructive pulmonary disease	21. Multiple sclerosis
9. Coronary artery disease	22. Parkinson's disease
10. Crohn's disease	23. Rheumatoid arthritis
11. Diabetes insipidus	24. Schizophrenia
12. Diabetes mellitus type 1	25. Systematic lupus erythematosus
13. Diabetes mellitus type 2	26. Ulcerative colitis

In addition, the following non-CDL conditions are covered by the Comprehensive Option only:

COMPREHENSIVE	
1. Acne	15. Endocarditis
2. Attention Deficit Hyperactivity Disorder (ADHD)	16. Gastro-oesophageal reflux disease
3. Allergic rhinitis	17. Gout
4. Alzheimers	18. Heart valve disease
5. Ankylosing spondylitis	19. Hepatomegaly and splenomegaly
6. Benign prostatic hypertrophy	20. Hypoparathyroidism
7. Carcinoid syndrome	21. Menopause
8. Cardiac dysrhythmias	22. Osteoarthritis
9. Cerebral palsy	23. Osteoporosis
10. Cerebrovascular disease	24. Paraplegia/quadriplegia
11. Congenital malformation of heart	25. Polycystic ovarian syndrome
12. Depression	26. Psoriasis
13. Deep vein and other thrombosis	27. Pulmonary hypertension
14. Eczema	28. Stroke

CHRONIC CARE MANAGEMENT

The Scheme applies clinical guidelines to assess each chronic application and ensure the suggested medicines are appropriate, correctly prescribed and cost effective. You will need to apply for all Chronic Benefits.

REMEMBER

Our chronic medicine application process is telephonic and real-time. Ask your doctor to contact the Customer Care Centre on 0860 002 133 and speak to a pharmacist to approve your medicine.

REFERENCE PRICE AND MEDICINE MANAGEMENT

The Reference Price is the maximum price that the Scheme will pay for a group of medicines within the same therapeutic class. If you claim for a medicine that is more expensive than the Reference Price, you'll have to pay in the difference out of your own pocket at the pharmacy.

When we set the Reference Price, we always make sure that there's a choice of clinically appropriate drugs at or below the Reference Price. We also regularly review the Reference Pricing structure, looking at new medicine that has emerged, medicine discontinuations, medicine enhancements, clinical literature, price changes and other factors.

To search for the Reference Pricing page on our website, log in to **www.sabmas.co.za** and then click on Health and then Chronic Illness Benefit. In the diagram below, we unpack Reference Pricing, Network Providers and dispensing fees to help you save money when obtaining your chronic medicine.

EXAMPLE A

Member has hyperlipidaemia (high cholesterol) and requires chronic medicine. They do NOT use a Network pharmacy and refuse to try a less expensive alternative.

Medicine: Lipitor costs: R280.85 (incl. dispensing fee)

Cost of less expensive alternative covered by Scheme: R45.99 (The member must pay R234.86 to the pharmacy)

A member who uses a non-network pharmacy will have an additional 20% co-payment of R9.19, which he or she must pay to the pharmacy at the point of sale, i.e. final cost covered by the Scheme will be R36.80 (R45.99 less R9.19) if a non-network pharmacy is used.

FINAL COSTS

Paid by Scheme: R36.80
Paid by member: R244.05

EXAMPLE B

Member has hyperlipidaemia (high cholesterol) and requires chronic medicine. Member uses a Network Provider and takes the less expensive alternative that the Scheme pays for.

Medication: Therapeutic alternative Atorvastatin costs: R45.99 (incl. dispensing fee)

As the pharmacy is part of the Network, the Scheme will pay the claim in full to the amount of R45.99.

FINAL COSTS

Paid by Scheme: R45.99
Paid by member: R0.00

Note that the rand values given above are provided purely for illustration – medicine prices may fluctuate from time to time.

ADVANCED ILLNESS BENEFIT (AIB) AND COMPASSIONATE CARE BENEFIT (CCB)

Through the Advanced Illness Benefit (AIB), SABMAS will ensure that members with advanced cancer have access to comprehensive palliative care that offers quality care in the comfort of their own home, with minimum disruption to normal routine and family life. In the same way, the Compassionate Care Benefit (CCB) will offer these additional benefits to members who have advanced diseases, other than cancer.

CHOOSING A PHARMACY

Remember that if you use a pharmacy in our Network your out-of-pocket expenses can be reduced. More than 90% of pharmacies in South Africa are part of our Network. Visit **www.sabmas.co.za** and look under *Pharmacy Network* where you will find a list of SABMAS Network Providers.

If you choose not to use a pharmacy in our network, you should shop around. Ask each pharmacy what their dispensing fee is (in short, how much they add to the cost of the medicine for giving it to you).

When the pharmacist dispenses medicine, feel free
to ask if there's a less expensive generic or alternative. Pharmacists are qualified and required by law to substitute with alternatives, unless otherwise mentioned on your prescription.

Question any co-payments (amounts you have to pay from your own pocket) and find out the reason behind the co-payment – like Reference Pricing and dispensing fees.

TREATMENT BASKETS FOR THE PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL) CONDITIONS

Members who are registered with a chronic condition that falls within the Chronic Disease List conditions listed as Prescribed Minimum Benefits, will now be eligible for a new chronic medicine basket. This includes defined tests and a limited number of specialist consultations, all of which are covered up to the Scheme Rate for each year.

To view the document on treatment baskets that lists the procedures, investigations and specialist consultations we cover for your approved PMB CDL conditions, visit www.sabmas.co.za.

The number of tests and consultations are calculated based on the number of months left in the year at the time we approve cover for your condition. If you have cover for the same procedures or tests from more than one basket, we limit funding to the basket that gives you the most procedures or tests.

It is important that the correct ICD-10 code is used when your claim is submitted to the Scheme. This is to make sure we pay from the correct benefit.

If you need more cover than what is included in the treatment basket, your doctor may follow an appeals process to request extra funding for the tests, procedures and consultations you need. Your doctor needs to complete a form titled: Request for additional cover for approved Chronic Disease List conditions, which can be downloaded from our website at www.sabmas.co.za and sent back to us for review. It is important to note that an appeals process does not guarantee approval for the additional cover.

MAJOR MEDICAL BENEFITS

It probably won't surprise you to hear that hospitalisation is the most expensive benefit we provide. All those scans, surgeries and specialists cost a fortune in hospital. The Major Medical Benefit gives you cover for hospitalisation and certain out-of-hospital procedures. These procedures can be performed in a doctor's room, a registered day clinic or an outpatient facility, if treatment is clinically appropriate and pre-authorised.

PRE-AUTHORISATION

You need to get pre-authorisation for planned admissions, **before** being admitted to hospital, as well as for certain out-of-hospital procedures. But in an emergency, when there's no time to think about these things, we make an exception – so you can get authorisation afterwards. This must be done within 48 hours of admission to avoid penalties. (Also, please see the Netcare 911 information on page 20).

To get pre-authorisation, call 0860 002 133 and have the following information on hand:

- Membership number
- Name of admitting doctor
- Name of hospital
- Diagnosis
- The diagnostic code/s (called the ICD-10 code)
- Procedure to be performed – with relevant tariff codes.

You will get this information from the Healthcare Provider referring you to hospital. Pre-authorisation is given once benefits have been checked and the Scheme Rules have been applied. As an example, if you are on the Essential Option, we check to see whether you have used all your benefits. If a hospital or a doctor obtains authorisation on your behalf, you are responsible for obtaining the information that has been given to your hospital or doctor.

PLEASE NOTE:

If you do not get pre-authorisation for a planned procedure, you may have to pay the full account yourself.

BENEFIT CHANGES FOR 2023

REMOVAL OF GP CO-PAYMENTS ON BOTH OPTIONS

Co-payments for consultations with a General Practitioner (GP) will no longer apply. The change applies to both the Comprehensive and Essential Options.

CONTINUOUS GLUCOSE MONITORING ON BOTH OPTIONS

The Scheme now offers a benefit for a home-use continuous blood glucose monitor to members with diabetes who meet our clinical entry criteria. This device makes it easier to continuously monitor blood glucose levels than constantly pricking your finger. A self-monitoring blood glucose device allows members to conveniently monitor their glucose levels many times a day, accurately measure glucose concentrations, and collect a wealth of valuable data that they and their doctors can use to better manage their diabetes.

A BREAST REDUCTION BENEFIT ON THE COMPREHENSIVE OPTION

The Scheme is introducing a Mammoplasty/Breast Reduction benefit on the Comprehensive Option, subject to approved clinical protocols. Members are covered in full at the Scheme Rate when meeting the Scheme's clinical entry criteria.

ENHANCED BENEFIT IN THE TREATMENT OF URINARY INCONTINENCE ON THE COMPREHENSIVE OPTION

Members on the Comprehensive Option will have access to chronic supportive treatment for Urinary Incontinence, as prescribed by your doctor and subject to the Scheme's clinical entry criteria and clinical protocols. Urinary Incontinence is defined by the International Continence Society as involuntary loss of urine that is a hygienic or social problem to the individual. Treatment to manage the condition varies depending on the specific cause of incontinence.

INTRODUCTION OF A GP TO SPECIALIST REFERRAL ON THE COMPREHENSIVE OPTION

Members on the Comprehensive Option must ensure that any visit to a specialist is referred by your GP, to avoid additional co-payments. If members on the Comprehensive option go directly to the specialist without a GP referral, an additional 20% co-payment will be applied.

