PG GROUP MEDICAL SCHEME

2021
MEMBER GUIDE

The PG Group Medical Scheme is managed by a Board of Trustees, whose primary objective it is to look after the interests of the members.

The Scheme continues to be well managed and it is pleasing to note that we continue to achieve the stringent criteria and solvency levels set by the Registrar of the Council for Medical Schemes.

We are committed to providing members with access to appropriate and quality healthcare benefits at competitive rates in a managed healthcare environment, supported by efficient administration.

Our Scheme is open to PG Group employees only. We believe that our valued members utilise their benefits in an honest and responsible manner and are conscious of the importance of good health.

Contents

Membership

Membership of the PG Group Medical Scheme is compulsory unless you are covered by your spouse's medical scheme and do not wish to change your medical scheme membership.

Responsibilities of a member
Upon joining the Scheme, you need to provide us with all the information regarding any treatment, care and diagnosis that you and your depedants have received in the 12 months preceding your application. It is essential that you familiarise yourself with the Scheme rules to ensure that you understand your rights, responsibilities and benefit entitlement.

You are further required to inform the Scheme timeously of changes to your beneficiaries' details. For example, when a child or any other dependant is no longer eligible to be a dependant, you need to notify the Scheme to cancel his or her membership as a dependant. You should be familiar with the Scheme's membership eligibility provisions, since the Scheme offers restricted membership. Remember that you and your dependants may only belong to one medical scheme at any given time.

Retirement
The Medical Schemes Act and the Scheme rules make provision for you to retain your membership of the Scheme in the event of your services being terminated from the company on account of normal retirement, early retirement or retirement due to ill-health or other disability. For further details and conditions that may apply, contact your Human Resources department.

Scheme rules
You are bound by the Scheme rules, as amended from time to time.

How do you join?
If you have just joined the PG Group, your employer will issue you with a membership application form. Once you have completed the form, return it to your Human Resources department, who will inform the Scheme. Remember to include all the details of your dependants that you wish to register on the application form.

Proof of membership
A membership card will be issued to you reflecting your membership number, your name, the names of your registered dependants and the date from which you are entitled to benefits.

Do not lend your card to anyone other than your registered dependants. Use of the card by, or on behalf of, any other party is illegal and will result in criminal prosecution and termination of your membership. Fraudulent use of cards leads directly to increased costs for you.

Who can you register as a dependant?
You can register your spouse or partner and dependent children of your immediate family, in respect of whom you are liable for family care and support.

Dependants of deceased members
Dependants of deceased members are entitled to remain members of the Scheme, provided they were registered as beneficiaries at the time of the member's death.

REMEMBER

Please complete the appropriate form and send it to your Human Resources department to advise the Scheme of any changes to your personal details, including:

- a change to your marital status;
- the birth or legal adoption of a child;
- any dependant who is no longer entitled to dependant membership;
- any changes to your contact telephone or cell phone number;
- a change to your postal or email address; and
- any changes to your banking details.

Please inform the Scheme promptly about any changes, as a delay may have an impact on the efficient settlement of your claims.

Glossary

Acute medication
Acute medication is normally prescribed by a doctor to alleviate the symptoms of an acute illness or condition, for example antibiotics or painkillers for headaches. Vaccinations that are clinically indicated and dispensed by a pharmacy are also covered under this benefit.

Adult dependant
A dependant who is 21 years and older is regarded as an adult dependant.

Agreed tariff
The Scheme has an agreement with preferred healthcare providers, such as general practitioners (GPs), specialists and/or hospitals, where specific rates have been negotiated.

Ambulance services
This includes all medically equipped transport, like ambulances or helicopters, utilised for medical emergencies.

Beneficiary
A beneficiary is a principal member or a person registered as a dependant of the member.

Benefits
The Scheme pays amounts for medical services provided to you and your dependants in accordance with the Scheme rules.

Benefit limits
The Scheme implements maximum treatment/amounts payable for a specific benefit category.

Branded/Patented medication
Pharmaceutical companies incur high costs for research and development before a product is finally manufactured and released into the market. The company is given the patent right to be the sole manufacturer of the specific medication brand for a number of years to recover these costs. This medication does not have generic equivalents available yet.

Capitated services
Capitated services are clinical and/or administrative services provided by preferred healthcare providers. These services are paid on a per-member-per-month basis and are delivered subject to limits specified in agreements with the preferred healthcare provider concerned.

Chronic disease list (CDL)
The CDL consists of 26 chronic conditions covered by the Scheme in terms of the regulations governing all medical schemes.

Chronic conditions
These are illnesses or conditions requiring medication for prolonged periods of time. The Medical Schemes Act provides a prescribed minimum benefit (PMB) list that indicates the minimum chronic conditions a medical scheme must cover by law – for example, high blood pressure, diabetes or cholesterol. The diagnoses, treatment and medical management of the CDL conditions are covered according to the Scheme algorithms and designated service providers (DSPs).

Chronic medication
This refers to medication prescribed by a healthcare provider for an uninterrupted, prolonged period of time. It is used for a medical condition that appears on the Scheme's list of approved chronic conditions. It should, however, be noted that not all conditions necessitating treatment for more than three months can be termed chronic conditions – some acute conditions may also last a few months. Chronic conditions usually require life-sustaining medication that is prescribed or dispensed to members registered on the chronic medication programme – Medicine Risk Management (MRM) – and the medication is included in the list of chronic medication.

Claim
After you have received medical treatment, you or the healthcare provider (your GP, specialist or hospital, etc.) submits a claim to the Scheme to request payment. If the healthcare provider charges Scheme rates, the Scheme will pay the healthcare provider directly. Alternatively, you can pay the account from your own pocket and then claim reimbursement from the Scheme.

Clinical algorithms and protocols
These are step-by-step, problem-solving procedures specifically established to diagnose and treat illnesses, which considers severity and treatment response.

Commencement date/Effective date/Inception date
This is the date on which you became a member of the Scheme and your dependants' membership is registered. Your contributions are payable from this date.

Consultation
This refers to an appointment with a healthcare provider, such as your GP, specialist, physiotherapist, etc., for treatment.

Contributions
Contributions are the fixed amounts that you are paying monthly to be registered as a member of the Scheme. You pay a fixed amount for each adult dependant and each child dependant registered on your membership.

Costs
Costs represent the actual amount charged by a healthcare provider.

Co-payment
This refers to a percentage of a claim for services rendered by a healthcare provider where fees exceed the Scheme rate. You are liable to pay this amount (out-of-pocket expenses) directly to the healthcare provider. The aim is to place some cost burden on you and thereby discourage you from excessive use of healthcare services.

Creditable coverage
Any period during which a late joiner was a member or dependant on a medical scheme is considered creditable coverage.

CT and MRI scans
CT and MRI scans are special X-rays taken of the internal organs of your body to determine the diagnosis and/or treatment.

Day-to-day benefits
You and your dependants can spend a certain maximum amount of money in a particular year for out-of-hospital expenses.

Dental benefits
These include a wide range of different dental treatments and procedures – please refer to your DENIS dental benefit information booklet.

Dependant
This includes your spouse or partner, who is not a registered member of another medical scheme, as well as a child dependant.

Designated service providers (DSPs)
A DSP is a provider of service or a group of healthcare providers contracted to the Scheme to deliver quality healthcare services. They participate in the managed healthcare process of beneficiaries to diagnose and provide treatment and care in respect of PMB conditions or any other relevant healthcare service covered by the Scheme. This includes selected hospitals, pharmacies, doctors, physiotherapists, pathologists and radiology services.

