commed
COMMUNITY MEDICAL AID SCHEME

PEACE OF MIND
THROUGH AFFORDABLE HEALTHCARE

ROOTS OPTION
2017 BENEFITS

General disclaimers

The information in this brochure is subject to approval by the Council of Medical Schemes.
This brochure is intended for marketing purposes and contains only a summary of the COMMED benefits.
In terms of the Medical Schemes Act. medical schemes may apply waiting periods and/or late joiner penalties to new members joining. The member will be notified in writing should a waiting period or late joiner penalty apply.

GLOSSARY of terms

CDL	Chronic Disease List of 25 chronic conditions.	Clinical Protocols	These are used to manage benefits for specific conditions.
PMB	Prescribed Minimum Benefits. List of benefits in term of the Medical Schemes Act No. 131 of 1998	Co-Payments	A payment made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care.
EMC	An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation.	Pre-Authorisation	Pre-Authorisation is important. Failure to authorise could result in your account not being covered in full.
Tariff	Claims are paid at Scheme/Negotiated Tariffs	DSP	A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc.) that is a medical scheme's first choice when its members need diagnosis, treatment or care for a PMB condition.
Limits	Limits are per annum unless otherwise indicated.	FRP	Formulary Reference Price.
Formulary	Approved List of Medication based on Clinical Protocols.	Out of Hospital Procedures	Procedures performed in the doctor's rooms.

IMPORTANT CONTACT DETAILS

Please have your membership or ID number handy when contacting the Scheme

Important Telephone Number

CareCross Call Centre Number	086 010 3491
Hospital Authorisations	0861 311 911
Ambulance - ER24	084 124
Chronic Authorisations	086 010 3491
Lifesense (HIV)	0860 506 080

Important Email Addresses

General Email	admin@allcare.co.za
Authorisations	auths@allcare.co.za
Claims	claimsqueries@allcare.co.za
Membership	membership@allcare.co.za

Website Address

Dashboard :	http://live.allcare.co.za
Website :	www.commed.co.za

Roots Option Benefits

Overall Annual Limit

- Limited to R400,000 per person
- Limited to R800,000 per family

Authorised admissions to Hospital

Consultations

General Practitioners

Network Service Providers
- GP Network providers
- Unlimited for medically necessary visits

Non-Network Service Provider
- Limited to 3 Consultations per person per year or R1,000 per family per annum

Network Specialists
- Limited to R2,500 per beneficiary per annum to a maximum of R5,000 per family per annum, subject to pre-authorisation

Emergency Room Treatment
- Limited to 3 visits per family per annum to a maximum of R1,000 per annum
- Member to pay and claim back from CareCross
- Facility Fees not covered

Dentistry

Basic Dentistry
- Consultations
- Primary Extractions
- Fillings
- Scaling and Polishing
- Plastic Dentures
  Limited to 1 Plastic Denture per person over the age of 21 every 24 months

Specialised Dentistry
- PMB conditions only
- Subject to pre-authorisation
- No benefit for root canal treatment, intermediate or advanced dentistry

Benefit only available from Network Provider

Ambulance & Emergency Services

Contact **ER24** on **084 124** for all emergencies
- DSP Provider only

Pharmacy

Acute Medicine
- Obtainable from a dispensing Network GP
- Medication from a non-dispensing GP may be obtained from a Medikredit Pharmacy
- Network formulary applies

Chronic Medicine
- 100% of single exit price plus agreed dispensing fee (subject to chronic medication reference price list and use of a Designated Service Provider
- Non CDL not covered
- Network GP referral applies

Pharmacist Advised Therapy (Over the Counter)
- Limited to R300 per family per year and R100 per prescription
- Excludes herbal remedies, nutritional supplements and vitamins
- One script every 5 days

Maternity Benefits

Maternity
- NVD Limited to 3 days in Hospital
- Caesar Limited to 4 days in Hospital
- Subject to pre-authorisation and DSP arrangements
- Ante natal consultations available from the GP network provider
- Limited to 1 "2D" scan in first trimester
- Ante natal visits at gynaecologists are subject to the out of hospital specialist limit
- Only medically necessary caesareans are covered

Optical Benefits

Optical
- Limited to one optical test per person every 24 months, including consultation.
- One pair of white standard mono or bi focal lenses in a standard frame up to R150 or contact lenses to the value of R395 in lieu of spectacles

Benefit only available from Network Provider

Cover outside of South African Borders

Emergency cover only when travelling in SADC countries. Subject to the equivalent of Scheme tariff rates and South African Currency.
Out of hospital consultations are subject to the out of network benefit.