PATIENT ADVOCACY

SAB Medical Aid is consistently at work to add a large range of Healthcare Providers to our SABMAS Provider Networks for your convenience. Our SABMAS Provider Networks have been contracted to the Scheme to provide you with quality healthcare at negotiated rates. Negotiated rates are paid in full by the Scheme, protecting you from out-of-pocket expenses and therefore saving you money. It is each member's responsibility to ensure that you are consulting with a provider in the Network.

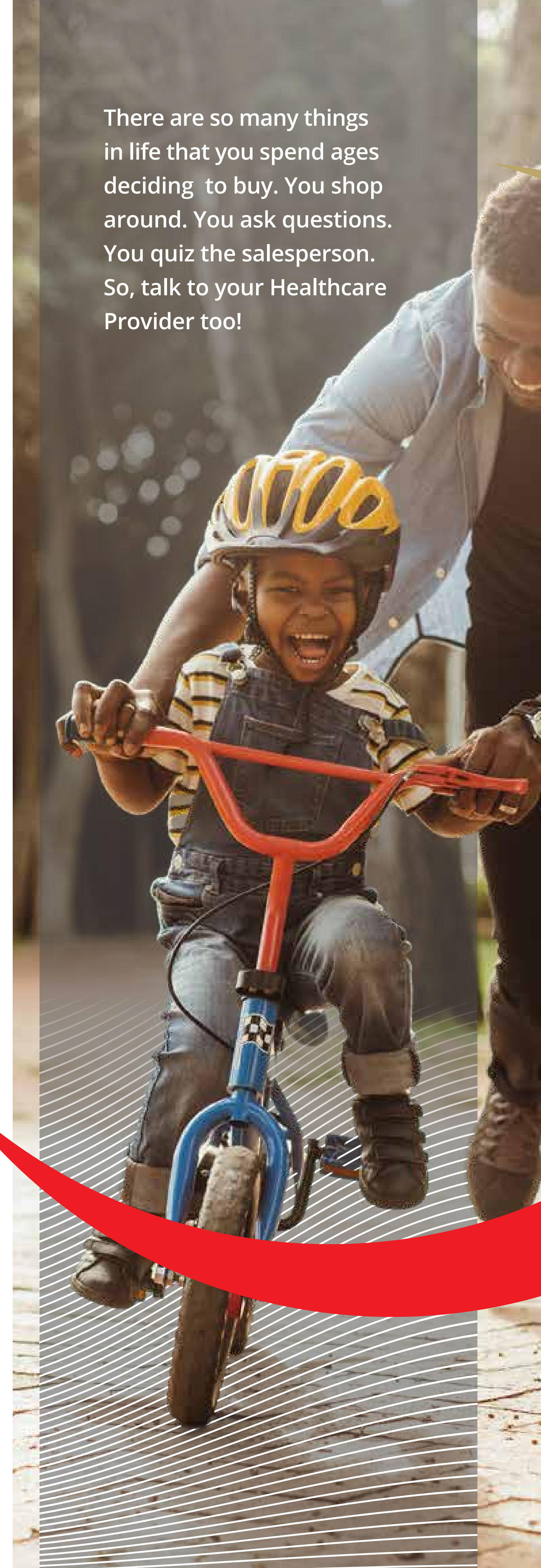
Visit **www.sabmas.co.za** to search for a Healthcare Provider in your area.

MEDICAL PROCEDURES

Medical procedures often include services from more than one Healthcare Provider. Please contact our Customer Care Centre on **0860 002 133** to determine if the Healthcare Provider involved in your procedure form part of the Network. You will benefit from using specialists on this Network, as they charge the agreed reimbursement rate, therefore the claim will be settled in full by the Scheme without any co-payments payable by the member.

If you do not use Healthcare Providers that form part of the Network, please ensure that you negotiate reduced rates prior to the procedure, as you will be liable for the shortfall between the rates charged and the Scheme's Rate.

A little preparation will go a long way to curb exorbitant medical costs, making sure you get the right quality treatment at the right cost.



We asked one of our customer care agents how Patient Advocacy has helped save a member money. Here's her story:

'A member called in asking for pre-authorisation for shoulder surgery. I asked if she had discussed the costs with her doctor upfront. She hadn't, so I advised her to get a breakdown of the costs of the procedure. She received a written quote from her doctor.

We looked at the quote, and found that the anaesthetist's charge was very high. I advised her to call her doctor to discuss this cost.

It turned out that the anaesthetist was happy to negotiate, which ended up saving her thousands of rands.
All members should feel free to discuss costs with their doctors – just as they would with a builder or painter.
If you don't feel comfortable, get a second opinion.'

SAB MEDICAL AID PROVIDER NETWORKS

GENERAL PRACTITIONER NETWORK

Our GP Network consists of Preferred Providers who have contracted with the Scheme in order to provide you with quality care at an affordable rate.

If you visit a medical practitioner who forms part of our GP Network, the provider will not charge more than the contracted rate.

All members on the Essential Option are required to choose a GP to visit. If you see your chosen GP, 100% of the agreed or Scheme Rate will be covered, and the 20% will be the member portion If you choose to visit a GP who is not your chosen GP, you will be entitled to three out-of-network (OON) GP consultations, (This includes consultation and minor procedures done in the GP's consulting rooms).

The fourth (OON) consultation will be covered at 60% of the lower of cost or Scheme rate.

OPTOMETRY NETWORK

When you visit an optometrist on our Preferred Provider Optometry Network, you can now get a 20% discount on frames and lenses. You may still visit an optometrist who is not on the Network, however, you will then not benefit from the 20% discount.

SABMAS PHARMACY NETWORK

You are free to choose from the wide range of pharmacies in our Network.

Refer to page 9 for more information.

SPECIALIST NETWORK

This is the group of specialists we've negotiated with to give you quality healthcare services at specified rates. If you decide to use a specialist who's not on our list, and who charges more than our Scheme Rate, you will have to pay for the additional cost.

All members are required to consult a GP before seeing a Specialist. If you go straight to the Specialist, SABMAS will only pay 60% of the Scheme Rate.

HOW THINGS WORK

The below example has been done to explain how using a Network provider can help save you from out-of-pocket expenses.

Before you even make the appointment to see a Healthcare Provider, you can log in to our website at www.sabmas.co.za and use our self-help search tool Find a HealthCare Professional, to identify a Network Provider in your area.

BELOW IS AN EXAMPLE OF HOW THE SPECIALIST NETWORK WORKS:

A	B	C
1 | The specialist is not on the SABMAS Specialist Network. You request the details of a specialist who is.	1 | The specialist of your choice is not on the SABMAS Specialist Network. You decide not to switch to a provider who is.	1 | You meet with the non-network specialist who takes you through the procedure.
2 | You visit the new specialist to discuss the procedure. You are prepared with questions: What will be done? How long will I stay in hospital? Who is the anaesthetist you partner with? Are they on the SABMAS Specialist Network? If not, can you choose one who is? (Remember, you are the consumer).	2 | You meet with the specialist, who takes you through the procedure.	2 | You contact our Customer Care Centre. The agent takes you through the Patient Advocacy process, see page 10 for more information.
3 | Now that you have all the details of your procedure (not just a weird code), you contact the Customer Care Centre and check if all the costs will be covered.	3 | You contact the Customer Care Centre to get your authorisation number. They give you authorisation for the procedure and inform you of the portion of costs you have to pay. In addition, you'll receive an email or an SMS to confirm all your authorised benefits.	3 | You go back to the non-network specialist and discuss the costs. You try to negotiate on rates or a discount for payment upfront. You ask questions such as how long it will take, what's involved, the anaesthetist and their rates, etc.
4 | The Customer Care Centre may have one or two questions.	4 | You undergo the procedure.	4 | The non-network specialist agrees on a discounted rate. You undergo the procedure. You know what you are in for. You have been a savvy consumer and have taken control of your healthcare.
5 | You call the specialist to ask questions. Everything is clarified; you are good to go. In addition, you'll receive an email or an SMS to confirm all your authorised benefits.	5 | You get the bill from the specialist and the anaesthetist (oops, you forgot about them!).	5 | Next time, you look into the SABMAS Specialist Network first. Less hassle; less running around.
6 | Your procedure did not result in nasty surprises. You were an informed patient.	6 | You may have to pay thousands of rands. Why so much? Because you used a specialist outside the Network, whose rate was way above our Scheme Rate.	

ACUTE HOSPITAL LIST

Essential Option members are covered in full at hospitals in the Acute Hospital Network in accordance with your option benefits. For planned admissions to any other private hospital, you must pay an upfront amount of R7 650. This does not apply in an emergency

While members on the Comprehensive Option may use any private hospital without an upfront payment, remember that these private hospitals represent the Scheme's **PMB Hospital Network** for both Options. This means you will have full cover for your PMB condition when using any of these hospitals along with a Healthcare Provider in the SABMAS Provider Network. You also have access to more than 95 Day Clinics around the country. Please visit our website at www.sabmas.co.za or call us on 0860 002 133 to find out more.