Glossary (continued)

Disease management
Disease management is a holistic approach that focusses on your condition, using all the cost elements involved. It can include counselling and education, behaviour modification, therapeutic guidelines, incentives, penalties and case management. The member has to register on the Integrated Care Programme in order to receive the benefit.

Emergency medical condition
An emergency medical condition is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment. The failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunctions of a bodily organ or part, or would place the person's life in serious jeopardy in accordance with the Scheme protocols.

Exclusions
Exclusions refer to medical treatment and/or care that is not covered by the Scheme.

Formulary (list of prescribed medication)
A formulary is a defined, preferred list of medication used to treat specific conditions. This is a list of cost-effective medication that guides the healthcare provider in the treatment of specific medical conditions. Medication formularies are continuously checked and updated by medical experts to ensure they are consistent with the latest treatment guidelines.

Generic medication
Generic medication is medication that contains exactly the same active ingredients, strength and formulation as the branded/ethical equivalents. The same or another company manufactures the medication when the patent on the branded product has expired. As a result, the generic medication is usually significantly cheaper.

HIV/AIDS
The human immunodeficiency virus (HIV) is a retrovirus that breaks down the human body's immune system and can cause acquired immunodeficiency syndrome (AIDS). AIDS is a condition where the immune system starts to fail, leading to life-threatening opportunistic infections.

International classification of diseases codes (ICD-10)
Healthcare providers are required to include ICD-10 codes on all claims submitted to medical schemes. Every medical condition and diagnosis has a specific code, called ICD-10 codes. These codes are used primarily to enable medical schemes to accurately identify the conditions for which members seek healthcare services. This coding system ensures that claims for specific illnesses are paid via the correct benefit and that healthcare providers are appropriately reimbursed for services rendered.

Late-joiner penalty (LJP)
This is a penalty in the form of additional contributions that is imposed on an applicant who, at the date of application for membership or admission as an adult dependant, is 35 years and older; who did not have medical scheme coverage before 1 April 2001, and without a break in coverage exceeding three consecutive months since 1 April 2001.

Managed healthcare
Managed healthcare includes any effort to promote the rational, cost-effective and appropriate use of healthcare resources. Usually members only qualify for benefits if they have followed the Scheme guidelines and protocols to manage a particular condition. For example, in the case of oncology treatment, managed healthcare protocols would require you to join the Scheme's Oncology Risk Management Programme. Your doctors and specialists

will work with the Scheme's managed healthcare team of clinical experts to decide on the most cost-effective treatment programme for you. Managed healthcare may assist in the appropriate management of conditions that require chronic medication, including HIV/AIDS.

Medicine price list (MPL)
The Scheme has implemented a reference pricing structure whereby a ceiling price has been set for a group of medication similar in composition, clinical efficacy, safety and quality.

Member
A member is any person who is eligible to be a member of the Scheme in terms of the Scheme rules and who is registered as such by the Scheme.

Minor
A dependant who is younger than 21 years old is regarded as a minor.

Network
This refers to an institution or an individual healthcare provider contracted to the Scheme to provide specific services according to a defined reimbursement structure, or when a Scheme has negotiated preferential rates with a specific healthcare provider in offering benefits. You are often limited to using healthcare providers (i.e. doctors, pharmacies, hospitals, etc.) registered with this network. Refer to your benefit schedule foldout at the back of this guide for requirements applicable to you.

Oncology
This field of medication is included in the treatment of cancer. It can consist of chemotherapy and radiotherapy.

Out-of-pocket payment
This is a payment that you have to make directly to a healthcare provider where fees exceed the Scheme rate.

Overall annual limit (OAL)
The OAL is the overall maximum benefit that you and your registered dependants are entitled to according to the Scheme rules. This is calculated annually to coincide with the Scheme's financial year.

Over-the-counter (OTC) medication/Pharmacy-advised therapy (PAT)/Non-prescribed medication
This is medication obtained without a prescription at a pharmacy. This includes Schedule 0 to 2 medication. Most conditions can be treated effectively with medication available from your pharmacy without a doctor's prescription.

Personal medical savings account (MSA)
The Scheme manages a medical savings account on your behalf. As part of your monthly contribution, a portion is allocated towards your savings account. When you require day-to-day medical services or supplies, you can use your savings to pay for these services. The Scheme refers to it as the MSA.

Pre-authorisation
Pre-authorisation is the process of informing the Scheme of a procedure/treatment that requires hospitalisation, prior to the event, in order for approval to be obtained. Provided the member's contributions are up to date, the authorisation number confirms that benefits are available and guarantees the member's admission to hospital, however, it is not a guarantee of payment.

Pre-existing condition
This is a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period preceding the date on which an application for membership was made.

Prescribed minimum benefits (PMBs)
These are conditions that the Scheme covers according to the Medical Schemes Act.

Glossary (continued)

Prescribed minimum benefit (PMB) list
This is a list of medication that is primarily indicated for a PMB chronic disease list (CDL) condition and some chronic conditions.

Private hospital
Unlike State hospitals, private hospital groups are run as for-profit businesses and cost significantly more.

Professional dispensing fee
The professional dispensing fee is a legislated maximum fee that a pharmacist or dispensing doctor may charge for services rendered to dispense medication.

Pro-rata benefits
Certain Scheme benefits are provided on a calendar year basis, subject to an annual limit. If you joined the Scheme on a date other than 1 January, your benefits will be calculated pro rata. For example, if you joined in March of a year, you will only receive pro-rata benefits for nine months. If you exceed your annual limit, you will be liable to pay the excess costs out of your own pocket.

Rejection codes
This is a list of codes that usually appears on your claims statements, which are sent to you monthly if you have claimed and reflects the reasons for payment discrepancies.

Related account
A related account is any account that relates to an approved in-hospital admission, other than the hospital account (for example, the anaesthetist or specialist's account).

Restricted medical scheme
The Scheme is a restricted medical scheme as only employees of the PG Group may join.

Risk underwriting
Risk factors include the average age of members, the pensioner ratio, as well as the number of chronic medication users in the group. Once this information has been determined, the Scheme applies underwriting criteria to the group with regard to new applicants – please refer to the definition of underwriting on the next page.

Scheme rate/tariff
This is the rate determined by the Scheme to pay healthcare providers.

Single exit price (SEP)
The SEP is the price set by the manufacturer or importer of a medication or scheduled substance and combined with the logistics fee and VAT, as regulated in terms of the Medicines and Related Substances Act (1965), as amended.

South African Medical Association (SAMA) rates
This is the tariff structure that SAMA deems to be appropriate for their members (all healthcare providers). It is a guideline for healthcare providers in private practice regarding the fees that they may charge for their services.

To-take-out (TTO) medication
TTO medication is medication prescribed to you or your dependants while being hospitalised, which you are allowed to take home.

Therapeutic reference pricing
Therapeutic reference pricing allows members access to medication from various medication classes within the medication basket for a condition.

Underwriting
Depending on your previous medical scheme history, the Scheme may apply underwriting to your membership upon joining. This means that the Scheme is allowed to impose a three-month general waiting period and/or a 12-month pre-existing condition-specific waiting period. A late-joiner penalty may also be applied.

Waiting period (condition specific)
Depending on your previous medical scheme history, the Scheme may impose a waiting period of up to 12 months from the inception date of your membership for any pre-existing conditions, i.e. in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received prior to an application for membership. No benefits will be paid for any costs relating to any of these conditions.

Waiting period (general)
The Scheme may impose a three-month general waiting period on new members. No benefits will be paid during this period – not even from the MSA – except for treatment of PMBs in accordance with the Medical Schemes Act.