Radiology & Pathology

Radiology

X-Rays (black and white) Out of Hospital

- As requested by the Network GP Subject to the Network formulary
- X-Rays requested by a Specialist are subject to the Network formulary and annual specialist limit.

X-Rays (black and white) in Hospital

- 100% of Scheme/Negotiated Tariff
- Subject to annual limit

MRI and CT Scans Only (In and Out of Hospital)

- Limited to R2,200 per beneficiary per year out of hospital scans only
- Scans related to conservative back and neck treatment not covered
- Subject to pre-authorisation

Pathology

Out of Hospital

- As requested by the Network GP Subject to the Network formulary
- Pathology requested by a Specialist is subject to the Network formulary and annual specialist limit.

In Hospital

- 100% of Scheme/Negotiated Tariff, except for PMB

All the above benefits are subject to pre-authorisation

External Appliances

Crutches, Wheelchairs, Hearing Aids and Artificial Limbs

- Limited to R2,500 per family per year
- Wheelchairs every 36 months
- Stoma Care
- Hearing Aids every 24 months

Subject to pre-authorisation

Oncology

Oncology

- Limited to R165,000 per person
- Must be pre-authorised
- Designated Service Provider
- Use of SAOCA protocols

Supplementary Services

Physiotherapists, Occupational and Speech Therapists, Dieticians and Podiatrists

- Combined Limit of R1,500 per person and R3,000 per family per year
- Subject to pre-authorised

Hospitalisation

Hospital

- General Ward, High Care, ICU, Theatre and Medicine (formulary reference price)
- 100% of Scheme/Negotiated Tariff
- Subject to pre-authorisation

R5,000 penalty will be levied if an out of network hospital is voluntarily used

Specialists

- 100% of Scheme/Negotiated Tariff, except for PMB
- Failure to obtain services from a network service provider will result in a co-payment of 30% of the specialists claim

Allied Healthcare Service (Occupational, Physiotherapists, Speech therapist and Dieticians

- 100% of Scheme/Negotiated Tariff
- Subject to pre-authorisation

Prostheses and implants including hearing devices

- Limited to R18,000 per family per year
- Subject to pre-authorisation

Mental Illness, Alcoholism and Drug Abuse

- No cover, except for PMB
- Subject to pre-authorisation
- Limited to 21 days per annum

Step Down facilities, hospices, registered nurses and rehabilitation centres

- Limited to 14 days combined per person per year, except for PMB
- Hospice – 100% of cost
- Subject to pre-authorisation

Co-payments apply to specific procedures

HIV/AIDS Management Programme

HIV/AIDS

- Hospitalisation in a private hospital
- Education and Counselling
- Monitoring
- ARV therapy
- Treatment of Opportunistic Infections

List of Chronic Conditions

Addison's Disease
Asthma
Bipolar Mood Disorder
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Chronic Renal Disease
Chronic Obstructive Pulmonary Disease
Coronary Artery Disease
Crohn's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1 & 2
Dysrhythmias
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosis
Ulcerative Colitis

Co-Payments Apply to the following Procedures

Arthroscopy – except of diagnostic	3,000
Circumcision – except when medically indicated	2,000
Colonoscopy, Sigmoidoscopy, proctoscopy	2,500
Cystoscopy	2,000
Dental Admissions	2,000
Hospital and Anaesthetist	PMB only
Excision Nailbed	2,000
Gastroscopy	2,500
Hernia Repair	2,500
Hysterectomy	3,500
Hysteroscopy	3,500
Joint replacements	6,000
Laparoscopic procedures	3,500
Myringotomy	2,000
Nasal surgery (including endoscopy)	2,500
Reflux Surgery	3,500
Skin Lesions	2,000
Spinal surgery	6,000
Urinary incontinence repair	4,000
Varicose Veins	4,000

RATE TABLE - ROOTS OPTION

Salary Band	Member	Adult	Child
0 - 6000	822	822	342
6001 - 18000	950	950	458
18001+	1,454	1,454	620

LATE JOINER PENALTIES

Premium penalties for persons joining late in life:

Premium penalties will be applied in respect of persons over the age of 35 years, who were without medical scheme cover for the period indicated hereunder after the age of 35 years as follows:

1 - 4 @ 0.05 multiplied by the relevant contribution above
5 - 14 @ 0.25 multiplied by the relevant contribution above
15 - 24 @ 0.50 multiplied by the relevant contribution above
25+ years @ 0.75 multiplied by the relevant contribution above

IMPORTANT INFORMATION

All Benefits are subject to PMB guidelines and protocols.