GAUTENG

- Arwyp Medical Centre
- Life Bedford Gardens Hospital
- Netcare Bougainville Private Hospital
- Life Brenthurst Clinic
- Life Carstenhof Clinic
- Dr S K Matseke Memorial Hospital
- Clinix Naledi-Nkanyezi Private Hospital
- Netcare Clinton Clinic
- Life Genesis Clinic
- Mediclinic Emfuleni
- Netcare Femina Hospital
- Life Fourways Hospital
- Mediclinic Legae Private Hospital
- Lenmed Ahmed Kathrada Private Hospital
- Life Groenkloof Hospital
- Louis Pasteur Hospital
- Midvaal Private Hospital
- Mediclinic Morningside
- Life Robinson Private Hospital
- Life Roseacres Clinic
- Life Suikerbosrand Clinic
- Wits Donald Gordon Medical Centre
- Life Wilgeheuwel Hospital
- Botshelong Empilweni Clinic
- Bougainville Private Hospital
- Clinix Private Hospital Sebokeng
- Life Flora Hospital
- Life Springs Parkland Hospital
- Life Wilgers Hospital
- Nelson Mandela Childrens Hospital
- Union Hospital
- Unitas Hospital

Exception hospitals

- Mediclinic Medforum (maternity related admissions)
- Mediclinic Midstream (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)
- Milpark (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)
- Sunninghill nursing home (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)
- Zuid-Afrikaans (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)

LIMPOPO

- Mediclinic Limpopo

MPUMALANGA

- Life Cosmos Hospital

EASTERN CAPE

- Life Mercantile Hospital
- Life St George's Hospital

KWAZULU NATAL

- Life Chatsmed Garden Hospital
- Life Entabeni Hospital
- Midlands Medical Centre
- Life Westville Hospital
- Ethekwini Hospital and Heart Centre
- Hillcrest Private Hospital

Exception hospitals

- St Augustine's (Cardiac electrophysiology centre – arrhythmia conditions only)
- Gateway Private Hospital (Cardiac electrophysiology centre – arrhythmia conditions only)
- Ethekwini (Cardiac Electrophysiology centre of excellence - admissions allowed for all arrhythmia related conditions)

NORTH WEST

- Netcare Ferncrest Hospital

FREE STATE

- Life Rosepark Hospital
- Netcare Universitas Private Hospital
- Horizon Eye Care Centre

WESTERN CAPE

- Mediclinic Cape Town
- Life Vincent Pallotti Hospital
- Melomed Mitchells Plain
- Mediclinic Panorama
- Mediclinic Stellenbosch
- Mediclinic Vergelegen
- Life Peninsula Hospital
- Melomed Gatesville
- Mediclinic Winelands Orthopaedic Hospital
- Netcare Kuilsriver Hospital

Exception hospitals

- Melomed Bellville (Cardiac electrophysiology centre – arrhythmia conditions only)
- Life Kingsbury Hospital (Ophthalmology and peripheral vascular surgery only)
- Christiaan Barnard Memorial hospital (Cardiac electrophysiology centre – arrhythmia conditions only)
- Melomed Tokai (Cardiac electrophysiology centre – arrhythmia conditions only)

YOUR BENEFIT OPTIONS

ESSENTIAL 2023

BENEFITS	ESSENTIAL OPTION	ESSENTIAL MONETARY LIMIT R471 050 OVERALL ANNUAL LIMIT PER FAMILY (M)	
DAY-TO-DAY BENEFITS IS SUBJECT TO OVERALL ANNUAL LIMIT			
ROUTINE		There are no Routine limits on this Option Benefits are subject to the category sub-limits listed below, as well as the Overall Annual Limit Member liable for a co-payment where applicable	
ALTERNATIVE HEALTHCARE SERVICES	Acupuncture, naturopathy and osteopathy	No benefit	–
CONSULTATIONS AND VISITS WITH A GP OR NURSE	Out-of-hospital (rooms or home)	For your chosen GP or 3 consultations with a different GP: 100% of the lower of cost or Scheme Rate R2 436 per beneficiary per year (on all) including minor procedures and consumables For consultations with an out-of-area GP: First 3 consultations at 100% of the lower of cost or Scheme Rate Fourth consultation onwards at 60% of the lower of cost or Scheme Rate	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	Single endoscopy: Co-payment R5 000 Multiple endoscopy: Co-payment R6 250 Limited to Overall Annual Limit	
CONSULTATION AND VISITS WITH SPECIALISTS	Out-of-hospital (rooms or home)	If referred by GP: 80% of the lower of cost or Scheme Rate (including minor procedures and consumables) R2 374 per beneficiary per year If not referred by GP: 60% of the lower of cost or Scheme Rate R2 374 per beneficiary per year	M
DENTISTRY	Dental practitioners For basic dentistry; Oral Hygienist and Dental Therapists	80% of the lower of cost or Scheme Rate M = R3 890 M + 1 = R6 419 M + 2 = R7 551 M + 3 = R8 663	M
	Advanced dentistry	No benefit	–
MEDICINE AND INJECTION MATERIAL	Chronic medicines* (other than antiretrovirals) as per Chronic Disease List (26 conditions covered)	100% of SEP including dispensing fee subject to use of SABMAS Pharmacy Network Provider 20% co-payment for non-Network Provider Reference pricing/MMAP applies	M
	Prescribed acute medicines.	Acute Medicine Limit: M = R3 757 M + 1 = R6 163 M + 2 = R6 973 M + 3 = R7 653	M
	Contraceptives	Subject to the Overall Annual Limit, and further limited to R2 534 per female beneficiary	M
	TTO after hospital event	Subject to the Acute Medicine Limit	
	Pharmacy-advised therapy (PAT)/Over-the-counter medicines (OTC) ##	No benefit	–
	Homeopathic medicine	Subject to the Acute Medicine Limit	
	Immunisation and vaccines	Subject to the acute medicine limit	M
MENTAL HEALTH	Consults and procedures	R4 859 per family and dual accumulation of 21 days in hospital or 15 out of hospital psychotherapy sessions	M
NON-SURGICAL PROCEDURES AND TESTS	Out-of-hospital (performed in doctor's rooms only)	Limited Overall Annual Limit	M
OPTICAL	Frames and readers including spectacle lenses	R1 948 per beneficiary every 2 benefit years	M
	Contact lenses	No benefit	–
	Eye examinations	Limited to Overall Annual Limit	M
PATHOLOGY AND MEDICAL TECHNOLOGY	Pathology	Limited to Overall Annual Limit	M
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	Physiother apy and Biokinetics	R2 102 per family per year	M
RADIOLOGY AND RADIOGRAPHY	Basic Radiology	Limited to Overall Annual Limit	M
	Specialised Radiology	Limited to Overall Annual Limit Co-payment of R1 500 on MRI & CT scans	
REMEDIAL AND OTHER THERAPIES	Audiology, dietetics, hearing aid acoustics, occupational therapy, orthoptics, podiatry and speech therapy	80% of the lower of cost or Scheme Rate R2 240 per family collectively for all services	
	Treatment and medicines prescribed or supplied for: Homeopathy, Naturopathy, Osteopathy	Homeopathic medication covered from acute if prescribed by a registered homeopath	M
MAJOR MEDICAL BENEFITS (SUBJECT TO OVERALL ANNUAL LIMIT)			
ALCOHOLISM AND DRUG DEPENDENCY*	For applicable services	100% of the lower of cost or Scheme Rate 21 days at a SANCA facility or SANCA rates per beneficiary	M
AMBULANCE SERVICES*	Emergency transport only (call 082 911)	100% of the lower of cost or Scheme Rate (Netcare 911)	M
MEDICAL AND SURGICAL APPLIANCES	Medical and surgical appliances	Medical and Surgical Appliances Limit – R8 122 per family per year	M
	Hearing aids	Once every three years per ear subject to the Medical and Surgical Appliances Limit	
	Hearing aid repairs (including batteries)	Once every two years, Sub-limit or R3 397 per beneficiary subject to the Medical and Surgical Appliances Limit	M
	Home oxygen, cylinders, concentrators and ventilation expenses, excluding CPAP machines	Limited Overall Annual Limit and subject to approval if purchased	M