Value-added products for 2021

Web-based, self-help facility (Customer Online)

Visit **www.pggmeds.co.za**, click on the **'Sign in'** button on the right hand side of the homepage, select the Member option and enter your username and password to log in.

If you have not registered on the Scheme's website to view your personal medical scheme information, you can follow the easy steps below:

- Log onto **www.pggmeds.co.za**.
- Click on ***Sign in***.
- Select the ***Member option*** and then click on ***Register***.
- Please read the Terms and Conditions, then click on ***'I Agree'*** at the bottom of the webpage.
- Select ***Register as a Member*** and then complete the required fields. You will be required to enter a username and password.
- To complete the registration process, click on ***Register Member***.

Please contact customer care on **0860 00 50 37** should you require assistance or support to log in.

Tax certificate
- View your current tax certificate.

Membership
- Check and update your contact details.

Statements
- View past monthly claims statements.

Membership card
- Apply for a new membership card.

Claims
- Check claims for the last six months, including claimed amounts, paid amounts, co-payments and claims payment dates.

Netcare 911 emergency services

In emergency situations, Netcare 911 provides ambulance services by road and air throughout South Africa. Netcare 911 is South Africa's largest private emergency service, with highly skilled medical staff and a national network of emergency vehicles. Their emergency care practitioner-based helicopter service can be dispatched, should it be required. By simply dialling **082 911** from any landline or cell phone, you and your dependants have access to excellent emergency medical care.

Points to remember when calling Netcare 911:

- Dial **082 911** if there is a medical emergency.
- Give your name and the telephone number you are calling from.
- Give a brief description of the incident and try to explain how serious the situation is.
- Give the address or location of the incident and the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please inform the controller that you are a member of the PG Group Medical Scheme.
- Do not put the phone down until the controller has disconnected.

Ambulance authorisation procedure

Should you be admitted to hospital and need to be transferred to another hospital (an inter-hospital transfer), please inform the admitting hospital that you are with Netcare 911 and that any transfers must be arranged by contacting **082 911**.

What do you need to do with the Netcare 911 vehicle sticker you receive?

Netcare 911 encourages you to place the vehicle sticker, which you will receive from the Scheme, on one of the side windows of your motor vehicle. This will alert any emergency service on the scene that you use Netcare 911.

Your benefits include:

- **Health-on-Line – emergency telephonic medical advice and information**
  Assistance and advice is just a phone call away through Health-on-Line, which provides emergency and non-emergency telephonic medical advice to you by qualified nursing sisters via the Netcare 911 24-hour emergency operations centre and in accordance with current clinical best practice.
- **Emergency medical response by road or air from scene of medical emergency**
  Netcare 911 offers immediate response by using the most appropriate and closest road or air medical resource, which is staffed by doctors, nurses and paramedics, administering instant, life-saving treatment, resuscitation and stabilisation.

We encourage you to share this information with your family, so that they too will know what to do in an emergency situation.

Contact details

Netcare 911 Head Office
010 209 8911

Emergencies/Health-on-Line
082 911

Website
www.netcare911.co.za

Email
customer.service@netcare.co.za

Managed care programmes

LifeSense Disease Management (HIV Management Programme)

You and your beneficiaries have access to benefits for the treatment and management of HIV/AIDS. These benefits can be accessed by joining LifeSense Disease Management.

We care about your quality of life!
People with HIV are entitled to live normal, productive lives, free from discrimination or misunderstanding. Every person needs to take care of his or her body and health. For people who are HIV positive, this is more important because their immune systems are less able to fight off diseases or minor ailments.

When should I join?
Join us today! By joining the programme, you will benefit even if you are at a stage before you and/or your beneficiaries get ill or require treatment with antiretrovirals. Over the years, we have achieved significant outcomes with members who had the courage to join the programme. We encourage all members and/or beneficiaries who test HIV positive to join the programme as soon as the diagnosis is made. It is important that pregnant females who test HIV positive during their pregnancy, or are already aware of their HIV status when they fall pregnant, inform us as soon as they are diagnosed. Mother-to-child transmission can be prevented.

How do I register?
Please contact our confidential line on **0860 50 60 80** to start the registration process.

Will my condition remain confidential?
This programme is confidential. Please be assured that confidentiality will be respected by all staff managing your condition. Our nursing sisters and your treating healthcare provider form part of a dynamic team. A confidentiality clause ensures that the details of all registered members are treated with the strictest of confidence. Your status will under no circumstances be disclosed to anyone, including your employer.

What benefits do I qualify for?
The benefits are focused on your total wellbeing and not just the virus. The condition may be experienced differently by individuals, as each individual has different needs. On registration, you are allocated a dedicated case manager who will manage your condition.

Benefits for post-exposure treatment
Please contact us on **0860 50 60 80** to get access to recommended treatment with antiretrovirals specific for the prevention of infection by the virus after accidental exposure. It is important to do this within at least two to six hours after exposure to the virus, in order to meet optimal treatment guidelines.

We understand this diagnosis brings with it added social burdens and emotions. Our experienced staff are there to assist you to overcome your fears, and most of all, to assist you to live a positive and healthy life.

Contact details

Telephone
0860 50 60 80

Fax
0860 80 49 60

Email
results@lifesense.co.za

Oncology Risk Management Programme

All members diagnosed with cancer need to register on the programme to access oncology benefits. Your treating oncologist must provide a detailed treatment plan with histology results, outlining all chemotherapy, radiotherapy, radiology, pathology, supporting medication and pre- and anti-nausea medication.

All individual treatment plans for chemotherapy, radiotherapy, pathology and radiology are assessed and authorised according to clinical protocols. Please negotiate with your oncologist to charge you preferred rates. Please contact **0860 00 50 37**.

Renal Management Programme

All patients with impaired renal function need to register on the programme to ensure detailed treatment plans and protocols for renal dialysis and renal transplants are adhered to. A chronic renal application form needs to be completed by the treating specialist and submitted to the Scheme. You are advised to negotiate preferred rates with your healthcare providers. Please contact **0860 00 50 37**.

Maternity Programme

The programme affords pregnant members additional benefits during their pregnancy at no extra cost. The programme is managed by qualified midwives who are available to answer questions relating to the confinement, post-natal care as well as any questions about the newborn baby. Registration on the programme is compulsory during the first trimester of pregnancy. Please contact **0860 00 50 37** during office hours.

Benefits of joining the Maternity Programme:

- free access to all services offered by the programme
- information to enable you to understand the benefits offered by the Scheme during your pregnancy and after the birth of your child
- advice on the number of days of hospital accommodation that will be covered by the Scheme during your confinement and other alternatives you may have
- access to healthcare information that will enable you to participate with your midwife or doctor in making decisions about your health and birth options
- authorisation for your admission to the hospital/birthing facility of your choice
- telephonic advice and support if you encounter problems during the first few weeks of parenthood.

Belly Babies online support

Belly Babies is an online support programme, which provides antenatal and post-natal support to registered members in the comfort of their own home.

By registering on **www.bellybabies.co.za**, you will have access to the following:

- an online antenatal and post-natal course consisting of educational videos from various experts in the field; and
- booking a face-to-face, online consultation with a qualified lactation (breastfeeding) specialist to help you and your baby establish and maintain a happy breastfeeding routine. Access to a follow-up, online consultation is available, if required.

Your available savings may be used to pay for these services.