Where pre-authorisation is required, failure to do so may result in a 30% penalty or non-payment of claims. Pre-authorisation must be obtained before undergoing a procedure and/or admission.

All claims must be submitted within 120 days from date of treatment. Claims submitted after 120 days will be rejected. Please note that it remains the member's responsibility to ensure that claims are received by the Scheme for processing.

PMBs are the minimum level of diagnosis, treatment and care that your Medical Scheme must cover and it must pay for your PMB condition/s. PMBs include 270 serious health conditions, any emergency condition and 25 chronic diseases, they can be found on our website by accessing the link provided below:-
(www.medicalschemes.com/medical_schemes_pmb/index.htm)

EXCLUSIONS

LIMITATIONS AND RESTRICTIONS OF BENEFITS

- The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme. The procedure to be followed in obtaining a second opinion is outlined in the relevant Scheme protocol (Protocol Regarding Requests for Second Opinions).
- Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.
- If the Scheme or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of clinical guidelines.
- If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure A, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its managed healthcare organisation may impose.
- "Medical necessity" is defined in the Scheme policy: Definition of Medical Necessity.
- The Scheme reserves the right not to pay for any new technology. Coverage of new technology will be assessed by the Scheme with due consideration given to:
  - Medical necessity;
  - Clinical evidence of its use in clinical medicine including outcome studies;
  - Its cost-effectiveness; Its affordability; Its safety.
  - Its value relative to existing services or supplies;
  - New technology is defined as any clinical intervention of a novel nature as well as those that the Scheme has not had previous experience with.
- A 10% co-payment will be applied on the following procedure codes:
  - 1034 - Autogenous nasal bone transplant: Bone removal included
  - 1035 - Functional endoscopic sinus surgery: Unilateral
  - 1036 - Functional endoscopic sinus surgery: Bilateral
  - 1087 - Sub-total reconstruction consisting of any two of the following:Septum plasty, osteotomy and nasal tip reconstruction
- Mirena Device - Fund according to scheme protocol:
  - 40 years of age. Not covered if used for contraception. Cover for abnormal uterine bleeding.
  - Insertion in rooms no co-payment applicable
  - Insertion in theatre – co-payment R800.00 even if done in conjunction with another procedure
  - Mirena device – cost from acute medicine benefit
- The Scheme reserves the right to impose and apply exclusions and limits to the benefits that will be paid for medicines/ procedures/interventions which have been accepted into the practice of clinical medicine through a process of health technology assessment/evaluation.
- Benefits in respect of the cost of emergency medical treatment, whilst abroad, are covered at the applicable South African tariff rates and RSA currency;
- High myopia – payable as per scheme protocols
- Biologicals and polygams will be subject to a 30% co-payment by the member. Subject to overall limit and preauthorization required from designated service provider
- In the event of an emergency, the Scheme shall be notified of such emergency within two working days after ADMISSION. Failing which, a levy of 10% or R 500 (whichever is higher) will be levied.
- In the case of a PMB, the scheme will pay according to the Scheme's protocols and at the Scheme's rates.
- In the case of a non PMB, the Scheme has the right to repudiate the claim.
- All costs which in the opinion of the Scheme's medical advisor are not medically necessary and appropriate and necessary to meet the health care needs of the patient, consistent with the diagnosis or condition; rendered in a cost effective manner and type of setting appropriate to the supply of the service required for purposes other than comfort or convenience; and consistent in type, frequency and duration of treatment with scientifically based guidelines of medical practice and of demonstrated medical value.
- The benefits covered include:
- Accommodation in hospital (ward fees i.e. for ICU, high care, general wards), theatre fees, medicines and disposables used in theatre, medicines and disposables used in the ward. surgical procedures including GP and specialist consultations whilst in hospital, approved diagnostic investigations, blood transfusions, physiotherapy and biokinetics, renal dialysis (if pre-authorisation is obtained in writing from the Scheme's Medical Advisor) and emergency ambulance services.
- The benefits specifically excluded:
  - Oncology treatment, sterilization/vasectomy, internal prosthesis (unless pre-authorisation is obtained in writing from the Scheme's Medical Advisor), dental hospitalisation, back surgery, outpatient visits (which are covered in 2 below), private nursing (unless pre-authorisation is obtained in writing from the Scheme's Medical Advisor and only for the period granted by the Medical Advisor).