* Benefits denoted by an asterisk are subject to authorisation

Denotes benefits which are only available on the Comprehensive option

COMPREHENSIVE 2023

DAY-TO-DAY BENEFITS			
ROUTINE		Benefits are subject to the following routine benefit limits (R) and category sub-limits M R24 258 M+1 R32 343 M+2 R38 895 M+3 R43 901 Member liable for a co-payment where applicable	
ALTERNATIVE HEALTHCARE SERVICES	Acupuncture, naturopathy and osteopathy	80% of the lower of cost or Scheme Rate	R
CONSULTATIONS AND VISITS WITH A GP OR NURSE	Out-of-hospital (rooms or home)	Consultations and visits limit: (including minor procedures and consumables) R5 370 per beneficiary per year	R
CONSULTATIONS AND VISITS WITH SPECIALISTS	Out-of-hospital (rooms or home)	If referred by GP: 80% of the lower of cost or Scheme Rate (including minor procedures and consumables) R5 370 per beneficiary per year If not referred by GP: 60% of the lower of cost or Scheme Rate R5 370 per beneficiary per year	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	Single endoscopy: Co-payment R4 100 Multiple endoscopy: Co-payment R5 150 Subject to the day-to-day-limit	
DENTISTRY	Dental practitioners For basic dentistry; Oral Hygienist and Dental Therapists	Upfront deductible for Basic dentistry In Hospital depending on age and place of service: 12 years and younger – R2 650 In Hospital / R1200 in Day Clinic. 13 years and older – R6 800 In Hospital / R4 350 Day	R
	Advanced dentistry	Advanced Dental limit: M: R12 129 M + 1 or more: R15 868	M
MEDICINES AND INJECTION MATERIAL	Chronic medicines* (other than antiretrovirals) as per Chronic Disease List (26 conditions covered)	100% of SEP including dispensing fee, subject to use of SABMAS Pharmacy Network Provider. 20% co-payment for non-Network Provider. Reference pricing/MMAP applies	
	Prescribed acute medicine	Subject to the day-to-day limit	M
	Contraceptives	Subject to the day-to-day limit, and further limited to R2 546 per female beneficiary	R
	TTO after hospital event	Subject to the day-to-day limit	
	Pharmacy assisted therapy	Subject to Positive MSA	MSA
	Immunisation and vaccines	Subject to the day-to-day limit	R
	Homeopathic medicine	Subject to the day-to-day limit	
MENTAL HEALTH	Consults and procedures	R14 601 per family and dual accumulation of 21 days in hospital or 15 out-of-hospital psychotherapy sessions.	M
NON-SURGICAL PROCEDURES AND TESTS	Out-of-hospital (performed in doctor's rooms only)	Unlimited Overall Annual Limit	M
OPTICAL	Frames and readers	R2 082 per beneficiary every two benefit years, funded from day-to-day limit	R
	Spectacle lenses	Subject to the day-to-day limit One pair per person per year Sub-limit for lens hardening – R316 per lens for hardening and tinting up to 35%	R
	Contact lenses	Subject to the day-to-day limit One pair per person per year Sub-limit of R2 082 per beneficiary once every benefit year	R
	Eye examinations	Subject to the day-to-day limit	R
PATHOLOGY AND MEDICAL TECHNOLOGY	Pathology	Subject to the day-to-day limit	R
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	Out-of-hospital	Subject to the day-to-day limit	R
RADIOLOGY AND RADIOGRAPHY	Basic Radiology	Subject to the day-to-day limit	R
	Specialised radiology	Unlimited Overall Annual Limit (Co-payment of R1 500 on MRI & CT scans)	
REMEDIAL AND OTHER THERAPIES	Audiology, dietetics, hearing aid acoustics, occupational therapy, orthoptics, podiatry and speech therapy	Subject to the day-to-day limit	
	Alternative Healthcare Services Treatment and medicines prescribed or supplied for: Homeopathy, Naturopathy, Osteopathy	Subject to the day-to-day limit	R
MAJOR MEDICAL BENEFITS			
ALCOHOLISM AND DRUG DEPENDENCY*	For applicable services	100% of the cost for all services 21 days at a SANCA facility or SANCA rates per beneficiary	M
AMBULANCE SERVICES*	Emergency transport only (call 082 911)	100% of the lower of cost or Scheme Rate (Netcare 911)	M
MEDICAL AND SURGICAL APPLIANCES	Medical and surgical appliances	R19 435 per family per year	M
	Hearing aids	Once every three years per ear subject to the Medical and Surgical Appliances Limit	
	Hearing aid repairs (including batteries)	Once every two years Sub-limit or R3 397 per beneficiary subject to the Medical and Surgical Appliances Limit	M
	Home oxygen, cylinders, concentrators and ventilation expenses, excluding CPAP machines	Unlimited Overall Annual Limit, subject to approval if purchased	M

* Benefits denoted by an asterisk are subject to authorisation

NOTE: This benefit summary is for information purposes only and does not supersede the Scheme Rules. In the event of any discrepancy between the Scheme Rules, the Rules will prevail.

TREATMENT	ESSENTIAL OPTION	ESSENTIAL MONETARY LIMIT	
MAJOR MEDICAL BENEFITS (CONTINUED)			
BLOOD AND BLOOD PRODUCTS	Blood, blood equivalents and blood products	Limited to Overall Annual Limit	M
CONSULTATIONS AND VISITS	In-hospital (general practitioners, specialists and nurse practitioners)	100% of the lower of cost or Scheme Rate	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	Single endoscopy: Co-payment R5 000 Multiple endoscopy: Co-payment R6 250 Limited to Overall Annual Limit	
DENTISTRY*	Osseo-integrated implants and Orthognatic surgery Orthodontic treatment	Upfront deductible for Basic dentistry In Hospital 12 years and younger – R2 650 In Hospital / R1 200 in Day Clinic. 13 years and older – 6 800 In Hospital / R4 350 in Day Clinic	–
	Oral Surgery and Maxillo-Facial Surgery	100% of the lower of cost or Scheme Rate	M
HOSPITALISATION*	In patient (accommodation in general ward, high care ward and intensive care unit, theatre fees, medicines, materials, hospital equipment and transportation of blood)	Admissions outside this network will result in a R7 650 deductible. 100% of the lower of cost or Scheme Rate in an Acute Hospital Network facility	M
	Outpatient (services and materials, excluding TTOs)	100% of the lower of cost or Scheme Rate	M
	Alternatives to hospitalisation (step-down facility, private nursing and rehabilitation centres)	Limited to Overall Annual Limit	M
IMMUNE DEFICIENCY RELATED TO HIV/AIDS*	Antiretroviral and related medicines All other services	100% as determined by Aid for AIDS (DSP) Subject to registration on the Aid for AIDS Programme	M
MATERNITY*	Normal delivery: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate Register with the Maternity Management Programme	M
	Caesarean section: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate Limited to R25 938 per confinement (limit may be exceeded for emergency/clinical reasons) Register with the Maternity Management Programme	M
	Medical services and midwifery (antenatal consultations, pregnancy scans, tests, delivery services by a midwife)	100% of the lower of cost or Scheme Rate	M
MENTAL HEALTH*	Hospitalisation (accommodation in a general ward)	Mental Health limit (in-hospital): R30 687 per beneficiary	M
	In-hospital consultations, visits and procedures	R30 687 per beneficiary and dual accumulation of 21 days in hospital or 15 out of hospital psychotherapy sessions.	
NON-SURGICAL PROCEDURES AND TESTS*	In-hospital	100% of the lower of cost or Scheme Rate Limited Overall Annual Limit	M
ONCOLOGY*	Consultations, visits, treatment, medicines and material used in radiotherapy/chemotherapy	Access to PMB and non PMB treatment at 100% of the lower of cost or Scheme Rate up to R200 000 per beneficiary per rolling 12 months subject to the Overall Annual limit, after which 80% of the lower of cost or Scheme Rate. Once either the R 200 000 Oncology Benefit threshold or Overall annual limit is depleted, approved Oncology PMB treatment will fund at 100% of the scheme rate.	M
OPTICAL	Refractive surgery ##	No benefit	–
ORGAN TRANSPLANTS*	Consultations, visits, harvesting and transplantation	Organ Transplant Limit: R69 607 per family	M
	Anti-rejection medicines	100% of cost Subject to organ transplant limit	M
PATHOLOGY AND MEDICAL TECHNOLOGY	In-hospital	100% of the lower of cost or Scheme Rate	M
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	In-hospital	R2 102 per family per year No benefit for chiropractors	M
PROSTHESES*	Internal and external	100% of cost R71 300 per family per year	M
RADIOLOGY AND RADIOGRAPHY*	Basic radiology	Limited to Overall Annual Limit	M
	Specialised radiology* (In-and-out-of-hospital (including magnetic resonance imaging (MRI), CT scans, angiography, bone densitometry and mammograms)	Limited to Overall Annual Limit (Co-payment of R1500 on MRI and CT scans)	M
RENAL DIALYSIS*	Acute and Chronic Renal Dialysis including specialists	100% of the lower of cost or Scheme Rate R62 361 per family	M
SURGICAL PROCEDURES*	In-and-out-of-hospital	100% of the lower of cost or Scheme Rate No benefit for elective knee and hip replacement surgery For PMB approved hip and knee prostheses, the Internal and External Prostheses limit will apply if a non-preferred supplier is used	M
COMPASSIONATE CARE BENEFIT	Holistic hospice/home-based end-of-life care	100% of the lower of cost or Scheme Rate Subject to your Overall Annual Limit with a sub-limit of R49 258 per beneficiary per lifetime	

* Benefits denoted by an asterisk are subject to authorisation

Denotes benefits which are only available on the Comprehensive option

COMPREHENSIVE 2023

TREATMENT	COMPREHENSIVE OPTION	COMPREHENSIVE MONETARY LIMIT	
	MAJOR MEDICAL BENEFITS (CONTINUED)		
BLOOD AND BLOOD PRODUCTS	Blood, blood equivalents and blood products	Unlimited Overall Annual Limit	M
CONSULTATIONS AND VISITS	In-hospital (general practitioners, specialists and nurse practitioners)	Consultations and visits limit: R5 370 per beneficiary per year including minor procedures and consumables	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	Single endoscopy: Co-payment R4 100 Multiple endoscopy: Co-payment R5 150	
DENTISTRY*	Osseo-integrated implants and orthognatic surgery (including the cost of hospitalisation, dental practitioners, anaesthetist fees and implants)	Advanced Dental limit: M: R12 129 M + 1 or more: R15 868	M
	Oral Surgery and Maxillo-Facial Surgery	Unlimited Overall Annual Limit	M
HOSPITALISATION*	In patient (accommodation in general ward, high care ward and intensive care unit, theatre fees, medicines, materials, hospital equipment and transportation of blood)	100% of the lower of cost or Scheme Rate	M
	Outpatient (services and materials, excluding TTOs)	100% of the lower of cost or Scheme Rate	M
	Alternatives to hospitalisation (step-down facility and private nursing)	Step-down facilities and private nursing: Unlimited	M
	Rehabilitation centres	Unlimited	M
	Private hospital rehabilitation services	R97 092 per family per year	
IMMUNE DEFICIENCY RELATED TO HIV/AIDS*	Antiretroviral and related medicines All other services	100% as determined by Aid for AIDS (DSP) Subject to registration on the Aid for AIDS Programme	M
MATERNITY*	Normal delivery: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate Register with the Maternity Management Programme	M
	Caesarean section: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate Register with the Maternity Management Programme	M
	Medical services and midwifery (antenatal consultations, pregnancy scans, tests, delivery services by a midwife)	100% of the lower of cost or Scheme Rate	M
MENTAL HEALTH*	Hospitalisation (accommodation in a general ward, electro convulsive therapy (ECT), medicines, materials and hospital equipment)	100% of the lower of cost or Scheme Rate R45 179 per beneficiary	M
	In-hospital consultations, visits and procedures	100% of the lower of cost or Scheme Rate	M
NON-SURGICAL PROCEDURES AND TESTS*	In-hospital	Unlimited Overall Annual Limit	M
ONCOLOGY*	Consultations, visits, treatment, medicines and material used in radiotherapy/chemotherapy	Access to PMB and non PMB treatment at 100% of the lower of cost or Scheme Rate up to R400 000 per beneficiary per rolling 12 months, after which 80% of the lower of cost or Scheme Rate. Once the R 400 000 Oncology Benefit threshold is depleted, approved Oncology PMB treatment will fund at 100% of the scheme rate.	M
OPTICAL	Refractive surgery##	100% of the lower of cost or Scheme Rate R10 778 per beneficiary per life-time subject to clinical protocols	M
ORGAN TRANSPLANTS*	Consultations, visits, harvesting and transplantation	Unlimited Overall Annual Limit	M
	Anti-rejection medicines	Unlimited Overall Annual Limit	M
PATHOLOGY AND MEDICAL TECHNOLOGY	In-hospital	Subject to the day-to-day limit	M
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	In-hospital	Subject to the day-to-day limit	M
PROSTHESES*	Internal and external	100% of cost R81 249 per family per year. Hip, knee and spinal prostheses will pay at the agreed rate and will not accumulate to this limit if a preferred supplier is used.	M
RADIOLOGY AND RADIOGRAPHY*	Basic radiology: In-hospital diagnostic radiology tests and scans	Subject to the day-to-day limit	M
	Specialised radiology*: In-and-out-of-hospital (including magnetic resonance imaging (MRI), CT scans, angiography, bone densitometry and mammograms)	Unlimited Overall Annual Limit. Co-payment of R1500 on MRI and CT scans	M
RENAL DIALYSIS*	Acute and chronic (consultations, visits, associated services and materials)	Unlimited Overall Annual Limit	M
SURGICAL PROCEDURES*	In-and-out-of-hospital	Unlimited Overall Annual Limit	M
COMPASSIONATE CARE BENEFIT	Holistic hospice/home-based end-of-life care	100% of the lower of cost or Scheme Rate Subject to a limit of R69 412 per beneficiary per lifetime	