Medication

Chronic medication

Chronic medication is medication taken continuously for a period of three months or longer for chronic conditions that are usually recognised as life threatening. To ensure that medication is paid from your chronic medication benefit rather than your acute medication benefit or MSA, you must contact the Medicine Risk Management (MRM) department to register your medication on the chronic medication programme. The MRM department is responsible for the management of your chronic medication benefits. An effectively managed chronic condition will result in fewer acute or long-term medical complications or side effects.

The MRM department, which includes registered pharmacists and clinicians, uses set guidelines and protocols to assess each application for chronic medication benefits and ensures that the medication prescribed is appropriate, cost-effective and prescribed in the correct therapeutic dosages. The MRM department's guidelines are maintained in conjunction with medical specialists and local and international treatment protocols.

By following the telephonic process, you can now apply for chronic medication or change your existing chronic medication authorisation. Should you require access to your chronic medication benefit or need to update your existing authorisation, please ask your healthcare provider or pharmacist to contact the Scheme on **0860 00 50 37**, where our team of pharmacists and assistants will process your authorisation online.

The MRM department does not supply the medication – it is their function to authorise the medication as chronic. You must register with the MRM department in order to qualify for benefits. Failure to register will result in benefits being paid from your positive savings account.

Chronic medication can be obtained from our preferred suppliers, namely:

- Schuin-Villa Pharmacy;
- Strubenvale Pharmacy;
- Clicks;
- Dis-Chem; and
- Medipost (courier pharmacy).

Alternatively, please visit **www.pggmeds.co.za (Programmes > Medicine Risk Management)** to find a pharmacy registered on the Scheme's pharmacy network list.

Chronic disease list (CDL)

The CDL includes 26 conditions that the Scheme is required to cover in terms of diagnosis, treatment and medical management. This is done according to the Scheme's algorithms and DSPs.

The CDL list consists of:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic renal disease
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus 1 and 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- HIV/AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis.

Acute medication

Members are advised to shop around to secure the best discount from pharmacies for their acute medication requirements. Reduced costs will enable members to purchase more within their benefit limits.

Please note: Many of the Clicks and Dis-Chem pharmacies offer courier services. Please ask for details at the counter on your next visit.

Generic medication

Generic medication can help you save money. Did you know that it is not necessary for a pharmacist to consult a healthcare provider prior to making a generic substitution? The decision to substitute medication now rests with you, following the advice of your pharmacist.

What is generic medication?
Generic medication is equivalent to the brand-name medication. They contain the same active ingredient, strength and dosage form as the original product. It is, however, important to purchase your medication from a reputable and trustworthy source.

Why is brand-name medication more expensive than generic medication?
Once the brand-name medication has undergone research and development, which is very costly and time consuming, the pharmaceutical manufacturer receives a license or a patent. This patent gives the pharmaceutical manufacturer exclusive rights to market the product to the public for a certain period of time.

When the patent expires, other pharmaceutical manufacturers may produce the same medication under a generic name. The generic medication is less costly because it does not have to undergo the same expensive research and development.

Is generic medication as safe as the original product?
The Medicines Control Council (MCC) of South Africa requires that all medication, whether brand name or generics, meet the standards of safety, strength, purity and effectiveness. For a medication to be marketed under a generic label, the manufacturer must comply with the MCC's standards. The MCC determines the guidelines and requires strict testing to ensure generic medication is the same as the original product.

REMEMBER

The Scheme will only pay for generic medication and does not cover brand-name products if there are generic alternatives available.

The prescribed minimum benefit (PMB) list

The PMB list is a list of medication that is primarily indicated for a PMB CDL condition and some chronic conditions. The medication on the list is carefully chosen to avoid medication that has possible acute indications. You are entitled to one submission of this type of medication (which will normally have been directed to the chronic medication benefit) to be claimed from the acute medication benefit. If you attempt to claim this type of medication from your acute medication benefit for a second time, the claim will be rejected and you will be requested to register this particular medication on the chronic medication benefit (a message will be displayed on the pharmacy's system).

Pre-authorisation for hospitalisation

If you require hospitalisation for procedures and treatment, you need to obtain prior approval by contacting the Scheme on **0860 00 50 37**.

When contacting the Scheme for hospital pre-authorisation, you need to have the following information on hand:

- your membership number;
- the name and practice number of the admitting doctor;
- the date of admission to hospital or healthcare facility;
- the name of hospital or healthcare facility;
- the medical condition;
- the diagnosis;
- the ICD-10/procedure code(s);
- the type of procedure/operation (where applicable); and
- the expected length of stay.

Once the hospitalisation has been approved, you will receive an authorisation number that is valid for 30 days from the date of issue. You are required to provide the authorisation number to your treating healthcare provider and the relevant hospital or clinic.

The authorisation number confirms that benefits are available and guarantees your admission provided that your contributions are paid up to date; however, it is not a guarantee of payment.

Failure to obtain hospital pre-authorisation will result in you being liable for the full cost of hospitalisation and any related expenses.

Emergency admission

In the event of emergency hospitalisation, where you are unable to obtain pre-authorisation, your spouse or a family member must inform the Scheme on **0860 00 50 37** within 48 hours (two days) of admission. This will enable the Scheme to ensure you receive quality care and that the account is processed correctly.

Other treatment that requires pre-authorisation includes (but is not limited to):

- bone densitometry scans;
- cancer treatment;
- dentistry in hospital;
- dialysis;
- emergency services via Netcare 911;
- external appliances;
- mammograms;
- MRI, CT and PET scans;
- organ transplants;
- oxygen supply;
- private nursing and hospice;
- psychiatric hospitalisation;
- rehabilitation;
- stomatherapy; and
- surgical prostheses.

Please refer to the benefit schedule fold out at the back of this guide.

Accidents and injuries
(including motor vehicle accidents)

Accidents and injuries resulting from motor vehicle accidents will be reimbursed at 100% of cost if PMB related, even if you are involved as a third party, e.g. a pedestrian. Members are required to submit claims to the Road Accident Fund. Any amounts recovered for medical expenses already paid by the Scheme, are immediately refundable to the Scheme.

The following documents should be submitted for your claim to be considered:
- an accident injury report;
- a police/accident report; and
- a signed legal undertaking.

Reports on injuries
Even if you suffer a minor injury, you will be required to submit a report/letter from your healthcare provider detailing the cause of the injury. Where the injury is severe, you will be required to complete and submit an accident/injury report before any claims will be considered for payment. Please contact **0860 00 50 37**.

Tips to combat the high costs of healthcare

Remember, this is your Scheme and it is your responsibility to manage it effectively in order to maximise your benefits.

The following suggestions can help reduce costs and minimise high annual contribution increases:
- Please request a copy of your account even if the healthcare provider/pharmacist submits the account to the Scheme directly.
- Check all accounts carefully.
- Ensure that your healthcare provider only prescribes the required amount of medication (not surplus medication).
- Enquire about equivalent substitute medication (generic as opposed to patented medication).
- Prior to undergoing treatment, find out if your healthcare provider will charge Scheme rates.
- When you consult a specialist, please ensure the results of all pathological and radiological tests (including X-rays and blood tests) are provided to the specialist. The Scheme will not pay for duplicated tests.
- Keep a record of all claims submitted.

The correct claims procedure

Please submit your postal claims directly to:

PG Group Medical Scheme, PO Box 2070, Bellville 7535

Alternatively, claims may be deposited into the dedicated on-site collection box or emailed separately to **claims@pggmeds.co.za**. Please include one claim per email to ensure that all claims are received. Zipped files will not be accepted.

Original prescriptions have to be submitted. Submit your claims promptly as all claims expire four months after the end of the month in which the treatment was received. Approved claims will be paid within 30 days of receipt.