BENEFITS EXCLUDED

General exclusions mentioned in this paragraph are not affected by any specific exclusion. Unless otherwise decided by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme),
expenses incurred in connection with any of the following will not be paid by the Scheme:

- All costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure A, for the benefits to which the member is entitled in terms of the rules;
- All costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons;
- If, in the opinion of the medical advisor, the healthcare service in respect of which a claim is made, is not appropriate and necessary for any aspect of the management of the medical condition at an affordable level of service and cost;
- All costs for treatment, if the efficacy and safety of such treatment cannot be proved;
- Cost incurred from a member which arose or may have arisen as a result of the actions or omission of another party.
  - Where such cost is a result of an injury sustained by the member the scheme will require a full injury report.
  - If such cost results from a work related injury the scheme will cover it and will be referred to the COID commissioner and any amounts paid out will be refunded to the Scheme.
  - Where such cost result from negligence of another party that may result in a public liability insurance claim the scheme will cover the cost arising, subject to PMBs and annual benefits available in terms of the rules of the scheme.
  - Where such cost result from a motor vehicle accident the following will apply in term of the Regulations of the RAF Act.:
- Member and attorney must submit to the scheme a signed letter of undertaking that, if there is a successful RAF claim, all money paid with respect to medical expenses will be reimbursed in full to the medical scheme.
- If a valid RAF claim exists and the member opts not to claim from the RAF the scheme will only cover medical expenses related to the accident, up to and including PMBs and annual benefits available.
- The cost of any injury not covered by the RAF will be borne by the scheme at UPFS (Uniform Patient Fee Schedule) rates.
- Cost for emergency treatment will be covered at the tariff published by the RAF in the regulations.
- All costs for services rendered by:
  - Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
  - Any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law;
- Abdominoplasties (including the repair of divarication of the abdominal muscles);
- Accommodation and services provided in a geriatric hospital, old age home, frail care facility or the like (unless specifically provided for in Annexure A);
- Acupuncture;
- Anabolic steroids, immunostimulants (except for immunoglobulins and growth hormones, which are subject to pre-authorisation by the relevant managed healthcare programme);
- Ante and postnatal exercises;
- Appointments which a beneficiary fails to keep;
- Appliances, devices and procedures deemed by the Scheme not to be scientifically proven or appropriate;
- Arch supports including shoe inserts and foot orthotics
- Aromatherapy;
- Autopsies;
- Appliances
  - Back rests, chair seats and transfer boards unless motivated by a doctor
  - Toilet seat raisers unless motivated by a doctor
- Bandages and dressings (except medicated dressings subject to authorisation by the relevant managed healthcare programme);
- Beds and mattresses;
- Ayurvedics medicine and related cost
- Bilateral gynaecomastia in beneficiaries under the age of 18 years (in beneficiaries over 18 years Scheme protocol will apply);
- Blepharoplasties;
- Breast augmentation;
- Breast reconstruction (unless necessitated by pre-authorised surgical mastectomy, traumatic mastectomy or congenital unilateral absence of a breast which is subject to Scheme protocol);
- Breast reductions;
- Nasal surgery done by a plastic surgeon, nasal cautery (procedure code 1069) if done with other intranasal procedures;
- External cardiac assistive devices;
- Coloured or cosmetic effect contact lenses, and contact lens accessories and contact lens solutions;
- Cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, not including coal tar products and the treatment of lice infestation, scabies and other microbial infections (subject to PMB regulations);
- Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable; and costs for:
- Anaesthetics in respect of dental services:
- general anaesthetics, conscious analgo-sedation and hospitalisation for dental work except in the case of patients under the age of 7 years and bony impaction of third molars;
- Labial frenectomies in respect of beneficiaries under the age of 12 years;
- Orthodontic treatment over the age of 18 years;
- Periodontal plastic procedures for cosmetic reasons;
- Use of high impact acrylic and precious metal in dentures or the cost of precious metal as an alternative to semi-precious or non-precious metal in dental prosthesis;
- Osseo-integrated tooth implants; genioplasty and dental osteotomy
- Contraception other than oral contraceptives, IUD's for contraceptive purposes, contraceptive foams and barrier contraceptive methods;
- Diagnostic kits, agents and appliances unless otherwise stated except for diabetic accessories (subject to PMB regulations and Scheme protocols);
- Electric tooth brushes;
- Treatment for erectile dysfunction and loss of libido;
- Food and nutritional supplements including baby food and special milk preparations;
- Sleep therapy for the treatment of depression;
- Gender re-assignment treatment;
- Genioplasty except as a consequence of major maxillofacial injury
- Headaches: oral appliances and the ligation of temporal artery and its branches for the treatment of headaches;
- Hirsutism;
- Holidays for recuperative purposes;
- Humidifiers;
- Hyperbaric oxygen therapy subject to PMB regulations and Scheme protocols;
- Infertility treatment, subject to PMB regulations;
- Ionizers and air purifiers;
- Iridology;
- Surrogate pregnancy;
- Keloid surgery, except for those resulting from burns and functional impairment deemed by the Scheme to medically necessary;
- Laxatives, subject to Scheme protocols
- Medical, surgical and orthopaedic appliances, devices and products, including oxygen hire or purchase and attachments, subject to PMB regulations and Scheme protocols;
- Medication in respect of substance abuse treatment unless specifically authorised by the relevant managed healthcare programme, subject to PMB regulations;
- Medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines (except for schedule 0,1 and 2 medicines supplied by a registered pharmacist);
- Medicine not approved by the Medicines Control Council or other statutory body empowered to approve/register medications;
- MRI scans ordered by a general practitioner, subject to Scheme protocols;
- Obesity treatment;