* Benefits denoted by an asterisk are subject to authorisation

Denotes benefits which are only available on the Comprehensive option

Glossary

DSP: Designated Service Provider
M: Major Medical Benefit
MMAP: Maximum Medical Aid Pricing
MSA: Medical Savings Account
OAL: Overall Annual Limit
R: Routine benefit
SCHEME RATE: Negotiated Rate
SEP: Single Exit Price
TTO: To take home medication

Visit www.sabmas.co.za and select Doctor Visits and then Find a Healthcare Provider to find a network pharmacy nearest to you.

CONTRIBUTIONS FOR 2023

BASIC MONTHLY INCOME (R)	ESSENTIAL OPTION TOTAL MONTHLY CONTRIBUTION			COMPREHENSIVE OPTION TOTAL MONTHLY CONTRIBUTION (INCLUDES 10% SAVINGS)		
	MAIN MEMBER	ADULT	CHILD	MAIN MEMBER	ADULT	CHILD
0 – 6 300	1 398	1 398	417	3 329	3 329	999
6 301 – 9 600	1 642	1 642	490	3 565	3 565	1 073
9 601 – 12 700	1 689	1 689	503	3 640	3 640	1 093
12 701 – 15 900	1 745	1 745	525	3 713	3 713	1 112
15 901 – 19 000	1 799	1 799	538	3 788	3 788	1 143
19 001 – 22 200	1 857	1 857	558	3 874	3 874	1 159
22 201 – 25 500	1 931	1 931	578	3 950	3 950	1 186
25 501 – 31 800	2 002	2 002	602	4 032	4 032	1 207
31 801 – 38 000	2 072	2 072	626	4 103	4 103	1 227
38 001 – 43 800	2 147	2 147	645	4 180	4 180	1 252
43 801 – 49 600	2 212	2 212	664	4 265	4 265	1 275
49 601+	2 278	2 278	685	4 351	4 351	1 301

THE WELLNESS BENEFIT

This benefit is available to all members and their registered beneficiaries. The Wellness Benefit empowers you with better awareness of your health status through the Early Detection Programmes.

The Early Detection and Immunisation Programmes not only assist to avoid expensive medical costs in the future, but encourage you to keep healthy and improve your quality of life. For your convenience there is no need to register for this benefit; your membership qualifies you automatically.

Know your health status – we cover 100% of the Scheme Rate for a variety of health checks.

WHAT WE COVER AS PART OF THE WELLNESS BENEFIT

WHAT PROGRAMMES ARE COVERED?	WHAT DO THE PROGRAMMES COVER?	WHICH AGES ARE COVERED?	HOW OFTEN ARE BENEFITS ALLOWED?	HOW MUCH DO WE COVER?
IMMUNISATION PROGRAMMES	Baby immunisations		In line with Department of Health protocols	100% of the lower of cost or Scheme Rate
	Tetanus diphtheria booster	As needed	As needed	100% of the lower of cost or Scheme Rate
	Influenza vaccination	All	Every year	100% of the lower of cost or Scheme Rate
	Pneumococcal vaccination	60+ years old and high-risk individuals	Every year	100% of the lower of cost or Scheme Rate
EARLY DETECTION PROGRAMMES	Screening benefit (health assessment) at Clicks or Dis-Chem.			
	▪ Body Mass Index (BMI)	All adults	Once a year	100% of the lower of cost or Scheme Rate
	▪ Blood sugar test (finger prick)	All adults	Once a year	100% of the lower of cost or Scheme Rate
	▪ Blood pressure test	All adults	Once a year	100% of the lower of cost or Scheme Rate
	▪ Cholesterol test (finger prick)	All adults	Once a year	100% of the lower of cost or Scheme Rate
	▪ HIV test (finger prick)	16+ years old	Once a year	100% of the lower of cost or Scheme Rate
	General physical examination (at a GP)	30-59 years old	One medical examination every three years	100% of the lower of cost or Scheme Rate
		60-69 years old	One medical examination every two years	100% of the lower of cost or Scheme Rate
		70+ years old	One medical examination every year	100% of the lower of cost or Scheme Rate
	Mammogram	Females 40+ years old	Once every two years	100% of the lower of cost or Scheme Rate
	Prostate-specific antigen test (Pathologist) (for prostate cancer)	Males 40-49 years old	Once every five years	100% of the lower of cost or Scheme Rate
		Males 50-59 years old	Once every three years	100% of the lower of cost or Scheme Rate
		Males 60-69 years old	One every two years	100% of the lower of cost or Scheme Rate
		Males 70+ years old	Once a year	100% of the lower of cost or Scheme Rate

WHAT PROGRAMMES ARE COVERED?	WHAT DO THE PROGRAMMES COVER?	WHICH AGES ARE COVERED?	HOW OFTEN ARE BENEFITS ALLOWED?	HOW MUCH DO WE COVER?
EARLY DETECTION PROGRAMMES	DEXA bone density scan (for osteoporosis and bone fragmentation)	50+ years old	Once every 3 years	100% of the lower of cost or Scheme Rate
	Cholesterol test (Pathologist)	All adults	Once a year	100% of the lower of cost or Scheme Rate
	Blood sugar/glucose test (Pathologist) (for diabetes)	All adults	Once a year	100% of the lower of cost or Scheme Rate
	HIV test	All beneficiaries	Once a year	100% of the lower of cost or Scheme Rate
	HbA1C test Lipogram	High risk members	Once a year	R250
	Pap smear	Females	Once every 3 years	100% of the lower of cost or Scheme Rate
	Colon Cancer Faecal Occult blood test	All adults	Once every 2 years	100% of the lower of cost or Scheme Rate
	▪ Pathology test	Females	Once a year	100% of the lower of cost or Scheme Rate
	▪ Consultation (for cervical cancer prevention)	Females	Once a year	100% of the lower of cost or Scheme Rate
	Glaucoma test (for blindness)	40-49 years old	Once every two years	100% of the lower of cost or Scheme Rate
		50+ years old	Once a year	100% of the lower of cost or Scheme Rate
	Maternity – subject to registration on the Maternity Management Programme. REGISTRATION ON THE MATERNITY MANAGEMENT PROGRAMME IS COMPULSORY	Direct Antiglobulin test (Coombs)	One test per female beneficiary per pregnancy	
		Full blood count	One test per female beneficiary per pregnancy	
		Platelet count	One test per female beneficiary per pregnancy	
		Grouping: Rh blood group antigen	One test per female beneficiary per pregnancy	
		HIV antibody/ELISA	Two tests per female beneficiary per pregnancy	
		Rubella-IgM: Specific antibody titer: ELISE/EMIT per Ag	One test per female beneficiary per pregnancy	
		Quantitative Khan VDLR or other flocculation	One test per female beneficiary per pregnancy	
		Beta-HCG qualitative blood test	One test per female beneficiary per pregnancy	
		Hepatitis B surface antigen	Two tests per female beneficiary per pregnancy	
	Dentistry	General full mouth examination by a general dentist or oral hygienist (including sterile tray and gloves), plus polishing and scaling	Once a year per beneficiary	100%

PLEASE NOTE:

As a member, either on the Comprehensive or Essential Option, you automatically qualify for this Wellness Benefit. You do not need to register.