Members must ensure that all claims and prescriptions reflect:

- the Scheme's registered name – PG Group Medical Scheme;
- the main member's name and the name of the patient treated (main member or dependant) as registered and indicated on the membership card;
- the correct medical scheme membership/reference number;
- the member's signature and date;
- the doctor's practice number; and
- proof of payment signed by the member and indicated as **'PAID'** (where applicable).

Keep copies of all claims submitted to the Scheme for payment. The onus rests on you to check your claims statements regularly to ensure that payments have been made. It is also your responsibility to provide healthcare providers (doctor, pharmacist, etc.) with the correct name and address details of the Scheme.

Payment of claims – Scheme rate

Claims for services rendered by healthcare providers who charge fees in accordance with the Scheme rate will be paid directly to the healthcare providers. If healthcare providers charge fees in excess of the Scheme rate, the Scheme will reimburse you. It remains your responsibility to settle the healthcare provider's account in full.

If you pay cash for treatment and/or medication, you are required to attach a signed receipt to your claim as proof that payment has been made. The word **'PAID'** should be clearly reflected on the claim to prevent the Scheme from inadvertently paying the healthcare provider instead of you.

Remember the ICD-10 codes

All healthcare providers are required, by law, to indicate ICD-10 codes on their claims and next to each medication item on a prescription. Even if you submit a claim after having paid for the services upfront, a valid applicable ICD-10 code should be indicated on the claim. If items on a prescription are used for the treatment of more than one condition, the correct and applicable ICD-10 code should be indicated next to each medication item and not only once on the prescription.

You should, therefore, confirm with your healthcare provider that he or she has indicated the correct ICD-10 codes on all prescriptions and claims. Check your claims statements regularly to ensure that claims have been paid correctly. A claim where the ICD-10 codes are missing or the incorrect ICD-10 codes have been indicated, will be rejected and a revised claim reflecting the correct ICD-10 codes will have to be submitted for payment.

Rejection codes

An explanation of the transaction codes and any rejections will be reflected on your claims statement.

Scheme exclusions

The following services are excluded from Scheme benefits:

- All costs relating to appointments not kept or cancelled by a member.
- Any other medical costs referred to as exclusions by the Committee.
- Cosmetic procedures, including treatment for obesity.
- Costs related to legal fees arising out of overdue medical accounts.
- Dangerous sport and activities, e.g. speed contest. Subject to PMBs.
- Elective, non-medically justifiable treatment.
- Executive medical examinations.
- Holidays for recuperative purposes.
- Injuries arising out of riots, unrest, etc. Subject to PMBs.
- Injury caused by alcohol or drug abuse. Subject to PMBs.
- Insurance or physical fitness examinations.
- Laser refractive eye surgery.
- Medical costs in excess of defined limits. Subject to PMBs.
- Medical costs that can be recovered from a third party.
- Participation in medical research.
- Patent, proprietary medication and bandages, patent food preparations and domestic/biochemical remedies. Subject to PMBs.
- Sunglasses.
- Tonic and mineral supplements. Subject to PMBs.
- Treatment of infertility and artificial insemination. Subject to PMBs.
- Wilful, self-inflicted injury. Subject to PMBs.

Underwriting

Waiting periods and exclusions are categorised under the broader definition of underwriting and are measures prescribed by law, the Medical Schemes Act, which allow medical schemes to protect their financial wellbeing. All medical schemes may apply certain underwriting policies to new members. It is not regarded as fair practice to allow new members to join a medical scheme, not having contributed to the reserves of the medical scheme, to be able to claim and have these claims met by the reserves that existing members have built up over a period of time. The policies also prevent what is known as 'medical scheme hopping', whereby members who have exhausted their funds in one medical scheme, resign and join another medical scheme to be able to claim further.

The rules state that anyone who joins a medical scheme, other than as a result of changing employment, will not be able to claim from the medical scheme for the first three months (a general waiting period). In addition, the medical scheme will not pay any claim that arises in the first 12 months for any condition that existed prior to the member joining (a condition-specific waiting period/exclusion).

A penalty is also applied to any person over the age of 35 years who joins a medical scheme for the first time (having not previously belonged to any medical scheme or having had limited cover on a medical scheme after the age of 35 years). This is referred to as a late-joiner penalty (LJP). In this case, a percentage penalty will be charged on top of your monthly contribution. This can be as high as 75% and will remain in force for the duration of your membership. Should you join another medical scheme, the penalty will continue to apply.

We do not apply underwriting to new employees, provided that they join the Scheme within the first month of commencing employment with the PG Group. This will also apply to their dependants. Should you marry or have a baby after joining, you need to register your dependant within 30 days of the event, otherwise underwriting will be applied to your new dependant.

It is important that you obtain proof of membership of all previous medical schemes in order to reduce the LJP, failing which, the LJP will be charged until you are able to supply the required proof of previous medical scheme cover. Please note that any LJP applied will not be refunded, even if proof is obtained at a later stage.

Medical savings account (MSA)

A fixed amount is allocated to your MSA for the 12 months in the year. The total allocation for the year is made available at the beginning of the year if you are registered from 1 January. Should you join during the course of a year, the amount in your MSA will be prorated according to the number of months during that year that you are a member of the Scheme.

If you have funds available in your MSA at the end of the year, this amount will be carried over and added to your savings balance for the following year. Being careful with your MSA funds will enable you to build up a considerable savings account over time. If you resign from the Scheme during the course of the year, any money remaining in your MSA will only be paid out after four months. This time lapse ensures that all your claims will be paid. If you join another medical scheme that has a savings account option, your remaining funds will be transferred to your new medical scheme.

Should you resign from the Scheme during the year and have already spent your entire MSA amount for the year, you will be required to repay the difference between the total amount spent and the benefit entitlement due to the Scheme on your date of termination. Your savings account is administered by the Scheme; however, you have full control over how you spend the funds in your MSA.

The MSA can be used to cover:
- acute and over-the-counter (OTC) medication;
- audiology;
- chiropody and podiatry;
- chiropractors;
- clinical psychology;
- dentistry co-payments;
- dieticians;
- optometry co-payments;
- general practitioner (GP) and some specialist consultations (visit in rooms and at emergency facilities);
- homeopaths and naturopaths (including medication);
- out-of-hospital care;
- physiotherapy (out of hospital);
- social and other auxiliary services; and
- speech and occupational therapy.

What about claims deducted from your MSA?
Should your healthcare provider charge Scheme rates, the Scheme will pay him or her directly – unless you have paid the account upfront and have included a receipt with your account. If your healthcare provider charges private rates (more than the Scheme rate), you need to settle the account directly with the healthcare provider, whereupon the Scheme will reimburse you with the appropriate benefit at the Scheme rate. The MSA cannot be used to pay for PMBs, including co-payments relating to PMBs.

Important notes on the MSA
You contribute a portion of your monthly contribution to the MSA. You have an overdraft facility to the value of your total annual savings allocation for the year, available from 1 January.

If your employment is terminated during the year, you will be liable to repay any amount that you have overspent. Similarly, if you resign from the Scheme during the year and have used your full year's savings allocation (which you have not yet contributed to), you will need to pay the Scheme the portion of contribution that is still outstanding.

Any remaining savings balances at the end of the year will be carried over to cover benefits in subsequent years. The Medical Schemes Act does not allow the Scheme to reimburse any cash payments of these balances to you, unless you resign from the Scheme.

Should you join another medical scheme with a savings option, you are required to transfer any money you have accumulated to your new medical scheme.

With effect from 1 January 2018, the Scheme no longer pays interest on positive savings balances.

NOTE

Payment for acute medication will automatically be paid from your available positive savings account.

