Preventative Care Benefit 2024

Who we are

Sasolmed (referred to as 'the Scheme'), registration number 1234, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

Overview

Preventive screening is important as early detection improves long-term clinical outcomes and ensures that you receive the best care. The Preventative Care Benefit covers screening tests, a seasonal flu vaccination and a pneumococcal vaccine. Clinical entry criteria may apply, and some of these tests and treatments have specified frequency and age limits.

The screening tests and vaccinations must be done by an appropriately registered healthcare provider, and network provider where applicable.

About some of the terms we use

Here is a list of some of the terms that you may not be familiar with, along with their meanings:

TERMINOLOGY	DESCRIPTION
Designated Service Provider (DSP)	A healthcare provider or group of providers designated by the Scheme to provide services to our members for the diagnosis, treatment and care of medical conditions.
ICD-10 code	A clinical code that describes diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Prescribed Minimum Benefits (PMB)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment, and care of: • An emergency medical condition • A defined list of 271 diagnoses • A defined list of 27 chronic conditions

	To access PMBs, there are rules defined by the Council for Medical Schemes (CMS) that apply: • Your medical condition must qualify for cover and be part of the defined list of PMB conditions • The treatment needed must match the treatments in the defined benefits • You must use Designated Service Providers (DSPs). This does not apply in emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If you do not use a DSP, we will pay up to the Scheme Tariff. The difference between what we pay and the actual cost of your treatment will be for your own cost. If your treatment doesn't meet the above criteria, we will pay according to your network option.
Scheme Tariff	This is a tariff we pay for healthcare services from hospitals, pharmacies, healthcare providers and other providers of relevant health services.

Tests covered by the Preventative Care Benefit

We pay certain screening tests from the Preventative Care Benefit. Consultations and related costs are paid from your available out of hospital benefits, where applicable, unless they relate to a PMB diagnosis.

Once you have reached the frequency limit for the tests set out below, any additional screening and preventive tests and treatments will be paid from your available out of hospital benefits, if available.

We will pay for these healthcare services as long as you use appropriately registered providers, and provided that this healthcare service or product has a valid tariff code, ICD-10 diagnosis code and price.

TEST	COVER
Preventative medical examination: General practitioner	Limited to one visit per beneficiary per annum. The annual preventative medical examination does not form part of the GP consultation limit of 8.

Pap smear and liquid-based cytology test	Limited to one pap smear and one liquid-based cytology test per female beneficiary aged 21 years and older per annum. Where a beneficiary is not eligible for the Preventative Care Benefit, the Pathology Benefit and/or PMBs will apply.
Midstream urine dipstick test	Limited to one test per beneficiary per annum. All further tests revert to the Pathology Benefit and PMBs; clinical and funding protocols may apply.
Mammogram	Limited to one mammogram per female beneficiary aged 40 to 49 years every two years or one mammogram per female beneficiary aged 50 years and older per annum. Where a beneficiary is not eligible for the Preventative Care Benefit the Radiology Benefit and/or PMBs will apply.
Cholesterol test, including a lipogram	Limited to one test per beneficiary aged 20 years and older per annum. Where a beneficiary is not eligible for the Preventative Care Benefit, the Pathology benefit and/or PMBs will apply.
Blood glucose test (fasting)	Limited to one test per beneficiary per annum. All further tests revert to the Pathology Benefit and PMBs; clinical and funding protocols may apply.
Bone density scan (female)	Limited to one scan per female beneficiary aged 55 years and older every two years. Where a beneficiary is not eligible for the Preventative Care Benefit, the Radiology Benefit and/or PMBs, will apply.
Bone density scan (male)	Limited to one scan per male beneficiary aged 70 years and older every two years. Where a beneficiary is not eligible for the Preventative Care Benefit, the Radiology Benefit and/or PMBs, will apply.
Flu vaccination	Limited to one vaccination per beneficiary aged 6 months and older per annum.
Pneumococcal vaccination	Limited to one vaccination per beneficiary aged 18 years and older every five years.
HPV vaccination	Limited to one course per lifetime per beneficiary.
Faecal-Occult Blood (Colorectal screening)	One per beneficiary aged 50 years and older per annum.
PSA Test (Prostate specific antigen)	Limited to one test per male beneficiary aged 40 years and older per annum. All further tests revert to the Pathology Benefit and PMBs, clinical and funding protocols may apply.

Health Risk Assessments	Includes body mass index, blood pressure, cholesterol (finger-prick test) and blood sugar (finger prick test). The benefit is only available to beneficiaries aged 18 and older and limited to one Health Risk Assessment at contracted providers, per beneficiary per annum.
HIV screening tests	Limited to one screening test per beneficiary per annum. All further tests revert the Pathology Benefit and PMBs, clinical and funding protocols may apply.
Child immunisations	The childhood immunisations benefit is subject to the South African Expanded Programme of Immunisation and is as per the Department of Health Protocol. The benefit excludes consultation costs as they are covered from available consultation benefits.

Complaints process

You may lodge a complaint or query with Sasolmed directly on **0860 002 134** or send an email to enquiries@sasolmed.co.za

If your query or complaint is not resolved to your satisfaction, address a complaint in writing to the Principal Officer at the Scheme's registered address. Please be sure to include the reference number obtained through your direct contact with the Scheme.

Should your complaint still remain unresolved, you may lodge a formal dispute by following the Sasolmed internal disputes process, which is explained on the website at sasolmed.co.za.

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

Contact us

You can find other important information on our website at sasolmed.co.za or contact us on **0860 002 134**.