OTHER AREAS WE HELP WITH

MATERNITY MANAGEMENT PROGRAMME

We care about your little ones, even before they're born.
This is why our Maternity Management Programme is there to assist you during pregnancy. Benefit from pre-natal healthcare, including advice tailored to the stage in your pregnancy. Access quality care in the form of two scans, 12 antenatal consultations, antenatal classes, a pregnancy birth book and pre-natal supplements up to a limit of R438 per month. You will be entitled to various pathology tests as set out on page 21

IMPORTANT:

You need to register on the Maternity Management Programme as soon as your pregnancy has been confirmed. Twelve-week-scan time? Contact us on 0860 002 133. Please keep in mind that if you don't join this programme, you'll have to pay for the gynaecologist consultations and your two scans out of your Day-to-day Benefits – this will make it run out quicker. Wouldn't you rather save that money for a new pram or a car seat?

OUT-OF-HOSPITAL DTP PMB (DIAGNOSED TREATMENT PAIR PRESCRIBED MINIMUM BENEFIT)

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include treatment, acute medicine, consultations, blood tests and other investigative tests. We cover kidney, heart or liver treatment relating to transplants as a Prescribed Minimum Benefit (PMB).

If you want to apply for cover under Prescribed Minimum Benefits for treatment of a condition without hospital admission, you must complete a Prescribed Minimum Benefit form.

ONCOLOGY MANAGEMENT PROGRAMME

Members registered on the Oncology Management Programme have access to an oncology ancillary basket. This basket includes items that are not necessarily part of your direct treatment, but that will assist with your care during treatment, for example, anti-nausea medications following chemotherapy.

The basket also consists of a list of all the consultations, radiology and pathology available to you.

All of the items within the ancillary basket will be paid from your Oncology Benefit, as long as the correct ICD-10 code is used. These baskets are allocated based on defined protocols.

If you need any treatment that does not form part of the oncology PMB ancillary basket or if you have used up certain items within the basket, your Healthcare Provider must contact us to motivate for extended cover.

The Scheme will cover the costs of your oncology treatment at 100% of the Scheme Rate, up to a threshold. Once this threshold has been reached, the Scheme will continue cover at 80% of the Scheme Rate. Once the Oncology Benefit threshold is depleted, approved Oncology PMB treatment will fund at 100% of the scheme rate.

To register on the Oncology Programme, please ask your Healthcare Provider to send through the histology report confirming the cancer to **oncology@sabmas.co.za** or fax it through to **011 539 5417.** Alternatively, you can contact us on **0860 002 133.**

COMPASSIONATE CARE

The Compassionate Care Benefit gives you access to holistic home-based end-of-life care per person in their lifetime.

ADVANCED ILLNESS BENEFIT (AIB) AND MEMBER SUPPORT PROGRAMME

Members with cancer have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home.

The advanced illness member support programme is a pre-AIB benefit, with access to providers specializing in palliation. This allows members to establish relationships and create a link to support and maintain their wellbeing until such time that they may require AIB benefits.

Please remember to negotiate the best rates with your doctor.

MENTAL HEALTH SUPPORT AND RELAPSE PREVENTION PROGRAMME:

The Scheme offers a GP disease management programme for the treatment of acute and/or episodic Major Depression, available to members who meet the clinical entry criteria. Eligible members who register on the Mental Health Programme will have access to a network of Psychologists, Occupational Therapists, Social workers and registered Counsellors.

SPINAL CARE PROGRAMME AND CENTRE OF EXCELLENCE:

The spinal care programme provides members with conservative care interventions and appropriate treatment at primary care level for the management of back pain. Eligible members will have access to a network of physiotherapists that have been trained in the management of back pain and have the support of mentors that specialize in back pain management.

In addition, the programme is structured in such a way that when surgery is the only option, this is performed at the best possible place of service (A Centre of Excellence), by the best possible surgeons to ensure the best possible outcomes. Therapists, Social workers and registered Counsellors.

READMISSION PREVENTION BENEFIT:

The benefit is aimed at members identified as high risk for a readmission. It is offered to those members being admitted for a defined list of conditions and includes a home-care component, a doctor follow-up consultation and a medicine reconciliation done at the point of discharge by the treating doctor.

AID FOR AIDS PROGRAMME

Aid for AIDS, our HIV management programme, offers members and dependants:

- Medicine to treat HIV* and vitamins to boost the immune system
- Regular monitoring of the condition
- Monitoring of the patient's response to therapy
- Monitoring tests to detect side effects
- Ongoing patient support via dedicated counsellors
- Assistance in finding a registered counsellor for emotional support.

* This includes medicine to prevent mother-to-child transmission and infection after sexual assault or needle-stick injury.

If a test confirms that you are HIV positive, you must register with Aid for AIDS as soon as possible. Aid for AIDS will keep your status confidential. Contact them on **0860 100 646** and request an application form, or ask your Healthcare Provider to call them on your behalf.

If you are exposed to HIV through sexual assault or from a needle or injection, please ask your doctor to call Aid for AIDS urgently. We can authorise special antiretroviral medicine and we can help you to prevent possible HIV infection.

To register, please visit www.aidforaids.co.za or send a confidential text message to 083 410 9078. You can also fax your membership number to 0800 600 773.

NETCARE 911 ON 082 911

If the unthinkable happens and you're faced with a medical emergency like a car accident or a heart attack, there's only one number you must remember: **082 911**. (Don't wait. Put it into your cellphone and your loved ones' cellphones now!).

Not only is Netcare 911 South Africa's favourite provider of emergency medical services, it has several benefits:

- They ensure great response times
- They ensure the correct emergency staff is sent to a medical emergency to provide the correct level of care
- Invoices are sent directly to Netcare 911, so you don't have to worry about receiving and submitting them.

Another important benefit of Netcare 911 is that you have access to free telephonic advice from registered nurses and telephonic trauma assistance by qualified trauma counsellors. We encourage you to use this benefit. It's available 24/7.

Remember, in an emergency call **082 911.**

DID YOU KNOW:

Netcare 911 has over 200 emergency vehicles as well as a fleet of fixed-wing and helicopter air ambulances.

TREATMENT BASKETS FOR THE PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE (CDL) CONDITIONS

The Prescribed Minimum Benefit Chronic Disease List is a list of conditions which all medical schemes need to cover on all the Options they offer to their members. This cover includes funding for the diagnosis, treatment and ongoing care of the listed conditions.

We will only pay Prescribed Minimum Benefit claims if cover for your condition has been approved on the Chronic Medicine Benefit. Only claims for procedures and consultations listed in the Prescribed Minimum Benefit (PMB) treatment Baskets will be paid from the Chronic Disease Basket of Care.

We will pay for tests and procedures for your condition according to the treatment baskets. We pay for certain tests like blood tests and X-rays according to the PMB treatment Baskets. This cover includes tests and procedures for both the diagnosis and ongoing management for each of the PMB Chronic Disease List conditions. We pay for listed blood tests, scans and X-rays up to a maximum of the Scheme Rate.

We will not pay claims from the Chronic Disease Basket of Care in the following instances

- The claims are submitted without the relevant ICD-10 codes
- You are not yet registered on the Chronic Disease Programme for the specific PMB condition
- You have exceeded the frequency limit on consultations or tests in the registered Chronic Disease Basket of Care.

To find a doctor who is a Network Provider, please use the Find a HealthCare Professional tool on www.sabmas.co.za.

BENEFIT EXCLUSIONS

Like most medical schemes, we don't cover costs related to treating obesity, self-inflicted injuries, injuries resulting from professional sport and holidays for healing purposes.

While we cover dental procedures, we don't cover dental treatment under general anaesthetic or conscious sedation, once the patient is older than eight years.

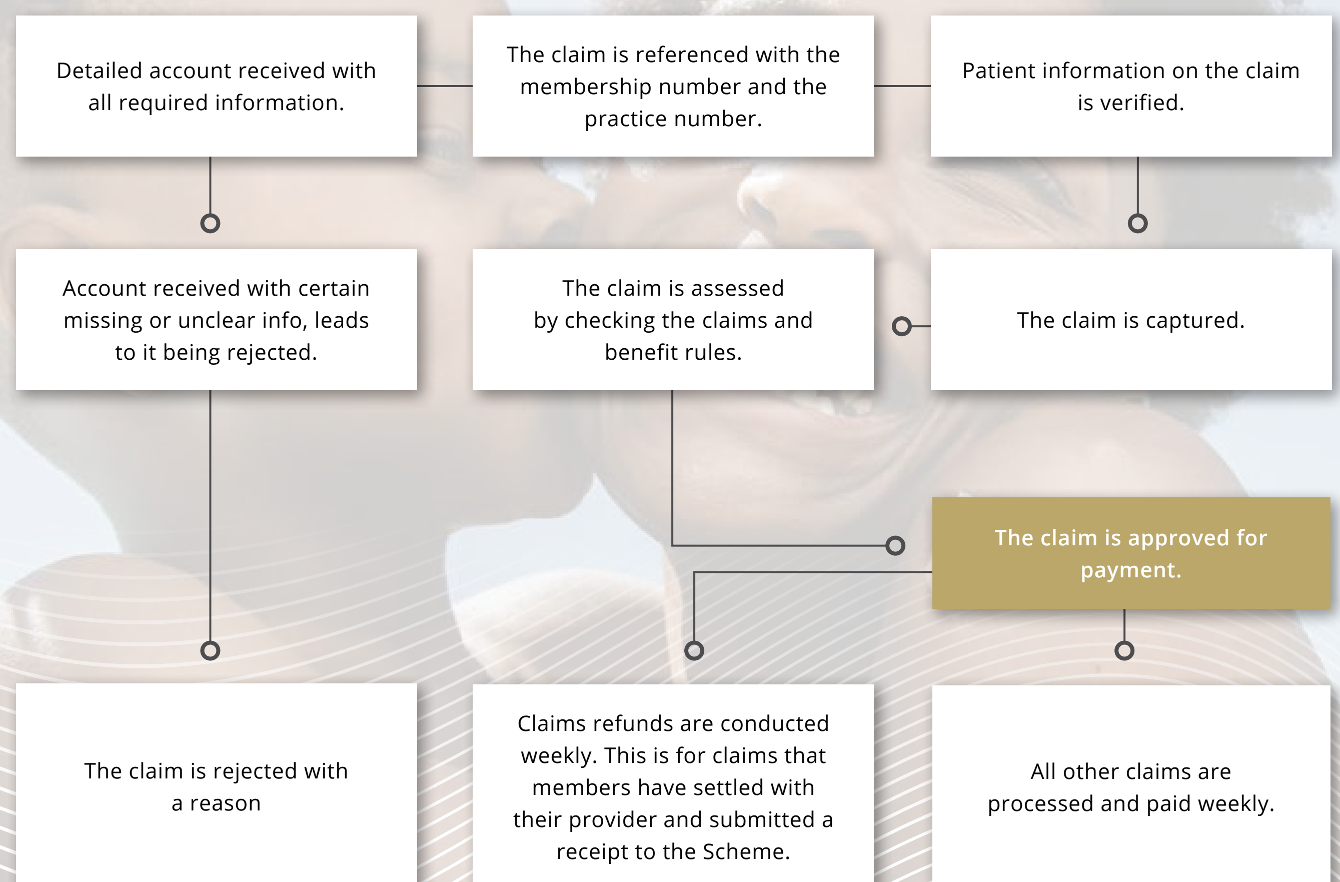
We also don't cover cosmetic procedures like certain plastic, reconstructive surgeries or dental implants. Look at the Scheme Rules at www.sabmas.co.za, or check with the Customer Care Centre for a list of exclusions.