- Parenteral contraceptives;
- Optical devices excluded by the Scheme;
- Orthopaedic shoes and boots, subject to Scheme protocols;
- Osteopathy;
- Otoplasties;
- Pain relieving machines e.g. TENS, APS;
- Medicines, household remedies and propriety preparations and preparations not otherwise classified;
- Positron Emission Tomography (PET) scans ;
- Refractive surgery;
- Excimer laser treatment;
- Reflexology;
- Revision of scars ;
- Rhinoplasties;
- Smoking cessation and anti-smoking preparations;
- Stethoscopes;
- Sphygmomanometers/blood pressure monitors;
- Sunglasses and repairs to spectacle frames;
- Counselling, subject to prescribed minimum benefits;
- Telephone consultations;
- Tonics, evening primrose oil, fish liver oils, nutritional supplements, multivitamin preparations and minerals except prenatal vitamins as approved by the Scheme's pharmacy benefit management programme;
- Topical preparations excluding topical steroid and acne preparations;
- Travelling expenses ;
- Uvulo-palatal pharyngoplasty (UPPP and LAUP);
- Veterinary products;
- Pharmacy service fees, except for services related to the Schemes preventative benefit which requires pre-authorisation;
- Facility fees;
- Fentonplasty;
- Insulin pumps except for children 7 years or younger subject to Scheme protocols ;
- Services rendered during any waiting periods that are imposed on the member or any dependent joining the Scheme;
- Medical expenses resulting from the treatment of occupational diseases and injuries;
- All claims where ICD-10 codes are missing, invalid or incomplete will be rejected;
- Allergy tests ordered by general practitioners
- Radiotherapy for non-malignant conditions
- Bone substitutes
- Nasal tip reconstructions
- Private isolation in ICU and High Care and barrier not covered
- Bariatric surgery
- Virtual colonoscopy
- Somatostatins except after medically necessary surgical intervention

- Hypnosis therapy
- Preoperative day admission with exception of invasive preoperative preparation
- Surgical treatment for hyperhidrosis
- Examination and tests for purposes of visa or insurance application
- Interest and legal costs on outstanding account
- Professionally applied topical fluoride in adults
- Root canal treatment on third molars
- Pulp capping
- Bleaching
- Crowns on third molars
- Pontics on second molars
- Crowns used to repair teeth damaged due to bruxism erosion or fluorosis
- Crowns used to restore teeth for cosmetic reasons
- Fixed prosthodontics (crowns) where a reasonable attempt has not been made to restore or replace the toothe conservatively
- Fixed prosthodontics (crowns) where the member is periodontically compromised
- Crowning of teeth involving failed root canal treatment
- PerioChip
- Orthodontic re-treatment
- Cost of implant component
- Cost of gold, precious metal or semi-precious metal
- Full series peri-apical radiographs
- Porcelain/ceramic crowns
- Metal, porcelain or resin inlays
- Treatment of attrition or abrasion
- Temporary crown/emergency crown
- Oral/facial image for dentist work
- Special report
- Cosmetic dentistry
- Composite veneer
- Orthodontic/removable appliance repairs
- Cantilever bridges
- Veneer
- Orthognathic and associated hospitalization
- Mouth protectors/gum guards
- Ozone therapy
- Lingual orthodontics/ceramic brackets
- Snoring appliances including dental laboratory and material costs
- Storing/caring case for intra-oral appliances
- Resin bonding for restoration
- Alveola augmentation

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