Pro-rata apportionment of benefits
If you join the Scheme as a new member during the year, i.e. after the month of January, your benefits and limits are calculated pro rata on a monthly basis from your joining date until 31 December. Your membership card will indicate your starting date. You will be liable for contributions up to the month of termination.

Optical benefits

Preferred Provider Negotiators (PPN), South Africa's largest optometric network, provides members with enhanced optometry benefits on behalf of the Scheme. PPN has agreements with more than 2 300 optometrists throughout South Africa. To view a list of all optometrists who form part of PPN or for more information about your optical benefits, please visit www.ppn.co.za or contact 0861 10 35 29. By using a PPN provider, you and your beneficiaries are entitled to a composite consultation and either a frame and/or lens enhancements or **R1 350** towards an alternative frame and/or lens enhancements and a pair of clear single vision, bifocal or multifocal lenses, or contact lenses. Prescriptions less than 0.50 dioptre will not be covered.

Once you or your beneficiaries have claimed for any of the products below, you may only do so again after 24 months.

In and out of network	
Frame and/or lens enhancements	**R1 350** for frames and/or lens enhancements per beneficiary at a PPN provider and **R979** per beneficiary at a non-PPN provider every two years
One pair of clear Aquity single vision lenses; **or**	**R210** per lens
One pair of clear Aquity bifocal lenses; **or**	**R445** per lens
One pair of multifocal lenses	**R770** per lens
OR	
Contact lenses	**R1 935**
Contact lens re-examination (subject to the Scheme rules and can only be claimed in six-monthly intervals)	**R255** x three

In addition to the above benefits, beneficiaries have access to the following:

Network benefits

- One composite consultation, inclusive of refraction, tonometry and visual field screening, and either spectacles or contact lenses. These claims will be paid at 100% of the prescribed benefit limits.
- Ready-made readers: two pairs (in a two-year cycle) – **R150** per pair in leiu of spectacle lenses.

Out-of-network benefits

- One consultation paid at **R350** and either spectacles or contact lenses.

By asking your optometrist the following questions, you can ensure that you optimise your optical benefit and reduce the risk of co-payments:

1. Are you part of the PPN network?
2. Could you please tell me more about the Aquity range of lenses?
3. Can I see the PPN range of frames available?

Please submit all optical claims to:

Post
Preferred Provider Negotiators
PO Box 12450
Centrahil
6006

Fax
041 586 4184

Email
claims@ppn.co.za

PLEASE NOTE

Shortfalls can still be paid from your available positive savings account. These requests need to be forwarded directly to PPN.

DENIS dental management

Dental Information Systems (DENIS), Africa's leading dental funder, manages your dental benefits on behalf of the Scheme. There is a pre-defined benefit per procedure, which is paid at the published PG Group Dental Tariff (PDT). Visit **www.denis.co.za** for a list of the dental tariffs. Your dental practitioner will also be able to provide information about your benefits, as DENIS supplies all practitioners with a chair side and benefit guide, which illustrates the benefits for 2021.

Maxillofacial and oral surgery
These relevant health services (unless otherwise limited or excluded) are regarded as specialist medical services and will only apply in respect of oncology cases. Claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms the diagnosis.

Dentistry
All claims will be paid at the PDT, published and distributed by DENIS annually.

Conservative dentistry
- Consultations, oral hygiene, X-rays, fillings or extractions: Covered at the PDT; two annual check-ups per beneficiary (once every six months); a motivation or treatment plan may be requested for extensive restorative fillings.
- Root canals: Covered at the PDT.
- Plastic dentures: One set of plastic dentures (an upper and lower) per beneficiary in a four-year period – subject to pre-authorisation.

Specialised dentistry
- Crowns and bridges: Covered at the PDT; three crowns per family per year; benefit is granted once per tooth in a five-year period – subject to pre-authorisation.
- Partial chrome cobalt frame dentures: Two partial frames per beneficiary in a five-year period – subject to pre-authorisation.
- Orthodontics (fixed braces): **R14 952** per beneficiary per lifetime will apply to each case assessed as severe according to the orthodontic index; limited to individuals from age nine and younger than 18 years of age – subject to pre-authorisation.
- Implants: Two implants per beneficiary in a five-year period; cost of implant components limited to **R2 604** per implant – subject to pre-authorisation.
- Surgery in dental rooms: Covered at the PDT.

Hospitalisation and anaesthesia
- General anaesthesia in hospital: Subject to pre-authorisation – admission protocols apply.
- Inhalation sedation in dental rooms: Covered at the PDT.
- Moderate/Deep sedation in dental rooms: Subject to pre-authorisation.

Please refer to the general benefit exclusion summary in the dental benefit information booklet.

Please submit all dental claims to:

Post
DENIS Claims Department
Private Bag X1
Century City
7446

Fax
0866 77 03 36

Email
claims@denis.co.za

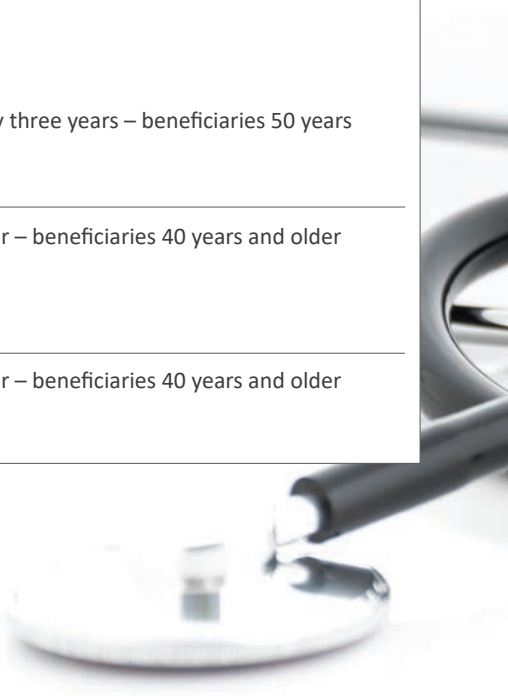
PLEASE NOTE

Shortfalls will automatically be paid from your available positive savings account.

denis

Wellness benefits

Benefit	ICD-10 code	2021 limits
Immunisation programmes		
Baby immunisation programme	-	As required by the Department of Health – covered for the first six years of a child's life
Flu vaccinations	Z25.1	Once a year – all beneficiaries
Tetanus diphtheria booster	Z23.5	As needed – all beneficiaries
Pneumococcal vaccinations	Z23.8	As needed – beneficiaries 60 years and older and high-risk beneficiaries
Early detection programmes		
General physical examination (GP) Tariff codes 190 - 192 Tariff code 4188 – Urine dipstick test	Z0.00	One medical examination every five years – adults 21 to 29 years old One medical examination every three years – adults 30 to 59 years old One medical examination every two years – adults 60 to 69 years old One medical examination every year – adults 70 years and older
Cholesterol test (Pathologist) Tariff codes 4025, 4026 and 4147	Z13.6	Once a year – all adult beneficiaries
Pap smear consultation (GP/Gynaecologist) Tariff codes 190 - 192 Pap smear Tariff code 4566	Z01.4 Z01.4	Once a year – females 15 years and older Covered by the Administrator
DEXA scan/Bone density (Radiologist) Tariff code 50120 OR Dexa scan/Bone density (GP/Gynaecologist) Tariff code 3604	Z01.6 Z01.6	Once every three years – beneficiaries 50 years and older Once every three years – beneficiaries 50 years and older
Immunological faecal occult blood test (Pathologist) Tariff code 4352	-	Once a year – beneficiaries 40 years and older
Colorectal screening test (Pathologist) Tariff code 4352	-	Once a year – beneficiaries 40 years and older