ADMIN HOW-TO'S

Remember: if you're injured in an accident, call the Customer Care Centre on 0860 002 133 to find out the procedure and paperwork to be completed to submit a third-party claim.

CLAIMS SUBMISSION

Life's uncertain enough without medical schemes being complicated too, so we've unpacked our 'claims chain' to give you insight into the admin of our Scheme.



APPLICABLE TO BOTH REJECTED AND APPROVED CLAIMS

If you have a valid email address, your assessed claims will be sent to you twice a month in your claims notification. If you do not have an email address, your claims statement will be posted to you.

Q&A: CLAIMS

WHO IS RESPONSIBLE FOR SUBMITTING MY CLAIMS?

Many service providers will submit accounts for you. But whether they do or not, you're ultimately responsible for submitting your accounts. Check your claims statements thoroughly and often, so that you're always on top of things.

WHAT INFORMATION SHOULD APPEAR ON MY CLAIM TO ENSURE PAYMENT?

The following information should appear on your claim:

- Your name and initials
- The patient's name, as shown on the membership card
- Your membership number
- The treatment date
- The amount charged
- The tariff code/s (where applicable)
- The ICD-10 code/s.

Members on the Essential Option who see a Specialist must also ensure that the referring GP's name is reflected.

HOW CAN I SUBMIT MY CLAIM?

If you're submitting the claim; email, post or deliver a clear and easily readable copy to the Scheme as soon as possible. Send a detailed invoice – please don't send statements.

If you've already paid the claim, attach your receipt and mark the account "PAID". Most important is your claims statement which you'll receive when the Scheme processes a claim for you during that month. Like a bank statement, this shows payments made to you or for you (with explanations of the various pay codes, so you understand why something may not have been covered).

You can submit your claims through the following methods:

Email: **claims@sabmas.co.za**

Post: **PO Box 10436, Johannesburg, 2000**

WHEN AND HOW MUCH CAN I EXPECT TO BE PAID?

The Scheme has two statement runs per month for both members and suppliers. However, claims will be paid weekly.

- Accounts charged equal to our tariff will be paid directly and in full, once benefit rules have been applied, to the supplier.
- Accounts charged above our tariff will be paid directly to the provider at the Scheme Rate. The member will be liable to cover the difference between the Scheme Rate and the amount charged by the provider, in line with the Scheme Rules per Benefit Option.
- Accounts with a receipt to prove your payment will be refunded to you.
- Any co-payments owed by you to the Scheme will either be deducted from available savings (Comprehensive Option) or deducted from your salary or alternatively, deducted by debit order, if you are a self-paying member (Comprehensive and Essential Options).
- However, if you are due for a refund, any co-payments that are due by you in the same payment run will be offset against the refund*.

* Refunds are paid into your bank account because it is safest that way, so always let the Scheme know of changes to your banking details.

WHAT CAN I DO TO AVOID PAYMENTS OUT OF POCKET?

If you're submitting the claim; email, post or deliver a clear and easily readable copy to the Scheme as soon as possible. check which of your benefits are limited and whether you have available limits read your statements to understand the reasons why claims have not paid and contact your health professional if necessary to amend the account read your brochure to understand when you may need to preauthorize your procedure minimise shortfalls on your claims by visiting your nominated GP on Essential Option and use the Find a Healthcare Provider tool on **www.sabmas.co.za** to find a health professional we have an agreement with.

IMPORTANT:

You have four months from the date of your treatment during which to submit your account.

HOW DO I TRACK CLAIMS ONLINE?

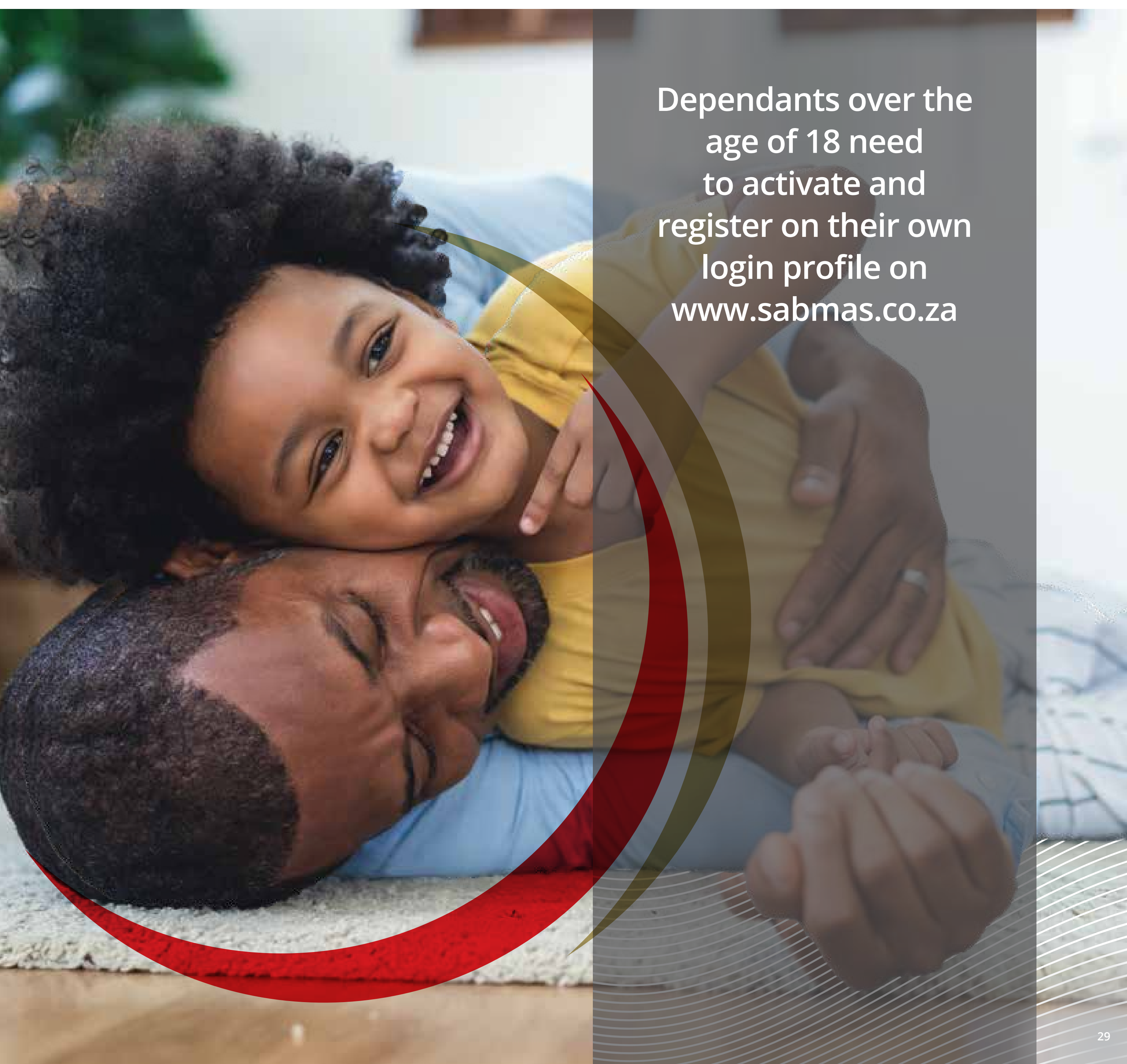
If you have Internet access, **www.sabmas.co.za** will show your updated claim, benefit details and information. This data is password protected for your security, so you'll need to register, confirm your password and then log in.

Follow these easy steps to register on the website:

1. Go to **www.sabmas.co.za.**
2. Click on the *Register* button on the top right hand side of the screen.
3. Select your identification type from the dropdown menu. You can choose either ID or passport number. We use this information to confirm that you are allowed to register.
4. Choose if you would like to receive your One Time Password (OTP) by SMS or email.
5. Once you have received and entered your OTP, click Continue.
6. Select a username – the username you choose is permanent and cannot be changed.
7. Create a password.

   Once you are logged in you can:

   - View your membership details
   - View and edit your contact details
   - Find your claims and monitor their status
   - View claims statements
   - Locate a Network Provider
   - View authorisations for chronic conditions along with baskets of care.



ADMIN INFORMATION

IMPORTANT THINGS TO REMEMBER

- Comprehensive Option members should check your Medical Savings Account often so that you're prepared for any co-payments you may need to make.
- Save money by using the Healthcare Providers in our GP, Optometry, Specialist Networks and Pharmacy Networks.
- Feel free to negotiate with specialists who don't charge Scheme Rates.
- Check with your pharmacist for alternatives if you have co-payments.

MEMBERSHIP

Only full-time permanent employees of South African Breweries and participating employers can join SAB Medical Aid. This is a condition of employment when you join.

PLEASE NOTE: If you're registered as a dependant on your partner's medical scheme, you cannot join SAB Medical Aid, because the Medical Schemes Act does not allow individuals to be members of more than one medical scheme at a time.

WHO QUALIFIES AS A DEPENDANT?

The following individuals qualify as dependants:

- Your spouse or partner
- Your children, stepchildren or adopted children, or any children in your custody
- A registered student at university or recognised institution of higher learning
- A dependant not permanently employed
- A child of 21 years or older who is mentally or physically disabled and does not work
- Your grandchild may qualify as a dependant if you are their legal guardian or if their parent is a dependant on your medical scheme.
- Your financially dependent parent or parent-in-law may qualify as a dependant, subject to certain criteria being met (additional information and documentation needed to determine eligibility for dependent membership of a parent/parent-in-law will be requested on the application form).
- We may ask you for evidence of the status of your dependant.

NOTE:

The contributions for a child of 21 years or older is charged at adult rates, whether or not they are a registered student except for a disabled child (a disabled child pays adult rates from the age of 26).

WHAT ABOUT PENSIONERS, SURVIVING SPOUSES AND DISABILITY CLAIMANTS?

These individuals may remain on the Scheme and receive the same benefits as other members, but only if:

Pensioner members:

- Have retired from their employers; or
- Are members of the Scheme before retiring.

A surviving spouse and child members:

- Are registered as dependants at the time of the member's death, including a posthumous child (a child conceived before the time of the principal member's death).

Disability claimants:

- Are members of the Scheme before they become disabled; and
- Are placed on disability by their employer's disability insurers.

WAITING PERIODS

The Scheme does not impose waiting periods or any other penalties on new employees joining the Scheme within 90 days of employment, or on regular dependants (e.g. spouse or child) joining within 90 days of becoming eligible to join e.g. through marriage or birth. But please be aware that a three-month general waiting period and/or a 12-month condition-specific waiting period and/or a late joiner penalty may be applied if you/they join the Scheme at any other time. You are also allowed to add your financially dependent parents/parents-in-law as your dependants. However, if they were not your dependants on your previous medical scheme, i.e. if they are transferring to SAB Medical Aid on a voluntary basis, waiting periods and/or late joiner penalties may be imposed, even if they join within 90 days of you becoming a member.

LATE JOINER PENALTIES

If you're a 'late joiner', i.e. any beneficiary over the age of 35 years who has not had medical scheme cover for a number of years, you may be subject to certain penalties as stipulated in the Medical Schemes Act. These depend on how long you had no cover. Late joiner penalties are applied as follows:

NUMBER OF YEARS NOT ON A MEDICAL SCHEME	MAXIMUM PENALTY
1 – 4 years	5% increase in contribution
5 – 14 years	25% increase in contribution
15 – 24 years	50% increase in contribution
25+ years	75% increase in contribution

CONSENT AND CONFIDENTIALITY

We are committed to safeguarding and protecting your personal information. As part of this commitment, we need written consent from the principal member or dependant for us to disclose any personal, medical or claims information to a third party such as your doctor, specialist or employer.

Any dependant on your policy older than 18 years also needs to give consent for you to access their information. You will need to complete a document highlighting what information each beneficiary will have access to.

This *Third-party consent* form is available on the website at **www.sabmas.co.za** or you can contact the Customer Care Centre on **0860 002 133** and they will send you one.

IMPORTANT:

Please notify the Scheme of any changes to your postal and residential address, email address, contact numbers and marital status.

Divorced spouses no longer qualify for membership from the first of the month following the effective date of the divorce. The principal member is responsible for advising the Scheme.

Common law spouses cannot remain members of the Scheme once the relationship has ended.

If you resign from a participating employer, your membership will be terminated as you are no longer eligible to be a member of the Scheme.

Non-payment of contributions and co-payments will result in suspension of your membership after 30 days and can result in termination.

Q&A: PROVIDER NETWORKS

Medical schemes are required by law to pay Prescribed Minimum Benefit (PMB) claims at cost. This has significantly increased the financial burden on all medical schemes. In the long term, this may impact members by way of excessive contribution increases.

WHAT HAS SAB MEDICAL AID DONE TO PROTECT ITS MEMBERS FROM RISING COSTS?

In an attempt to control the risk of escalating costs to our members and the Scheme, the Board of Trustees has introduced a GP, Optometry and Specialist Network.

WHAT IS THE BENEFIT OF HAVING THESE NETWORKS?

The Scheme has contracted with a group of providers to deliver quality healthcare services to you at a pre-negotiated rate.
In order to avoid co-payments, you are encouraged to use these Networks for treatment both in-and out-of-hospital.
In partnering with these providers, the Scheme can manage claims costs, which helps us to keep contribution increases as low as possible while still offering you great benefits.

For your convenience, the Scheme will pay the Network Providers directly and in full, sparing you any up-front payments.

ARE MEMBERS ALLOWED TO USE A PROVIDER OUTSIDE OF THE NETWORK?

Members on the Comprehensive Option are entitled to use a provider of your choice; however, if they charge above the Scheme Rate, you will have to pay the difference from your own pocket. If a non-network provider charges more than the Scheme Rate, we will pay the claim.

All members on the Essential Option will be required to choose a GP but will be allowed 3 consultations per year with a different GP.

CAN I SEE A SPECIALIST WITHOUT VISITING A GP FIRST?

Members on both options need to see a GP first. If you don't we will only pay 60% of the Scheme Rate.

WHAT HAPPENS IN AN EMERGENCY?

We know that your family's health is the most important thing to you, so we do not expect you to shop around for a provider on the Network in the event of an emergency. PMB claims, such as claims arising from a stroke or heart attack, will be covered in full, whilst non-PMB claims will be covered at the Scheme Rate if a non-network provider is used.

WHAT ROLE CAN YOU PLAY?

As a member of the Scheme you are encouraged to play a part in protecting your Scheme against rising healthcare costs.
Please contact the Customer Care Centre on 0860 002 133 or visit **www.sabmas.co.za** (click on DOCTOR and then *Find a Healthcare Provider*), to determine whether your provider is on a network.

WHAT ABOUT OTHER PROVIDERS ASSISTING IN THE PROCEDURE?

Do not assume that if the attending provider is in the Network, the other providers are also in the Network.

Check if they are part of the Network and discuss their rates beforehand. Visit **www.sabmas.co.za** (click on DOCTOR and then *Find a Healthcare Provider*) or contact the Customer Care Centre who can assist you with recommendations of Network Providers.

WHAT MORE CAN YOU EXPECT?

There is a sustained effort to ensure the Network continues to grow, to make it easy and convenient for each member to access quality healthcare at a contained cost.

CONTACT US

	TELEPHONE AND FAX	EMAIL	POSTAL ADDRESS AND PHYSICAL ADDRESS
CUSTOMER CARE CENTRE	Tel: 0860 002 133	Queries: info@sabmas.co.za Claims: claims@sabmas.co.za Membership changes: membership@sabmas.co.za	Po Box 10436, Johannesburg 2000 7 West Street Houghton Johannesburg
AID FOR AIDS	Tel: 0860 100 646 Fax: 0800 600 773 Confidential SMS line: 083 410 9078	info@afadm.co.za	
PRE-AUTHORISATIONS: HOSPITAL AND OTHER	Tel: 0860 002 133 Fax: 010 593 2074 (Oncology) Fax: 011 770 6247 (Chronic)	oncology@sabmas.co.za chronic@sabmas.co.za	
NETCARE 911 (EMERGENCIES)	Tel: 082 911		
SCHEME WEBSITE	www.sabmas.co.za		

FORENSICS

If you even slightly suspect someone of committing fraud, report all information directly to the fraud department:

Toll-free phone: 0800 204 702

Toll-free fax: 0800 00 77 88

Email: sabmas@tip-offs.com

COMPLAINTS AND APPEALS

The Scheme Rules allow you to lodge a complaint or appeal. Your first step would be to lodge your complaint with the administrator, by calling us on **0860 002 133**, sending an email to **info@sabmas.co.za** or by post to PO Box 10436, Johannesburg, 2000. If you are not satisfied with the response, you may forward your complaint to the Principal Officer (PO Box 10436, Johannesburg, 2000), who may refer it to the Board of Trustees or an Independent Disputes Committee, if necessary. If you are still not happy with the outcome, you can lodge your complaint with the Council for Medical Schemes (CMS), which oversees all medical schemes and will treat each individual case on its merit.

Complaints can be submitted to CMS, by any reasonable means such as a letter, fax, email or in person:

Fax: 086 673 2466

Email: complaints@medicalschemes.com

Postal address: Private Bag X34, Hatfield 0028

Physical address: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157

Website: www.medicalschemes.co.za

SAB Medical Aid, registration number 1209, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider (until 31 December 2022).

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