Benefit	ICD-10 code	2021 limits
Maternity Programme (subject to compulsory registration on the Maternity Programme*)		
Antenatal visits (GP/Gynaecologist) Tariff codes 190 - 192 OR Antenatal visits (Midwives) Tariff code 88420	- -	12 visits* 12 visits*
Urine test (GP/Gynaecologist) Tariff code 4188	-	Included in the 12 antenatal vists*
Scans – one before the 24th week and one after the 24th week (Radiologist) Tariff codes 43250, 43260, 43270, 43273 and 43277 OR Scans – one before the 24th week and one after the 24th week (GP/Gynaecologist) Tariff codes 5106, 5107, 5108, 3615 and 3617	- -	Two scans* Two scans*
Paediatrician visits Tariff codes 190 - 192	-	Two visits in the baby's first year* – babies up to 12 months registered on the programme

Additional tests covered at no cost to you

Test	Tariff code(s)	Limited to
Cholesterol screening (Pathologist)	4027	One every two years – adult beneficiaries
Mammogram (Radiologist)	34100 34101	One every two years – females 40 years and older Once a year – females with risk factors where clinically indicated family history exists
Mammogram (GP/Gynaecologist)	3605	One every two years – females 40 years and older Once a year – females with risk factors
Glaucoma screening	3014	One screening every two years – adults 40 years and older
Prostate screening	4519	One screening every year – males 50 years and older
HIV test (Pathologist)	3932	Once a year – beneficiaries 15 years and older

2021 contributions

The contribution amounts for 2020 will apply for the first three months of 2021, i.e. 1 January to 31 March 2021; thereafter, new contribution amounts will charged from 1 April until 31 December 2021. Please note that the gross income bands will also be adjusted from 1 April 2021.

Total consolidated contribution table

1 January 2021 until 31 March 2021

Gross income	Principal member	Adult dependant	Child dependant
R0 - R4 600	R2 190	R2 190	R580
R4 601 - R8 000	R2 770	R2 770	R740
R8 001 - R11 100	R3 070	R3 070	R770
R11 101 - R15 100	R3 320	R3 320	R830
R15 101 - R19 000	R3 520	R3 520	R850
R19 001 +	R3 660	R3 660	R880

Increased contribution amounts from 1 April to 31 December 2021 with adjusted gross income bands

Gross income	Principal member	Adult dependant	Child dependant
R0 - R4 800	R2 260	R2 260	R600
R4 801 - R8 400	R2 850	R2 850	R760
R8 401 - R11 700	R3 160	R3 160	R790
R11 701 - R15 900	R3 420	R3 420	R850
R15 901 - R20 000	R3 630	R3 630	R880
R20 001 +	R3 770	R3 770	R910

Monthly member medical savings account contribution table

1 January 2021 until 31 March 2021

Gross income	Principal member	Adult dependant	Child dependant
R0 - R4 600	R444	R444	R118
R4 601 - R8 000	R561	R561	R150
R8 001 - R11 100	R622	R622	R156
R11 101 - R15 100	R673	R673	R168
R15 101 - R19 000	R713	R713	R172
R19 001 +	R742	R742	R178

Increased contribution amounts from 1 April to 31 December 2021 with adjusted gross income bands

Gross income	Principal member	Adult dependant	Child dependant
R0 - R4 800	R457	R457	R121
R4 801 - R8 400	R576	R576	R154
R8 401 - R11 700	R638	R638	R160
R11 701 - R15 900	R691	R691	R172
R15 901 - R20 000	R733	R733	R178
R20 001 +	R762	R762	R184

PG GROUP MEDICAL SCHEME

This member guide is for information purposes only and does not supersede the rules of the Scheme. In the event of any discrepancy between the rules and the summary, the rules shall prevail.

A copy of the rules can be obtained from the Scheme. The Board of Trustees has the right to change the rules of the Scheme to comply with statutory requirements and the sound management of the Scheme, as it may deem necessary.

2021 Benefits

See fold out

2021 Benefits

OVERALL ANNUAL LIMIT (OAL):
R400 000 per beneficiary

In-hospital treatment	Limits	Paid from	Pre-authorisation
PRE-AUTHORISATION REQUIRED FOR ALL IN-HOSPITAL TREATMENT Emergencies must be authorised within 48 hours following admission to hospital. Failure to obtain pre-authorisation will result in you being liable for the full cost of hospitalisation and related expenses. Benefits will be provided in accordance with the Scheme rules, benefits, clinical protocols and limits.			
HOSPITALISATION Including ward and theatre fees, ICU and high care wards, medication, material, equipment, blood transfusions and transfer of blood. Excluding: Cost of dental implants, accommodation in a private ward, refractive surgery, psychiatric treatment, organ transplants (see organ transplants benefit) and to-take-out (TTO) medication (see acute medication benefit).	100% of Scheme rate	Common benefits Subject to OAL	**Yes**
ACCIDENTS AND INJURIES, INCLUDING MOTOR VEHICLE ACCIDENTS (MVAs) Including injuries relating to third-party cases. Subject to accident/injury report and legal undertaking – to be completed and submitted by you.	100% of Scheme rate	Common benefits Subject to OAL	**Yes**
MATERNITY BENEFITS (CONFINEMENTS IN HOSPITAL) Normal deliveries and caesarean sections in private and State hospitals (includes complications for mother and child).	100% of Scheme rate	Common benefits Subject to OAL	**Yes**
MATERNITY BENEFITS (HOME DELIVERIES BY A REGISTERED NURSE/MIDWIFE AND ANTENATAL VISITS) Benefit includes all costs relating to hospitalisation.	100% of cost	Common benefits Subject to OAL	**Yes**
MEDICAL PRACTITIONERS – IN-HOSPITAL TREATMENT (CONSULTATIONS AND SERVICES IN HOSPITAL) Treatment and consultations in hospital by specialist and general practitioners (GPs), technicians and physiotherapy. Excluding costs for maxillofacial and oral surgery, except for oncology cases.	100% of Scheme rate	Common benefits Subject to OAL	**Yes**
AMBULANCE SERVICES (EMERGENCY SERVICES) Road ambulances, emergency services, general advice line, air evacuation and transportation. Contact Netcare 911 on 082 911. Pre-authorisation required.	100% of Scheme rate	**R3 060** per family if Netcare 911 is not used	**Yes**
INTERNAL PROSTHESES AND APPLIANCES Including pacemakers, electronic devices, coronary stents and joint replacements.	100% of agreed cost	**R49 500** per family per year Subject to OAL	**Yes**

In-hospital treatment	Limits	Paid from	Pre-authorisation
RENAL DISORDERS (KIDNEY AND HOME DIALYSIS) Including related medication therapy (through approved healthcare providers only). All cases subject to full investigation, registration on the renal programme and pre-authorisation.	100% of cost	**R218 300** per family Subject to OAL	**Yes**
ORGAN TRANSPLANTS – SUBJECT TO PRESCRIBED MINIMUM BENEFITS (PMBs) Including organ harvesting and immunosuppressive medication therapy. Subject to transplant motivation, PMBs and pre-authorisation.	100% of cost	Subject to pre-authorisation	**Yes**
PSYCHIATRY IN AND OUT OF HOSPITAL INCLUDING PSYCHOLOGICAL CONDITIONS Hospitalisation conditions include anorexia nervosa, bulimia, alcoholism, treatment for alcohol and chemical substance abuse, and all related accounts at approved facilities.	100% of cost	**R46 200** per family per annum – 21 days per beneficiary Subject to pre-authorisation	**Yes**
Out-of-hospital treatment received in rooms	**Limits**	**Paid from**	**Pre-authorisation**
CONSULTATIVE SERVICES (SPECIALIST TREATMENT) Specialist conditions and treatment out of hospital by anaesthetists, physicians, neurosurgeons, surgeons, orthopaedic specialists, otorhinolaryngologists (ENT), radiotherapists, thoracic surgeons, urologists and cardiologists and nursing practitioners.	100% of Scheme rate	M: **R3 910** M+1: **R6 390** M+2: **R7 830** M+3: **R8 410** Subject to OAL	–
GENERAL PRACTITIONERS AND CERTAIN SPECIALISTS Outpatients, out-of-hospital consultations, treatment in rooms and procedures in doctors' rooms. Includes dermatologists, gynaecologists, ophthalmologists, paediatricians, neurologists, plastic surgeons and physical medication (including needles, syringes and sterile trays).	100% of Scheme rate	Subject to available MSA	–
DIAGNOSTIC RADIOLOGY AND PATHOLOGY Including materials. Referring healthcare provider's practice number must appear on all claims. Pre-authorisation required for MRI, bone densitometry, mammograms and CT scans. Out-of-hospital radiology and pathology benefits are covered at 80% of the Scheme tariff, with 20% paid from MSA subject to PMB requirements.	100% of Scheme rate	M: **R15 300** M+1: **R25 300** M+2: **R28 600** M+3: **R35 800** Subject to OAL	**Yes**
ONCOLOGY Chemotherapy, radiotherapy, intravenous medication and materials. This benefit is subject to the approval of a comprehensive treatment plan that must be submitted to the pre-authorisation department via info@pggmeds.co.za or via post to PO Box 2070, Bellville 7535.	100% of cost	Subject to pre-authorisation	**Yes**

Out-of-hospital treatment received in rooms	Limits	Paid from	Pre-authorisation
PRESCRIBED CHRONIC MEDICATION Medication prescribed or dispensed to patients registered on the Scheme's chronic medication programme. Limits applicable to non-PMB chronic medication. Unlimited cover for CDL/PMB chronic medication.	100% of SEP and dispensing fee	M: **R22 800** M+1: **R38 000** M+2: **R45 600** M+3: **R53 300** per family per year	**Yes**
HIV/AIDS Antiretroviral treatment (ART).	100% of cost	Unlimited Subject to pre-authorisation	**Yes**
ACUTE MEDICATION All medication including TTO's (maximum seven days' supply) other than those obtained by members through the Medicine Risk Management programme. Pharmacy-advised therapy medication prescribed and dispensed by pharmacists limited to **R263** per prescription. Clinically and pharmacy-dispensed vaccinations.	100% of SEP and dispensing fee	Subject to available MSA	–
PHYSIOTHERAPY/BIOKINETICS	100% of Scheme rate	Subject to available MSA	**Yes**
EXTERNAL APPLIANCES Includes nebulisers, wheelchairs, stoma products and home oxygen. Pre-authorisation required.	100% of cost	**R6 520** per family per year	**Yes**
HEARING AIDS Pre-authorisation required.	100% of cost	**R14 850** per ear per beneficiary every four years	**Yes**
Community care	**Limits**	**Paid from**	**Pre-authorisation**
PRIVATE NURSING AND HOSPICES – IN-PATIENT SERVICES AT AN APPROVED FACILITY In lieu of hospitalisation only. Nursing services and sub-acute facilities. Subject to submission of healthcare provider's comprehensive treatment plan and Scheme approval. Frail care services are not included.	100% of cost	Subject to OAL	**Yes**
REHABILITATION (PHYSICAL REHABILITATION) Subject to submission and approval of a treatment plan.	100% of Scheme rate	27 days per family per year (except for PMBs) Subject to OAL	**Yes**

Community care	Limits	Paid from	Pre-authorisation
REHABILITATION (PSYCHIATRIC/SUBSTANCE ABUSE) To treat abuse or dependence on psychoactive substances including alcohol.	100% of Scheme rate	Benefit of 21 days per beneficiary per year in a SANCA-approved facility Subject to OAL	**Yes**
BLOOD TRANSFUSION AND TECHNOLOGISTS Bags, pouches and flanges.	100% of Scheme rate	Common benefits Subject to OAL	**Yes**
ALTERNATIVE MEDICAL SERVICES Homeopaths and chiropractors, chiropodists, naturopaths and osteopaths. Including all services.	100% of Scheme rate	Subject to available MSA	–
OTHER MEDICAL SERVICES Speech therapy, audiology, occupational therapy, podiatry, dieticians, social workers, educational and remedial counselling, marriage counselling and orthoptists.	100% of Scheme rate	Subject to available MSA	–

All individual benefit limits are subject to the OAL.

ABBREVIATIONS:

CDL | Chronic disease list
MSA | Medical savings account
OAL | Overall annual limit
PMBs | Prescribed minimum benefits
SANCA | South African National Council on Alcoholism
SEP | Single exit price

Contact details

Scheme contact details

Claims and administration
Postal address for claims and correspondence:
PG Group Medical Scheme
PO Box 2070
Bellville
7535

Physical address
Parc du Cap
7 Mispel Road
Bellville
7530

Customer care
Tel: 0860 00 50 37
Fax: 0861 64 77 75
Email: info@pggmeds.co.za

Members can dial 0860 00 50 37 for any Scheme queries
Monday - Friday: 08:00 to 16:30

The following options are available:
Option 1: PPN
Option 2: DENIS
Option 3: Pre-authorisation (medical)
Option 4: All other queries

Membership department
Fax: 0861 22 26 64
Email: membership@pggmeds.co.za

Claims email address
claims@pggmeds.co.za

Scheme website address
www.pggmeds.co.za

Managed care programmes
Oncology, renal and maternity programmes
Tel: 0860 00 50 37

Hospitalisation and pre-authorisation
Tel: 0860 00 50 37

Chronic medication registration and queries
Medicine Risk Management (MRM)
Tel: 0860 00 50 37
Fax: 031 580 0597
Email: chronic@pggmeds.co.za

Scheme's fraud hotline
0800 000 436

Contact details (continued)

Third party service providers

LifeSense Disease Management (Pty) Ltd/HIV Programme
(for the treatment and management of HIV/AIDS)
Tel: 0860 50 60 80
Fax: 0860 80 49 60
Email: results@lifesense.co.za

Netcare 911
(emergency assistance and ambulance)
Tel: 082 911

Multiply Lifestyle Programme
Tel: 0861 10 07 89
Website: www.multiply.co.za

Preferred Provider Negotiators (PPN)
Tel: 0861 10 14 77
Email: info@ppn.co.za

DENIS Dental Management
Tel: 0860 10 49 39
Email: claims@denis.co.za

Preferred suppliers of chronic medication

Schuin-Villa Pharmacy
Tel: 041 364 3566
PO Box 7824
Port Elizabeth
6055

Strubenvale Pharmacy
Tel: 011 362 5989/011 362 5597
PO Box 10440
Strubenvale
1570

Clicks/Dis-Chem Pharmacy
Please visit or contact your nearest branch to make enquiries

Medipost Pharmacy (Courier pharmacy)
Tel: 012 426 4017/012 426 4007
PO Box 40101
Arcadia
0007

Please visit **www.pggmeds.co.za (Programmes > Medicine Risk Management)** to find a pharmacy registered on the Scheme's pharmacy network list

www.pggmeds.co.za